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.

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