

# Social Reinsurance

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A New Approach to Sustainable Community  
Health Financing

Editors

**David M. Dror** and **Alexander S. Preker**



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World Bank  
1818 H Street, NW  
Washington, DC 20433  
Telephone: 202-473-1000  
Internet: [www.worldbank.org](http://www.worldbank.org)  
E-mail: [feedback@worldbank.org](mailto:feedback@worldbank.org)

International Labour Office  
4, route des Morillons  
CH-1211 Geneva 22  
Switzerland  
Fax: (+41 22) 799 6938  
Internet: [www.ilo.org/publns](http://www.ilo.org/publns)  
E-mail: [pubvente@ilo.org](mailto:pubvente@ilo.org)

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## CHAPTER 13

# Role of Subsidies in Microinsurance: Closing the “Recovery Gap”

*Reinhard Busse*

No matter how well reinsurance mechanisms deal with insolvency risks associated with randomly fluctuating expenditure, microinsurance units may encounter a *recovery gap*, a systematic excess of expenditure on benefits over income (Preker, Langenbrunner, and Jakab, chapter 1, this volume). Because the recovery gap is not random, reinsurance cannot solve it. Solutions for this financial problem should therefore be sought outside the context of risk management—through subsidies.

This chapter draws heavily on Western Europe’s experience with social health insurance.<sup>1</sup> It describes reasons for the recovery gap, including uninsurable health expenses, and offers a model for analyzing the role of subsidies financed from taxation, foreign donors, or other sources in filling the gap.<sup>2</sup> It examines the role and extent of tax subsidies in West European countries, addressing such questions as whether tax subsidies increase systemic equity and whether they are only a short-term measure or are needed permanently. Two reasons argue for drawing on the West European experience, even though we are discussing seemingly different circumstances of microinsurers in low- and middle-income countries:

- Most health insurance funds started out as a kind of microinsurance.
- Long-term dependence on tax subsidies can best be estimated by studying well-developed systems in countries with a long history of social health insurance.

From this experience come some lessons for low- and middle-income countries embarking on the insurance route.

### WHENCE THE RECOVERY GAP?

Where does a recovery gap come from? Both theory and history hold some answers.

In projecting an insurance scheme’s income, five main factors come into play: the contribution rate or per capita premium, the contribution base, the

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declaration rate, the collection rate, and the expenditure. Errors in estimating any of these can result in a deficit.

Microinsurers have two options for calculating an income that meets their needs, either as a per capita premium or, more commonly, as a percentage of the contribution base, the *contribution rate*. The contribution base is usually work-related income but may also include other income (for example, from investments) or assets.

Box 13.1 presents some simple formulas for calculating the necessary per capita premium and contribution rate. The formulas take into account factors such as the beneficiaries' honesty in declaring their income (*the declaration rate*) as well as the microinsurer's ability to fully collect the premiums or contributions (*the collection*

#### **BOX 13.1 CALCULATING A MICROINSURER'S PREMIUM OR CONTRIBUTION RATE**

The basic formula for calculating the *premium* is:

$$(1a) \text{ Necessary per capita premium} = \frac{\text{total expenditure} - \text{copayments} - \text{other income}}{\text{number of beneficiaries.}}$$

Using an easy example of 1,000 currency units (CU) expenditure, CU100 in copayments (assuming no other income), and 100 beneficiaries, this would result in a premium of CU9.

The formula for calculating the *contribution rate*, given by Cichon and others (1999) is:

$$(2a) \text{ Necessary contribution rate} = \frac{\text{total expenditure} - \text{copayments} - \text{other income}}{\text{contribution base.}}$$

Assuming the same expenditure, copayments, and number of beneficiaries, and a contribution base of CU10,000 (an average of CU100 per person), this would result in a contribution rate of 9 percent.

Taking both the declaration rate and the collection rate into account, the formulas are as follows:

$$(1b) \text{ Necessary per capita premium} = \frac{\text{total expenditure} - \text{copayments} - \text{other income}}{\text{number of beneficiaries} \times \text{collection rate.}}$$

Retaining the values of (1a), a collection rate of 90 percent would increase the necessary premium to CU10; one of 80 percent, to CU11.25. (Note: As the premium is independent of the beneficiaries' income, the declaration rate does not enter the formula.)

$$(2b) \text{ Necessary contribution rate} = \frac{\text{total expenditure} - \text{copayments} - \text{other income}}{\text{contribution base} \times \text{declaration rate} \times \text{collection rate.}}$$

Retaining the values of (2a), a declaration and collection rate of 90 percent each would increase the necessary contribution rate to 11.1 percent; rates of 80 percent, to around 14.1 percent (that is, by more than half).

*(Box continues on the following page.)*

**BOX 13.1** (continued)**Adjusting for Income Deficits**

If the necessary premium/contribution rate is below these levels (that is, if the actual premium/contribution rate is lower than necessary), a new variable—a deficit—has to be introduced in the formulas:

(1c) Actual per capita premium = total expenditure – copayments – other income – deficit/number of beneficiaries x collection rate.

Building on (1b) but assuming an actual per capita premium of only CU9, the deficit would reach CU100 under the 90 percent collection rate and CU212.50 under the 80 percent rate.

(2c) Actual contribution rate = total expenditure – copayments – other income – deficit/contribution base x declaration rate x collection rate.

Building on (2b) but assuming an actual contribution rate of only 9 percent, the deficit would reach CU211.11 under the 90 percent and CU500.63 under the 80 percent assumption for declaration and collection rate.

**Adjusting to Cover Indigents**

The effects of including indigents can be demonstrated by the calculations for the per capita premium (1a) and the contribution rate (2a). Let us assume that, in both cases, the number of beneficiaries is increased by 20 indigents whose health needs are comparable to those of the other 100 members. The result is stable per capita expenditure.

As the 20 new members can pay neither a premium nor copayments, total expenditure would increase to CU1100 from CU900. Adding the 20 indigents would *either* result in an increase in each of the original beneficiaries’ premiums to CU11 (and the necessary contribution rate to 11 percent) *or* cause a deficit of CU200 (potentially adding to the deficit resulting from imperfect declaration and collection rates). Subsidies can solve this kind of recovery gap, which is caused by adding health coverage for indigents.

*rate*). The two rates will fluctuate between a maximum of 100 percent (meaning that all income is declared or collected) and a theoretical 0 percent. As can be seen from the formulas in the box, if these factors do not reach 100 percent, premiums or contributions will have to increase—or a deficit will result.

Thus, misjudging the declaration and the collection rate can easily lead to a deficit—if the actual rates are less than 100 percent. Although such deficits constitute a certain type of “recovery gap,” they do not qualify for subsidies to cover them. They should be addressed by tackling the reasons for the shortfalls.

As candidates for generating a real recovery gap, the expenditure and the contribution base deserve close attention.

On the expenditure side, Dror has pointed to several problems (chapter 5, this volume). A recovery gap could reflect:

- Demand-side expectations of increased benefits without any corresponding increase in the premium on the income side
- Supply-induced moral hazard and monopolistic pricing if competition between suppliers is weak or nonexistent
- Pressures from inflation or from a pandemic (for example, HIV-AIDS).

If expenditure is not driven by providers' unrealistically high income expectations, a recovery gap resulting from the other reasons given should be considered a candidate for subsidies. (A liberal attitude may be justified when assessing whether income expectations are "unrealistic." After all, highly trained professionals are expected to work in low-income rural areas where the income differential between them and the insured population may, of necessity, be high.) The expenditure side, not further explored here, is a topic all by itself (Dror, chapter 5, this volume).

Regarding the contribution base, a distinction has to be made between a recovery gap that relates to the whole insured population and a gap that is concentrated in certain segments of the insured population. In the first instance, the economic base is too weak in comparison to expenditure (see box 13.1).

The second case, concentration in certain population segments, was not originally a problem in Western Europe because social health insurance was work related. All participants were employed, even though their incomes, number of dependents, and health status might have been different.

Gradually, coverage was expanded to nonworking population segments throughout Western Europe, achieving population-wide coverage only in Switzerland (1996), Belgium (1998), and France (2000). Since 1968, introduced under the Exceptional Medical Expenses Act, the Netherlands' universal *Algemene Wet Bijzondere Ziektekosten* (Exceptional Medical Expenses) has covered long-term care and populationwide prevention programs, mainly "uninsurable" services.

The creation of social health insurance schemes covering most or all of the population put pressure on planners to find ways of including everyone without creating a recovery gap. Contributing members were not always willing to see their contributions used to cover noncontributing members' health costs.<sup>3</sup> A deficit resulting from adding insurance coverage for indigents is a prime candidate for subsidies. Subsidies can avoid overburdening the contributing population (leading to decreasing acceptability of the whole scheme) and the exclusion of individuals who cannot (fully) contribute to financing.

The four factors addressed so far—declaration rate, collection rate, expenditure, and contribution base—all relate to the inability to raise contributions for various reasons. Another reason for a gap between health insurance fund income and expenditure is an "unwillingness" to set a high enough contribution rate to cover spending. Who among the decisionmakers is unwilling? Although health



insurance funds in most West European social health insurance countries are “self-governing,” the government or legislature exerts the decisive influence in setting contributions. In France, by law, contribution rates are negotiated between the government and representatives of employees, employers, and the social security organizations, but the government makes the final decision. In the Netherlands, the Board for Health Care Insurance (College voor zorgverzekeringen, CvZ) runs the central funds required under AWBZ and the Sickness Funds Act (ZFW) and recommends the next year’s contribution rates to the Ministry of Health. The Ministry of Health then sets the rates.

Only Germany and Luxembourg have delegated power to decide upon contribution rates to self-governing bodies—Luxembourg, to the Union of Sickness Funds, and Germany, to the individual funds. However, their decisions are subject to governmental approval. For regionally operated funds in Germany, “the government” is the statutory health insurance unit within the Länder ministry responsible for health. An independent agency, the Federal Insurance Office, is charged with the supervision of countrywide health insurance funds. The health insurance funds are legally obliged to calculate a contribution rate that is neither too high nor too low to cover all expenditure and to keep reserves at the required level (Social Code Book V, Article 220). The government may refuse approval if the rate does not meet this requirement, but it can also act if a health insurance fund does not suggest a rate change when it should. Similarly, under supervision of the Federal Office for Social Insurance, Swiss insurers are allowed to set their own community-based premiums.

Needless to say, neither the unwillingness to set an appropriate contribution rate nor regulations preventing microinsurers from doing so—although leading to a recovery gap—justify subsidies. The deficit should be addressed instead by changing the regulatory framework or the supervision of the fund’s decisions.

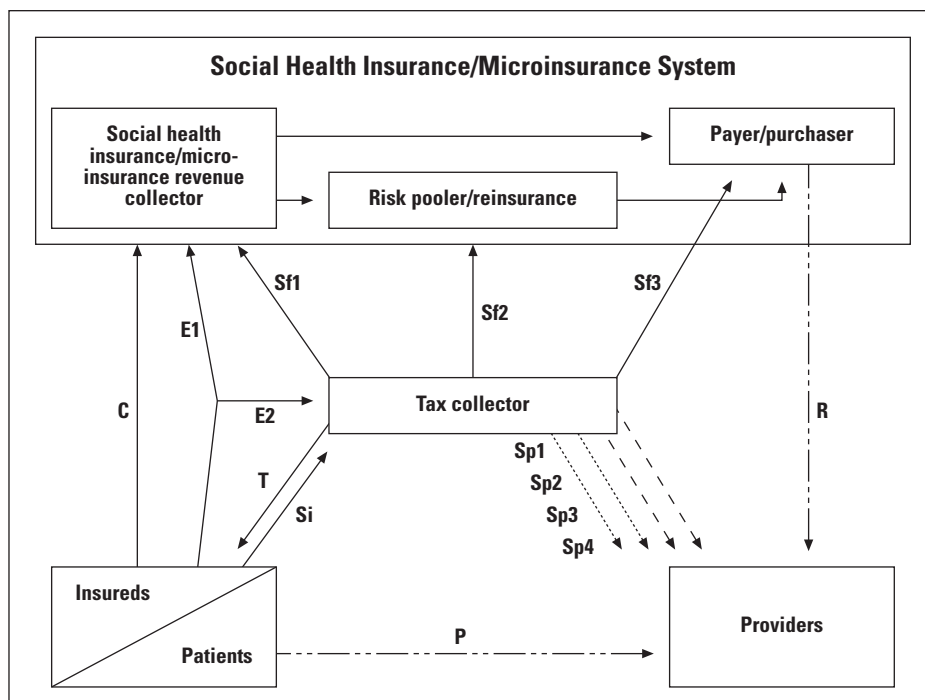
### **CLOSING THE RECOVERY GAP: A MODEL**

At first glance, closing the recovery gap through tax subsidies is a straightforward affair. But a closer look reveals many possibilities, each with a different rationale and potentially different implications (figure 13.1).

Subsidies can be paid into the system in three ways: to individuals (Si in figure 13.1), to the social or community-financed microinsurance unit (Sf), or to providers (Sp).

#### **Paying Subsidies to Individuals**

The first option is paying subsidies directly to the needy, usually defined in terms of low income but sometimes including individuals in poor health (Si). The subsidy, in extreme cases amounting to the entire contribution, enables individuals to acquire health insurance coverage they could not otherwise afford.

**FIGURE 13.1** Role of Taxes and Tax-Financed Subsidies in Financial Flows under Social Health Insurance or in Community-Financed Microinsurance Units

C Contributions (both income and nonincome related).

E Earmarked/hypothecated health taxes.

P Private expenditure (cost sharing for social health insurance/microinsurance services; voluntary health insurance; and out-of-pocket for nonsocial health insurance/microinsurance services).

R Provider payment/reimbursement (directly under contract model or indirectly under patient reimbursement model).

Sf1 Tax-financed contributions, for example, for nonsalaried persons.

Sf2 General subsidies for pooled social health insurance/microinsurance finances/reinsurance.

Sf3 Subsidies for individual funds/community schemes.

Si Subsidies to individuals to purchase insurance.

Sp1 General, unspecified subsidies to providers.

Sp2 Nonservice payments (for example, for investments).

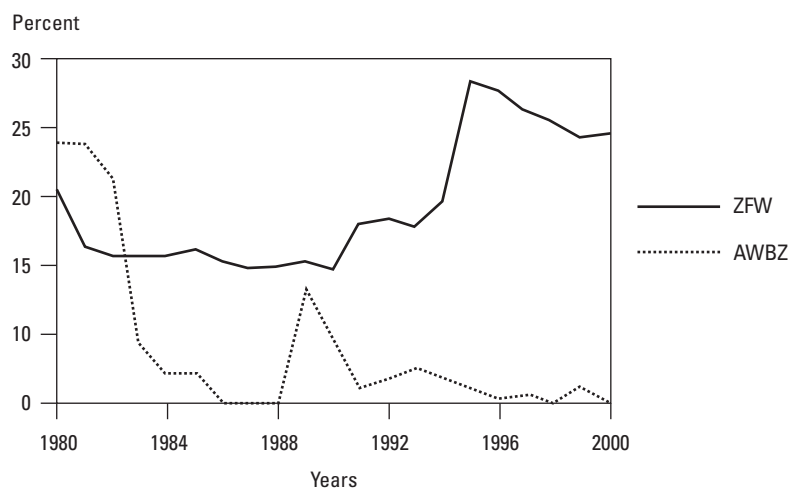
Sp3 Reimbursement for nonsocial health insurance/microinsurance services (for example, public health).

Sp4 Reimbursement of services for nonsocial health insurance/microinsurance-covered persons.

T Taxes used for health care (general).

This kind of subsidy can be targeted directly to needy individuals. However, direct subsidies also have disadvantages: having to define limits for entitlement, verify that applicants fulfill these limits, and ascertain that recipients of a subsidy use it for the intended purpose—here, to buy health insurance. Thus, a fairly extensive monitoring mechanism is needed—which may be available in Switzerland but not in every country introducing health insurance.

**FIGURE 13.2 Tax Subsidies in Dutch Social Health Insurance, 1980–2000**  
(percent of total income)



*Note:* These are payments into the pooled fund, Sf2 in figure 13.1.

*Source:* F. Bertens, personal communication, January 26, 2001.

### Paying Subsidies into Funds or Microinsurance Units

Paying contributions for the needy directly into the social health insurance fund or microinsurance units (Sf1) may therefore be more appropriate. Many Central and East European countries have chosen this option. In this case, the subsidies must cover 100 percent of the contributions for the needy or the same problems arise as with subsidies to individuals.

This option, too, has disadvantages. People who do not have to contribute might feel less ownership in the insurance fund. People outside the subsidized group might feel unfairly treated if their incomes are only slightly higher. A second set of concerns is related to the ability (and willingness) of the subsidy payer (whether finance ministry or outside donor) to pay the amount needed as long as it is needed.

Many of these disadvantages are circumvented if the subsidies are paid into the pooled financial resources of the social health insurance or microinsurer (Sf2) instead of to individuals. Every individual must join the scheme if such a subsidy is to close the recovery gap for the entire covered population (and not just forestall contribution increases for people who can afford insurance). This means that the contribution amount should not be set so high as to prevent the poor from joining, as could happen under a per capita premium (instead of an income-dependent contribution). If the contribution is income differentiated,

paying a subsidy into the financial pool—or to reinsurance—is a flexible possibility for closing the recovery gap.

Sometimes a subsidy payment to the purchasing fund (Sf3) is appropriate, for example, if income and risk differences between funds or microinsurers are insufficiently offset through the pooling mechanism. Examples include funds/microinsurance for only the self-employed when most other insured individuals split the contribution with a third party (usually their employer). Without a subsidy, the self-employed would have to pay much more than wage earners. Sf3 may also be relevant in case of large regional differences in per capita income that are not mediated via the pooling mechanism (for example, to maintain compliance with the system in high-income areas). Sf3 would then subsidize regionally organized purchasers located in low-income areas. Again, the choice is between subsidizing service provision or purchase. In either case, geographic targeting may be easier for most countries than targeting based on individual income or risk profiles.

### Paying Subsidies to Providers

Providers are the third group of subsidy recipients. These subsidies can serve many purposes:

1. General, unspecified uses, including debt coverage (Sp1)
2. Specific, but not service-related, uses, often for investments (Sp2)
3. Reimbursement for services outside the benefit package such as public health measures (Sp3)
4. Reimbursement for services provided to uninsured persons such as the needy (Sp4)

Options 1 and 4 point toward deficits in the system while 2 and 3 can be effectively integrated into the overall financing. Sp1 subsidies decrease the chances of bringing providers into a system where they agree with the funds on volume and reimbursement levels that do not endanger systemic sustainability. Sp4 subsidies sound an alarm that other subsidies in the system are not targeted in a way that ensures the poor the same entitlements as everybody else. They will be better served by Si- or Sf1-type subsidies. Sp4 might also cost the subsidy payer more than would the other types because no insurance contributions are paid for those individuals, and the full reimbursement cost falls on the subsidy payer (with the possible exception of out-of-pocket user fees).

Sp2 subsidies enable providers to offer facilities in remote areas, where microinsurers are often based. Without subsidies, the investment costs might prove too high for a prospective investor to locate in areas lacking the “guaranteed” purchasing power promised by wealthier urban areas. Additionally, Sp2 subsidies help hold down reimbursements, thereby alleviating one potential source of a

recovery gap. Sp3 subsidies provide an option for restricting the social health insurance/microinsurance benefit package to insurable services, that is, excluding the uninsurable services that should be promoted as a matter of public health (for example, immunizations).

## CLOSING THE RECOVERY GAP: EUROPE'S EXPERIENCE

West European countries have taken different approaches to dealing with recovery gaps.

### The Netherlands

As the first universal social health insurance scheme, the Dutch AWBZ is a good place to start. Before AWBZ, much of the care it now covers was funded from general revenue. The new insurance scheme saved the government a good deal of money, and part of those savings was recycled into the AWBZ Fund as a structural subsidy. Over the years, this government subsidy has changed many times, as benefits have been added or removed from the ambit of the Act. The AWBZ Fund therefore consists of both contributions (C) and government subsidy (Sf2) in figure 13.1.

At first, the health insurance scheme for the elderly and the voluntary health insurance scheme were partially funded by the government. On April 1, 1986, both funds were taken over by the General Fund for the sickness fund scheme. When the Medical Insurance (Access) Act and the Act governing the Joint Funding of Elderly Sickness Fund Patients went into force on the above date, the ZFW was amended to the effect that the government would pay an annual grant into the pooled fund (Sf2) toward the cost of financing sickness funds scheme for all. The grant amount, determined annually, has fluctuated widely as benefits and population groups have been included or excluded from the two schemes (figure 13.2).

### France

France, with its state-fixed social insurance contributions, provides an example of a different type of recovery gap. The social security system ran a deficit throughout the 1990s, and health care was the main source. Political unwillingness to adjust the contribution rate to need was based on the notion that social contributions were increasing labor costs, thereby dampening employment. In an effort to address these structural problems leading to financial difficulties, Prime Minister Alain Juppé, in December 1995, presented a plan to reform social security financing.

Widening the contribution of the General Social Levy Tax was a main proposal. This tax, levied on all types of income (savings, subsidies, pensions, stocks), was set at 1.1 percent in 1991. Initially allocated to the family allowances branch, revenue generated by this tax was earmarked for health in 1996. Additionally,

employee payroll contributions for health were largely replaced by an increase in the earmarked health tax, starting in 1998. The payroll contribution rate decreased from 5.5 percent to 0.75 percent, and the earmarked health tax increased from 3.4 percent to 7.5 percent—thereby reducing the overall contribution/tax rate from 8.9 percent to 8.25 percent but widening the contribution/tax base. The employer contribution was maintained.

A social debt-reducing fund (*Caisse d'Amortissement de la dette sociale*) was also created. It manages a new income tax, the Social Debt Tax (*Remboursement de la dette sociale*), to pay off the social security system's deficit (Lancry and Sandier 1999, pp. 443–70). Since 1996, this new 13-year tax, set at 0.5 percent of total income, has been levied on everyone but recipients of government social assistance and disability pensions.

Now France has three different sources of social security financing: social contributions (C), the earmarked health tax (E1), and the social debt-payment tax (E2) in figure 13.1. E2 is a mechanism through which social health insurance financing (originally contribution based) has been made partly tax based. Future debate will revolve around the collective choice between proportional taxes, notably the earmarked health tax, and progressive taxes such as the income tax (Bouget 1998).

### Switzerland

While the Netherlands fills the financial risk pool with tax money and France has shifted a good part of its financing from contributions to earmarked taxes, Switzerland takes yet another approach. Instead of paying subsidies into the social health insurance system, Switzerland gives them directly to individuals, on a means-tested basis, to enable them to purchase health insurance (Si in figure 13.1). Before the introduction of the current system of compulsory insurance in 1996, health insurance funds received subsidies amounting to about 30 percent of their expenditure (Sf3). Premiums for persons in poor health nonetheless became so costly that such people could no longer acquire any health insurance, especially in high-expenditure cantons. The new act made health insurance compulsory, introduced community rating by canton, and cut off direct subsidies to the health insurance funds. Subsidies to individuals are calculated in different ways from canton to canton but can include a full premium subsidy, depending on the insurance policy chosen (Minder, Schoenholzer, and Amiet 2000).

### How Much Subsidization from Taxes?

In all these experiences, some degree of tax subsidization is present, but just how much is hard to tell. International statistics are often fuzzy on sources of health care funding, for example, whether expenditure through taxation includes tax-financed payments to social health insurance (Sf in figure 13.1) or whether these are included as social health insurance expenditures.

Austria and Switzerland, for example, finance a large part of hospital care directly through taxation—and have therefore relatively low figures for the social health insurance expenditure share. In the Netherlands and other countries, hospital care is financed exclusively by the health insurance funds, which receive substantial subsidies from general taxation. Tax subsidies paid into the joint health insurance funds’ pool (Sf2) are also substantial in Belgium and Luxembourg. In Belgium, about 60 percent of all subsidies are paid into the social health insurance scheme’s pooled finances (Sf2), and the rest goes directly to providers, mainly to cover investments (Sp2). In Austria and Germany, the social health insurance schemes receive no tax subsidies—with the small but noteworthy exception of the farmers’ funds in both countries (Sf3). Besides the special taxes mentioned earlier, France also uses direct tax subsidies to funds with low-income/high-need members, such as the farmers’ fund.

To estimate the degree to which countries rely on wage-based social health insurance contributions, two factors have to be combined: the percentage of social health insurance income from contributions ( $C/C + E1 + Sf$ ) (figure 13.1; data for Western Europe, table 13.1) and the percentage of overall health expenditure covered through social health insurance ( $C + E1 + Sf/C + E + P + T$ ).

Based on that calculation, Germany and the Netherlands are the only countries in Western Europe that cover more than 60 percent of all health care expenditure from wage-related contributions. Until 1997, France was the country that relied most heavily on wage-related contributions but, since its shift to a wider contribution base, that share has dropped below 60 percent. Austria and Luxembourg finance a little less than 50 percent, and Belgium less than 40 percent, of total health care expenditure from wage-related contributions. In some respects, Belgium is closer to a “mixed” system of funding, as taxes accounted for 38 percent and social security contributions for 36 percent in 1994 (Crainich and Closos 1999, pp. 219–66).

**TABLE 13.1 Tax Financing in West European Social Health Insurance Systems, 1999–2000**

	<i>Austria</i>	<i>Belgium</i>	<i>France</i>	<i>Germany</i>	<i>Luxembourg</i>	<i>Netherlands</i>	<i>Switzerland</i>
Extent of taxes for social health insurance financing (if available: percent of fund income)	Generally no (except 23% for farmers fund, that is, 0.5% of total)	Yes, 35–40%	Yes (up to 8%); plus special taxes (up to 34%) <sup>a</sup>	Generally no (except 52% for farmers’ funds, that is, < 1% of total)	Yes, max. 40 <sup>a</sup>	Yes, AWBZ < 1%, ZFW 25%	Only indirect subsidies (that is, to insureds, not to funds)

a. Supplement of 250 percent on pensioners’ contributions, 10 percent on other contributions.

b. On car insurance, alcoholic drinks, and pharmaceutical marketing.

Source: Author’s calculations, based on various sources.

## Central and Eastern Europe

To include Central and East European countries in the comparison, both direct, wage-related contributions and the overall social health insurance contributions to total health expenditure have to be considered. For example, in both the Czech Republic and Slovak Republic, the state pays contributions for all nonwage earners (Sf1 in figure 13.1). This group encompasses more than 50 percent of the population, including not only pensioners and the unemployed but also nonwage-earning spouses and children, persons covered as dependents in Western Europe (Busse 2000; Hlavacka and Skackova 2000). Wage-related contributions cover around 65 percent of total health care expenditure—as much as or slightly more than in Germany or the Netherlands and more than one-and-a-half times as much as in Belgium. This apparent contradiction results from the state's low contributions, a major source of those countries' financial difficulties.

### DO MORE SUBSIDIES MEAN MORE EQUITY?

When evaluating equity in health care financing, an analogy can be made to taxation systems. In a *progressive* tax system, the proportion of income paid in taxes rises as income rises. In a *regressive* system, the proportion falls as income rises. And so it is with health care—the proportion of income paid for health care rises as income rises in progressive funding and falls in a regressive system.

In Western Europe, social health insurance is slightly less progressive than general taxation, but much more progressive than private financing arrangements (Wagstaff and others 1999; van Doorslaer, Wagstaff, and Rutten 1993). In poorer countries, with very different taxation systems and revenue-collection performance, these findings may not be applicable. In either setting, however, private out-of-pocket spending is the most regressive form of health care financing.

Differences in tax loads within tax-financed systems depend on the mix between (progressive) income taxes and (regressive) indirect taxes as well as their completeness of collection. Equity differences among social health insurance countries depend on the extent of the tax-financing component and its progressivity, the proportion of private direct payments, and differences in social insurance contributions. In West European social health insurance countries, there is no direct correlation between the extent of tax subsidies and “financing fairness,” as measured in the *World Health Report 2000* (WHO 2000). Belgium and Luxembourg, with high subsidies, rank almost equal with Austria and Germany. This finding suggests that it is not the extent of tax subsidies that makes health care financing more or less equitable but the exact design and mix within different categories of funding.

Equity differences in social insurance contributions depend on the extent to which contributions are income-based (instead of per capita premiums); the relative tax burdens of rich and poor (through income ceilings or no-claim bonuses); the extent of contribution pooling and adjustment for differing risks;



and the extent to which benefits are fully covered or require cost sharing (Normand and Busse 2002). When considering these points, special attention has to be given to the inclusion or exclusion of dependents—equity decreases if per capita premiums are charged for dependents as well as members (as in the Netherlands). Conversely, the inclusion of dependents might increase inequity if there is a ceiling on contributory income—a “millionaire” with a nonworking spouse pays only once, while a middle-class, double-income couple pays twice.

## CONCLUSIONS

The European experience suggests several important lessons for countries embarking on the insurance route. First, no matter how skillfully the social health insurance or community-financed health system is designed, no matter how long it has been in operation, and no matter how rich the country is, some sort of subsidization will always be needed to complement the main system of finance. Subsidies are the only way of ensuring adequate population coverage, stimulating delivery in otherwise underserved areas, or encouraging the delivery of certain, often public health-related, services. In Europe, the extent of subsidization varies from modest amounts to 50 percent of total finance.

Second, there is no single, perfect way to put subsidies into the health finance system. Based on a country’s needs, administrative capacity, banking system, and political priorities, subsidies can be given directly to individuals to acquire health insurance, paid into a financial pool (through mechanisms including reinsurance), or given to providers to cover investments or uninsurable services. In reality, a balanced mixture between these options has to be found, and adjustments may be necessary if the desired propoor effect is not achieved (as in Switzerland).

Third, subsidies do not guarantee social fairness or improved access for the poor. How the money for subsidies is raised and how it is spent are both important. Depending on the means used, fund raising or spending can worsen the situation of the poor if the subsidy system is not carefully designed.

## NOTES

1. Using the social health insurance definition in the System of National Accounts, microinsurance also falls into this category if “the programme is operated on behalf of a group and restricted to group members” (SNA 1993, annex IV, para. 4.111). As long as they are not “imposed and controlled by government units” (SNA 1993, annex IV, para. 4.130) as in Western Europe, they would, however, be classified as “private social insurance.”
2. The model incorporates elements from other health financing frameworks (OECD 1992; Kutzin 2001).
3. For the largest group of indigents, the pensioners, contributions vary from country to country in Western Europe, both in the amounts paid and in the agency responsible for paying them. In most cases, pensioners pay the same rate on their pension

as employees pay on their income (or, in Switzerland, the same per capita premium). This amount may be split between the pensioner and the statutory pension fund (substituting for the employer, as in Germany and Luxembourg) or it may be placed entirely on the pensioner (as in the Netherlands). The contribution rate may, however, also be lower or higher. In Belgium, pensioners pay only the employee's part of 3.55 percent. In Austria, pensioners pay more, with a contribution rate of more than 11 percent. Because pensioners themselves pay only as much as working members on average (3.75 percent), two-thirds of the contribution falls on the pension funds (European Commission 1999). These arrangements are feasible only if a fund has enough nonpensioner members to cover additional expenditures. A fund with only pensioners—or a microinsurer with only indigent members—would not be viable.

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