SURE Rapid Response

Does Social Health Insurance improve Health System organization and utilization of services?

April 2011

This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

Key messages

- The legislative and re-organizational process involved in setting up Social Health Insurance schemes provides orderly and planned structures for administration and execution of plans, requiring the creation of an autonomous organizational unit to manage the activities

- Social Health Insurance improves organization away from the three tier level of the health care system that results from publicly financed and operated health care systems which usually leads to exclusion of the poor thereby improving equity

- Not many rigorous studies have been done on appraising Social Health Insurance, however those found show that it improves service utilization for the general population and for vulnerable groups too.

Who requested this rapid response?

This document was prepared in response to a specific question from a policy maker in Uganda.

This rapid response includes:

- **Key findings** from research
- **Considerations about the relevance** of this research for health system decisions in Uganda

Not included:

- Policy or practice related recommendations
- Detailed descriptions

What is SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network **(EVIPNet) in** Africa and the Regional East African Community Health **(REACH)** Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme. www.evipnet.org/sure

Glossary

of terms used in this report: www.evipnet.org/sure/rr/glossary

Background

One of the major barriers for access to healthcare in both developed and developing countries is organizational and financial constraints, which may be worse for some groups in the population. Within these countries several sections of the population are even more vulnerable than others and may, for example, be impoverished due to high out-of-pocket expenditures on seeking and using health services; these sections of society need protection from this kind of risk and one of the interventions that is thought to provide a solution to this is Social Health Insurance, also called Voluntary Health Insurance. The potential effect of social health insurance on individuals, populations and health systems is significant. For example, its effects could cause significant progress towards achieving the Millennium Development Goals (MDGs); universal access to health care services due to Social Health Insurance would not only affect the MDGs directly related to health, that is, goal 4 (reducing child mortality), goal 5 (improving maternal health) and goal 6 (combating HIV/AIDS, malaria and other diseases), but would also have a major impact on achieving the first goal of halving poverty by 2015.

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

The World Health Organization and the World Bank do support strategies to mobilize more resources for health, risk pooling, increasing access to health care for the poor and delivering quality health care in all member states but especially low income countries [1, 2].

The main objective or aim that health systems turn to Social Health Insurance for is to attempt universal coverage of health care for their populations providing financial protection from catastrophic spending during ill health. They effectively spread the risk and pool revenues in the process. When the risk of utilizing services is reduced, it is assumed utilization of services should increase and this paper will show that that is one of the effects of social health insurance. In addition it will explore the literature for the fact that as the scheme is set up and run, it in fact improves health system and services organization.

Summary of findings

These findings that show a positive impact on health system organization by Social Health Insurance are based on a series of publications [3-6]

During the set up and implementation of a Social Health Insurance scheme, legislation providing a legal framework that would be responsible for the authorization of mandatory and earmarked contributions for different health care activities and services is required. In addition, it also requires the creation of an autonomous organizational unit out of the usual main stream health system structures to manage the program. This legislative and re-organizational process provides orderly and planned structures for administration and execution of plans. The process of setting these up especially the legislation, has also been found to prompt national debate and discussion, raising public awareness of the problems facing the health services and sector as a whole, and trying to find possible options for solutions especially for its organization.

Social Health Insurance uses unit costing to decide on the actual costs of different benefit packages and therefore establish whether they are affordable under the given financial circumstances. It is the norm that choices are made on the inclusion or exclusion of given services under the arrangement. This is advantageous for health system organization, in terms of planning and projecting, and evaluation eventually, for the providers and planners and also for the public's expectations. If there are any left-over funds these can be used to fund co-payments and deductibles. So with Social Health Insurance there are opportunities for more careful and rational planning as health authorities endeavor to equate the revenues collected to what they are spent on. Organization and planning is better as authorities are forced to avoid over-generous and vague entitlement packages (which is quite common in the state-funded arrangements), packages here are usually well defined. For example in Kenya, there was a hesitation in passing a law for implementation of Social Health Insurance because of the vagueness of definitions, benefits and the like.

Social Health Insurance will eventually improve organization as it increases equity considerations because of the debate it leads to, on subsidizing and expanding coverage for the poor. This exclusion of the poor that ensues from the three tier level of the health care system of publicly financed and operated health care system is usually present and known but it is not often debated and discussed as it is under Social Health Insurance. Social Health Insurance debate makes the lack of coverage visible and even quantifiable, and mounts political and social pressure for it to be dealt with. Authorities are forced to organize services better or discuss options of doing so to ensure equity.

Health system and service organization is better as there is better clarification and redefinition of the roles of ministry of health. Because there is formation of a new, usually semi-autonomous organization to raise the revenues and contract providers, the Ministry may then be left to run other important roles like licensing and accreditation of providers, policy making and overseeing the activities of the new organization and provide guidelines for providers or settle disputes that may arise. Roles are re-distributed with the central body being relieved of some duties that are delegated elsewhere thereby increasing its efficiency. For example, the ministry of health in Ghana is now placed to make policy and regulate health care services but not provide them, and the feeling is that it is working much more efficiently than before.

With Social Health Insurance and therefore extra revenue, the ministry is able to re-organize and streamline its activities, avoiding the effort to package many of them under one name so as to fit in a lot under one program under funding for one line item. For example in the Philippines, providers that offer services such as DOTS and maternity coverage are reimbursed by Social Health Insurance, these do not have to be under different programs but can run in their entirety. Similarly in Colombia, about 4% of Social Health Insurance revenues are allocated to a promotion and prevention fund which funds different prevention and promotion activities without these having to be compromised as is the case with so many health systems that are limited by funds. In Columbia still, another 2% of Social Health Insurance contributions is set aside for maternity leave benefits which is probably not feasible without this additional funding.

Social Health Insurance facilitates the separation of financing and provision of services, which policy is becoming quite popular. The insurance fund manages the financing and contracts out to public and private providers the delivery of services. This is derived from the fact that government is a good fund mobilizer but usually a poorer service provider, at least when compared to the private health care providers. So Social Health Insurance acting as a third party purchases (but does not provide) services and leads to a competitive environment which pushes providers for quality services. Therefore through Social Health Insurance re-definition of, and increased emphasis on various public roles, it makes better use of the public sector's comparative advantage stewardship strengths and those of financing public goods and health services with positive externalities, and subsidizing the poor, and looks to alternative entities to take care of the roles that they seem to be relatively stronger at.

Social Health Insurance improves organization as the arrangement is more responsive to clients or users of health services' preferences and complaints, and is also more accountable, which is quite rare in developing country settings. For example there are procedures provided to handle grievances; the social contract between contributing members and the Social

Health Insurance system provides for grievance procedures if benefit entitlements have not been honoured. In fact this provision is among the criteria World Health Organization uses to assess the performance of national health systems. It improves the responsiveness and accountability of the system.

Social Health Insurance is able to provide mechanisms of revenue pooling and spreading of risk within the health system. This not only expands access to quality services by the insured, but is also able to raise more revenues for health in addition to what is generated from general taxation; for example in the Philippines, this resulted in a reduction in out-of-pocket expenditures for health by about 10% in a period of 5 years, thereby removing one of the barriers to health services and increasing utilization. Furthermore this reduced out of pocket expenditures for health services coupled with the spreading of risk is able to avert catastrophic spending for a number of people in the lower income levels.
In addition, the health system and services are less dependent on budget negotiations than state funded systems are. This improves their organization in terms of disbursement and availability of funds for programs and procurement of drugs and equipment or payment for given activities. It improves planning as well because the available funds are more certain than when they have to be sent from the state authorities.

Social Health Insurance encourages innovation and even experimentation on different fronts as there is an effort to get value for money and also to meet the commitment to member expansion. Within, it may and does involve consultations with more stakeholders than is usually done with state funded systems. Stakeholders may involve patient or health consumer groups, industrial groups, cooperatives, religious groups, Non Governmental Organizations, schools, insurance groups, politicians and many others, all in a bid to cause good organization of services and better health outcomes, that is attractive to new enrolments but also that is the ultimate goal of the health system authorities.

Social Health Insurance does improve health service utilization.

Not many rigorous studies have been done on this but a prospective study was performed to follow-up health service utilization and out-of-pocket expenses using a cohort design in four Colombian cities applying a four part econometric model with different socioeconomic, geographic, and risk associated variables [7]. The results showed that subsidized health insurance improves health service utilization and reduces the financial burden for the poorest, as compared to those non-insured. Other social health insurance schemes preserved high utilization with variable out-of-pocket expenditures. There were variables like family, age, geographic location and income that had a significant effect on this service utilization and out of pocket expenses. Geographic variables play a significant role in hospital inpatient service utilization.

A World Health Organization case study on Vietnam evaluating the impact of social health insurance on the use of health services and on financial protection, however pointed out that the noted increase in utilization of services is more in the access to public facility services but not to private facility services [8].

This increase in access is not only noted for the general population but even for specific and sometimes vulnerable groups. For example, a survey was done to try and establish the effect of social health insurance on children's access to primary care and it was found that among children, having health insurance is strongly associated with access to primary care [9]. And similarly in another survey to describe factors associated with use of and perceived barriers to receipt of health care among homeless persons, insurance was associated with a greater use of ambulatory care and fewer reported barriers, implying that provision of insurance may improve the substantial morbidity experienced by homeless persons [10]. Another study looking at the relationship between health insurance status and access to care among low-income persons 65 years of age and under, taking into account their social demographic characteristics and health care needs found that having social health insurance, in contrast to having private insurance or being without health insurance, was related to use of both ambulatory care and hospital care [11]. The access differences for persons in poverty were markedly significant. Among the near-poor the same was found, although the differences were less marked. Using a large state-wide database, a study was done to examine the relationship between breast and cervical cancer screening rates and socioeconomic and health insurance status among foreign-born Latinas, US-born Latinas, and non-Latina whites in California [12]. It was found that lack of health insurance coverage was the strongest predictor of cancer screening underutilization among the different groups. Similar findings were found in a study whose purpose was to identify the factors explaining utilization of health and social services by older people, social health insurance increased utilization of services in this group [13].

Conclusion

This paper has confirmed and shown that Social Health Insurance does improve organization of services in health systems and in addition improves utilization for the services in the general public and in different vulnerable groups as well. If and when implemented well and carefully, Social Health Insurance would benefit a low income country greatly in improving how its services are organised and in increasing utilization of available services, which in turn should improve the efficiency and equity of the systems too with better health outcomes.

References

1. WHO. *Sustainable Health Financing, Universal Coverage, and Social Health Insurance*. in *58th World Health Assembly*. 2005. Geneva.
2. Hsiao W and Shaw RP, eds. *Social Health Insurance for Developing Nations*. 2007, The World Bank: Washington, D.C.
3. Josep Figueras, Ray Robinson, and Elke Jakubowski, eds. *Purchasing to improve health systems performance*. European Observatory on Health Systems and Policies Series. 2005, Open University Press: Berkshire.
4. Josep Figueras, et al., eds. *Health systems in transition: learning from experience*. European Observatory on Health Systems and Policies, ed. WHO. 2004.
5. William C. Hsiao and R. Paul Shaw, eds. *Social Health Insurance for Developing Nations,*. WBI DEVELOPMENT STUDIES. 2007, The World Bank.
6. Pablo Gottret, George J. Schieber, and Hugh R. Waters, eds. *Good Practices in Health Financing Lessons from Reforms in Low- and Middle-Income Countries*. ed. T.W. Bank. 2008.
7. Fernando Ruiz, Liliana Amaya, and Stella Venegas, *Progressive segmented health insurance: Colombian health reform and access to health services*. Health Economics, 2007. **16**(1): p. 3-18.
8. Ke Xu, et al., *Health service utilization and the financial burden on households in Vietnam: the impact of social health insurance*, in *2nd International Conference on Health Financing in Developing Countries*. 2006: Clermont-Ferrand.
9. Paul W. Newacheck, et al., *HEALTH INSURANCE AND ACCESS TO PRIMARY CARE FOR CHILDREN*. The New England Journal of Medicine, 1998. **338**(8): p. 513-519.
10. Margot B. Kushel, Eric Vittinghoff, and Jennifer S. Haas, *Factors Associated With the Health Care Utilization of Homeless Persons*. The Journal of the American Medical Association, 2001. **285**(2): p. 200-206.
11. H E Freeman and C R Corey, *Insurance status and access to health services among poor persons*. Health Serv Res., 1993. **28**(5): p. 531–541.
12. Michael A. Rodríguez, Lisa M. Ward, and Eliseo J. Pérez-Stable, *Breast and Cervical Cancer Screening: Impact of Health Insurance Status, Ethnicity, and Nativity of Latinas*. Annals of Family Medicine, 2005. **3**: p. 235-241.
13. Connie Evashwick, et al., *Factors explaining the use of health care services by the elderly*. Health Serv Res., 1984. **19**(3).

The **Regional East African Community Health-Policy Initiative (REACH)** links health researchers with policy-makers and other vital research-users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States. www.eac.int/health

The **Evidence-Informed Policy Network (EVIPNet)** promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available. www.evipnet.org

This summary was prepared by

Rhona Mijumbi, Supporting Use of Research Evidence for Policy (SURE Project), Office of the Principal, College of Health Sciences, Makerere University, New Mulago Hospital Complex, Administration Building, 2nd Floor, P.O Box 7072, Kampala, Uganda

Conflicts of interest

None known.

This Rapid Response should be cited as

Rhona Mijumbi, MPH, MSc. **Does SHI improve Health System organization and utilization of services?** A SURE Rapid Response. April 2011.

For more information contact

Rhona Mijumbi, mijumbi@yahoo.com