



Session 3: Health Financing Function 2 **Risk pooling**

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**Jakarta
February 3, 2016**



In this session

- ▶▶ What is risk pooling?
- ▶▶ What are the main risk pooling mechanisms?
- ▶▶ Why risk pooling matters for UHC



The health financing functions

- ▶▶ Resource mobilization
- ▶▶ Pooling of resources/risks
- ▶▶ Purchasing of services



The health financing functions

▶▶ Resource mobilization

▶▶ Pooling of resources/risks

- ❖ How can we make household spending on health care more predictable?
- ❖ How can we protect households from having to pay the full cost of care out-of-pocket in the event of illness?



Risk pooling is about **solidarity**

through **cross-subsidization**

- ▶▶ Between low-risk and high-risk individuals (risk subsidy)
- ▶▶ Between rich and poor (equity subsidy)

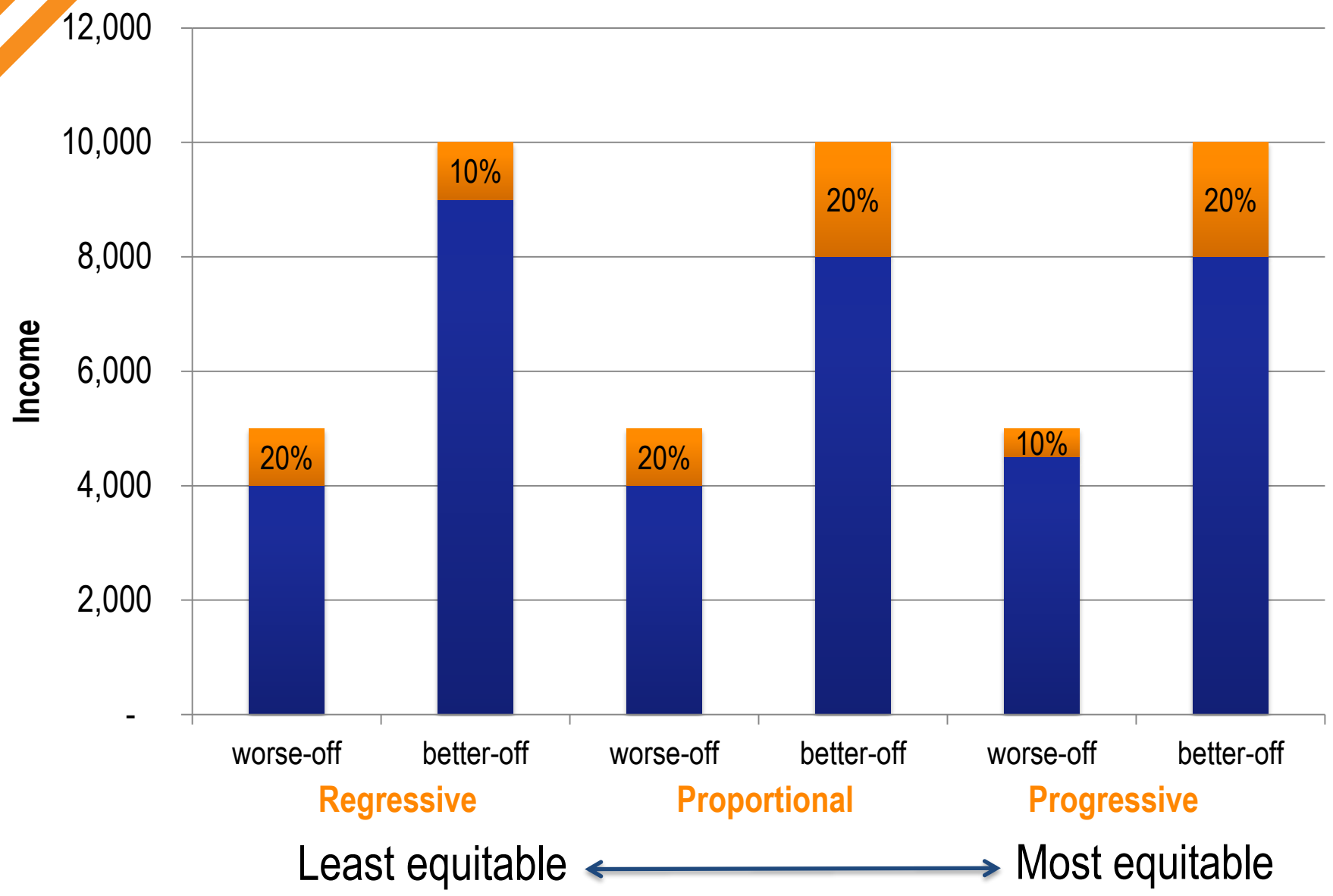
→ **increased financial protection** for all pool members



Cross-subsidization between rich and poor (equity subsidy)

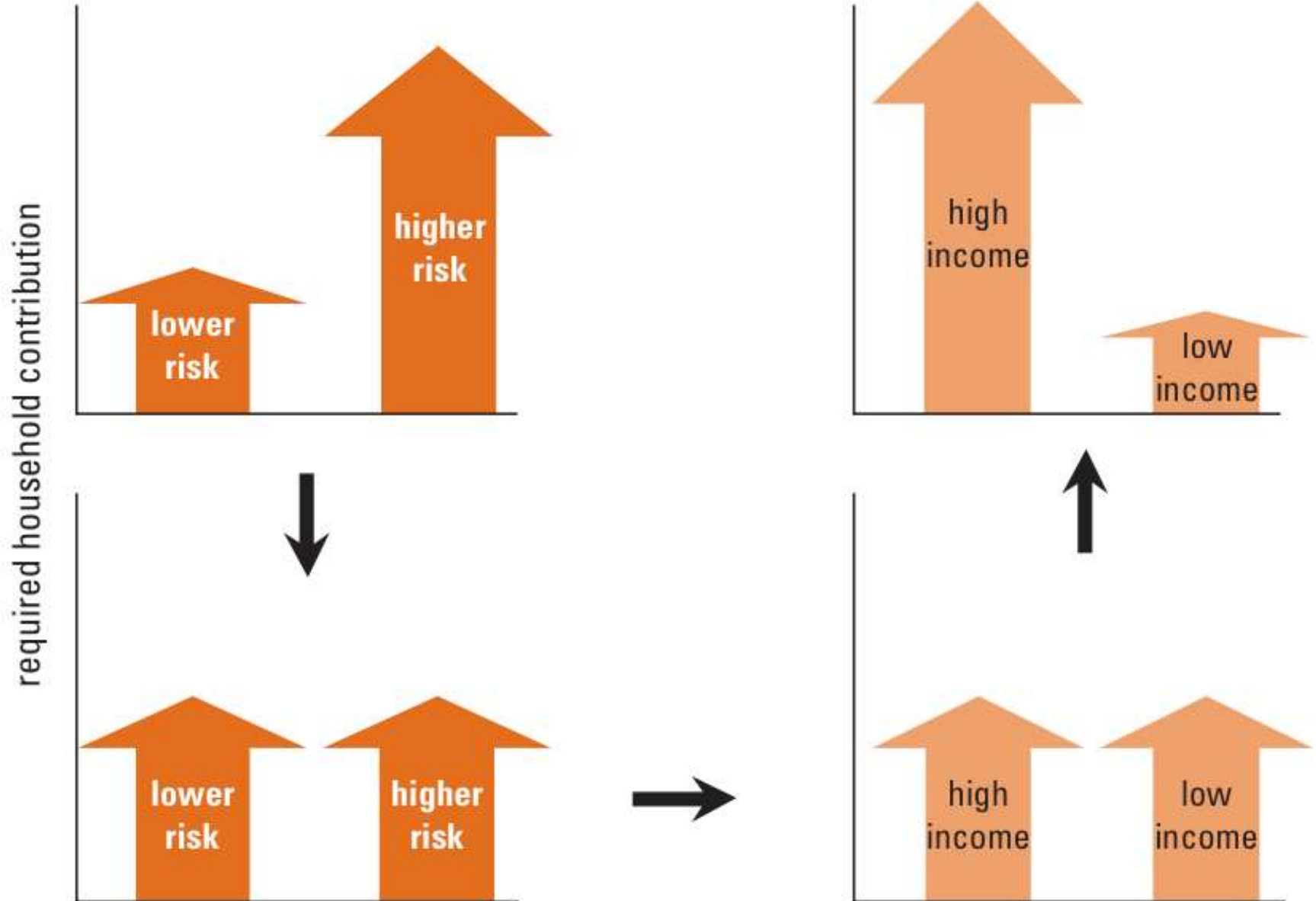
→ Contribution to the pool should not be based on risk

It should be based on ability to pay



Risk pooling

Equity





Risk pooling mechanisms

- ▶▶ Government-funded systems through ministries of health or national health services
- ▶▶ Social health insurance
- ▶▶ ‘Modern’ social health insurance
- ▶▶ Community-based health insurance
- ▶▶ Voluntary or private health insurance



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Government-funded systems

Main features:

- ❖ Primary funding comes from **general revenues**
- ❖ Provide medical coverage to the country's **entire population**
- ❖ Services often delivered through a network of **public providers**



Government-funded systems

Have the **potential to be equitable and efficient**
(lower transaction costs)

BUT

- ❖ Potential coordination problems in decentralized system
- ❖ Dependence on annual budget process and changing political priorities
- ❖ In most low-income developing countries, public health spending as a share of the budget is low



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Social health insurance

Main features:

- ❖ Independent or quasi-independent insurance funds
- ❖ A reliance on mandatory earmarked payroll contributions (usually from individuals and employers)
- ❖ A clear link between these contributions and the right to a defined package of health benefits



Social health insurance

Common problems:

- ▶▶ May **require additional funding** from general tax revenues
- ▶▶ Tends to be **less progressive** than general revenue financing
- ▶▶ May have **negative effect** on employment and economic growth
- ▶▶ Tends to cover limited population, and **hard to extent to informal sector**



Social health insurance

Some of the preconditions for success:

- ❖ Level of income and economic growth
- ❖ Dominance of formal sector versus informal sector
- ❖ Demographic characteristics of the population
- ❖ Room to increase labor costs
- ❖ Strong administrative capacity
- ❖ Quality health care infrastructure
- ❖ Ability to extend the system



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'Modern' Social health insurance

More and more countries are moving towards
a hybrid model

Main features

- ❖ Covers **all citizens**
- ❖ Financed by mandatory contributions from employers and workers in formal sector
 - + General tax revenues from government to cover poor, unemployed, informal sector
- ❖ Access to benefits not dependent on contributions



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Community-based health insurance

Main features:

- ▶▶ Not-for-profit
- ▶▶ Managed by a community
- ▶▶ Voluntary membership



Community-based health insurance

Potential strengths:

- ▶▶ Reduce out-of-pocket spending
- ▶▶ May fill gaps in existing schemes and form part of a transition to a more universal health care coverage system



Community-based health insurance

BUT:

- ▶▶ Sustainability often questionable
- ▶▶ Limited resource raising capacity
- ▶▶ Limited risk pooling capacity
- ▶▶ Limited management capacity at community level
- ▶▶ Limited impact on the delivery of health care
- ▶▶ Often fail to cover the poorest

Some of these limitations can be partially addressed by government intervention



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Voluntary or private health insurance

Main features:

- ▶ Often supplements publicly funded coverage (especially in high-income countries)
- ▶ Paid for by non-income-based premiums
- ▶ Voluntary membership



Voluntary or private health insurance

Can play several roles:

- ❖ **Primary** [main source of coverage for a population or subpopulation]
- ❖ **Duplicate** [same services or benefits as public coverage, but differing in the providers, time of access, quality, and amenities]
- ❖ **Complementary** [covering cost-sharing under the public program]
- ❖ **Supplementary** [services not covered by the public program]



Voluntary or private health insurance

BUT:

- ❖ ‘Adverse selection’ and ‘cream skimming’
- ❖ There are financial barriers to access
- ❖ Do little to reduce cost pressures on public systems
- ❖ Relevance and feasibility in low-income countries questionable

Regulation can address some of these problems, but difficult to implement and enforce



Risk pooling implies prepayment

but

Prepayment does not necessarily imply risk pooling



Medical Savings Accounts

Main features:

- ▶▶ Tax-deferred deposits made for medical expenses
- ▶▶ Withdrawals from the account are tax-free if used to pay for qualified medical expenses

(Examples: Singapore, USA, China)



Medical Savings Accounts

BUT

- ▶▶ Do not involve any risk pooling
- ▶▶ Those with chronic diseases may not have enough savings for medical care
- ▶▶ Impossible for the poor to save enough



Risk pooling mechanisms

Mechanism	Risk pooling	Equity
General revenue	Widest risk pooling	Most equitable
Social insurance	Within the covered population	Redistributive within the covered population
Private insurance Group	Within a group	Redistributive within a group
Individual	Within an age/sex group	Not equitable
Community financing	Within a community	Redistributive within a community
User fees, MSA	No risk pooling	Not equitable



Key message:

Focus on underlying principles

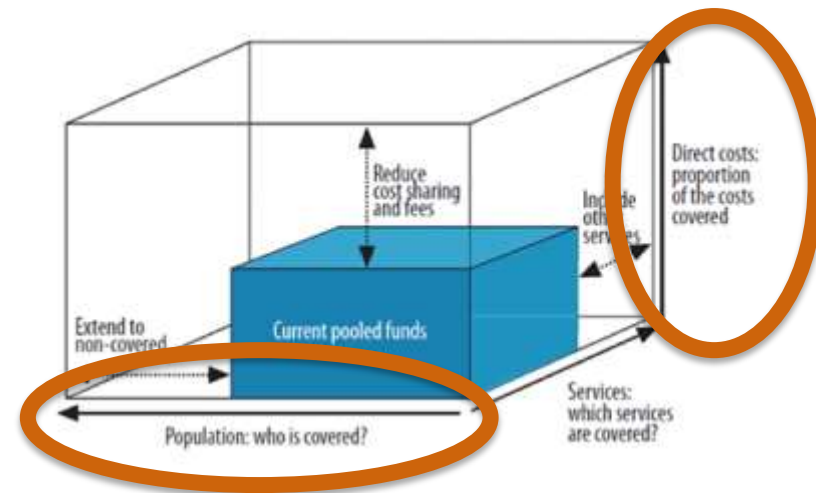
(maximizing risk pooling and assuring equitable, efficient, and sustainable financing)

not on labels or generic models



Why risk pooling matters for UHC

The 'direct cost' dimension
reducing out-of-pocket payments



but also the 'population' dimension
reducing out-of-pocket payments for whom



**Risk pooling is essential to
reducing out-of-pocket payments and
improving financial protection**



Key lessons relating to risk pooling

- ▶▶ Equitable access with financial protection requires pooling arrangements that redistribute prepaid resources to individuals with the greatest health service needs
- ▶▶ Fragmentation exists when there are barriers to this redistribution
- ▶▶ Consolidation of risk pools (where different pools exist) is therefore essential



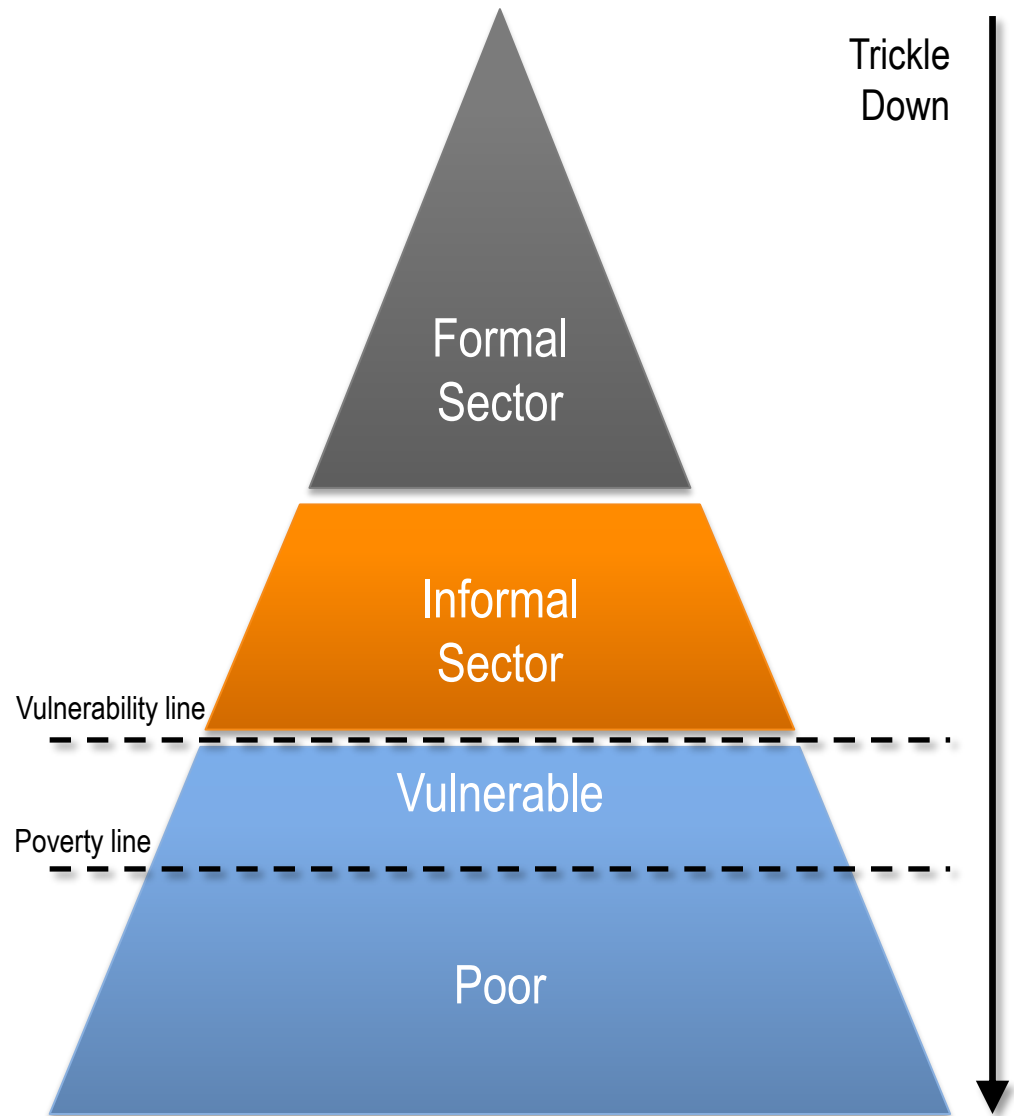
Different countries have adopted different approaches

- ❖ **Single national pool** (Costa Rica, Ghana, Georgia, Kyrgyz, Philippines)
- ❖ **Multiple parallel pools** (Chile, Guatemala, Jamaica, Kenya, Peru, Thailand, Tunisia)
- ❖ **Sub-national pools** (Argentina, Brazil, China, Colombia, India, Mexico, Vietnam)

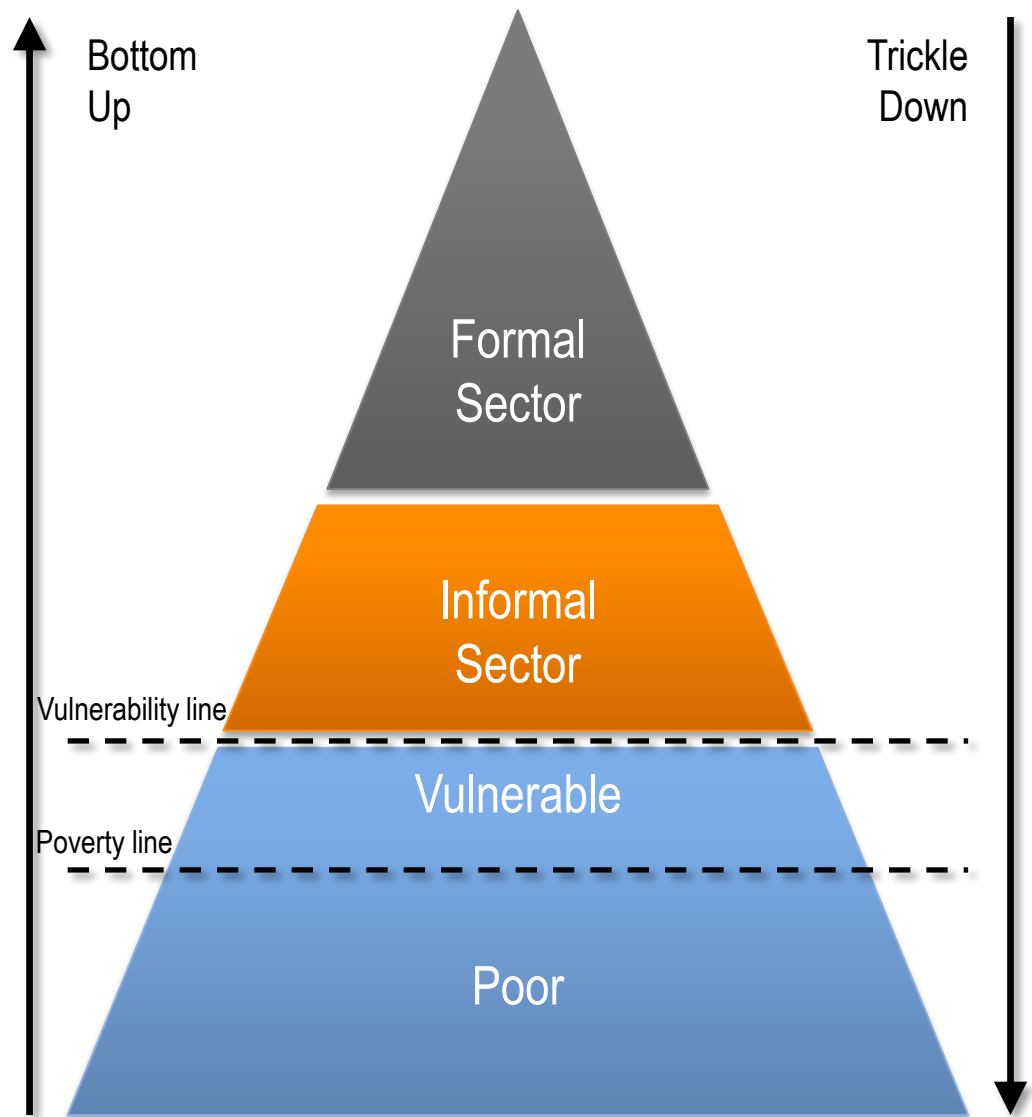
Main challenge faced by countries with more than one pool:

harmonizing contributions, benefits and purchasing policies across different pools

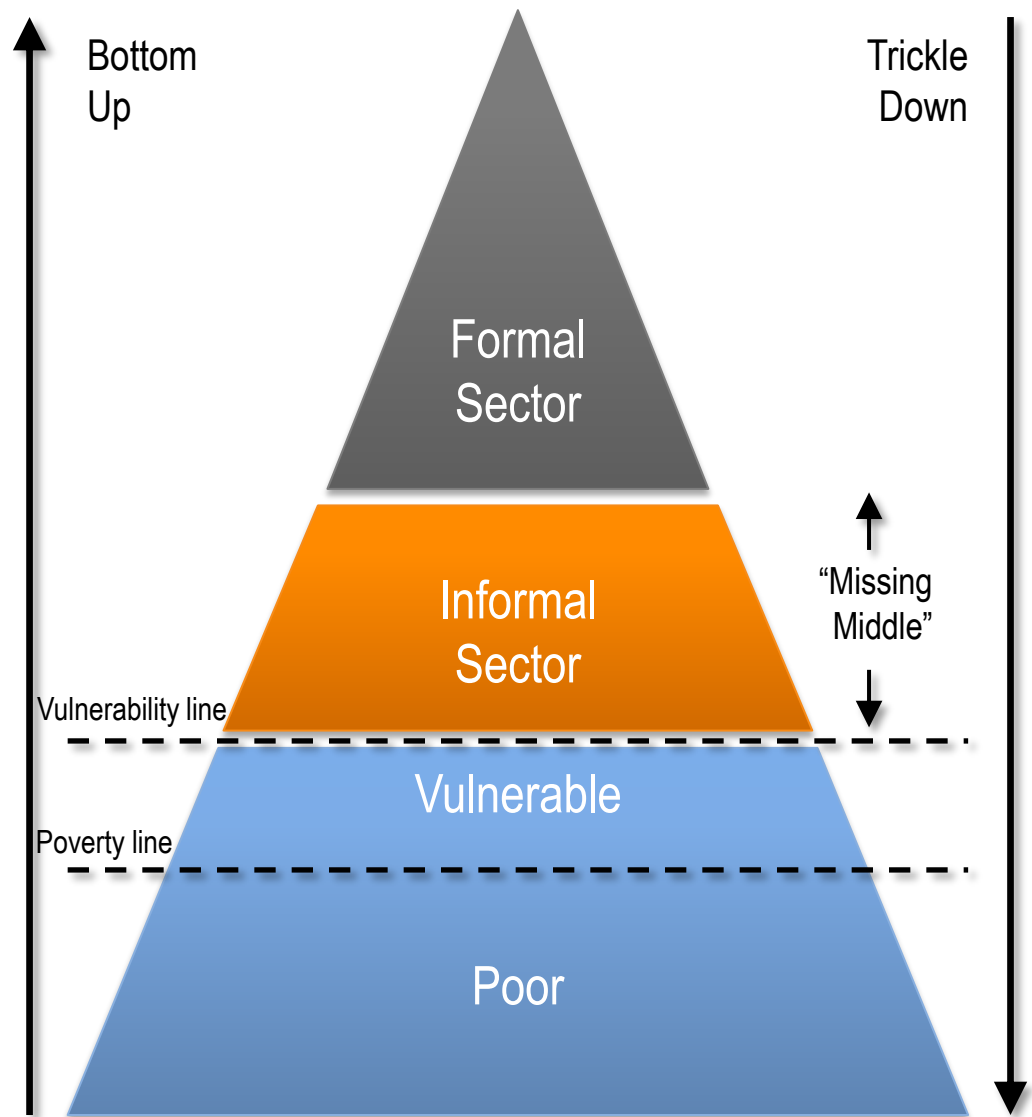
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- Early 2000s: evidence of pro-rich bias of public health spending – “trickle down”
- Many UHC programs now seek to reverse this trend – “bottom-up”
- Targeting priority populations as a foundation of “bottom up” UHC
- Key challenges:
 - How to identify the poor?
 - How to cover informal sector (“missing middle”)?





What are the options for the 'missing middle'?

Important clarification:

The question IS NOT

"how do we get people in the informal sector to contribute"

The question IS

"how do we improve effective access to services with financial protection for persons in the informal sector"

→ The options fall into two categories:

contributory versus **non-contributory**



What are the options for the 'missing middle'?

- ▶▶ Collecting unsubsidized voluntary contributions from non-poor informal workers does not seem to work
- ▶▶ Even if highly subsidized, as in Vietnam and China, collecting voluntary contributions from non-poor informal workers is very difficult
- Legitimate question: **is it worth it?**
[voluntary contributions inhibit enrollment and lead to adverse selection; they bring in only limited revenues while requiring high administrative costs]



What are the options for the ‘missing middle’?

- ▶▶ Some countries make contributions by non-poor informal workers compulsory (e.g. in the Philippines, you must be insured to get access to certain services such as getting a driver’s license)
- ▶▶ Some countries where the size of the informal non-poor sector is relatively small consider having their premiums subsidized by the government (e.g. Dominican Republic)
(Fiscal constraints if size is large)
- ▶▶ Many countries do not have the capacity to make contributions mandatory or to finance a substantial non-contributory program for the non-poor – they often rely on a transitory voluntary insurance program



Demand-side reforms are not enough

Increasing demand (e.g. through health insurance) without enough supply of services being available is “pseudo coverage” and does not advance UHC

Supply-side readiness
is equally important for UHC

Having the right mix of resources used efficiently to make sure that services included in the benefit package are effectively available and that they are accessible and of quality



Getting more people covered is necessary but not enough

Mobilizing additional funds to extend coverage to more people is a necessary but insufficient condition to decrease reliance on out-of-pocket payments

Illustrated by: China, Ghana, Mexico, Vietnam

Greater insurance coverage has improved access to health services for the poor and the non-poor informal

BUT

It has not yet improved financial protection for these target groups

WHY?

In Vietnam:

- ▶ out-of-pocket payments by informal sector workers with insurance are not capped
- ▶ public providers demand high informal payments

In China

- ▶ High reliance of government health system on revenues from user-fees
- ▶ Inefficiencies, waste, and perverse incentives



Thank you

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