PARALLEL SESSION 3.5

UNIVERSAL HEALTH COVERAGE:
POLITICAL COMMITMENT AND FINANCING
FOR COMPLEX PUBLIC HEALTH NEEDS
IN THE NEXT TWO DECADES
KEY MESSAGES

- State budget transfers to health insurance type schemes are one way to finance coverage extension to vulnerable and poor people. This enables these population groups to have an entitlement to an explicit benefit package on the basis of a partial contribution only or without paying any contribution by themselves.
- Evidence shows that these subsidization transfers helped to increase enrolment and population coverage of poor and vulnerable population groups.
- Effective UHC extension is contingent upon the careful design and effective implementation of critical institutional design features, which include the targeting mechanism for high targeting effectiveness, a high degree of subsidization, integrated pooling of the subsidized and contributors, harmonized benefit package and reduced co-payment rates for the subsidized.
- Core policy questions are: How to improve coverage of informal sector workers and their families? How to merge separate schemes to create an integrated system with no-opt out options for the better off?

BACKGROUND AND PURPOSE OF THE PAPER

Universal, fully budget funded, population-based health care system (“National Health Service”-type) have not successfully materialized in many low- and middle-income countries (LMIC), as funding shortages often translated into non-availability of care, while high out-of-pocket (OOP) expenditure and user fees led to financial barriers. Likewise, “traditional” contributory social health insurance (SHI) for formal sector employees has proven challenging for moving towards universal health coverage (UHC), because the informal worker population and the poor remain excluded.

There are various ways to extend UHC extension. Non-contributory approaches include user fee exemption for specific groups and free health care policies for selected health services and/or selected population groups. A common feature of these approaches is that they are usually not based on affiliation and enrolment of entitled individuals. An alternative approach is to fully or partially subsidize health insurance type contributions for economically and medically vulnerable population groups from general government revenues. This approach, being a mix of contributory and non-contributory, typically requires affiliation and enrolment of beneficiaries identified as eligible. The aim is to enhance equity in coverage extension, financing and access to care, by putting the poor, vulnerable or otherwise uninsured people at the centre.
This paper focuses on such state budget subsidization arrangements, with the objective to provide a global overview of this health financing option in LMICs. The purpose is to reveal those critical institutional design aspects that are conducive to progress towards UHC. This could offer lessons to other LMICs, which explore the introduction of subsidization schemes.

As a starting point, based on a literature review, an assessment of LMICs with state budget subsidization arrangements was undertaken for each WHO region (European, African, Eastern-Mediterranean, South East Asia & Western Pacific region and Pan-American region) to capture the growing body of country evidence with a regional perspective. This global overview paper (Mathauer et al. 2015) is a synthesis of these regional studies.

Country experiences are assessed along the following institutional design features: enrolment and eligibility rules, targeting mechanism, pooling arrangements, financing arrangements, purchasing mechanisms and benefit package design. For this matter, UHC progress is captured as increased total population coverage and coverage of the subsidized, improved financial risk protection (lower OOP burden of the subsidized, lower incidence of catastrophic and impoverishing expenditure), and improvements in utilization as a proxy for access to health services.

CONCEPTUAL UNDERPINNINGS

While such subsidization schemes often show a number of health insurance characteristics, general government revenues are an equally important source of funding. The resulting hybrid financing overcomes the dichotomous thinking of a “Bismarckian” versus “Beveridge” system. From a Health Accounts perspective, such schemes may fall in the category of a government program or a SHI, ultimately depending on how explicit subsidization of contributions on behalf of the subsidized is. As Figure 1 depicts, subsidization implies delinking or weakening the link between contributions and entitlements, in that subsidies may cover the full or a part of the contribution. Many of such schemes have a separate third-party payer as a purchasing agency, although this is not a defining feature. Table 1 below outlines the policy choices related to the institutional design of such schemes.

Figure 1: Weakening the link between contributions and entitlement
State budget subsidization of health insurance type schemes contribute to improving coverage along the three UHC dimensions. They increase population coverage by enrolling population groups that previously had insufficient financial risk protection, and often focus in particular on those most in need, i.e. the economically and medically vulnerable. The package of services covered is made explicit and thus usually larger than what these population groups could access prior to being enrolled in such schemes, hence expanding service coverage. Cost coverage and financial risk protection may improve, in particular if eligible groups no longer face the full cost-sharing rates.

Table 1: Key institutional design features and related policy choices of subsidization schemes

<table>
<thead>
<tr>
<th>Function</th>
<th>Institutional design aspects</th>
<th>Policy choices</th>
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<tbody>
<tr>
<td>Revenue collection</td>
<td>Eligible groups</td>
<td>Large variety in eligibility definitions</td>
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<td></td>
<td>Targeting rules for the subsidized</td>
<td>Direct targeting is based on a threshold income or poverty lines; indirect targeting focuses primarily on socio-demographic, socio-economic and geographic characteristics; a universalistic approach considers everybody outside a formal sector scheme as eligible</td>
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<td></td>
<td>Source of funding for subsidies</td>
<td>Central budget revenues, sometimes earmarked; social security funds for specific population groups [e.g. the unemployed]; also local government budgets and charity funds</td>
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<td></td>
<td>Degree of subsidization</td>
<td>Full subsidization or partial subsidization (semi-contributory)</td>
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<td></td>
<td>Calculation of state budget subsidies</td>
<td>Calculated on a per capita basis using average contribution rates, average wage or minimum wage as a reference point; based on a share of the government budget, or negotiated</td>
</tr>
<tr>
<td>Pooling</td>
<td>Nature of pool</td>
<td>The pool of the subsidized can be integrated with the pool for formal sector employees, or remain separate with no potential for cross-subsidization</td>
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<tr>
<td></td>
<td>Type of membership</td>
<td>Voluntary or mandatory</td>
</tr>
<tr>
<td>Purchasing</td>
<td>Purchasing arrangement</td>
<td>Separate purchasing agency, with explicit purchaser-provider split, or MOH as purchaser and provider</td>
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<tr>
<td></td>
<td>Provider payment</td>
<td>In separate schemes: same or different provider payment mechanisms</td>
</tr>
<tr>
<td>Benefit package</td>
<td>Scope of services covered</td>
<td>Clearly defined (positive list or negative list); range from being more limited (outpatient care or only inpatient care) to more comprehensive packages, including drugs</td>
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Source: Mathauer (2014)
PARALLEL SESSION 3.5

GLOBAL EVIDENCE

Trends and patterns in institutional design

The global synthesis paper (Mathauer et al. 2015) shows that by 2014, over 40 LMICs across the globe have introduced state subsidization of poor and vulnerable groups (four of which moved into the group of high-income countries since 2012). Despite many commonalities, there is also considerable variation in institutional design and performance. Moreover, an increasing number of countries is exploring and preparing the introduction of such schemes.

Meanwhile, 25 LMICs operate an integrated scheme, i.e. a single pool that allows for cross-subsidization from within. LMICs in the WHO European region avoided fragmentation by establishing right from its start a health insurance type scheme that pools both contributors and the subsidized as a way to maximize risk pooling and redistributive capacity. More and more countries explore how to merge their different schemes into one. It is found that integrated schemes usually offer the same benefit package to both the contributors and the subsidized, sometimes even a larger one to the latter. In about 15 countries, the subsidized are enrolled in separate schemes resulting in a multiple pool setup. Most of the separate schemes provide a smaller benefit package than that for formal sector employees, with some few exceptions only.

Effects on population coverage, access to health services and financial risk protection

Subsidization schemes helped to strongly increase enrolment and population coverage in a relatively equitable way as they focus on poor and vulnerable population groups. Population coverage rates turn out to be highest in countries with a "universalistic" targeting approach, but only a few countries have a universalistic approach in place. Coverage rates are somewhat lower when indirect targeting is applied, and again lower with direct targeting. Most countries in fact apply a mix of direct and indirect targeting.

Full subsidization via general government revenues has allowed to cover a substantial share of the population and a range of different vulnerable and otherwise uninsured population groups outside the formal sector. In contrast, partial subsidization has in general not succeeded as much in increasing enrolment rates, although China and Rwanda did so due to a combination of institutional design features and their particular context. Challenges remain: Inclusion and exclusion errors relating to the targeting process are still significant in a number of countries and result in leakage and under-coverage, thus resulting in inequitable population coverage.

Few subsidization programs have undergone a systematic and comprehensive evaluation, but evidence, while scarce for several countries, suggests that in their majority, financial risk protection and access to services improved for the subsidized. In several countries, co-payment rates are differentiated and thus lower for the subsidized as a way to reduce the burden of OOP expenditure. Nonetheless, lower income quintiles frequently continue facing a heavier burden of OOPs.

In separate schemes with smaller benefit packages for the subsidized, inequities in access and financial protection continue to prevail. But even in integrated schemes, differences in utilization remain and may not be easily removed completely (Mathauer et al. 2015).

CONCLUSION AND POLICY RECOMMENDATIONS

In conclusion, among the financing options for UHC extension, state budget subsidization of health insurance type schemes can be an effective mechanism to move towards UHC and cover poor and vulnerable people or otherwise uninsured population groups. But state budget subsidization is no magic bullet and only contributes to UHC progress, if critical institutional design features are well designed and effectively implemented. This includes the targeting mechanism for high targeting effectiveness, a high degree of subsidization, harmonized benefit package and reduced co-payment rates for the subsidized. It also requires explicit funding for the provision of an explicit benefit package. The most important institutional design feature for enhancing equity is the integration of the subsidized in the same pool as the contributors, which facilitates the provision of a uniform benefit package and more equal access to health services.
However, challenges remain: Coverage of the poor and vulnerable population groups needs to deepen through improved institutional design. And a comprehensive benefit package on paper is not enough as long as supply side constraints and gaps in health service quality prevail. The core policy question is how to improve coverage of informal sector workers and their families. The other key policy issue relates to countries with separated schemes and how these can eventually merge to create an integrated system with no-opting out for the better off. In the short and medium term, the aim should be to harmonize different benefit packages.

Regional studies: http://www.who.int/health_financing/documents/other_mechanisms/en/

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