Social Health Insurance:
Institutional Transformation – Accountability and Choice[1]

by

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Note to the Reader

This working paper is about the concept and evolution of social health insurance. In its final form, the paper is to be published in

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Consequently, the paper refers to other papers to be eventually published in the book. These papers are not fully referenced below.

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1. Introduction

The United States, one of the richest countries on earth, outspends every other country on state-of-the-art medical technology. Yet its health indicators and its people's satisfaction with its health care system compare unfavorably with those of other highly developed countries (Davis et al. 2007; Schoen et al. 2006, Chernichovsky 2009). Unlike the United States, these other countries have integrated health care systems that secure access for all their people to socially set medical benefits, funded by mandatory, and usually means-tested, contributions. Though diverse also in their health care systems, these countries share the basic health system features termed the "Emerging Paradigm" (EP) (Chernichovsky 1995, 2002; Chernichovsky et al.2012).

Indeed, considering epidemiology, socioeconomic factors, and availability of medical and other resources, countries that protect their citizens' health as well as income by the features or principles of the EP, show better health results and a more satisfied public than countries that rely mostly on commercial insurance, let alone out-of-pocket (OOP) payment, to fund medical care. The superior outcomes follow because the countries that adhere to the EP are better able to deal with issues of equity, cost containment, efficiency, and client choice than countries that do not.

Against this background, many low-income and transitional economies mainly in Africa, Latin America, and the Caribbean (LAC), and Southeast Asia (SEA) may have a great deal of untapped potential for mobilizing private funding for more equitable and productive health systems than they currently have. Between 70 and 90 percent of their medical care funding is private, mostly out of pocket, whereas in the industrial nations (except the United States) such spending is limited to the 20 percent to 30 percent range. Most of India's population, for example, relies on individual ability to pay for medical care and therefore lacks orderly access to basic quality care (Ellis, Alam, and Gupta 2000; World Bank 2004; Gottret and Schieber2006).

Although public funding in India and other less-developed and transitional economies in LAC, SEA, and Africa often signifies free access to medical services, possibly with some copay, these services are considered nominal at best, both in terms of population coverage and the scope of benefits, and unresponsive to clients and their needs. The vast majority of the population, relying only on nominal state services, is considered for all practical purposes "uninsured" even if constitutions stipulate the contrary.

Poor and transitional economies cannot be expected either to secure universal access to basic medical benefits or to shape a national integrated health care system using general revenues alone, not even factoring in the substantial foreign aid that is typical mainly of African countries. These economies have relatively low tax revenues because of their large, untaxable informal sectors and their generally low income levels. This reality is associated with a general lack of "fiscal space," jammed with pressing priorities that crowd out medical care (Heller 2005, 2006), and governments not trusted with handling the taxes they collect. Moreover, their medical needs, especially considering HIV/AIDS and Malaria, are costly (Dukhan and Preker).

In addition, expansion of coverage and medical benefits by taxes and other centrally regulated mandated contributions—without a clear view of the overall nature of the expanded system, notably its ability to supply services—can yield unaccountable, inefficient, nonresponsive and even corrupt services. These contribute to people's unwillingness to contribute toward funding care that is not by out-of-pocket spending.

A lack of fiscal space as well as widespread distrust in the state have led Russia and other East European and Central Asian nations to fund health care from general revenues instead of with mandated earmarked funding (Chernichovsky, Barnum, and Potapchick 1996; Wagstaff and Moreno-Serra 2008).

Thus, a new approach is needed, based on the recognition that less-developed and transitional economies must get rid of health care systems funded almost entirely by out-of-pocket payments. At the same time, these nations indeed cannot be expected to achieve almost wholly state-funded systems. That is, solutions between general revenues and private funding, combined with a clear long-term strategy for an integrated and universal system, are both required and possible. These solutions must be based, however, on institutional-economic as well as political realities involving a combination of, on one hand, poor disenfranchised populations, albeit majorities in most cases, that make up the informal sectors, and politically strong, well-organized groups that make up the formal sector, on the other.

Carrin and James (2003) show that most developed countries started medical coverage for only a small part of the population (often 5 to 10 percent of the working population) and gradually extended coverage over many years. Less-developed and transitional economies of today neither

have nor need centuries or decades to make this transition, if they decide to do it and have the experience of developed health care systems to follow.

This paper attempts to bring together and generalize the key economic and institutional issues that can further understanding of the politics of health care finance. The pivot of the discussion is the rather fuzzy and often wrongly perceived concept of social health insurance (SHI).

Building on the experience of developed health care systems and theoretical considerations grounded in economics and social anthropology, the goal of this paper is to articulate SHI as a dynamic concept that offers a path out of a fragmented and failed health care market, based on ability and willingness to pay by large segments of the population, to an integrated, universal system, based on mandated, often means-tested, contributions. The milestones along this path represent economic, social, and institutional realities that translate into political realities that must be surmounted, often with the help of state stewardship.

The paper is divided into two major parts. The first, in three sections, identifies the parameters that help define SHI, sets its institutional and policy context, and builds a typology of SHI models. This part provides the different SHI milestones needed to establish an integrated system that secures meaningful universal coverage. The second part, three additional sections, deals with the obstacles to be overcome on the path to universal entitlement to care in an integrated health care system based on SHI

2. Social Health Insurance (SHI): The Concept

Social health insurance is commonly defined by what it is not. There is a wide consensus that SHI funding excludes the two basic and diametric forms of health care funding: funding from general state revenues and funding from out-of-pocket payments and individually rated voluntary medical insurance (figure 1) (Normand and Weber 1994; Saltman, Busse, and Figueras 2004; GTZ 2004; Gottret and Schieber 2006; WHO 2005).

Figure 1: The Domain of Social Health Insurance

Source: Authors.

Invariably SHI involves earmarked contributions mandated by a self-governing group[1] or corporation,[2] the state, or a combination thereof, to fund the medical benefits set by either for its membership or citizenry. This arrangement marks a quid pro quo between the collective and the individual. Earmarking disallows the collective, group, corporation, or state, discretionary use of members' contributions. Mandating denies the individual or the household discretionary use of part of its income, even when contributions are collected by employers. It is noteworthy here that mandating employers to pay for their employees' care is not the defining feature of SHI.

Some exceptions may exist even at the extremes, not considered SHI (figure 1). For example, the state may support SHI arrangements from general revenues in order to pay for the indigent who cannot themselves contribute to the system. Alternatively, the state may hand over taxing rights to self-governing closed groups and market-oriented corporations that maintain open enrolment. Additionally, private insurance can be regulated by the state to have SHI features such as community-rated premiums and open enrolment with insurers (Chernichovsky 2012).

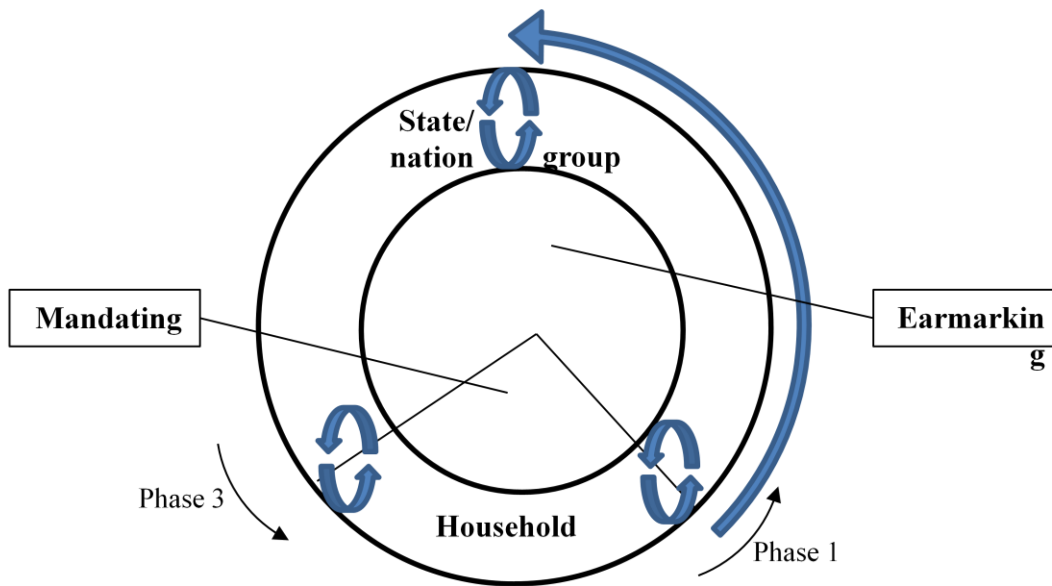
Mandated contributions mean coercive membership in the group and closed enrolment, to avoid adverse selection or, alternatively, to enforce subsidies from the good risks to bad risks within the collective. An individual's limited right and ability to enter or enroll in, and exit, groups is a thus critical element of SHI. Clearly, groups that share identical contributions and benefits can permit their members to move between such groups. For example, a labor union may allow its members to move among its geographic chapters. This portability of contributions and benefits reaches its maximum potential when the uniform state or federation forms the collective of the ultimate social group for SHI. In this case, membership is automatic and contributions and entitlement / eligibility rules are universal.

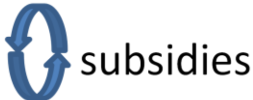
SHI can thus be envisioned as a social contract involving the household, a group, or a corporation, and the state (figure 2). Mandated contributions and their earmarking, combined with limits on entry and exit from the SHI collective, interlock shared risk and subsidized funding of collective medical benefits. The nature of the contract, which can be part of a broader social protection contract, varies by the organization of subsidies as delineated by the subsidy circles in the figure: households can subsidize each other within separate groups, groups subsidize each other within the state framework, and—eventually, with the dissolution of contribution-based groups—households subsidize each other within the state framework. Groups (and households) mandate contributions and participation for their internal arrangements. When the state is the SHI framework, participation is by default by groups, and households rather than groups may demand earmarking.

This organization concerns division of labor between the state and the self-governing group or corporations with regard to

- fund raising and fund allocation and
- contracting for care.

Figure 2: Evolution of SHI by Institutions, Subsidy Circles, Social Quid Pro Quo





Source: Authors.

The institutional evolution of SHI concerns the assumption of these responsibilities by different group or corporate arrangements and subsequent sharing of the responsibilities with the state, which has been increasing its control over fund raising and allocation.

A basic institutional feature of SHI is thus the self-governing group or corporation, which has responsibilities, often statutory, with regard to medical benefits and their funding. SHI thus combines the basic principles of public funding—affordable mandated contributions, and forced participation, with earmarking—the basic principle of private funding, including voluntary insurance.

The functional, institutional, and public-private dimensions of SHI can explain the complexity of defining and implementing it. By recognizing these dimensions and the shapes they can take, however, SHI can be organized by fairly structured institutional variants, each delineating a

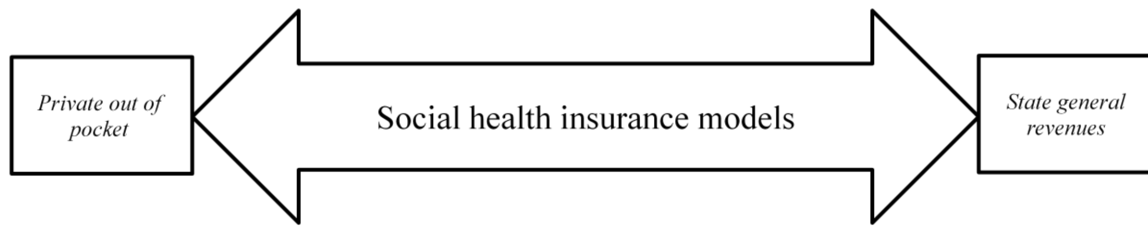
particular social contract and governance arrangements. It follows that SHI does not conform to a single model but to a family that shares the common features: mandated earmarked contributions, involving cross-subsidies and group responsibility for at least some aspects of care funding and fund holding in ways the keep these aspects sustainable.

3. Social Health Insurance Models: A Typology

Social health insurance does not conform to a single model. Within the SHI domain delineated by the types of health care funding not considered SHI (figure 1), the following major variants or models of SHI can be identified:

- the Informal Nonuniversal Nonmarket Model (INN)
- the Formal Nonuniversal Nonmarket Model (FNN)
- the Formal Nonuniversal Market Model (FNM)
- the Universal Group Model (UG)[3]
- the Universal Pool Model (UP).

Figure 3: Social Health Insurance Models



Source: Authors.

These models are delineated in figure 3, expanding on figure 1. They are organized, from left to right, by their proximity (on the right) to the basic funding principles of the EP—means-tested mandate contributions, possibly taxes, that fund universal entitlement to effective care, the ultimate goal of SHI. By their general principles, most reforms can be cast in this general framework. The models are not mutually exclusive; several, including those not considered SHI, can coexist in the same health care system. The policy challenge in this general scheme of things is thus to move models rightward while at the same time trying to assemble them.

Generally speaking, the INN Model conforms to mutual aid and microinsurance arrangements where groups assume common health care–related responsibility (semi-) voluntarily on the basis of an innate characteristic: tribe, religion, and so on. Because the underlying group characteristic is innate, enrolment is exclusive.

In contrast, the FNN Model is based on acquired characteristics, most notably profession, place of work, or union. Although the underlying group characteristic is attained, enrolment and exit can still be prohibitive for reasons discussed above, as it was in the European guilds well into the 19th century. This model is probably the most prevalent today in nonnational health systems, notably in Latin America and Africa, as well as in the United States.

The FNM Model is based on market corporations rather than exclusive groups. Enrolment is based on willingness and ability to pay the premium and follow regulations. This model, which

delineates private insurance arrangements, might be considered SHI, if there is cross-subsidization among group members, some paying above, others below, their "fair" premiums. Kaiser Permanente in the United States has age-based, community-rated premiums that involve cross-subsidies. Israeli sickness funds have similar arrangements for supplemental insurance for their membership.

The nonmarket models signify imperfect markets where households lack the right to enter or exit, self-governing groups. The remaining models signify situations in which individuals have such rights, in consistency with the EP free enrolment principles.[4]

The nonuniversal models denote systems comprising independent SHI schemes or plans, either groups or corporations, alongside uncovered or nominally covered populations. The most common groups are associated with state employees (e.g., Mexico, Tanzania, and the United States). The different schemes in each system do not constitute an integrated national system securing universal entitlement (Chernichovsky, Martinez, and Aguilera 2009).

The nonuniversal market arrangements are associated with a formal labor market; the nonmarket arrangements, with the informal labor market. This difference is significant from the SHI perspective. In the formal labor arrangements, employers and unions can provide frameworks for SHI; in the informal markets, other frameworks are needed for the establishment of SHI nuclei.

The last two models signify integrated national systems that secure universal entitlement and, by implication, mandated contributions and free enrolment. These, as well as the Universal General Revenues (UR) Model, not considered SHI, conform to the principles of the EP. In the UG and UP Models, the state secures universal entitlement by regulating the collection of contributions, and their allocation. Any of these three models is considered a strategic objective for developing a health care system, including that of the United States.

In general, the progression to the right by the models presented in figure 3 and counterclockwise (figure 2) indicates wider and larger social and economic circles of risk pooling and cross-subsidies, culminating at the national level in the UG, UP, as well as the UR Models. This progression occurs in a mercurial process in which households transform into groups marked by intra-group subsidies (phase 1, figure 2), and groups transform into a national system marked by intergroup subsidies (phase 2, figure 2), thus forming a universal national system marked by inter-household subsidies without group brokerage (phase 3).

3.a. The Informal, Nonuniversal, Nonmarket Model

The INN Model comprises mutual aid, microinsurance schemes, and voluntary community (social) health insurance.[5] These schemas can be considered primeval forms of SHI. Members of a cohesive group pool their resources to compensate for damages some members might incur in situations in which the probability of damage (risk) as well as the claim (benefits) are random.

Microinsurance units normally pay for each benefit (e.g., consultancies, lab fees, hospital bed, drugs) rather than covering specific pathologies. Because the "premium" is not determined in relation to the risk but rather in relation to the member's perceived ability to pay, it is a subsidy. Payments to the provider institution can be made in advance, but need not be. The pooling of resources to fund benefits is thus often of a virtual nature. This follows the group's inability to form an insurance scheme due to insufficient size and lack of appropriate infrastructure.

In the case of wider community social insurance, the system might be more advanced in that members "prepay" to some pool. If members' contributions are neither based on their individual risk nor on their actual income, both difficult to assess in many situations, the contribution could probably be viewed as a rudimentary form of community rating.[6] The pool is more obvious and so, too, is the payment system to providers.

In the general framework advanced here, the group controls both funding and fund holding. It controls the latter also by controlling entitlement and potentially morally hazardous as well as adversely selective behavior by disallowing opting out of the system. Members cannot use subsidized care at will, without due consideration of what the group is willing "to tolerate" and cover financially. The covenant is closed, for joining and leaving. Clearly, there is no scope for competition between groups because group cohesiveness, the foundation of its existence, defies competition. The role of the state in this case might be confined to reinsurance in the more rudimentary arrangements and, in the community arrangements, to some subsidies, in infrastructure, especially these initiated by the state itself.

3.b. The Formal, Nonuniversal, Nonmarket Model

The FNN Model comprises formal and well-defined self-governing groups that operate independently of each other, at least in funding, fund holding, and provision. This model is most common today in Latin America, for example, Mexico (Chernichovsky, Martinez, and Aquilera 2009) but it also resembles developments in Europe since the mid-20th century.

In the FNN Model, the group or corporation—mainly labor unions and large employers, notably the state—each have their own SHI arrangement along the lines defined above. Due to their considerable size and general infrastructure, such groups can effectively manage even their own supply of care. The dominance of this specific model has promoted the identification of SHI with employer-based arrangements.

Cross-subsidies and risk sharing are group or corporate endeavors, mainly through group-rated or means-tested contributions earmarked for the medical benefits of members.[7] The group governs itself, but may be subject to, and have rights under, general state law.[8]

Usually, membership in the group is based on a nonmedical cause and mandated in the relevant health care plan to prevent adverse selection. Benefits vary across schemes by their contribution base, even when some benefit from state subsidies. The different schemes or plans do not constitute an integrated national system, even if coverage can be almost universal and possibly subsidized by the state.[9]

3.c. The Formal, Nonuniversal, Market (FNM) Model

The FNM Model is closely associated with commercial insurers and plans operating as corporations that seek clients or members in a competitive market that does not exist in the context of universal insurance arrangements. Members have the right to enter and exit the groups at will for as long as they pay the required premiums. The FNM Model can exist alongside the other SHI closed-group arrangements within the same health care market. This is the case of the U.S. Kaiser Permanente, which is open to the public and uses community-rated premiums. Simultaneously, there are other programs such as the Federal Employees' Health Benefits Program (FEHB), a closed-group SHI insurance arrangement. Though applicable primarily to the United States, such arrangements are possible elsewhere, especially in the context of regulated private health insurance (Chernichovsky 2012). Such corporations might qualify as SHI schemes to the extent that they cross-subsidize between members or enrollees and have a clear form of self-governance. As such, not-for-profit institutions are more likely than for-profit institutions to qualify as SHI schemes.

Young people who are not sick, for example, are a good risk. They may enter such an arrangement, first, for the care of their children and, second, as a way to stay enrolled when they themselves age.

3.d. The Universal Group Model

The UG Model emerged from the Bismarck Model in Germany. It is based on universal, state-mandated contributions, by employers and households, supplemented by government contributions for special groups, notably the unemployed, the aged, and the indigent.

To secure universal entitlement, the state regulates the universal means-tested contribution schedules for raising funds, and the universal risk-adjustment (expected cost) need schedules for allocation of these funds. Contributions of any individual and the money allotted to him or her are now aligned nationally across groups, rather than only within individual groups. Any intra-group surpluses, positive or negative, between state-regulated collection and state-allowed spending are used for equalization across groups; groups that have surpluses subsidize groups that have shortages. The UG Model is thus an extension of the aforementioned models in that it aligns all groups as well as disenfranchised populations along common national and universal benefits and contribution rules.

Because all contributions are virtually pooled, an integrated health care system is formed for all practical purposes. The state secures equity and a measure of cost control by regulating spending. This system is also amenable to a unified health policy.

As the group—now the health care plan—continues to be the fund holder, it may or may not be sanctioned to provide care directly; it may purchase care from free-standing providers and continue to exercise strategic monopsony purchasing in tandem with group preferences about form of care. Supplemental group insurance can accommodate group and individual preferences.

In addition, and key to consistency with the EP, as contributions and benefits are universally or nationally aligned, free enrolment, signifying competition in internal markets, becomes possible. Competition is among self-governing corporations or sickness funds entrusted with the fund-holding function in the first-tier internal market and providers in the second tier (Chernichovsky 2002).

3.e. The Universal Pool Model

The emerging UP Model is financed by means-based contributions and taxes that are earmarked, and hence, paid directly into a public national or regional SHI pool rather than into the state revenue system. Similarly to the UG Model, the pool allocates funds to the plans via risk-adjusted capitation. In other words, in contrast to the previous model, employers and groups

cease to collect contributions for the group. They collect the contributions similarly to any other tax collection. This system is most pronounced in Israel (Chernichovsky and Chinitz 1995), Russia (Chernichovsky, Barnum, and Potapchik 1996), the Netherlands and Belgium (van de Ven and Chernichovsky 2003), and new systems emerging in Latin America, namely in Colombia (Londono 2000; Hsiao 2007).

4. Shaping the Institutional and Governance Infrastructure for SHI

Developed SHI frameworks, these beyond mutual aid and microinsurance, depends thus on self-governing groups and corporations. These, in turn, depend on the existence of a developed democratic civil society, on the one hand, and market insurance—management institutions, on the other. This political-economic infrastructure helped shape SHI in Europe.

Consequently, forming and reforming groups and corporations for advancing SHI (moving toward the right in figure 3) is a formidable challenge in the highly centralized state systems (e.g., Cuba, Democratic People's Republic of Korea and in the former socialist countries in Eastern Europe and Central Asia). It is no less challenging in segregated, nonmarket systems involving highly segregated environments such as these in Africa. These two political-economic extremes lack democratic traditions of a civil society, and competitive markets, including insurance-management infrastructure.

The focus of this section is on poor nations, mainly in Africa, and on transitional economies, mainly in Latin America and Southeast Asia that have wide informal disenfranchised populations that lack any form of credible health care insurance coverage.

4.a. The Group

Success in shaping groups and corporations for SHI greatly depends on the individual's incentive and discretionary readiness to become part of a collective, whether it is a socially-based closed group or a market-based open corporation.

Schwartz (1980) sees the group as an enterprise for mutual aid, an alliance of individuals who need each other, in varying degrees, to resolve common problems. A mutual aid group begins to form when a group has a need that lies beyond the original formative feature of the group, commonly, ethnicity and religion. This feature can be an extra need that causes members to

create combined social, economic, and psychosocial safety nets to deal with this need to protect themselves.

The group offers an advantage to its members by providing assistance with basic needs, including a secure food supply, self-esteem, and individual empowerment. Groups provide networks and channels for information, and give members easier access to goods and services. They are efficient mechanisms for receiving resources from other institutions including, government, nongovernmental organizations (NGOs), and development agencies. The groups can reduce the administrative transaction costs of lending and other financial endeavors (e.g., credit associations and unions) and reduce the risk of default through collective risk taking. Finally, groups can be learning laboratories, promoting skills such as enterprise management.

In the context of SHI, The group must provide these fundamental advantages to its members through the organization and management of funding, fund holding, provision, and oversight functions.

4.b. Mutual Aid, Group Solidarity, and the Social Quid pro Quo

Mutual aid can be the most natural arrangement for starting SHI because, beyond the framework of the household or extended family, this arrangement is the basic form of cross-subsidies. Mutual aid grows out of the sharing of people's hardships and suffering. It is further generated by a common concern and belief in the possibility, or rather the random probability, that the plight may occur to anyone and, as such, matters can be improved through a quid pro quo of mutual assistance. The help may take the form of group members' providing services and / or material assistance to each other or advocating that these resources be provided by the broader community. In other words, the group may combine advocacy with provision of service.

Mutual aid is characterized by delayed reciprocity among the members, depending on need and affordability. The recipient of aid is not expected to repay exactly what is received, but rather to help others in return, when fortunes change. The amount or degree of aid rendered depends on the recipient's own circumstances and those of the others in need.

An individual's income level is assessed through various mechanisms, to determine both a person's need and affordability. That is, contributions need to be fair and free of adverse-selection motives or concealed anticipation to abuse the system. Likewise, benefits need to be adequate and free of moral hazard motives or willingness to abuse the system. These conditions

are sufficient for the sustainability of mutual aid with respect to the willingness of the well-off to continue supporting the system. Fafchamps (1992) highlights how a group solidarity institution can reduce efficiency losses, mainly those that follow moral hazard and adverse selection inherent in voluntary arrangements.

The task of social and political leadership is to create a social solidarity network that promises and ensures adequate and desired behavior from group members. This task also depends on group characteristics, notably its cohesiveness: the strength of the group, its members' desire to remain part of it, and the intention of keeping the quid pro quo. Fafchamps (1992) summarizes that solidarity networks are usually based on family, kinship, lineage and clan membership, neighborhood and geographical proximity, religion, and even wealth. These feature help keep the necessary quid pro quo.

4.c. Group Formation and its Sustainability for SHI

The fundamental initial challenge of SHI is thus to create effective individual demand for mutual aid as well as microinsurance schemes. Existing and potential members must be motivated to realize a need that cannot be addressed by the individual or household, as well as the pertinent benefits from group membership, and to be convinced that these benefits would be available when needed.

The state can help organize mutual aid groups, edging toward microinsurance and community SHI, especially in developing environments and the informal sector. This effort can be built around time together and smallness, external threats, and privileged membership.

Time Together and Smallness

Time together is the fundamental asset of existing socioeconomic groups and can serve as the foundation for mutual aid and microinsurance. Small size is more likely to correlate with cohesiveness among members.

The addition of health care insurance to an existing group denominator, with the aid of legitimate leadership, is probably the most effective way to initiate group-based mutual aid and microinsurance in an environment based on out-of-pocket payment and mutual aid. The most efficient strategy is, therefore, to start with existing groups. As discussed below, though

inconsistent with effective insurance principles, starting with small cohesive groups may be inevitable.

External Threats

Examples of relevant threats can be the spreading of HIV/AIDS, malaria, and tuberculosis. Threats such as these can induce group formation consistent with an SHI strategy. While possibly cruel in some respects, this group formation confers privileges and preferential treatments to insurance holders, sending a message about the added value of the mutual aid scheme or microinsurance, rudimentary forms of SHI. Following the strategy suggested here, donor agencies are able to deal concurrently with particular medical issues while, simultaneously, helping shape the system by promoting SHI through the programs they advocate and support.

Privileged Membership

Membership must be a privilege that cannot be (ab)used at will. In Mexico, for example, sick people join the social security scheme (known as IMSS) but can leave it as soon as they recover. This adverse selective behavior undermines desirable insurance by negatively affecting the scheme financially as well as reducing any willingness to join when healthy or to subsidize the unhealthy. This undercuts a basic pillar of SHI. Closing this revolving door may involve some risks to willingness to join, but it can help a scheme establish itself. Such restricted access is essential for the initiation and viability of new mutual aid and microinsurance groups, even those built on existing social and economic groups. Finally, membership benefits from collective activity must be apparent. This can be achieved through pooling and managing resources, pooling and sharing risks, and centralized purchasing.

4.d. Take-Off (A): Escaping the Out-of-Pocket and Mutual Aid Traps

For the sake of simplifying discussion and maintaining consistency with the literature, the terms mutual aid and microinsurance have been used almost synonymously thus far in this chapter. However, the leap from mutual aid to insurance or to a microinsurance arrangement, especially in a cohesive group setting, is not trivial, even when the insurance premium is fair and affordable.

The transition from out-of-pocket payment and mutual aid, toward insurance and pertinent mandatory pay arrangements means shifting from retrospective pay (conditional upon receiving goods and services) to prospective pay (for promised goods and services, depending on eligibility rules). Prospective insurance undercuts, in some fundamental economic and probably cultural ways, the virtues of OOP and, more important from the perspective of this discussion, mutual aid.

The contractual advantages of retrospective pay are compelling, especially in an environment in which services are meager and insecure. Moreover, unaccountable civil workers and unchecked corruption contribute to the advantage of "cash on delivery." This can help explain why, in spite of the advantages of grouping for medical care insurance, the demand for insurance may be lacking in poor communities. The lack of financial markets and insurance infrastructure compounds the problem but may not be its primary source.

There are also social and cultural issues. Mutual aid is based on demonstrated need and use of medical services overseen and supervised by the group. Prospective pay of an insurance premium, especially by the poor and needy, can amount to a declaration of no need for (mutual) aid. Still worse, it may imply that the insured individual left the cohesive group in favor of an alternative arrangement that is external to the group.

These issues are reflected in the development of SHI in Europe where mutual aid was a feature of the group, guild, and eventually the insured group. This transformation from mutual aid to insurance reduces the transaction costs of mutual aid, making the arrangements more structured and transparent, but requires groups to become more coercive in terms of both contributions and membership. Moreover, groups in Europe at that time, as in mainly Latin America today, developed vertically integrated staffed models whereby the group acquired its own medical services by hiring medical staff and acquiring medical facilities. This may have been a way of ensuring service availability as some compensation for prospective payment.

Mandated membership, coupled with a vertical organizational combination between "insurance" and "provision," also compensated for loss of cohesiveness that resulted from the growth of group size and diversity. However, this kind of group, though possibly large and wide, is still not nationwide or public. The group has a common social, and possibly economic, denominator, mostly labor-market or union related.

4.e. Take-Off (B): Escaping the Trap of Subsidized and State-Run Services

Many developing and transitional economies support their populations by direct provision of free or heavily subsidized care, provided mostly in state facilities by civil servants. From the perspective of developing SHI, this situation poses several challenges.

First, it may preclude state subsidies for leveraging and promoting insurance, including basic microinsurance, for wider segments of the population and better care. Second, the price subsidies to the state-provided service can be detrimental to SHI in that they may reduce the incentive to acquire insurance by extra private contributions, especially when the service is free altogether. Third, state employees in public facilities may become major stakeholders with an incentive to block change, as they may benefit from the secure civil service status that often enables them to moonlight in the private sector.

4.f. Changing the Role of Government

With respect to the state's support to the system, the proposed shift in government responsibility from supporting the supply care or service-oriented subsidies to supporting the demand for it or insurance-oriented subsidies can be (made) a zero sum game. The institutional and political flip this transition requires is not, however, effortless, given the number of involved parties with heavily vested interests.

As outlined above, in the process of initiating SHI, the group must become an effective and credible receiving mechanism for resources from the state as well as from NGOs, development agencies, and so on. To this end, groups lacking financial and managerial infrastructure need state aid.

State support can involve assistance with managerial infrastructure, reinsurance, and safety net mechanisms, not least securing preferential availability of services for the insured. Specifically, the state needs to facilitate

- group-based insurance schemes;
- by-laws for self-governing SHI groups;

- affordable community-rated premiums deemed “fair” in an informal environment . Such premiums may actually subsidize the better-off who are heavier users of services, but are the “lesser evil” compared with out-of-pocket payment; and
- credible and accountable provider institutions identified with the group and whose income may depend on it.

Pertinent state managerial and financial infrastructure gives rise to questions of capacity and governance. These issues need to be squarely addressed in a successful SHI strategy.

4.g. Donors

Some potential ethical and political issues pose a particular challenge to the use of donor funds for SHI purposes. Donor funding plays a central role in the funding of care in many poor nations, for example, Tanzania. It is suggested above that donors can be instrumental in shaping SHI by combining the medical benefits they fund with insurance privileges. Securing preferential access to care when the supply of services is meager is the ultimate test of any insurance scheme, including SHI.

5. SHI Transitional Challenges—Transforming Groups and Stakeholders

The obstacles inherent in the transition from OOP payment arrangements to mutual aid arrangements, and from these to microinsurance and other forms of financing show the fundamental challenges involved in SHI development. The reason is that each milestone eventually creates stakeholders that can block progress to milestones farther along. Closed groups and even market corporations—critical for the initiation of SHI—can become an obstacle to its expansion through the second and third phases of SHI, when subsidies become intergroup, without group brokerage (figure 2).

Group and corporate development have been fairly spontaneous, as seen in Europe, Latin America, and the United States. However, the amalgamation of groups and the formation of integrated national systems that secure universal entitlement—through interpersonal and intergroup risk sharing and subsidies—have not been natural and have required strong leadership.

The state-led transition must be based on full understanding of the political economy of the required transitions, with due consideration given to the motives and views of stakeholders, notably existing groups as well as the key elements comprising them. That is, once self-governing groups and corporations are established and exist, the government must expand the circles of SHI to include the community at large—mostly the informal sector—and, eventually, the entire state signifying a universal arrangement. Thus, government needs to help transform nonmarket nonuniversal models (INN, FNN, and FNM) into universal group and pool (UG, UP) models and eventually, when feasible, into a general revenues model (UR). The amalgamation of groups, even those the state has helped establish and sustain, notably civil servant groups, is a key challenge in the advancement of the SHI strategy.

5.a. The Group and Market Corporation Revisited

Once formed, the group and the corporation are often statutory entities. They are political as well, balancing various intragroup interests and power sharing, especially those associated with control of the contributions for funding care (Chernichovsky, Mizrahi, and Frenkel 2009).

The common stakeholders in the closed group, part of the nonmarket models, are the unions representing labor, employers, and the professions. Internally, one of the three may dominate, and any two can form coalitions. The three can collude against the state or any other external entity that threatens the group's interests.

The same stakeholders may have considerable voice in the market corporation—the insurer, and the plan-HMO—in addition to the influence of shareholders, in the for-profit corporation. In many such situations the insurer or plan, though free-standing, may be an executive arm of a union, a large employer, or the two combined.

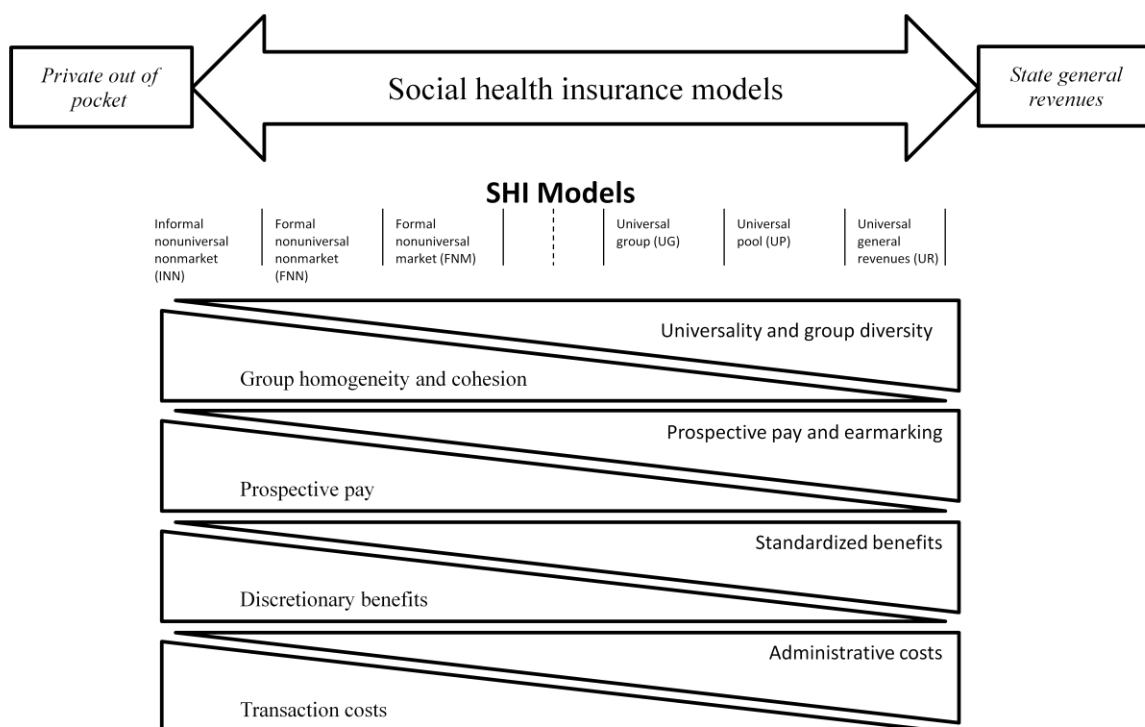
Often the state itself can form a "group" akin to the other stakeholders. This follows from several common realities. First and foremost, the state itself can control particular services it may not wish to share with others, as in Mexico (Martinez, Aguilera and Chernichovsky 2011). Second, and related to the first, such services are controlled by unions that often have their own health "plans." Third, these plans benefit from state subsidies in the form of contributions as well as privileges associated with access to state facilities, as in Tanzania, for example.

All key stakeholders, including shareholders, can stand to lose as a collective from advancing SHI to the "next step," and thus oppose change.

5.b. Collective Costs and Stakeholder Costs of SHI Expansion

The progress of SHI from one model or phase to the next, and the promise of an eventual universal integrated system, entails costs to the self-governing group and corporation. These costs are associated with the integration of diverse groups, mainly by divesting them from fundraising and fund-allocation responsibilities. The costs to the group or corporation, and by implication, the means required to overcome them are discussed with the aid of figure 4.

Figure 4: Social Health Insurance Development—Benefits and Costs



Source: Authors.

From Group Homogeneity to Communal Diversity

The erosion of homogeneity and cohesion in favor of increased universality and system integration runs emotionally deeper in an ethnically and religiously diverse environment where suspicion among groups may be substantial, and a new group identity is hard to forge. Economic growth, coupled with widening income disparity, may foster heterogeneity and diversity even in

originally homogenous groups. Specifically, the well-to-do and privileged may always wish to keep to themselves (box 4). This desire may be reinforced by new and costly medical technology that is harder to share.

The increase in group size and diversity reduces the potential for interaction among members and undermines the psychological advantages of keeping the group small for the sake of willingness to contribute for mutual aid. As the group grows and becomes less cohesive, transparency fades, and transaction costs increase. Additionally, accountability of individual members and leaders to the collective may decrease as well.

From Discretionary to Universally Shared Benefits

As universality evolves and widens, the benefits package needs to become more standardized. While standard benefits increase transparency and help earmarking of contributions and, hence, collection of funding, their uniformity can impede free choice, of individuals and groups. This is of particular consequence for the wealthy and well-to-do groups that contribute more and wish to retain their exclusive, often subsidized, benefits.

From Transaction to Administrative Costs

Wide risk-pooling circles of cross-subsidies, grounded in an optimally functioning public finance system, can substantially reduce pertinent transaction costs, mainly those involved in collecting and managing funds and purchasing care. In Israel, for example, the establishment of a national pool reduced collection costs from between 8 and 10 percent to about 2 percent. At the same time, public involvement increases administrative costs, aggravating transparency issues and giving rise to issues of accountability and governance, highlighted above. Thus, as SHI develops, there is a basic need to find ways to introduce and maintain transparency, accountability, and choice, especially for the relatively heavy contributors to the system.

5.c. Stakeholders

The privileged group or corporation is clearly the key obstacle to advancing SHI. However, opposition may also exist within other identifiable institutions.

The Privileged Group and the Corporation

To move toward the EP Model (figure 2, right) privileged groups need to be persuaded in one way or another to share existing and new state subsidies with the disenfranchised, the uninsured,

and the politically unorganized, and to open (for a fee) the closed group to potentially bad risks excluded under existing arrangements. The required change is not purely economic and financial; psychological issues associated with group identity are also involved.

The challenge of well-established market corporations, mainly insurers and HMOs, may not present a lesser challenge than do self-governing groups in the nonmarket situation. Like the self-governing groups, the corporations stand to lose their independence in organizing, funding, and managing the insurance, and may become subject to premium and open enrolment regulations. The recent Obama Health Overhaul Bill in the United States is a case in point; because it regulates insurance, the industry objected to the bill. Unlike the groups that stand to lose a social identity, the corporations—mainly insurers—stand to lose their corporate identity. In the end, they become fund-holding plans rather than pure insurers.

The Profession

The potential to increase the supply and lower the cost of medical personnel, physicians in particular, is a clear efficiency gain from funding integration and supporting monopsony purchasing in the system via SHI arrangements. Moreover, price and wage setting associated with collective purchasing of care can serve equity as well by protecting consumer surpluses from monopoly providers.

Thus, the medical profession traditionally objects to more universal coverage that usually involves more collective purchasing, although this approach may be short sighted, considering the clear benefits to the profession. Insurance increases the demand for care, in part because of moral hazard. This may allow providers even more opportunities to induce demand for care. In addition, insurance arrangements can serve more orderly payment arrangements. For providers, there can be an added measure of secure and stable income.

Medical infrastructure can be an added advantage for the profession from advanced SHI. As the system develops and the cost of technology increases, there can be clear economic and professional gains for medical personnel from centralized fund holding or purchasing institutions such as insurers that become plans and even from the state. These invest in infrastructure and centralized facilities such as labs, diagnostic facilities, and excellence centers that save individual providers resources and, at the same time, improve the quality of care.

Employers

SHI is usually associated with mandated employers' contributions. However, this view may be less significant than commonly thought. It might even be outright wrong. At the outset, employers withhold earnings-related taxes. In this regard a "health tax" (e.g., Israel) is not any different from any other tax withheld by employers. The employer is a collection arm of the state, even when the funds are eventually to be used by the employer-based self-governing group, as has happened in Germany for decades.

The health care contributions withheld by employers signify, first and foremost, their earmarked nature rather than their impact on wages. Even more important, the withholding does not necessarily suggest that employers rather than employees bear the burden of the contributions. This burden is determined by labor supply and demand conditions. Therefore, studies about the impact of the mandated contributions are inconclusive.[10]

An impact of SHI contributions on wages and employment may follow, nonetheless. Even under labor supply and demand conditions favorable to employers (in that the burden of the larger share of mandated contributions would eventually fall on employees), it might take time for employers to shift the burden to employees. In this dynamic situation, employers might finance the contributions even when they will not bear the burden eventually.

Regardless, employers have to bear the administrative as well as the labor relations costs of managing health care coverage. This is a deadweight burden on employers. Hence, regardless of how much they contribute in the short and long runs, employers and the economy overall can do without these costs.

6. Meeting Transitional Challenges

Control over the use of mandated contributions and the pertinent supply of care have been identified as critical for advancing SHI. Individuals, groups, and corporations may agree to surrender this control for the promise of a more equitable and efficient system following the EP principles, provided that the system is accountable and legitimate and provides choice.

Accountability and related legitimacy are served by transparency and good governance. The two are assisted in turn by earmarking contributions and by articulating the benefits they fund. These are key elements of the social SHI contract between individuals and the state (figure 2, phase 3),

substituting contracts between individuals and groups or corporations, and between the latter and the state (phases 1 and 2).

Choice is potentially best served by competition in internal markets where citizens can enroll freely with competing plans, where feasible, and with providers. These plans, replacing groups and corporations, can be self-governing and accountable—also through competition—both to their membership and the public at large, even when privately owned (Chernichovsky, Mizrahi, and Frenkel 2009). As suggested above, all must be supported by stewardship and leadership.

6.a. Earmarking

Earmarked mandated contributions are the key identifier of SHI. Earmarking state-mandated contributions is a constitutional-type tool that preserves the control of the contributor community over use of contributions. Contributions can be used only for politically set medical benefits and eligible beneficiaries, and not for other potential state budget uses.[11] Earmarking binds the state's budgetary processes; the state essentially becomes a trustee and a manager of the funds. Moreover, the task is often executed by a public authority that is separate from the state treasury. This institutional arrangement furthers the separation between mandated earmarked contributions and general taxation.

Earmarking is financially the basic separator between the group and the Universal Pool (UP) Model, known as the Continental Funding Model, and the Universal General Revenues (UR) Model, known as the Commonwealth Funding Model. The former is the ultimate SHI model (Chernichovsky et al. 2012).

As implied earlier, when compared with other taxes based on the same principles and schedules (such as income taxes), earmarked taxes are inconsequential for the paying individual or enterprise, and even more so for the receiving plan and provider. Israel has moved toward abolishing earmarked funding and yet has maintained other aspects of the system intact; by-and-large, general revenues fund competing sickness funds responsible for fund holding and provision of entitlement.

As implied, earmarking signifies some distrust in the state and the political process on the part of the contributors. Consequently, earmarking serves the political process: groups surrender their right over fundraising and allocation, in favor of a national covenant, on the condition that the funds are used for socially determined care benefits. Earmarking and its institutional separation

from the treasury is thus a way to help preserve transparency and accountability. For that reason, earmarking is probably an indispensable option for widening universal coverage through mandated contributions, especially where the trust of the state is low, and good governance mechanisms are weak. Earmarking can also be an effective tool for the informal sector, which might wish to avoid general taxation because of its deadweight, but would agree to pay an SHI tax, provided that its proceeds are indeed segregated from the "not trusted state."

Trust in the state's good governance and political processes can render earmarking redundant, leading up to the UR Model. By the same token, distrust of the state can reverse this progression from the UG and UP Models to the ultimate UR Model. Former socialist countries backed off the strict UR Model because of distrust of the state and its budgetary process, at least for funding medical care (Chernichovsky, Barnum, and Potapchik 1996).

Earmarking funds raised through public regulation and principles is, however, a contentious issue that concerns fiscal policy and budget management questions involving macroeconomic issues beyond the health care system. Because earmarking binds the state's budgetary process, treasuries (justifiably from their perspective) dislike it. When the taxes have not previously existed in the form of group- or corporate-mandated contributions, treasuries can become a major power blocking taxes earmarked for health.

In addition, earmarking is not costless to the health care system. A general tax is more equitable and efficient than an earmarked tax because it provides broader opportunities to use public funds: one of its goals is to serve the public's health through nonmedical spending. In other words, earmarked contributions, though serving medical care, may not serve health optimally. Moreover, since all systems benefit in one way or another from general revenues, the state can always use the earmarked amounts to justify a decrease in its own contribution. And, earmarked funding often requires extra collection mechanisms that raise the cost of running the system.

In addition, general revenues can potentially eliminate the business cycle effect, but an earmarked tax in itself cannot. The latter may expand with an economic upswing and contract with a downswing. General revenues can always include deficit finance to cope with business cycles.

Hence, an earmarked tax can be a double-edged sword. This state of affairs, combined with the reality that earmarked contributions can share identical public finance principles with general

taxation, make the debate on this issue normative and political because it deals with the social contract that earmarked taxes represent.[12] For all these reasons, earmarking should be carefully tailored to interact with the general budget to give the health care system financial stability and a safety net against cyclical fluctuations. Earmarked taxes can be phased out in the modern economy where they may still be a debated political issue.

6.b. Individual and Plan Choice and Empowerment

In addition to the consequences of loss of control over funding by individuals and groups, the progress of SHI (toward the right in figure 4) signifies standardized and uniform entitlement. Grouped and incorporated individuals lose some control over the content and form of care they fund.

The pertinent challenge of advancing developed SHI is dual. It must satisfy diverse and often politically powerful groups that surrender rights. Simultaneously, it must appeal to individuals who might be “liberated” of choices made by unresponsive bureaucrats and stakeholders. Educated and well-to-do clients have different aspirations, demands, and options from those of less-informed and poor clients. Moreover, the demands of the stronger groups continue to pose a risk to the public system, especially where supply of medical personnel and services is limited. Private pay—both over and under the table—can continue, luring civil servants and others paid by the public from serving everyone under public entitlement.

Diversity, and hence political support of the powerful groups, in the UG, UP, and even the UR Models (figure 3) can be served by statutory power-sharing between the central state and, where feasible, competing and self-governing health care plans or noncompeting local jurisdictions, about the determination of content and form of entitlement, and nature of voluntary medical insurance.

Contents and Form of Entitlement

Choice concerns content and form of benefits.[13] There is relatively little debate or argument about the form in which entitled care is offered. Competing plans (if any) and providers in the same internal market, operating under mandated contributions, can offer and experiment with variable forms of supplying identical benefits as the offering complies with the entitlement regulations and “common practice.” Content of care is more debated than form. The challenge is

dual: to allow pluralism in entitlement and to strike a balance between the supplies of publicly funded and privately funded care.

A potential solution entails defining three levels of entitlement**:** core benefits (CB) under public entitlement, supplemental benefits (SB) regulated by groups or even the central state, and wholly privately funded benefits. The first, basic level is common to all, involving types of care deemed not subject to individual discretion. Notable among these would be prevention and treatment of communicable diseases and treatment of diseases that are potentially “catastrophic” for the household’s financial well-being.

The second level is a discretionary package, available on a voluntary basis to groups self-formed around some common denominator, including the extra benefits package itself. Though voluntary, this package may be subject to community rating and open enrolment regulation. The third benefits package is a fully privately funded package of benefits paid by OOP and individually rated insurance. This solution exists in Israel where sickness funds, which provide CB, are regulated to offer “supplemental insurance” for community rating and with open enrolment. In Belgium, enrolment in insurance of this nature is mandatory.

The proposed arrangement might be implemented by a state administration (e.g., the National Health Service), but competition among several plans might be easier. Each plan could offer several combinations of CB + SB, affording a wider choice than would be possible under a single administration.

The proposed arrangements leave some choice about even content of care even under publicly supported or regulated care. The supply of these benefits must be organized to forestall interference with the publicly supported system. If inadequately regulated and organized, the supply of benefits under OOP and VMI can interfere with the objectives of the publicly supported system, notably equity and cost containment (Schut and Roos 2008; Chernichovsky 2012). Moreover, regulation, notably around open enrolment, should prevent making SB a means for selecting bad risk for the basic package.

Open Enrolment in Competing Plans

Open enrolment with plans, where feasible, and with providers, is critical for exercising choice and minimizing risk selection under universal entitlement.[14] Fund holding plans can thus be

considered “groups,” formed by citizens’ (or residents’) choice and open enrolment, regardless of innate or acquired traits (Chernichovsky 2002). As such, competing and open plans can be effective and politically appealing substitutes to the privileged group, especially if the latter is dominated by an unresponsive interest group and bureaucracy.

Still, some groups may wish to maintain their identity. In that case, they can become fund holders or plans that have relinquished their fundraising and allocation responsibilities for entitled services, but retained their fund-holding and provision responsibilities in agreement with the plan’s membership. Offering optional voluntary medical insurance within the plan can even strengthen the group’s political willingness to relinquish control over contributions to fund entitlement. Hence, while such groups may in the end lose control over spending levels and the full scope of the benefits package, they can express group preferences by determining the nature of contracting entitlement, and possibly influence the benefits package.

6.c. Governance

Good governance is about rules and regulations that serve transparency and legal and political accountability, and thereby support a well-functioning system. Good governance is thus also about political legitimacy to widening SHI. It can be a formidable challenge in “developing” situations where corrupt and unresponsive group bureaucratic “elites” may be the norm. At times, small, well-governed groups may provide a better, if second-best, solution than a corrupt, ill-functioning, and legitimacy-lacking government. This implies delicate balancing acts in the development of an SHI system and suggests trading responsibilities between the state and groups, with transparency and accountability the fundamental issue.

SHI organized in plans can present an institutional opportunity to introduce pluralism and market-based diversity into the publicly financed health system. The authority delegated to plans as consumer groups, through their ability to participate actively within the system, means that they can substantially determine the nature of public entitlement—both its elements and the form of its delivery (Chernichovsky 2002). This arrangement can preserve the powers of both groups, especially during transition, and of the citizenry at large.

7. Conclusion—The Roles of the State Revisited

The state's stewardship in devising and implementing SHI is indispensable because SHI involves integrating—at times through coercion—individuals into groups, and groups and corporations into larger entities. In view of the prospective nature of commercial insurance and its potential for exploitation, especially as the risk-sharing and cross-subsidy circles grow, there is a need to promote systemic legitimacy and trust through transparency and accountability. This involves setting and enforcing rules and regulations so that institutions and internal markets function well. To sustain their fiduciary role, plan institutions must be carefully regulated, while care to preserve their independent nature is exercised.

As for funding, the state needs to see that public funds are protected and used prudently and that the health budget is insulated from fortuitous events, including swings in the business cycle. A critical element in securing an equitable and efficient system is developing and upholding a universal, risk-adjusted capitation allocation mechanism so that groups get their fair share of public-based funding and people are not discriminated against.

The state must ensure citizens' access to plans of their choice through open enrolment. It must also guarantee their access to efficient and equitable services by securing service availability, controlling monopolies and monopsonies, and supporting research, training, and centers of excellence. These support the smooth functioning of internal markets.

Nonetheless, to the extent possible, the government should avoid issuing directives aimed at protecting the paying public's interest. Instead, it should achieve that objective through a fair (risk-adjusted, need-based) allocation system, public information, flexible guidelines, and the support of contractual arrangements between consumers and fund-holding institutions, and between those institutions and providers. Key to all the above is an unbiased government that can serve as an honest and credible broker for all, judging merit on efficiency and equity grounds. These require, first and foremost that the state itself does not assume and assert vested interests in the systems as a fund holder and provider.

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[1] The *group* is a social entity that comprises two or more individuals who bond to resolve common problems and provide mutual aid. Enrolment is based on innate or acquired social or economic characteristics. Opting out for privileges rendered by the group is forbidden.

[2] The *corporation* is an economic entity, for profit or not for profit, which individuals join by paying for the privileges rendered by the corporation. Entry and exit are based on willingness and ability to pay.

[3] Nominally there *is* universal coverage in most developing countries.

[4] For brevity of discussion, it is assumed here that an insurer’s right to refuse to admit a bad-risk individual into an insurance-based group is consistent with an individual’s market right. The sick individual always has the right to pay the highest fair premium: the fee for service. The fee amount may be prohibitive in terms of the individual’s ability to pay, a situation applicable to many other goods and services in the market.

[5] Here *mutual aid* and *microinsurance* are used almost synonymously. Subsequently, this approach is changed.

[6] The authors are indebted to D. Dror for this articulation of micro insurance (Dror and Jacquier 1999).

[7] At times the contributions for health care might be incorporated in general social security contributions involving notably pensions.

[8] Some arrangements with the state, for special groups and in lieu of state subsidies, are possible and common. State support of such groups in general invariably involves subsidies. Those, however, are not necessarily equalizing.

[9] About 95 percent of Israeli residents had health insurance coverage through the end of 1994, prior to the enactment of the National Health Insurance Bill, which secured every resident's entitlement to set medical benefits. This example signifies the importance of the integrated national health system, beyond universal coverage.

[10] To some extent, these studies may deal with the counterfactual. They cannot establish what the impact would be of an added income tax to fund health care.

[11] Earmarked funds may not be entirely immune from general government spending. Earmarked funds can be regulated, and probably should be, to be invested in state bonds that help set the government's spending envelop.

[12] For a more formal and detailed presentation of the arguments and the issues, see Chernichovsky and Chernichovsky (2006).

[13] For elaboration, see Chernichovsky (2002).

[14] Internal markets supporting plans are not always feasible, especially in nonurban areas where the supply of both providers and managerial and financial infrastructure is limited. Still, ways of empowering local populations need to be sought (Chernichovsky and Chernichovsky 2006).