Technical Note Plenary 2

Pooling for equity: "It's not (just) what you do, but the way that you do it"

POOLING AND EQUITY

Pooling arrangements influence equity in the receipt of health services because the structure of pooling establishes the potential to redistribute prepaid resources to the care of those with the greatest health needs. Therefore, pooling of risks and resources is of paramount importance for an equitable health financing system. Ultimately, however, actual redistribution occurs when the money is spent (i.e. through purchasing). Thus, the consequences of reforms in pooling for system-wide equity objectives depend on interactions with reforms in revenue raising and purchasing.

Definition of pooling and pooling models

Pooling can be defined as the accumulation and management of financial resources to ensure that the financial risk of having to pay for health care is borne by all members of the pool and not by the individuals who fall ill.

The purpose of pooling is to spread financial risk across the population so that no individual carries the full burden of paying for health care. Where most health spending is not pooled, large parts of the population (those with low income/wealth and/or poor health status – are vulnerable because they will either not be able to use needed health services due to financial barriers at the time of use, or they will experience financial hardship as a consequence of accessing health services. Conceptually, in the absence of pooling, payment for health services will be based on one's health risk rather than one's capacity to pay.

The configuration of the pooling function varies across countries, depending on key characteristics and institutional arrangements, in particular:

1. The number of pools: one or multiple pools;
2. The nature of enrolment: whether enrolment into these pools is compulsory or voluntary;
3. The relationship between the different pools: competing or non-competing; coordination mechanism; etc.;
4. The covered population: whether these pools target a specific population segment (e.g. civil servants, identified poor, etc.) or if they are formally open to the whole population.

THE ISSUE OF FRAGMENTATION

Fragmentation of risk pools occurs where there are barriers to the redistribution and use of prepaid funds. Fragmentation limits the scope for redistribution from a given level of prepaid funds, hindering progress towards the key objectives of universal coverage. In addition, fragmented pooling is a source of system-wide

inefficiency when it leads to duplication of administrative costs and dilution of the potential benefits from the use of strategic purchasing to support changes at the provider level.

Fragmentation leads to inequity when there are:

- Differences in eligibility across pools (or ineligibility /exclusion) related to factors likely to exacerbate existing social inequalities, particularly employment status, which may be magnified when the different pools entail differences in entitlements, unless these are justified by differences in needs;
- Differences in per capita public spending across pools – i.e. domestic general government revenue or donor funds – (whether in the context of decentralization or explicit insurance schemes) unless justified by differences in needs;
- Differences in levels of per capita spending across pools (unless justified by differences in needs), particularly where different pools are also associated with different provider networks, such that better-funded pools may result in higher salaries/incomes for providers that serve them;
- Within financing schemes, differences in per capita allocations from higher to lower autonomous, administrative units unless justified by differences in needs or the availability of funds from other sources;
- Within schemes or pools, differences in allocations of funds across diseases that are not justified by differences in needs or the availability of funds from other sources.

MAIN CAUSES OF FRAGMENTATION

It is important to note that pooling is not restricted to insurance funds, but also addresses central or decentralized levels of government with general tax revenues collected and spent on health services. Health systems are often characterized by fragmentation in risk pools, but many countries have mechanisms to mitigate this. The main identified causes of fragmentation in risk pools are:

Geographical fragmentation

General revenue may be allocated to regions, districts, counties, etc. using some form of resource allocation formula that may include an equalization objective to compensate poorer regions with less tax-generation capacity. If sub-national units have autonomy to decide how much to allocate across sectors and there is no further re-allocation within health, the result may be unequal levels of public spending on health per capita across regions, as in many countries of the former USSR and the recent devolution reform in Kenya. Geographic fragmentation may also arise with area-based health insurance pools where political economy factors limit potential for reallocation across funds, as in Bosnia and Herzegovina, with similar consequences, (i.e. inequalities in levels of per capita public spending on health). In other contexts, fragmentation arising from the existence of multiple insurance funds may be offset by government redistribution policies that allow all funds to offer the same benefit package at about the same level of per capita funding. This is reflected, for example, in the greater level of health insurance subsidies provided by China's central government to its poorer provinces, or the subsidies that the Japanese government provides to its 1,800 municipality-operated citizen's health insurance funds. Similarly, many higher-income countries that use multiple competing social health insurance funds (e.g. Germany, the Netherlands, Czech Republic) manage fragmentation through a risk equalization mechanism among these funds (pooling across the pools) and have achieved positive equity outcomes as a result.

Population segmentation

For many low- and middle-income countries, perhaps the most important form of fragmentation, and a major driver of inequity, has been the establishment of different financing/coverage systems for different socioeconomic groups. In its most common form, this is typified by the existence of a relatively well-funded social health insurance system for formal sector workers including civil servants (though they sometimes benefit from a separate scheme), and relatively less generous general revenue funded services for the informal sector and the poor, as has been historically documented as the problem of *segmentation* in some Latin American systems, but also exists elsewhere, such as in Thailand. In such contexts, pools, and their relative level of funding, are effectively driven by an individual's employment status rather than by need, and the resultant health financing architecture has been a major driver of inequity – directly contrary to the goal of Universal Health Coverage. Very few countries have been able to unify these pools into a common system with common benefits, though Turkey is a notable exception. Instead, countries such as Mexico, Peru and Thailand have taken the path of establishing explicit non-contributory coverage pools for the poor or the entire informal sector population, and then gradually raising the level of budget funding, and benefit entitlements, closer to that of the formal sector social health insurance program. Still, fragmentation-driven inequity across schemes remains.

Fragmentation of funding flows

Fragmentation through disease control programs occurs where funds for specific health programs and services – from both domestic and international sources – are managed in separate pools and fund "their" interventions through mechanisms different from the rest of the system.

CHALLENGES LINKED TO DEFRAGMENTATION

The corollary of the observation that fragmentation may be bad for equity is that defragmentation (reducing the number of pools by combining them) should improve equity, by expanding the potential for cross subsidy and by allowing for some kinds of efficiency gains.

However, efforts to reduce fragmentation in pooling face two types of challenges:

1. In many cases, there are strong political limitations that constrain country actions to reduce fragmentation, i.e. it is not feasible to implement. This is because such actions – and especially merging existing schemes – may require a "big bang" decision involving high-level political action (e.g. an act of Parliament). It is therefore politically sensitive, not to say politically challenging given strong vested interests in the status quo, and may not be feasible in the short term. When it is not possible to engineer this political solution, it is possible to address inequities arising from fragmented pools through other compensatory mechanisms.

2. Even where it is possible to reduce fragmentation, such action alone is not sufficient for improving equity. This is because pool structure only sets the *potential* for redistribution; actual redistribution happens when the money is spent (i.e. purchasing). In turn, two types of additional actions are needed to ensure pro-poor results: (i) aligning provider payment reforms with the pooling reforms; and (ii) addressing supply-side service availability inequities and demand-side barriers that may differentially limit use by the poor.

POTENTIAL STEPS FORWARD

In face of these problems, there are a range of technical interventions that have proved, in many occasions, to be effective in attenuating the negative effects of fragmentation, contributing to redistribution and paving the way for eventual merger/further defragmentation.

Some examples include:

- Harmonization of benefit package/entitlements across pools (e.g. Japan), and/or harmonization/integration of information systems to enable eventual merging of pools (e.g. Republic of Korea, Kyrgyzstan)
- Risk adjustment across pools (e.g. Czech Republic, Germany, the Netherlands)
- Pro-equity subsidies (e.g. China – three tiers of public subsidy to insurance scheme, following regional differences in socioeconomic status).
- Establishment of budget-funded pools with explicit coverage for the poor and/or informal sector, with gradual increase in funding levels to narrow the gap with the pools for the formal sector (e.g. Gabon, Mexico, Peru, Thailand), or establishment of subsidized pools for the high cost population groups (e.g., pool for the elder care in Japan)

The plenary session will focus on these technical and incremental measures to address pool fragmentation or mitigate its consequences to enable effective redistribution. It will also give an overview of those actions with which pooling reform needs to be aligned. It also recognizes that in pooling, as with all health financing functions, governments face other policy objectives in addition to reducing inequities, such as efficiency. In moving forward, it is important that they ensure that the pursuit of these other goals do not make existing inequities worse – for example, but decentralization of fiscal arrangements in health that end up favoring richer areas.

KEY MESSAGES

- In general, larger pools encompassing diverse health risks provide greater potential to improve equity than do smaller, fragmented pools that serve specific population groups.
- Defragmentation, however, on its own is not sufficient to improve equity – pool size only sets the potential for redistribution, but other actions are needed to ensure that the poor actually benefit.
- Even when defragmentation is not feasible for political or other reasons, it is possible to introduce arrangements across risk pools, such as risk equalization mechanisms, or harmonization of information systems that in turn can enable harmonization of benefit packages and payment mechanisms, that can help to improve equity across risk pools.