SOCIAL HEALTH INSURANCE: KEY FACTORS AFFECTING ITS IMPLEMENTATION FROM SOME TO ALL. EVIDENCE FROM SUCCESSFUL NATIONS

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Abstract
Ethiopia like any other several low and middle income countries is interested in extending the existing health insurance from specific groups to eventually cover the entire populations. For those countries and Ethiopia interested in such an extension, it is important to understand the factors that affect the transition from none to incomplete (some) and then to universal coverage (all). This paper analyses the experience of eight countries in the implementation of social health insurance (SHI). It highlights the importance of the socioeconomic and political context, particularly in relation to the level of income, structure of the economy, distribution of the population, ability to administer and level of solidarity within the country, and also stresses the important stewardship role government can and should play in facilitating the implementation and transition to universal coverage via social health insurance.

Keywords: Universal health coverage, health funding, social insurance, equity of health

I. APPROACH USED IN THE STUDY
Literary Analysis method was used to undertake this study by presenting experience of eight most successful nations in implementing the concept of social health insurance from none to some and then to all or universal health coverage.

II. INTRODUCTION
Social health insurance (SHI) is one of the possible organisational mechanisms for raising and pooling funds to finance health services, along with tax-financing, private health insurance, community insurance, and others. Typically in the more mature European SHI systems, working people and their employers, as well as the self-employed, pay contributions that cover a package of services available to the insured and their dependents. In most cases they are obliged to make these contributions by law. Many governments also pay subsidies into these systems in order to ensure or improve their financial sustainability (WHO 2000).

Social Health insurance schemes are an increasingly recognised factor as a tool to finance health care provision in low income countries (WHO 2000). Given the high latent demand from people for health care services of a good quality and the extreme under-utilisation of health services in several countries, it has been hoped that social health insurance may improve the access to health care of acceptable quality. Whereas alternative forms of health care financing and cost-recovery strategies like user fees have been heavily criticised, the option of insurance seems to be a promising alternative as it is a possibility to pool risk transferring, unforeseeable health care costs to fixed premiums (Griffin 1992). However, there is strong evidence that neither purely statutory social health insurance nor commercial insurance schemes alone can significantly contribute to increase coverage rates and thereby the access to health care. Especially in the environment of rural and remote areas where unit transaction cost of contracts are too high leading often to a state and market failure (Jütting 2000). As a consequence in low-income countries the majority of the population remains uncovered against the risk of illness (World Bank 1994). Africa has the highest burden of disease in the world. Explicitly, in 2007 more than half of the 53 African countries spent less than $ 50 per person on health. Of the total health expenditure, 30% came from governments, 20% from donors, and 50% from private sources – of which 71% was paid by patients themselves, the so-called out-of-pocket payments. Similarly in Ethiopia specifically, of the total health expenditure 31% comes from government, 37% from donors, 30% from nations as out of pocket and the remaining 2% from other sources like private insurances. Since health payments regularly take up a disproportional share of the household resources, out-of-pocket payments are an important barrier for seeking health in Sub-Saharan Africa including Ethiopia. So, out-of-pocket payments create inequity in access to health care. A social health insurance can be a solution to improve access to health care.

Most commonly, policy makers consider the introduction of SHI for one or more of the following reasons:

SHI is thought to:
(a) Be a way of mobilizing additional domestic resources for health;
(b) Allow organizational change for improved health system quality and efficiency which is easier to introduce through SHI (e.g. purchaser-provider splits, new provider payment Mechanisms);

(c) Extend financial risk protection to more people, or provide greater levels of protection to those already with coverage (e.g. replacing out-of-pocket spending with some form of prepayment, switching from private health insurance to SHI, at least for a basic package of health services). This additional financial protection is seen as a way of allowing more people to use needed services without incurring high out-of-pocket payments, effectively moving closer to universal coverage.

III. EMPIRICAL LITERATURES

Social health insurance (SHI) is one of the principal methods of health financing. Twenty-seven countries have established the principle of universal coverage via this method (Carrin et al. 2004). Several low- and middle-income countries are currently interested in extending their existing health insurance for specific groups to eventually cover their entire populations. For those countries interested in such an extension, it is important to understand the factors that affect the transition from incomplete to universal coverage. Many scholars have analysed key questions that need to be considered before a country embarks on the extension or establishment of social health insurance, along with implementation guidelines (Normand and Weber, 1994). This paper adds to the literature by analysing the transition to universal coverage via SHI. A question that remains of paramount importance in a majority of the world’s countries is how their health financing systems can provide sufficient financial risk protection to all of the population against the costs of healthcare. The latter objective is tantamount to the aim of universal coverage, which is to secure access to adequate healthcare for all at an affordable price. That is, universal coverage incorporates two different coverage dimensions: healthcare coverage (adequate healthcare) and population coverage (healthcare for all). A crucial concept in health financing policy towards universal coverage is that of society risk pooling, whereby all individuals and households share the financing of total healthcare costs. The larger the degree of risk pooling in a health financing system, the less people will have to bear the financial consequences of their own health risks, and the more they are likely to have access to the care they need.

There are essentially two main options for achieving universal coverage. One is a health financing system whereby general tax revenue is the main source of financing health services. These health services are usually provided by a network of public and contracted private providers, often referred to as a national health service. Second, there is social health insurance, which in principle involves compulsory member Social health insurance among all of the population. Workers, self-employed, enterprises and government pay contributions into a social health insurance fund. The base for workers’ and enterprises’ contributions is usually the worker’s salary. The contributions of self-employed persons are either flat-rate or based on estimated income. Government may provide contributions for those who otherwise would not be able to pay, such as unemployed people and low-income informal economy workers. SHI owns its own provider networks, works with accredited public and private healthcare providers, or uses a combination of both. Within SHI, a number of functions (for example registration, collection of contributions, contracting and reimbursement of providers) may also be executed by parastatal or non-governmental institutions, often referred to as sickness funds.

The researcher sees countries, however, which use a mix of the two main options. Thus, there are mixed health financing systems that have some part of the population partially covered via general tax revenue, and clearly specified population groups only covered by health insurance. This insurance can be provided by one or a number of parastatal health insurance schemes that function according to SHI principles. Alternatively, a system of private health insurers may also be in place, but one that is subject to government regulatory powers, especially ensuring a specified benefit package of care.

Note finally that within each of the options referred to above, private health insurance can also play a supplementary role. Sekhri and Savedoff (2003). It typically covers extra healthcare services that are not covered in a basic package of care (of one of the three systems described above), arranges for a reduction in waiting time, or covers some of the cost of patient repayments. Indeed, in reality no health financing system is entirely financed by general taxation, SHI or the mixed health financing system described above. However, these options are useful for describing what is the principal method driving a health financing system towards universal coverage.

In this paper the researcher focus on the development of SHI, especially in low, middle-income and developed countries, given that a choice is made in favour of this particular pathway. It was supposed that the basic feasibility questions have been answered properly by the country that has made such a choice. This means that the country has analysed carefully the pros and cons of general taxation, SHI and a mix of the two as options for reaching universal coverage.

IV. RESULT ANALYSIS

The researcher submits that a number of factors can in principle enhance the speed of implementing and achieving universal coverage via SHI, based on the literary survey of eight countries namely Germany, Austria, Belgium, Costa Rica, Israel, Ghana, Japan and Republic of Korea expecting that it will help Ethiopia (country under study) which is on the verge of implementing the concept of social health insurance by the time this study was undergone.

First, there is the general level of income and the rate of economic growth. A greater amount of income per capita is apt to increase the capacity of enterprises and citizens to prepay SHI contributions. In addition, tax revenues are likely to increase with income, facilitating the subsequent channelling of any government subsidies into SHI. Steady economic growth, therefore, is likely to enhance this capacity to prepay. Correlated with study made by Enser (1999, p.875).

Second, the structure of the economy also matters. What is most relevant here are the relative sizes of the formal sector and informal economy. Many developing countries do have important agricultural, manufacturing and service sectors where a notable part of employment is informal. Such countries then are likely to face administrative difficulties in
assessing incomes and collecting contributions because so many workers do not receive a formal salary. This may hamper provision of health protection for the informal segment of the population, especially when an SHI scheme would rely significantly on household contributions. This works more for Ethiopia since 87% of the population lives in rural area with dispersed livelihood and unknown income they earn.

Third, administrative costs may be influenced further by the distribution of the population that one intends to cover. The population in urban areas, where there is likely to be at least a minimum quality of infrastructure and communications, and high population density, is likely to be easier to serve with an SHI system than a widely dispersed rural population.

Universal coverage, that secure access to adequate healthcare for all at an affordable price, is the ultimate objective of SHI. Through analysis of the experience in eight countries with developed SHI schemes, this paper has shed light on what are important facilitating factors for the speed of the transition from none to some to all (universal Coverage). A number of factors were judged crucial in facilitating this transition: the level of income, the structure of the economy, the distribution of the population, the country's ability to administer SHI, and the level of solidarity within a society. It is essential that policymakers take these factors into account and try to use them as policy levers. Improving administrative capacity and fostering a sufficient level of solidarity are among those factors that can be impacted upon more directly via government stewardship.

Finally, the five facilitating factors discussed above may be present to a lesser or larger degree, but it will still take government's stewardship to launch and guide a process that leads to compulsory health insurance for all. Stewardship can be best understood as a function of a government that is responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry. A system of full financial protection requires a significant amount of cross-subsidization, both from rich to poor and from low risks to high risks. Each country needs to define what an appropriate level of solidarity to enable such cross-subsidization is. Policymakers can, at times, impose solidarity, but a sufficient degree of innate solidarity in society is needed in order to implement and sustain the cross-subsidization inherent within SHI.

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V. CONCLUSION

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Thus, while experience demonstrates that SHI development in a particular country to a large extent depends on that country's own specific socioeconomic and political context, experience also shows how the transition to universal coverage is dependent on the government's stewardship of the health system.

In addition to the above factors, Ethiopian government should begin the programme by few volunteers and for those individuals special Identity card shall be given so as to motivate the others to follow.

Lastly Ethiopian government shall arrange service providers for immediate reaction for those volunteers to encourage those left behind for further extension of the programme.

For more assurance and easy going of the programme, it is better if Ethiopian government disclose issues with society to create common understanding (build solidarity with the nations).

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