



WFPHA: World Federation of Public Health Associations

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Journal of Public Health Policy (2007) **28**, 281–289.
doi:10.1057/palgrave.jphp.3200133

THE FEDERATION'S PAGES

Editorial: Challenging Developments in Universal Insurance Coverage

Universal coverage is defined as an access to key health interventions, to promote, prevent, cure, and rehabilitate all members of society, and to do so at an affordable cost. One of the crucial factors for achieving effective universal coverage is to improve the quality of health services and interventions. Extension of social protection in health is a key strategy to remove financial barriers to health services and to protect people from the impoverishing effects of catastrophic health expenditures, thereby reducing poverty.

Core ethical principles inherited by Europe include solidarity and equal access, especially regarding the right to health for all people. Since the first introduction of health insurance by Bismarck in 1883, three models prevailed in Europe: the German Bismarck system of fee-based health insurances, the British National Health Service or Beveridge type of financing healthcare from taxes (introduced in 1948) and the communist Semashko model which disappeared in the early 1990s. The last left serious problems in most of the central and eastern European transition countries (CCEE). After first experiences with private HMO-type insurance after independence, CCEE countries began to experiment with the different western European systems. This has led to an interesting system mix. A convergent development between the different systems can be observed in Europe today. The European Union (EU) plays an increasing

role in prescribing implementation of the so-called *Aquis Communautaire* or the common legislative basis of the EU, to countries wishing to become members of the EU. Of special relevance is the decision of the European High Court on patient mobility within the Union, implying reimbursement by the 'home-insurance' wherever a treatment is sought.

Rebuilding the health insurance systems in the transition countries of Central and Eastern Europe involves a move towards enhanced risk sharing and risk pooling, thereby increasing the amount of prepayment and reducing the reliance on out-of-pocket payments. Aside from protecting people from the direct costs of illness, health financing through collective arrangements provides financial resources to diagnose, prevent, and treat illness, and to promote better health.

The main challenges are costs and quality of care, including its efficiency. Examples of mixed payment schedules with elements of capitation as well as of fee-for-service have been introduced together with defined benefit packages and specified lists of covered drugs. Regarding quality, the combination of clinical guidelines, indicator-based monitoring and setting of benchmarks, seems to be effective together with population-based standards for health service capacities. The health of the population can be assured only if access can be universal, costs contained, and quality improved. Health system development is a most important area of a New Public Health, comprising not only hygiene and epidemiology, but also effective management of the health systems.

The healthcare financing system has a direct impact on the accessibility of care for people in need. Poor access to health services rapidly leads to poverty and smaller future chances for a decent standard of living. In short, the way healthcare is financed has a strong influence in society; where the cut-off point that divides the winners and losers. These implications of a healthcare financing system had to be borne in mind by eastern European transition economies facing the extraordinary challenges of redesigning a healthcare system in a short time frame since the 1990s. The interesting new system mix emerging here may serve as a model for other countries in development around the globe.

A widely successful approach, running under the title of Social Health Insurance (SHI), has been analysed with regard to its implementation in developing countries at a conference in 2006 of WHO, ILO, and GTZ in

Berlin. One of the organisers has been asked to summarise some of the results (see below in the special reports section, Laaser and Radermacher, 2006).

REFERENCE

1. Ulrich Laaser, Ralf Radermacher, editors. *Financing Health Care. A Dialogue between South Eastern Europe and Germany*, Volume 18. Germany: Lage; 2006. 323 pp., ISBN 3-89918-154-9

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Special Reports

Social Health Insurance: Not Modern, But Not Old Fashion

It would be difficult to identify another issue that is comparably present in political debates as the future of social protection systems. In the industrialised world, the dispute stresses the potential insolvency of the traditional welfare state that requires an urgent “modernisation” and more “efficiency”. Recommendation urge developing countries to concentrate on economic growth and search their destinies in opening their markets while investment in social protection is considered secondary or even tertiary.

Effective and sustainable social protection is increasingly accepted as a key element of economic and social development that is negatively affected by social exclusion and huge income gaps (1). From a socio-political, as well as from a macro-economic point of view, three criteria are of utmost importance for performance, quality, and sustainability of healthcare systems: the extension of demographic coverage, the degree of risk pooling among various population groups, and the fairness of financing.

A prerequisite for achieving universal social protection is risk pooling. This refers to the accumulation and management of revenues in such a

way that all members of a cohort share the financial risk associated with health interventions for which the need is uncertain. Fair financing means that everyone prepays for adequate healthcare according to a household's ability to pay – without facing catastrophic healthcare expenditures.

Social Health Insurance (SHI) is a method for financing and managing healthcare by pooling the widest range of health risks possible, and, by pooling contributions of enterprises, households, and government. Broad-based risk pooling is an essential condition for the financial sustainability of any health insurance scheme. Risk pooling corresponds to the traditional insurance function of distributing the financial costs of an individual's healthcare to the group members as a whole. Its central purpose is to share the financial risk associated with the use of health services for which the need is uncertain, and it varies between individuals.

However, pooling is not only the accumulation, but also the management of revenues in a way that ensures that the risk of having to pay for healthcare is borne by all the members of the pool and not by each contributor individually. Contribution-based health financing schemes may be managed in various ways: through a single-government insurance fund, or through multiple non-governmental or para-statal funds. Independent from the structure and performance of health financing systems, one key common characteristic of successful social policy means that at least some part of the financial contributions of households is prepaid and pooled.

SHI is traditionally and usually based on payroll contributions that are shared among employers and employees where it is legally mandatory to obtain health insurance with a designated (statutory) funding agency. Health insurance funds act as third-party payers within the healthcare sector that receive non-risk-related contributions. These are separated from other legally mandated taxes or contributions. This general perception does not reflect accurately the full range of SHI mechanisms that are in place in the industrialised world. In several European countries, for instance, various types of differentiated flat-rates (Spain) or asset-related contributions (e.g. in Austria, Germany and Italy) are in place for agricultural producers and special professional groups.

SHI implies a close relationship between individual protection against certain life risks and the responsibility of the entire society. Society is more than the sum of its members, or than a great organised market on population level. A majority in Continental Europe and elsewhere

considers that the individual's true interests are best achieved in and through society. SHI can be perceived as socially organised, solidarity-driven, equity-oriented, and essentially fair mechanisms of collective healthcare financing.

One essential and indispensable criterion for a SHI is the implementation of an effective redistribution of income from the better- to the worse-off. SHI operationalises the social value of solidarity and realises various redistribution mechanisms:

- from healthy to sick;
- from wealthy to poor;
- from young to old;
- from economically active to passive;
- from individuals to families;
- from men to women.

Population surveys show a strong and time stable agreement of Western European citizens with the above-mentioned redistribution elements. Net payers within the social security systems show even the strongest support of the mentioned cross-subsidies. Obviously, the solidarity principle of well-performing classical SHI gives a convincing answer to the challenges of social inequity in the face of disease and death. People perceive solidarity as a big chance to reduce distribution inequality in capacity to face the material and individual risks of ill health.

The value of SHI for development is often challenged because it is considered a tool reserved for the industrialised world and not applicable for developing countries (2, 3). Indeed, the traditional approach of linking SHI to formal sector workers only is very likely to increase inequity and enhance social exclusion (4). If the implementation of SHI is aimed at enhancing resources available for healthcare, government spending will often decrease and thwart the intended reallocation effects. Also in many countries, SHI will face the general problems of bad political governance, lacking transparency and corruption. But these conditions have at the same negative effects on tax-financed health systems and on private health organisations. In the developing world, SHI is generally perceived as publicly run insurance funds. The existing SHI institutions in developing countries were once limited to a small group comprised mostly of formal sector workers and their families and, thus, reflected a clear segmentation of the healthcare system. In most cases, the attitude of SHI institutions towards other population groups, and their behaviour of protecting vested

rights in health sector reforms, gives them an ambiguous role when in design of a universal and fair healthcare financing systems.

SHI is but one option for organising healthcare financing in an equitable, fair and sustainable way through a prepayment. Entitlement to health services is linked to a contribution made by, or on behalf of, specific individuals in the population. As compared to tax-financed public health systems such as those in the United Kingdom, Sweden, Canada, or Brazil, universal coverage requires special efforts and can only be achieved if contribution payment is organised and assessed for each member of the population. For this reason, most SHI systems combine different sources of funding, with government often contributing on behalf of people who cannot afford to pay for themselves. This is especially relevant for the often long-term implementation process and for transition periods towards comprehensive SHI systems. European welfare states with SHI-based health systems also co-financed some social groups, especially the self-employed and the poor, using tax resources pooled through SHI funds.

Consequences of globalisation and economic structural adjustment, including the growing proportion of low-wage workers and the increasing informalisation of labour conditions, put the industrialised world under pressure to further reform classical SHI-systems. In developing countries, SHI can be a powerful tool for extending social health protection. Intelligent links with other health financing mechanisms are required in rich and in poor countries alike in order to maintain or achieve universal social protection and fair health financing.

REFERENCES

1. Perry G, Arias O, López H, Maloney W, Servén L. *Poverty Reduction and Growth: Virtuous and Vicious Circles*. Washington DC: World Bank; 2006 (http://siteresources.worldbank.org/EXTLACOFFICEOFCE/Resources/870892-1139877599088/virtuous_circles1_complete.pdf).
2. Savedoff W. Is there a case for social insurance? *Health Policy Plan*. 2004;19(3):183–4 (<http://heapol.oxfordjournals.org/cgi/reprint/19/3/183>).
3. Kutzin J. Myths, instruments, and objectives in health financing and insurance. In: Holst J, Brandrup-Lukanow, editors. *Extend-*

- ing Social Protection in Health. Developing Countries' Experiences, Lessons Learnt and Recommendations.* Berlin Conference Documentation, GTZ/ILO/WHO, VAS-Verlag, Frankfurt/Eschborn; 2007. pp. 87–95. ISBN 978-3-88864-425-2.
4. Lloyd-Sherlock P. When social health insurance goes wrong: lessons from Argentina and Mexico. *Social Policy and Administration.* 2006;40(4):353–68 (<http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1467-515.2006.00494.x?cookieSet=1>).

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WFPHA News and Notes

Strengthening Public Health Associations, An Initiative Led By The Canadian Public Health Association Since 1985

Since 1985, the Canadian Public Health Association (CPHA), with financial contributions from the Government of Canada, has worked to reduce poverty and promote sustainable development by providing technical assistance to national Public Health Associations (PHAs) in developing countries. In 1995, this project-based initiative evolved into the Strengthening of Public Health Associations (SOPHA) Program and over the years, has provided assistance to PHAs in over 30 locations. CPHA was awarded the WHO's Sasakawa Award in recognition of the Association's contribution to strengthening public health associations and primary healthcare around the world. In the 1994 World Bank Report *Better Health for Africa*, the Canadian contribution in support of the international public health association movement was cited as an important contribution to improve health sector effectiveness.

The purpose of the SOPHA Program is to develop the organisational capacity of partner PHAs. It endeavors to nurture their ability to: function as effective national PHAs; take a leadership and advocacy role for health; promote and support broad public participation in health issues and action; and build partnerships and alliances with other agencies, organisations, and professional associations for action on important health issues. This is accomplished by working closely with the PHAs to

provide the necessary training and support required to improve their ability to function as national health resources.

The work of local PHAs is very important. Given the close working relationship they have with their respective Ministries of Health, there is a clear benefit to national governments in low and middle-income countries to seek the evidence-based advice that independent, strong, capable, and self-sufficient PHAs provide.

During the Seventh WFPHA International Congress in Indonesia in 1994, discussions among partner PHAs resulted in the SOPHA program identifying three key themes of interest to all partners: environment and human health; health sector reform; and health promotion. In 1998, the SOPHA program added tobacco control as another theme. These priority themes have since evolved to include: globalisation and health; tobacco and health; and reinforcing essential public health functions.

It is clear that the SOPHA program has achieved much in the past 22 years. Today there are vibrant public health associations in countries where few existed previously. It has placed issues, such as tobacco, on the national and international agenda, and has offered a venue for the discussion of public health topics, both within the professional public health community, and the general community at large. In addition, the SOPHA program has also contributed to strengthening the global public health association movement by sponsoring and supporting membership of PHAs from low and middle-income countries in the WFPHA, and the participation of PHA members at international public health conferences. Also, the SOPHA program has been instrumental in having many governments recognise the critical role played by national public health associations in the development of important health policies and programs.

The SOPHA program recently received funding from the Canadian Government for another five years (2006 – 2011). As we consider the future, it is clear that what started as a small initiative over 20 years ago has grown to become a major element of the international public health movement.

For additional information about the SOPHA Program, visit: <http://www.sopha.cpha.ca/>.

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SOPHA Partner PHA Locations 1985–2006

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Brazil
Burkina Faso
Caribbean (CARIPHA)
Chile
Congo (Republic of)
Costa Rica
Cuba
Dominican Republic
East, Central and Southern Africa PHA
Egypt
Ethiopia
Haiti
Indonesia
Malawi
Mexico
Mozambique
Niger
Palestinian Territories (West Bank & Gaza)
Pakistan
Peru
Romania
Russian Federation
Serbia (Republic of)
Sudan
Tanzania
Thailand
Turkey
Uganda
Zaire (Democratic Rep of Congo)
Zimbabwe
UN administered province of Kosovo