Opinion piece

Is there a case for social insurance?

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Social insurance is an increasingly popular policy reform in developing countries. Thailand and Vietnam have long-standing efforts to achieve universal coverage through social insurance. Kenya is currently implementing such a reform. Caribbean countries have been debating the merits of ‘National Health Insurance’ since the mid-1990s; and many other countries in Asia and Africa are following suit. It is variously championed as providing a ‘new source’ of funding for health, of ‘protecting’ the poor against risk of major illness, and of reinvigorating public health services.

However, social insurance as it is being debated and implemented is probably a bad idea for most countries because it is likely to raise costs and increase inequities. It is notable that the one region of the world with little movement on introducing social insurance is Latin America, where such programmes have a history of more than 50 years and where promises of universal and equitable access remain out of reach (with the notable exceptions of the region’s costliest systems – Costa Rica, Uruguay and Chile).

What is social insurance?

One of the difficulties in assessing social insurance is that it means so many different things to different people. For some, it includes any insurance that is not for profit. For others, it refers exclusively to social security systems like the one that developed in Germany. However, the most typical social health insurance proposals are national programmes that aim to finance a basic package of services through a dedicated payroll tax. Often the proposals envision creating an independent agency for managing the health insurance fund and separating the financing of care from its provision.

Each of these elements – payroll taxes, basic packages, and separate financing and provision – can be beneficial in a well-governed health system and will probably lead to greater inequities and costs in a poorly-governed one. The risk in most developing countries is that the fundamental political problems of governing the health system will not be changed by introducing social insurance, only exacerbated. Here are some of the reasons why.

Payroll taxes and privilege

Social insurance proposals generally include a payroll tax with the justification that they: are easier to collect than general taxes or voluntary premiums; increase accountability by giving workers a ‘stake’ in the health insurance system; force employers to contribute to the cost of health care; and are more stable than allocations from the general budget.

Yet the ease of collecting payroll taxes is almost exclusively a consequence of taxing those working in formal jobs. In most developing countries the formal sector is a small, and sometimes shrinking, share of total employment. This poses the risk of turning the system into a ticket to privileged access to health services. For example, in Thailand, social security health spending per person is more than twice that of per capita spending by the Ministry of Health. In Mexico, this ratio is more than five to one.

The argument that the employers’ share of contributions will reduce the burden on workers ignores the fact that the ‘employers’ share’ comes out of business revenues, and hence is largely paid by consumers in the form of higher prices or by workers in the form of lower wages. Furthermore, payroll taxes are not necessarily more stable than allocations from government budgets. In fact, they tend to be more procyclical than general government spending.

Basic packages versus insurance

Countries often turn to social insurance because of the appeal of sharing the burden of health care costs across households. However, most proposals in developing countries focus on common health services, e.g. reproductive health care, vaccinations, treatment for gastrointestinal and respiratory illnesses. These are important health care services that national health policies should promote. But given that these services are common, frequent and ‘expected’, they do not constitute ‘insurable risks’. Consequently, funds that cover such services have to charge premiums that are high relative to benefits.

By way of illustration, consider an insurance fund for dental care. An annual check-up is considered cost-effective; everyone should get one. But then, the insurance premium has to cost at least the price of one dental visit per member. A small additional charge above that price will be necessary to cover the less frequent and more costly services (e.g. root canal treatments, implants). So insurance does not make the preventive care any more affordable. There is no ‘free lunch’. Only the portion aimed at infrequent and costly treatments actually shares the cost burden.
Thus, the intention of using the efficiencies of risk pooling to subsidize care for the poor cannot be realized. Instead, introducing a new insurance fund diverts attention from the basic social debate over how much to tax wealthier people in order to subsidize basic care for the poor.

**Active or passive purchasing?**

When social insurance separates financing and provision, it represents a significant break with more common approaches to public health services. But this separation also represents one of the greatest risks in social insurance. When payers are passive, providers can pass on cost increases and inflate health spending. In fact, payments into social insurance may not displace out-of-pocket spending at all, in which case households can end up with larger health expenditures than before.

**Social insurance does not solve the fundamental problem**

There are some very good reasons to adopt social insurance, either in whole or in part. In countries with a growing formal sector, perhaps some of the more dynamic Eastern European countries, it may be possible to follow a path similar to Western European countries that have achieved universal coverage with such schemes. In some developing countries, creating a new institution could be a good political strategy to bypass an existing system that has failed, and develop a better system aimed at achieving greater equity and better care.

Nevertheless, introducing social insurance is probably a bad idea for most low-income developing countries because the fundamental problem in these countries is not ineffective financing. The real problems are the systems of political governance that regularly under-finance health care services or spend public funds inefficiently. Under such conditions, even the best-designed social insurance system will fail.

Though many countries might benefit from creating an independent health agency, introducing ‘active purchasing’, or separating payer and provider, few require the adoption of an entire ‘social insurance’ package. At best, the attention to social insurance may divert attention from the key political and managerial problems; at worst, it will divert funds, raise health system costs and increase inequities.

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