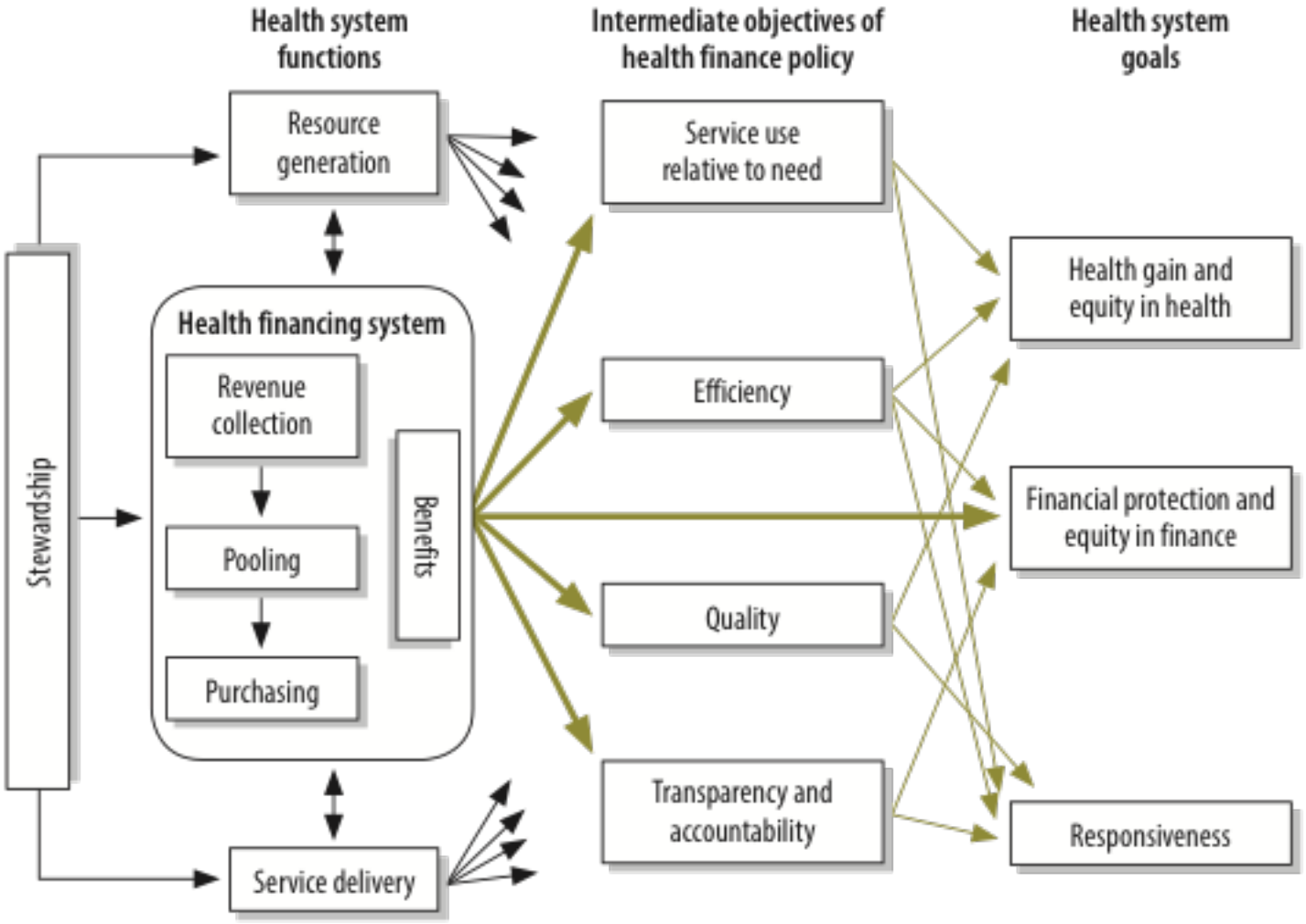
National Health Insurance

Key-concepts and country case studies

Subregional Dialogue on Health Financing in the Caribbean
Pan American Health Organization
Barbados, 28- 29 August 2018

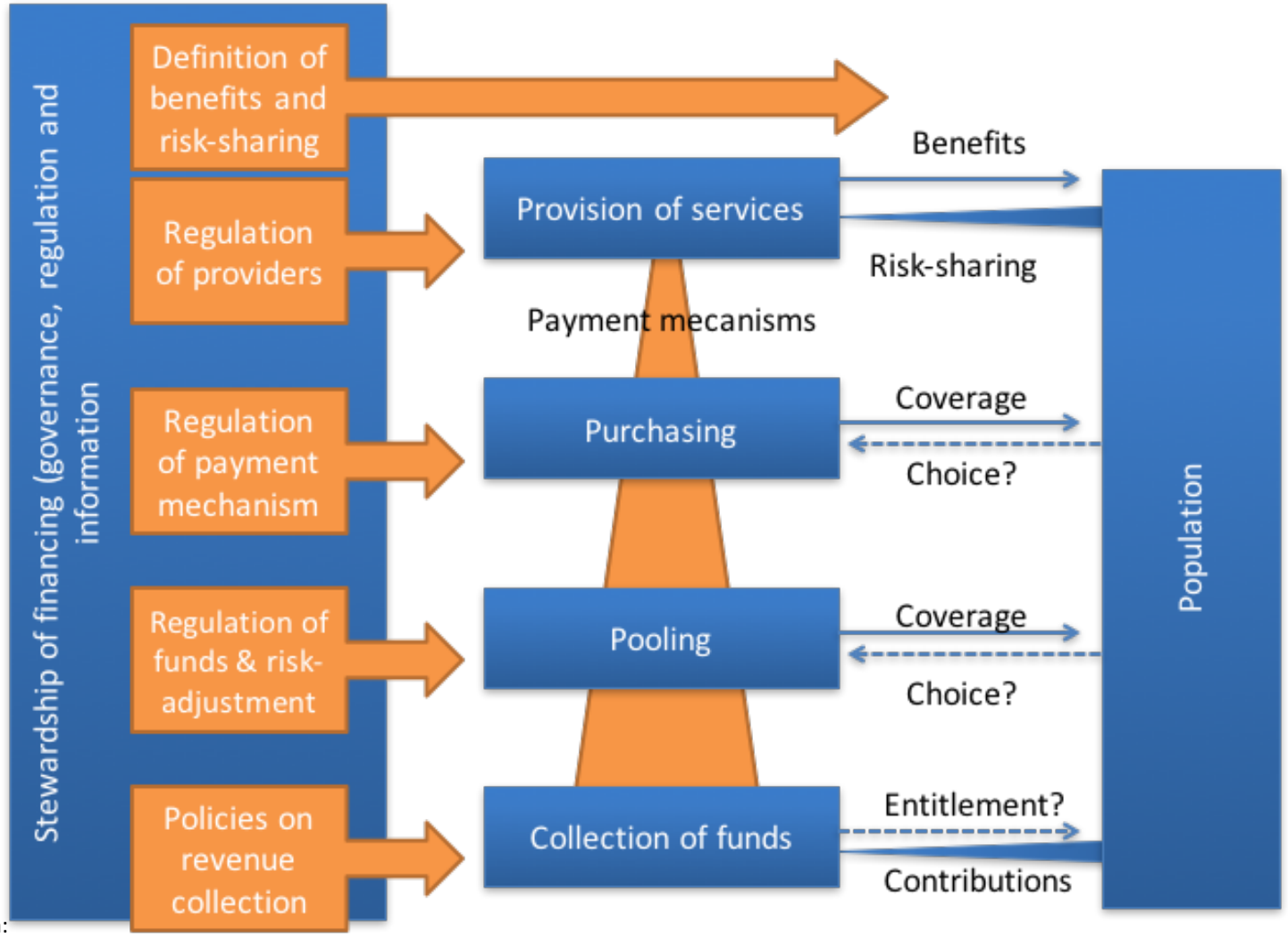
Cristóbal Cuadrado N.
School of Public Health
University of Chile

Health systems functions



Kutzin, J. Health financing for universal coverage and health system performance: concepts and implications for policy.Bull World Health Organ 2013;91:602–611

Health systems functions



Adapted from:

Kutzin, J, Cashin C, Jakab M (ed). 2010. Implementing Health Financing Reforms: lessons from countries in transition. Observatory Studies Series 21. European Observatory on Health Systems and Policies. WHO.

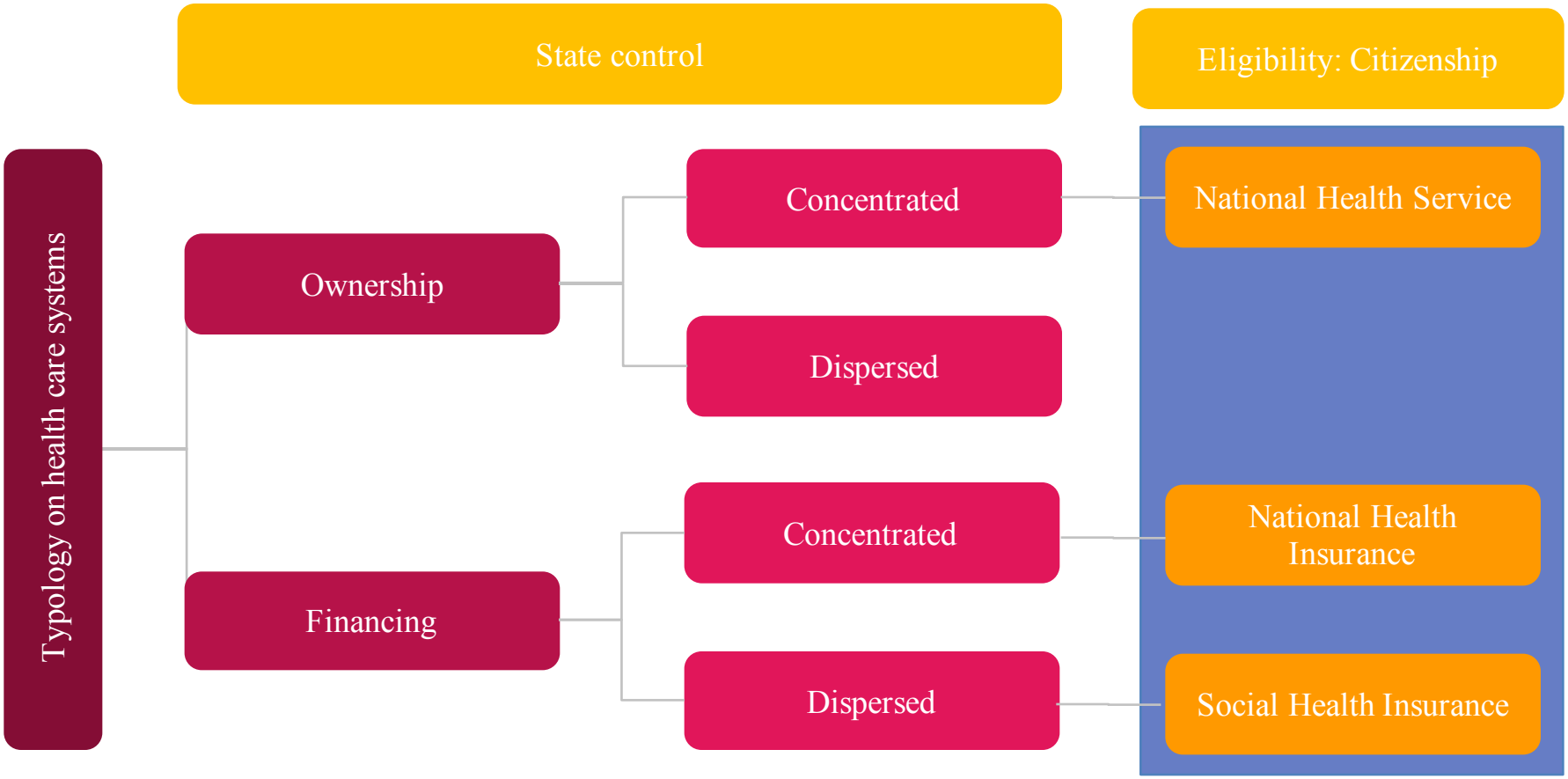
Kutzin, J. A descriptive framework for country-level analysis of health care financing arrangements. Health Policy 56 (2001) 171–204

Health systems taxonomies

Dimension	Bismarck	Beveridge
Entitlement	Contribution	Citizenship / residence
Funding base	Wages	Public revenues
Insurer	Occupational	State
Benefit package	Explicit	Implicit
Management	Independent	Government
Providers	Privately contracted	Salaried and publicly contracted

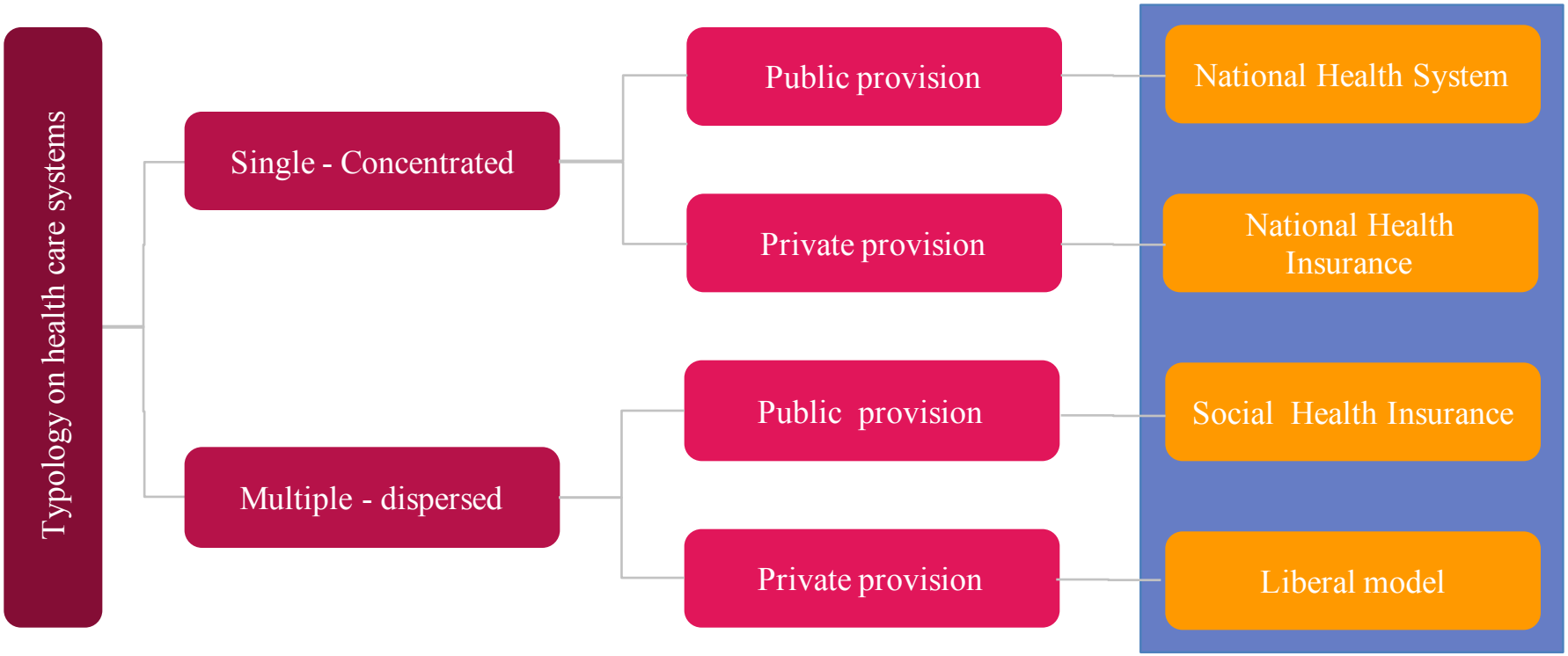
Kutzin, J. Bismarck vs. Beveridge: is there increasing convergence between health financing systems? 1st annual meeting of SBO network on health expenditure 21-22 November 2011. Paris, OECD

Health systems taxonomies



Frenk J & Donabedian A. 1987. State intervention in medical care: types, trends and variables. Health Policy and Planning; 2(1): 17-31

Health systems taxonomies



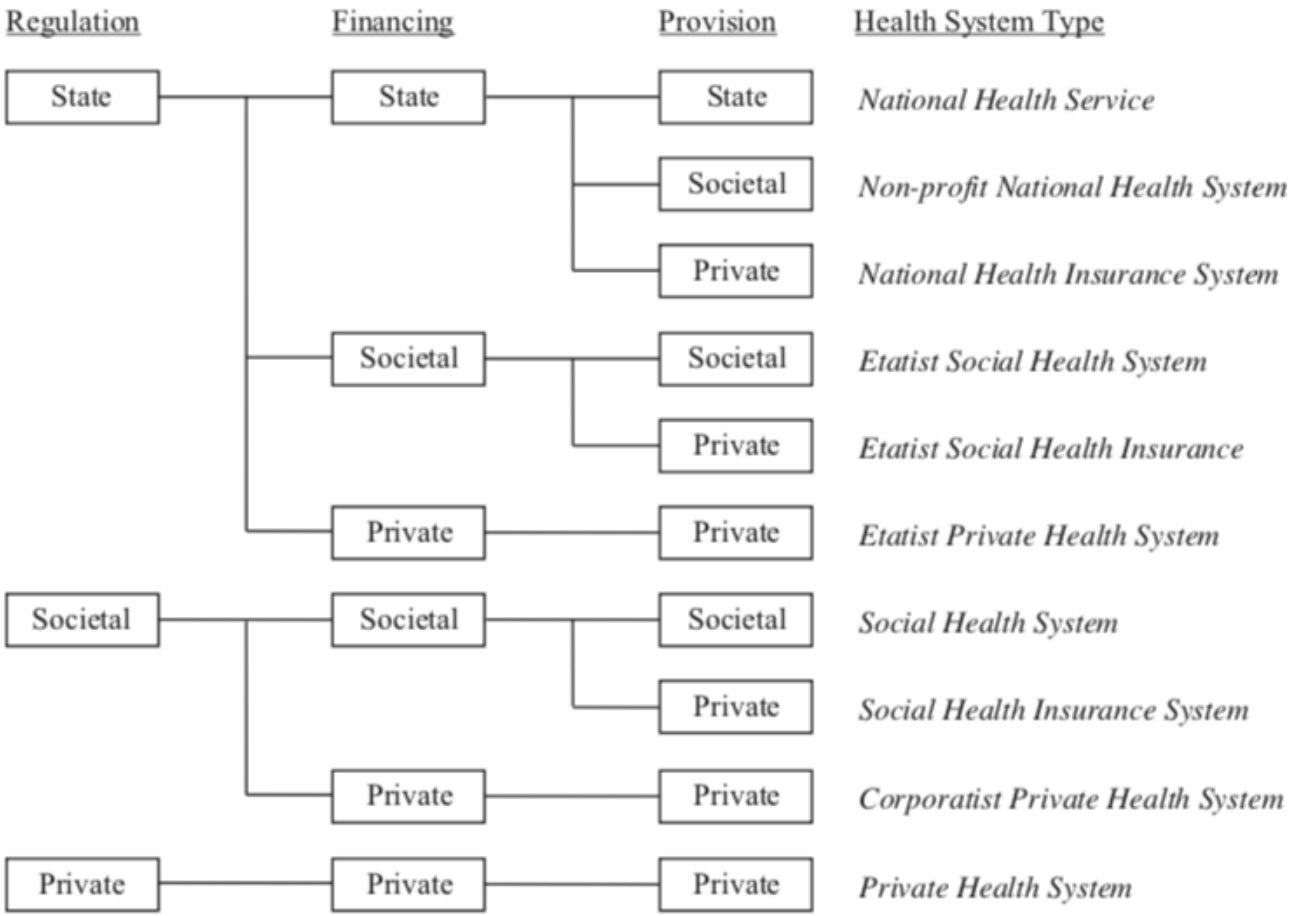
Lee S, Chun C, Lee Y, Seo N. The National Health Insurance system as one type of new typology: the case of South Korea and Taiwan. Health Policy 2008; 85(1), 105-113

Health systems taxonomies

Function	Key question	State	Societal	Private
Regulation	Who is in charge of regulating and controlling relationships relations between payer, providers and beneficiaries?	State regulation	Collective bargaining	Market mechanisms
Financing	How resources and collected and redistributed for health needs?	Taxation Ex-ante redistribution	Social insurance contributions	Private expenditure No or minimal redistribution
Provision	What is the predominant ownership of health services providers?	State provision	Private not for profit	Private for-profit

Bohm K, Schmid A, Gotze R, Landwehr C, Rothgang H. Five types of OECD healthcare systems: empirical results of a deductive classification. Health Policy 2013; 113(3), 258-269.

Health systems taxonomies



Bohm K, Schmid A, Gotze R, Landwehr C, Rothgang H. Five types of OECD healthcare systems: empirical results of a deductive classification. Health Policy 2013; 113(3), 258-269.

Health systems taxonomies

#	Healthcare system type	R	F	P	Cases
1	**National Health Service**	**St**	**St**	**St**	**Denmark, Finland, Iceland, Norway, Sweden, Portugal, Spain, UK**
2	Non-profit National Health System	St	St	So	
3	**National Health Insurance**	**St**	**St**	**Pr**	**Australia, Canada, Ireland, New Zealand, Italy**
4	State-based mixed-type	St	So	St	
5	State-based mixed-type	St	Pr	St	
6	State-based mixed-type	So	St	St	
7	State-based mixed-type	Pr	St	St	
8	**Etatist Social Health System**	**St**	**So**	**So**	
9	Social-based mixed-type	So	St	So	
10	Social-based mixed-type	So	So	St	Slovenia
11	**Social Health System**	**So**	**So**	**So**	
12	**Social Health Insurance**	**So**	**So**	**Pr**	**Austria*, Germany, Luxembourg, Switzerland***
13	Social-based mixed-type	So	Pr	So	
14	Social-based mixed-type	Pr	So	So	
15	**Etatist Private Health System**	**St**	**Pr**	**Pr**	
16	Private-based mixed-type	Pr	St	Pr	
17	Private-based mixed-type	Pr	Pr	St	
18	**Corporatist Private Health System**	**So**	**Pr**	**Pr**	
19	Private-based mixed-type	Pr	So	Pr	
20	Private-based mixed-type	Pr	Pr	So	
21	**Private Health System**	**Pr**	**Pr**	**Pr**	**USA**
22	Completely mixed-type	St	Pr	So	
23	**Etatist Social Health Insurance**	**St**	**So**	**Pr**	**Belgium, Estonia, France, Czech Republic, Hungary, Netherlands, Poland, Slovakia, Israel*†, Japan†, Korea***
24	Completely mixed-type	Pr	St	So	
25	Completelymixed-type	Pr	So	St	
26	Completelymixed-type	So	St	Pr	
27	Completelymixed-type	So	Pr	St	

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the cases of Ireland, Italy and the UK, however, we had to follow a more heuristic approach because we had no exact data on the distribution of health providers.

Bohm K, Schmid A, Gotze R, Landwehr C, Rothgang H. Five types of OECD healthcare systems: empirical results of a deductive classification. Health Policy 2013; 113(3), 258-269.

NHI definitions

Effective Insurance-provider separation

Private provider ownership

Terris (1977)

- The crucial feature of NHI is the relation of government to providers, and not the mode of financing.
- Providers are independent actors who enter into a contractual arrangement with the government to provide services.

Toth (2016)

- The name "national health service" should therefore be reserved only for integrated universalist systems; programs such as Medicare in Australia and in Canada deserve a separate category, that of "separated universalist systems".

Lee (2008)

- In the NHI model, private sectors dominantly provide health care services whereas the state centrally administers health care financing and covers all citizens.

Bohm (2013)

- NHI systems combine NHS regulatory structures and tax financing with dominantly private service provision.

Terris M, Cornely P, Daniels H, Kerr L. The Case for a National Health Service. APJH 1977; 67(12): 1183-1185

Bohm K, Schmid A, Gotze R, Landwehr C, Rothgang H. Five types of OECD healthcare systems: empirical results of a deductive classification. Health Policy 2013; 113(3), 258-269.

Lee S, Chun C, Lee Y, Seo N. The National Health Insurance system as one type of new typology: the case of South Korea and Taiwan. Health Policy 2008; 85(1), 105-113

Toth F. Classification of healthcare systems: Can we go further? Health Policy 2016; 120(5), 535-543

National Health Insurance

Functions	*Key characteristics of an NHI-type system*
Regulation	State regulation with some degree of societal representation
Revenue collection	Public sources (taxes and social security contributions)
Pooling	Single fund
Purchasing	Single payer
Provision	Ownership of providers vs payer-provider separation

Testing current definitions

Country	Provider ownership	
	Primary care	Hospital
Australia	Private	Predominantly public, 65% beds are publicly owned, 35% are private.
Canada	Private	Mixed, mostly private not-for profit
Korea	Private	Predominantly private not-for-profit. Less than 10% of beds are owned by public hospitals
New Zealand	Private	Predominantly public
Taiwan	Private	28% hospital beds are public and 72% are private not-for-profit

Table 1: *Provider ownership in NHI-type systems*

Sources: Based on Mossialos 2017, modified with data from WHO 2009, WHO 2012.

Testing current definitions

Hospital ownership in NHI-type candidate countries

Source: Health Care Resources. Hospitals. OECD Stats. OECD, 2018.

NHI in perspective

Collection	Tax-based systems	Social security based system		Privately financed systems	
Contribution	Income-related			Risk-related	
Pooling	Single fund		Multiple funds		No pooling
Purchasing	Single-payer		Multi-payer		
Providers	Public	Mixed			Private
Governance	Central government	Corporatism			Market
Provider-insurer relation	Integrated	Non-integrated			
Types of health systems	National Health System (NHS)	National health Insurance (NHI)	Social Health Insurance (SHI)	Structured pluralism (SP)	Private Insurance (PHS)
Examples	UK, Nordic countries	Korea, Taiwan, Canada, Australia	Germany, Netherlands	Chile, Perú, México	EE.UU.
Concentration	High				Low
State participation	High				Low
Market participation	Low				High
Segmentation	Low				High
Coverage	Universal				Individual

NHI in perspective

Collection	Tax-based systems		Social security based system		Privately financed systems
Contribution		Income-related		Risk-related	
Pooling	Single fund			Multiple funds	No pooling
Purchasing	Single-payer		Multi-payer		
Providers	Public		Mixed		Private
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Provider-insurer relation	Integrated		Non-integrated		
Types of health systems	National Health System (NHS)	National health Insurance (NHI)	Social Health Insurance (SHI)	Structured pluralism (SP)	Private Insurance (PHS)
Examples	UK, Nordic countries	Korea, Taiwan, Canada, Australia	Germany, Netherlands	Chile, Peru, México	EE.UU.
Concentration		Insurance = high Provider = variable			
State participation		Moderate			
Market participation		Variable			
Segmentation		Low			
Coverage		Universal			

NHI - an extension

A National Health Insurance (NHI) system is characterized by universal compulsory enrollment and benefits entitlement independent of the capacity to contribute. Collects revenues from different mandatory sources as general taxes and social security contributions. Resources are pooled in a single risk fund, achieving a minimal or inexistent population segmentation. In terms of the purchasing function, the NHI celebrates contractual or quasi-contractual agreements with both public and private providers as a single-payer. Therefore, the NHI and the providers are not vertically integrated.

Benefits

NHI - an extension

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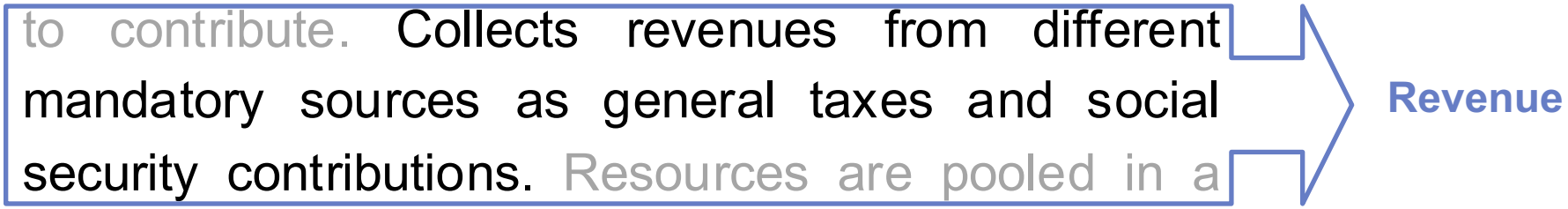

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Pooling

NHI - an extension

A National Health Insurance (NHI) system is characterized by universal compulsory enrollment and benefits entitlement independent of the capacity to contribute. Collects revenues from different mandatory sources as general taxes and social security contributions. Resources are pooled in a single risk fund, achieving a minimal or inexistent population segmentation. In terms of the purchasing function, the NHI celebrates contractual or quasi-contractual agreements with both public and private providers as a single-payer. Therefore, the NHI and the providers are not vertically integrated.

Purchasing

NHI at a glance

Functions	*Key characteristics of an NHI-type system*
Regulation	State regulation with some degree of societal representation
Revenue collection	Public sources (taxes and social security contributions)
Pooling	Single fund
Purchasing	Single payer
Provision	Different mix of providers in contractual agreements

PROSPERO

International prospective register of systematic reviews

NHS National Institute for Health Research

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The impact of a National Health Insurance in health system performance: a systematic review

Francisca Crispi, Matías Libuy, Cristóbal Cuadrado

Citation

Francisca Crispi, Matías Libuy, Cristóbal Cuadrado. The impact of a National Health Insurance in health system performance: a systematic review. PROSPERO 2018 CRD42018103439 Available from: http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42018103439

Review question

How does the implementation of a National Health Insurance scheme impact on relevant health performance indicators compared to an alternative health financing arrangement?

Searches

We will search the following electronic bibliographic databases: PubMed, EconLit, EMBASE, Campbell Collaboration Library of Systematic Reviews, Cochrane Library, MEDLINE, Epistemonikos, Health System Evidence (HSE), Centre for Reviews and Dissemination (CRD), Agency for Health Care Research and Quality (AHRQ), Grey Literature Report and OpenGrey. The search strategy will include terms related to or describing the intervention.

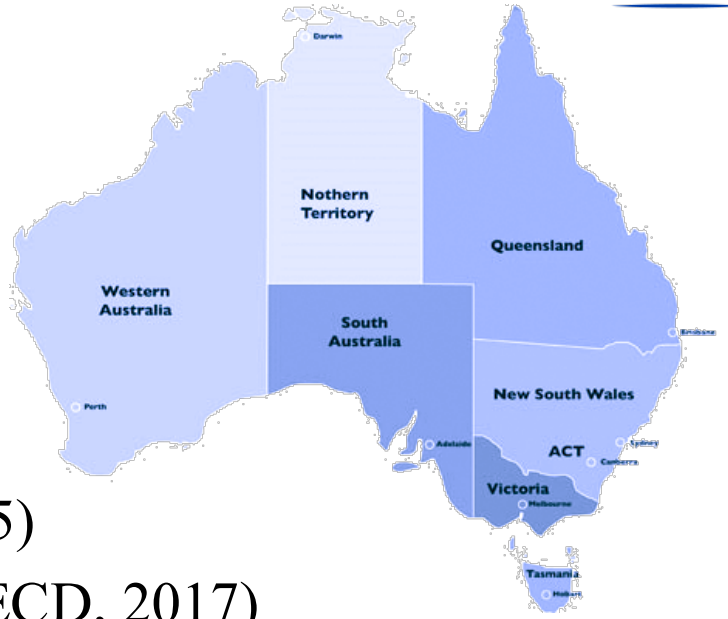
Country case-studies

How to get from here to there?

Australia - overview

24,6 million population

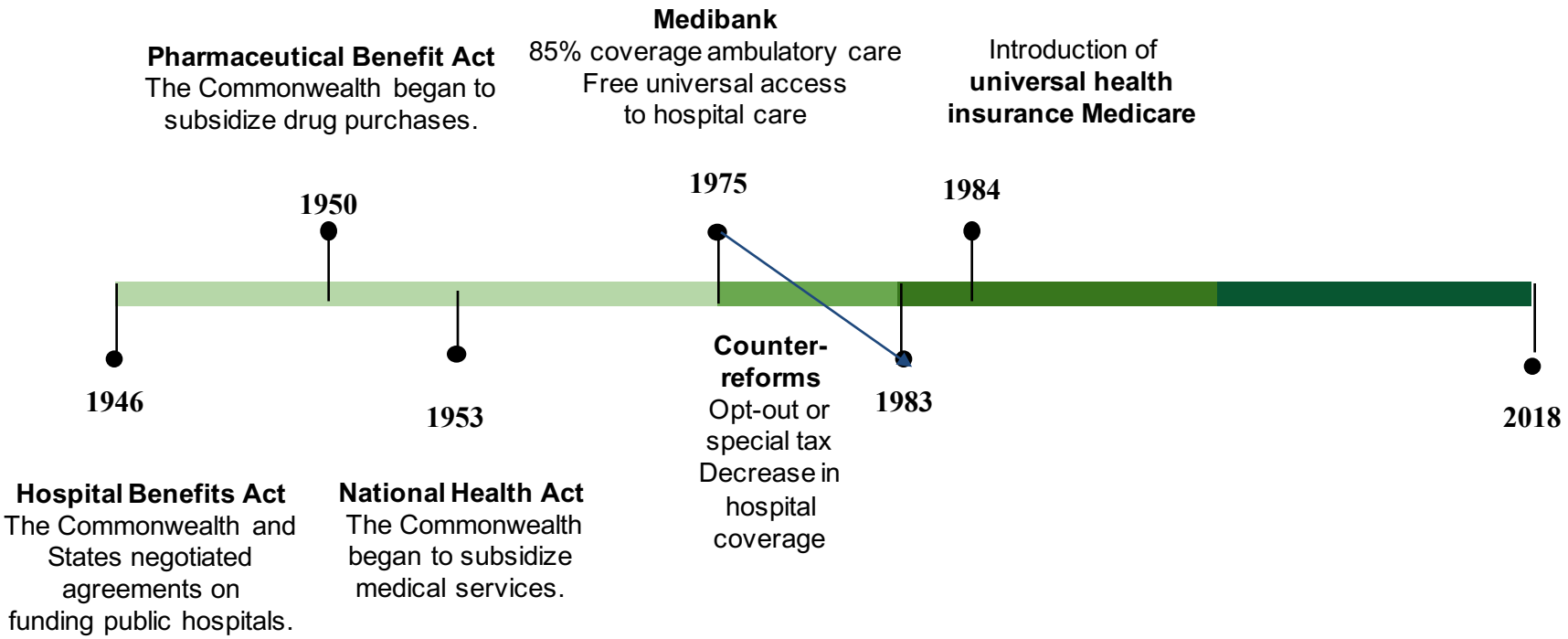
High-income country



Health expenditure

- 9.45% of the GDP (World Bank, 2015)
- Public expenditure 68.4% of THE (OECD, 2017)
- OOP 19,6%% of THE (World Bank, 2015)
- Health insurance
  - 100% of the population covered by Medicaid
- 4547 USD per capita (OECD, 2017)

Australia in transition



Healy J, Sharman E, Lokuge B. Australia: Health system review. Health Systems in Transition 2006; 8(5): 1–158.

Australia in transition

Dimension	Pre-transition	Effect	Post-Transition
Revenue collection	Before the WWII, healthcare was mainly privately funded.	✓	About 68% of total health expenditure comes from public sources, with the Australian Government financing 46% and the States 22%; the remaining 32% comes from private sources.
Pooling	Individual risk	✓	Single Fund
Purchase	Direct purchase to providers from indiv.	✓	Single payer The States differ in the way they allocate funds to health care administrators and providers.

Healy J, Sharman E, Lokuge B. Australia: Health system review. Health Systems in Transition 2006; 8(5): 1–158.

Australia in transition

Dimension	Pre-transition	Effect	Post-Transition
Benefits	- Benefits were progressively incorporated through the Hospital Benefits, Pharmaceutical and National Health Act before Medicare (or Medibank)	✓	-Medicare offers patients subsidized access to their doctor of choice for out-of-hospital care, free public hospital care and subsidized pharmaceuticals.
Stewardship	- The government had low control and healthcare was mainly privately funded and administered	✓	-The Australian Government funds, rather than provides, health services. -It funds and administers the Medicare scheme and the Pharmaceutical Benefits Scheme that subsidizes essential drugs. -Through the Australian Health Care Agreements contributes funds to the States to run public hospitals.

Healy J, Sharman E, Lokuge B. Australia: Health system review. Health Systems in Transition 2006; 8(5): 1–158.

Canada - overview

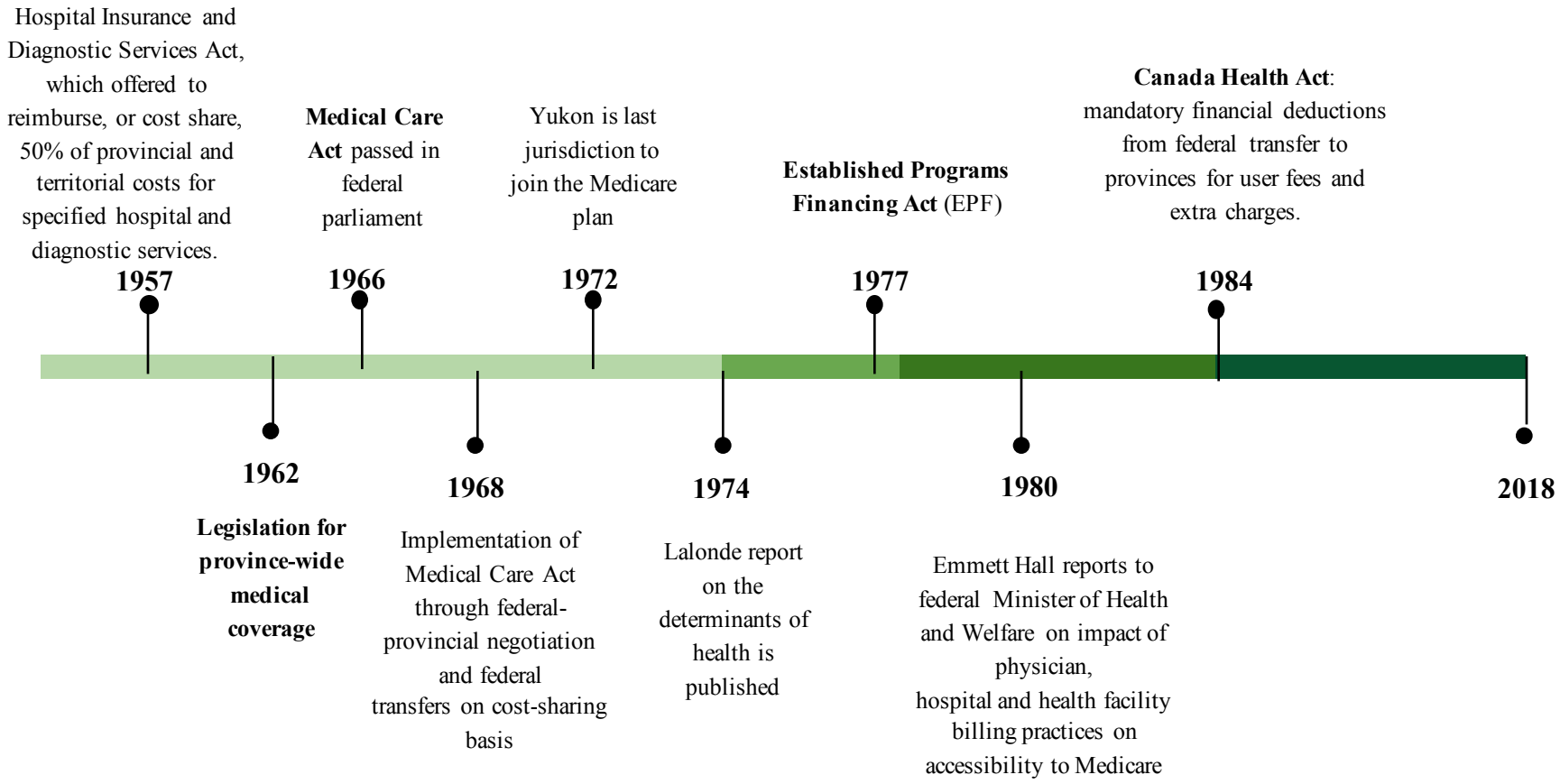
Population: 36.2 million

High-income country

Health expenditure

- 10.4% of GDP (OECD, 2017)
- Public expenditure 71% of THE (OECD, 2015)
- OOPE 14.6% of the THE (World Bank, 2015)
- Health insurance
  - 100% of the population is covered by the public insurance
- 4,826.3 USD (PPP) per cápita (OECD, 2017)

Canada in transition



Gregory P. Marchildon. Canada: Health system review. Health Systems in Transition, 2013.
Gregory P. Marchildon. Canada: Health system review. Health Systems in Transition, 2005.

Canada in transition

Dimension	Pre-transition	Effect	Post-Transition
Revenue collection	Before 1957, healthcare was mostly privately delivered and funded (OOPE)	✓	70% of health expenditures financed through the general tax revenues of the federal, provincial and territorial (F/P/T) governments.
Pooling	No pooling	✓	Single Fund, Canada Health Transfer from the federal government to provinces rely both on conditional and unconditional mechanisms for distribution of the resources to accomplish similar level of services across country
Purchase	Direct purchase from users to providers. Some public hospitals delivered free healthcare run by provincial governments.	✓	Each province acts as a single-payer for hospital, primary care and physician services using a wide variety of payment mechanisms.

Gregory P. Marchildon. Canada: Health system review. Health Systems in Transition, 2013; 15(1): 1–179.

Canada in transition

Dimension	Pre-transition	Effect	Post-Transition
Benefits	Some Hospitals offered free healthcare, but most services were privately funded.	✓	- Medically necessary hospital, diagnostic and physician services are free at the point of service for all provincial and territorial residents. The costs of outpatient prescription drugs and long-term care are subsidised. - Benefits largely defined at a provincial level.
Stewardship	Limited State or National participation. Some provinces run public hospitals	✓	- Governance, organization and delivery of health is highly decentralized - Most health system planning is conducted at the provincial and territorial levels although -The federal gov. has a role in setting the standards a general regulations for the national Medicare system.

Marchildon, G. Canada: Health system review. Health Systems in Transition, 2013; 15(1): 1–179.
Valle, V.M. An Assessment of Canada's Healthcare System Weighing Achievements and Challenges. *Norteamérica, 2016;* 11, 193-218.

Estonia Overview

1.3 million population

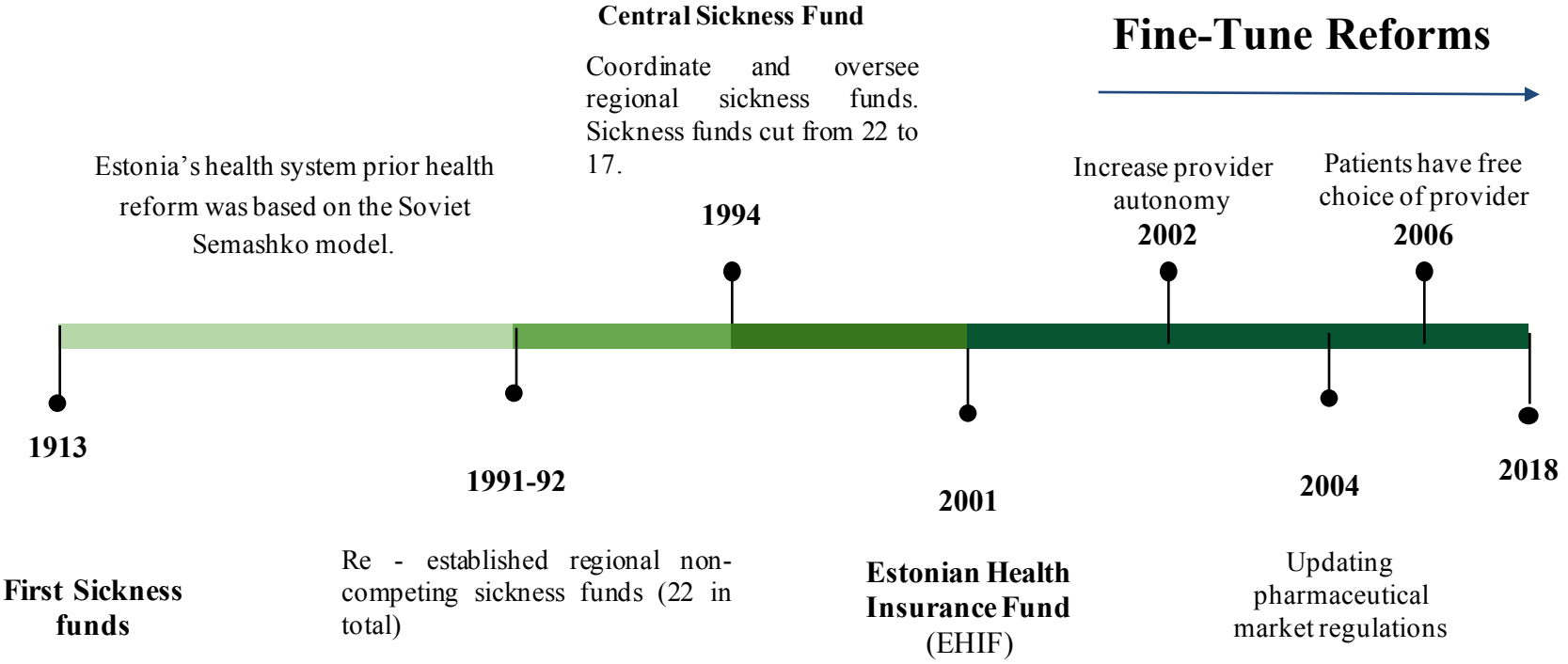
High-income country

- Member of the European Union (since 2004)

Health expenditure

- 6.7% of the GDP
- Public expenditure 75.7% of THE
- OOPE 22.8% of the THE (World Bank, 2015)
- Health insurance
  - 13% employers contribution → 65.0%
  - General revenues → 35%
- 1340 USD (PPP) per cápita (OECD, 2017)

Estonia in transition



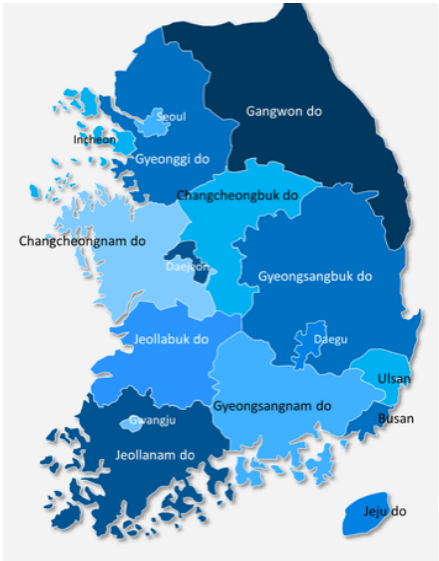
Couffinhal A & Habicht T, Health system financing in Estonia: situation and challenges in 2005

Habicht J & van Ginneken G, Estonia's health system in 2010:Improving performance while recovering from a financial crisis, Eurohealth 2010

Hsiao W & Done N, Implementation of Social Health Insurance in Estonia, World Bank Flagship Course in Health Reform and Sustainable Financing, 2009

Habicht T et al.,Strategic purchasing reform in Estonia: Reducing inequalities in access while improving care concentration and quality, Health Policy 2015

Korea - overview



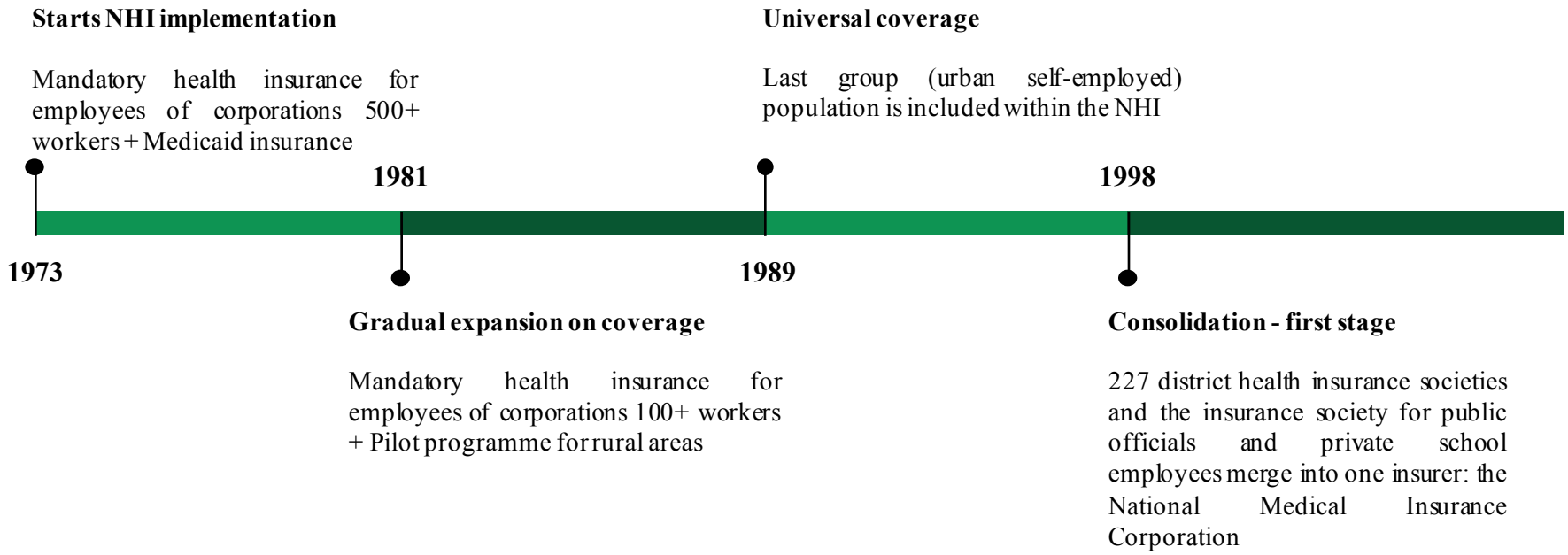
Population: 51.2 million

High-income country

Health expenditure

- 7.6% of the GDP (OECD, 2017)
- Public expenditure 58% of the THE (OECD, 2017)
- OOPE 36,8% of the THE (World Bank, 2015)
- National Health Insurance covers 96% of the population with the other 4% covered by Medicaid
- 2.897,1 per capita PPP (OECD, 2017)

Korea in transition



Jeong (2011), Korea's National Health Insurance—Lessons From The Past Three Decades, Health Aff (Millwood). 2011 Jan;30(1):136-44
Jones, R. (2010), "Health-Care Reform in Korea", OECD Economics Department Workin Papers, No. 797, OECD Publishing Paris
Kim, (2012), Gap Between Physicians and the Public in Satisfaction with the National Health Insurance System in Korea J Korean Med Sci 2012; 27: 579-585
Kwon (2008), Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage Health Policy and Planning 2009;24:63–71

Korea in transition

Consolidation - second stage

The National Medical Insurance Corporation integrate 139 workplace health insurance societies to become the present National Health Insurance in Korea single-payer

Expansion of health benefits

Progressive expansion of health benefits and increasing reform of payment mechanism and modernisation of system governance.

Complete consolidation

Insurance undis is managed integratedly for all districts, workplaces and regions.

Jeong (2011), Korea's National Health Insurance—Lessons From The Past Three Decades, Health Aff (Millwood). 2011 Jan;30(1):136-44
Jones, R. (2010), "Health-Care Reform in Korea", OECD Economics Department Workin Papers, No. 797, OECD Publishing Paris
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Korea in transition

Dimension	Pre-transition	Effect	Post-Transition
Revenue collection	- Voluntary insurance and out-of-pocket expenditures as the main source of financing. - Inequities in the capacity to raise resources between insurance sources (differences in contribution rates and contribution capacities)	✓	- Revenue mainly through mandatory social insurance contributions (5,33% of salary), half employer, half employee. - Social security contributions increased from <1% in the pre NHI period to 45,5% of current health expenditures in 2007.
Pooling	- Multiple funds (>400), - Absence of consumer choice. - Risk adjustment mechanism in the transition phase	✓	Single fund
Purchase	- Multi-payer, each fund have contracts with providers individually - Fee for services as main payment mechanism. - Fees are regulated since the early phases of implementation of the NHI for covered services.	✓	Single payer

Jeong (2011), Korea's National Health Insurance—Lessons From The Past Three Decades, Health Aff (Millwood). 2011 Jan;30(1):136-44
Jones, R. (2010), "Health-Care Reform in Korea", OECD Economics Department Workin Papers, No. 797, OECD Publishing Paris
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Korea in transition

Dimension	Pre-transition	Effect	Post-Transition
Benefits	- Heterogeneous coverage before NHI - There was no difference in the statutory benefit coverage between social insurance societies in the pre merge era. - No competition among health insurances to attract insured and no selective contracting	✓	-"Low contribution, low benefit" approach. -Progressive expansion of benefits after universal coverage. -Introduction of HTA processes to evaluate new coverages and technologies.
Stewardship	- Corporatist model (employees and employers), without state participation in the organization of the insurance funds or definition of benefit packages.	✓	- Strong control over fees of services included in the benefit package. - The MHWFA (MOH of Korea) decides upon insurance contribution rates, benefit standards, and costs of health (Health Insurance Policy Review and Coordination Committee)

Jeong (2011), Korea's National Health Insurance—Lessons From The Past Three Decades, Health Aff (Millwood). 2011 Jan;30(1):136-44
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Taiwan - overview

Population: 13 million

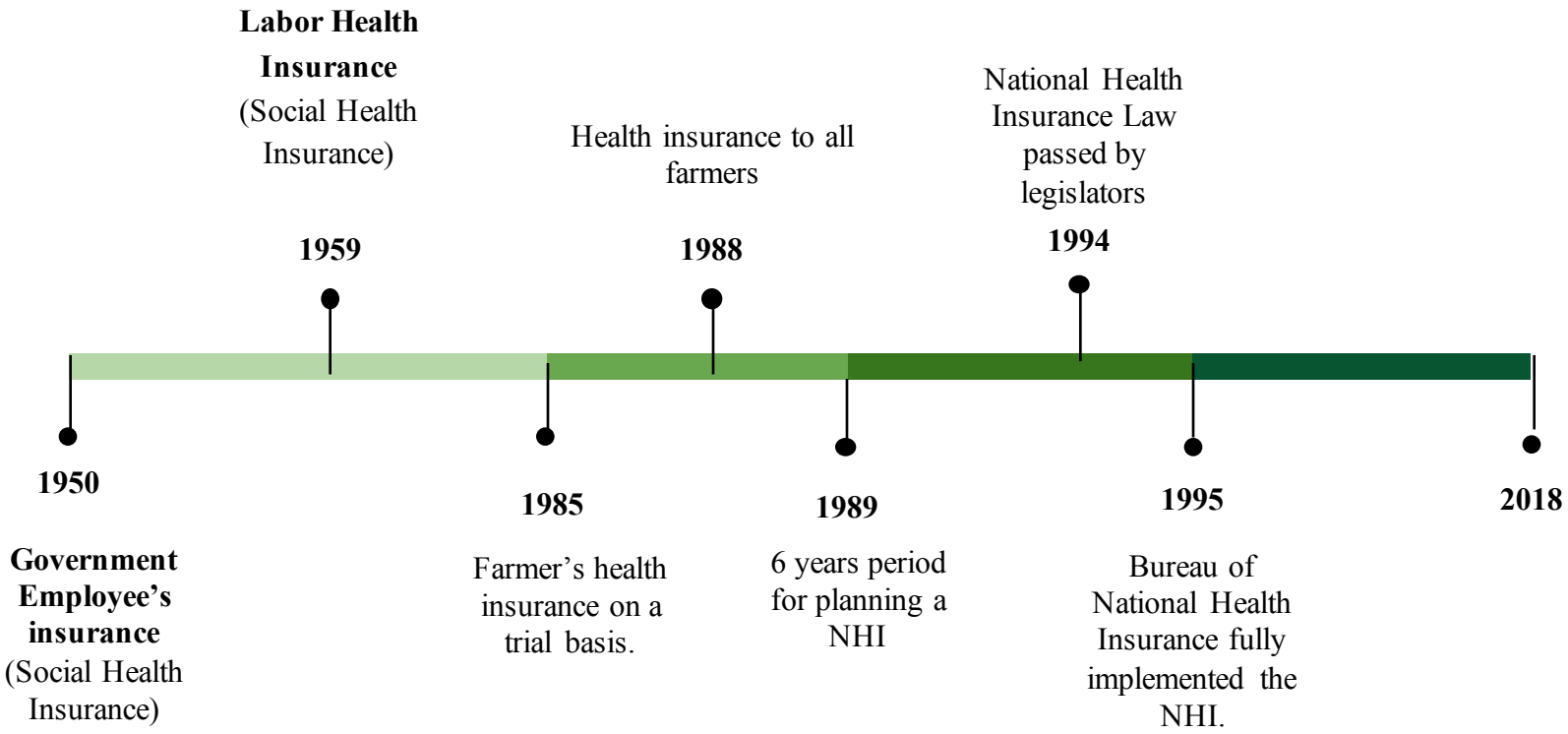
High-income country

Health expenditure

- 6.9% of the GDP (2012) (Jui-fen, 2014)
- Public expenditure 55% of THE (Jui-fen, 2014)
- OOPE 26% of THE (Jui-fen, 2014)
- Health insurance
  - 99% of the population covered (ex. prisoners and people that have moved out of Taiwan).
- 2,732 USD per capita PPP (Ministry of Health Taiwan, 2014)

Jui-fen, R. Universal Health Coverage Assessment: Taiwan. Global Network for Health Equity (GNHE). 2014. Available at: http://funsalud.org.mx/.
Ministry of Health and Welfare. Taiwan Health Profile. 2018. Available at: https://www.taiwanembassy.org/

Taiwan in transition



Wu, T.-Y., Majeed, A., & Kuo, K. N. (2010). An overview of the healthcare system in Taiwan. London Journal of Primary Care, 3(2), 115–119.

Chiang TL. Taiwan's 1995 health care reform. Health Policy. 1997;39(3):225–39. [PubMed]

Taiwan in transition

Dimension	Pre-transition	Effect	Post-Transition
Revenue collection	- Separate insurance schemes covering around 57% of the population. - Most of the general practitioners (GPs) practiced independently, high-level of out-of-pocket payments.	✓	- New sources: employees, employers and government, both national and local. - Revenue coming from government and the insured/employers was 23.2% and 76.8% in 2008..
Pooling	Multiple funds (4) with no pooling mechanisms between them	✓	Single fund
Purchase	Deconcentrated purchase (multi-payer) based on fee for service	✓	- Single payer to multiple private and public providers. - Payment is mainly F4S, although case payment and per diem are used for certain contexts

Wu, T.-Y., Majeed, A., & Kuo, K. N. (2010). An overview of the healthcare system in Taiwan. London Journal of Primary Care, 3(2), 115–119.
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Taiwan in transition

Dimension	Pre-transition	Effect	Post-Transition
Benefits	The Labor Insurance, the Government Employee's Insurance and the Farmers' Health Insurance provided a uniform comprehensive benefits on political rather than economic considerations.	✓	- The insured are classified into six main and 15 subcategories based on job and income. - They include inpatient and outpatient care, prescription drugs, dental care, traditional Chinese medicine, child birth care, physical rehabilitation, home care, chronic mental health care, and end-of-life care.
Stewardship	The state implemented and run the SHI's (Labor Insurance and Gov. Employee's Insurance) and the Farmer's insurance.	✓	- Department of Health negotiates with physicians and hospitals global budget (cost containment) - Panel review system of medical records to keep healthcare costs down and quality. Inappropriate procedures are not paid.

Wu, T.-Y., Majeed, A., & Kuo, K. N. (2010). An overview of the healthcare system in Taiwan. London Journal of Primary Care, 3(2), 115–119.
Chiang TL. Taiwan's 1995 health care reform. Health Policy. 1997;39(3):225–39. [PubMed]

Uruguay - overview

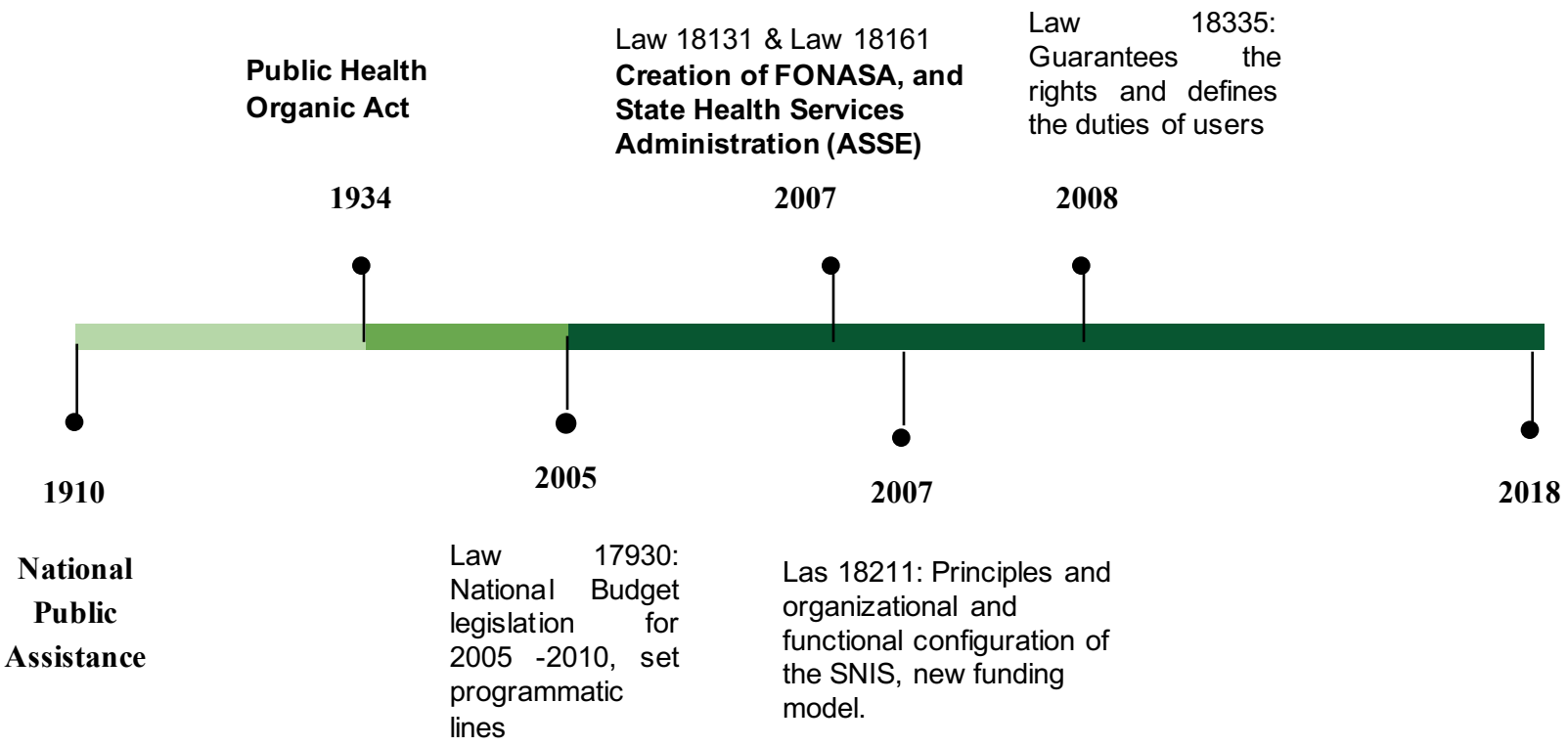
Population: 3.4 million

High income country since 2003

Health expenditure

- 9% of GDP (FONASA 2017)
- 6.9% OF GDP (76%) from public expenditure of THE (FONASA 2017)
- Health Insurance
  - Coverage: 84.4.% (Ministry of Health, Uruguay, 2017)
- OOPE 16,2% of THE (World Bank, 2015)
- 1,792 USD PPP per capita (WHO 2017)

Uruguay in transition



The SNIS was created through different laws.

Muñoz MJ, La construcción del sistema nacional Integrado de Salud 2005-2009, Ministry of Health, Uruguay, 2010
Uruguay, profile of Health System, PAHO 1999
Arbulo et al.. Building up the national integrated health system. WHO 2015

Lessons: What is a NHI?

Functions	*Key characteristics of an NHI-type system*
Regulation	State regulation with some degree of societal representation
Revenue collection	Public sources (taxes and social security contributions)
Pooling	Single fund
Purchasing	Single payer
Provision	Different mix of providers in contractual agreements

Lessons from countries in transition

- Different fiscal spaces and political contexts for the decision
- Graduality and path dependency
  - From different starting points and trajectories
  - Wide range of implementation periods
  - Merging process as a key-step
- Policy goals achieved
  - Broaden equitable access to healthcare
  - Strengthen governance and stewardship
  - Increase public financing advancing to eliminate OOPE

National Health Insurance

Key-concepts and country case studies

Subregional Dialogue on Health Financing in the Caribbean
Pan American Health Organization
Barbados, 28- 29 August 2018

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