

# Health Insurance as Social Protection in Latin America



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- Anti-poverty and efficiency considerations:
  - Large health costs might lead poor households into poverty (*catastrophic health care costs*)
  - Households might try to build a buffer of assets to cope with future uncertain health care costs
  - Possibly at the expense of more productive investments (secondary school)
  - Health care costs might inhibit or postpone treatment, worsening wellbeing and capacity to work

## Universal Health Coverage (WHO)

*Access of all people to comprehensive health services at affordable cost and without financial hardship through protection against catastrophic health expenditures (Knaul et al. 2012)*

Latin America offers two experiences of very large increases in health coverage: Colombia and Mexico

## Similar starting points

Before the reforms, salaried formal workers are covered under health insurance systems linked to their jobs (and financed through payroll contributions)

Self-employed, independent and informal workers lacked formal health care coverage

The health insurance for salaried formal workers are not replaced, but co-exist with the expansion of the new insurance system

## What does health coverage consist of?

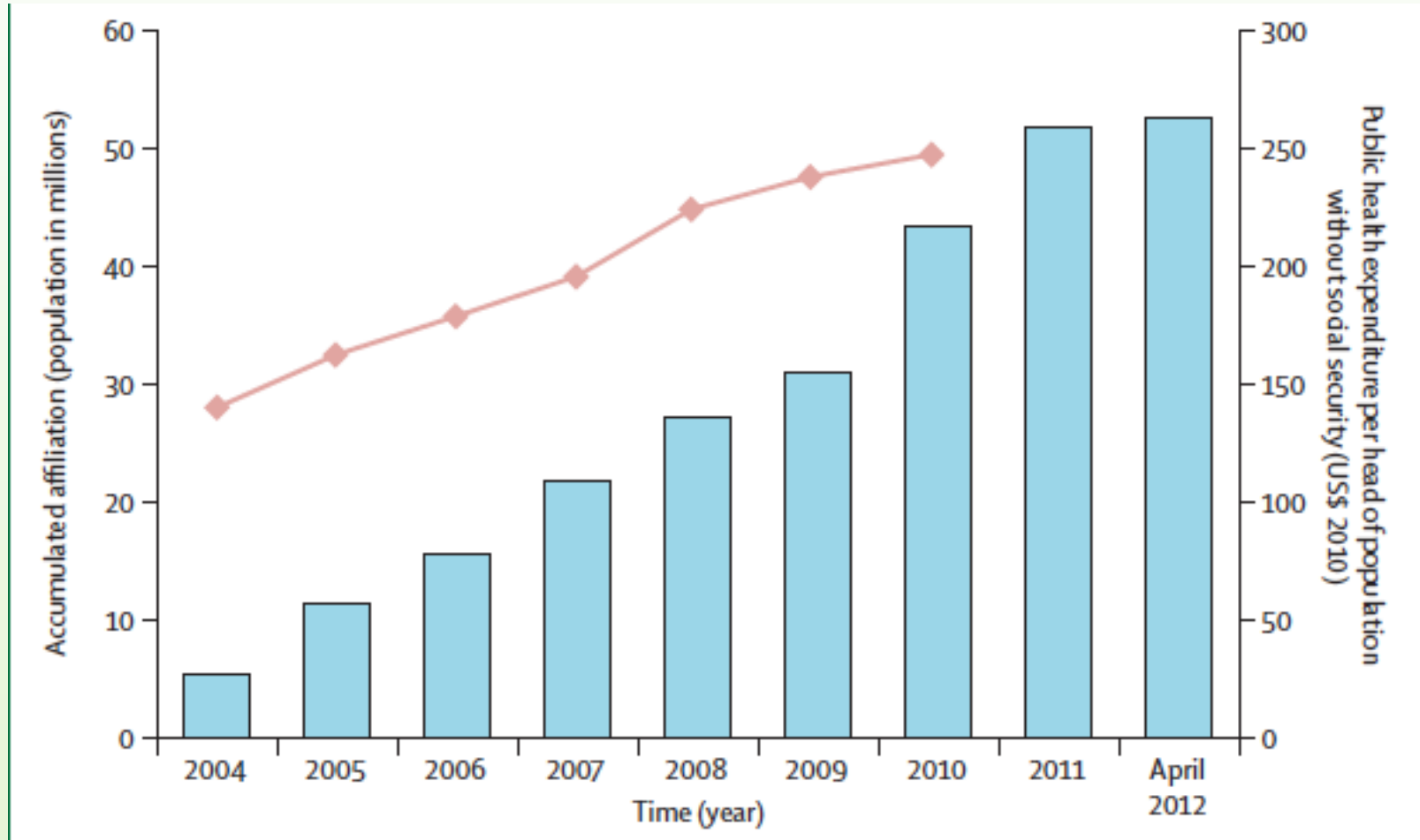
- Access to pre-specified set of treatments at zero or low co-payments
  - Provides *entitlements* to the individual
- Set increases gradually with time, but includes both primary care and hospital treatments
- Promotes preventive care: opportunities with complementarities with nutrition and other services

## Progress on coverage?

- Mexico:
  - “Popular Insurance” started in 2002
  - 51.8 million individuals had enrolled by 2011 (Knaul 2012)
  - 98% of Mexican population covered by some health insurance
- Colombia:
  - “Subsidized insurance” started in 1995
  - Population covered by health insurance increased from 25% in 1993 to 90% in 2011

In both countries, the set of covered treatments also increased considerably over time

# Increase in enrollment and public health care expenditure (Mexico)



Taken from Knaul *et al.* 2012

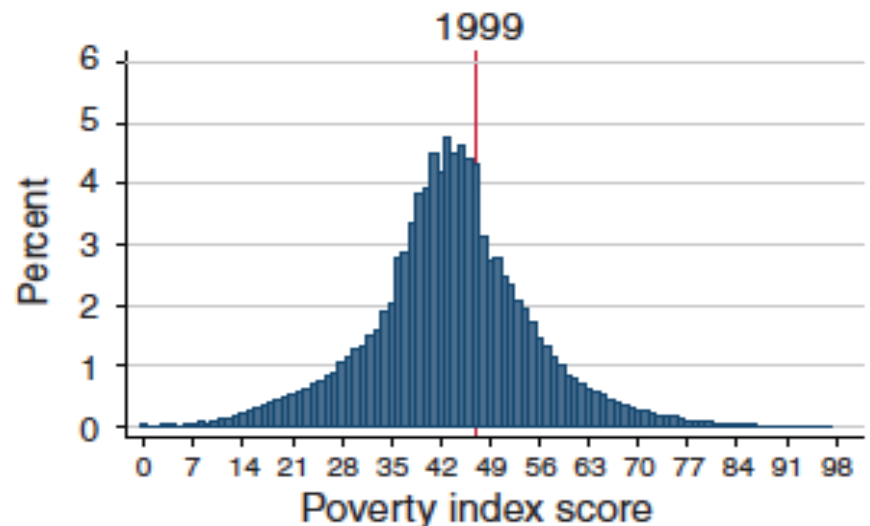
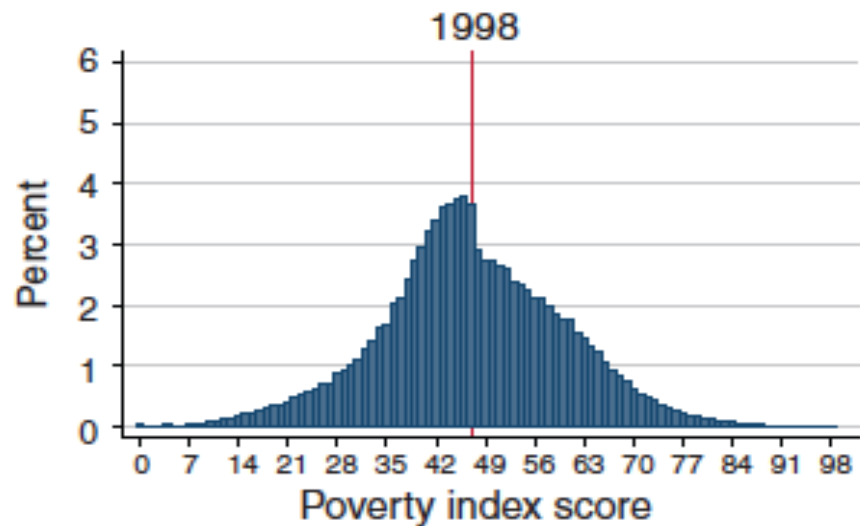
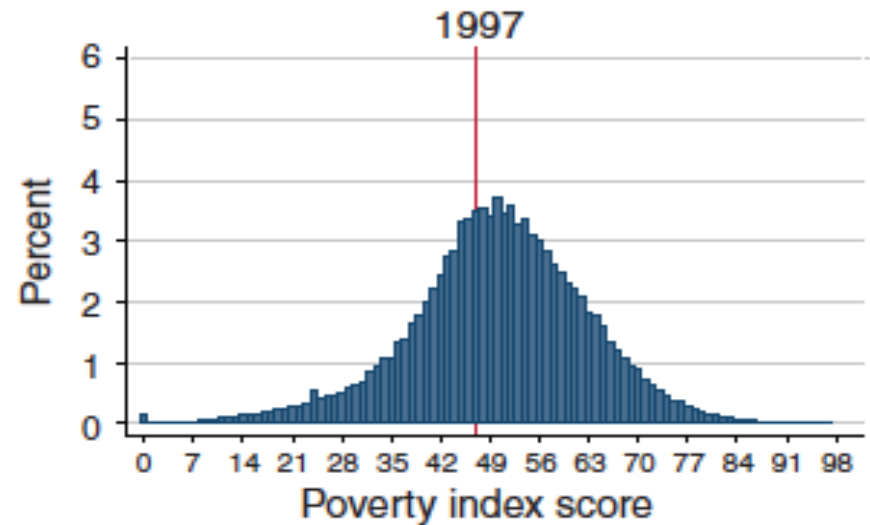
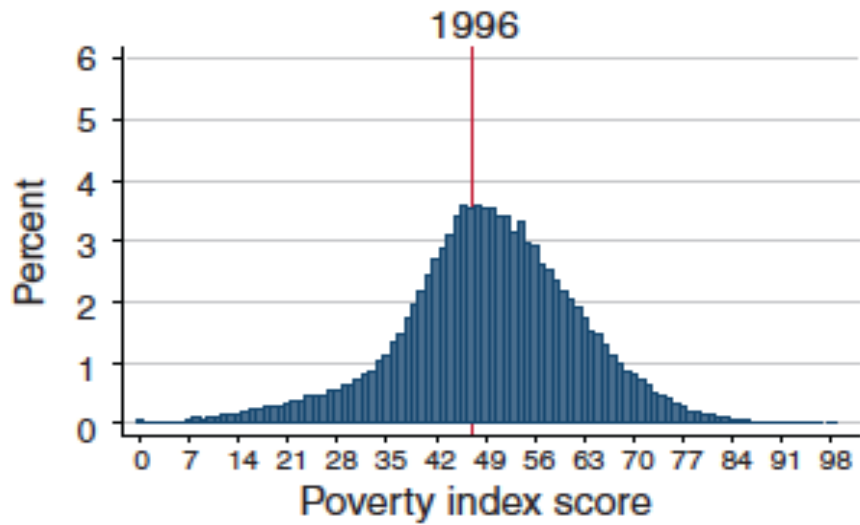
# Funding

- Mostly through general taxation
  - In Colombia, a % of the payroll contribution that funds the insurance coverage is used to partially fund the expansion (cross-subsidization)
  - Co-payments do exist but they are small
  - In Mexico, richer households must pay a small contribution towards the premium
- Insurance but not expected that individual contributions will fund it (**social protection**)



# Targeting

- Starting with the poorest, and gradually expand
- Who are the poorest?
- Colombia designed **SISBEN**:
  - Takes into account household living conditions (house construction materials, assets, neighborhood conditions, etc.) and use them in a formula
  - To create a poverty score
  - According to the score level, households are classified into one of 6 categories
  - Only individuals in category 1 & 2 are eligible
  - But this might bring problems if the formula is known



## Health care providers

- Both countries rely on public and private health care providers
- In larger communities, existence of several providers might increase accountability
- In Colombia, the individual chooses a insurance fund, and the insurance fund contracts with health care providers
- Note that health care coverage is only effective if there is geographical coverage of providers

## Preventive care

- In Mexico, it has increased because it is compulsory for individuals to undertake a preventive check-up following enrollment in the scheme
- In Colombia, insurers pay lump sum per individual to the health care provider, possibly giving them incentives to invest in preventive care and reduce future health care costs

## Preventive care and complementarities

- In Mexico, families that participate in their Conditional Cash Transfer program automatically are signed up in the health insurance system
  - Conditional Cash Transfer program promotes preventive care (payments to women are conditional on participation in preventive care)
- In Colombia, participants in childcare-nutrition programs are required to be up to date with preventive health care

# Insurance vs. free health care in public facilities

- With insurance, the individual is explicitly entitled to a set of treatments
- Individuals can choose amongst insurance fund or health care provider
- It increases provider accountability
- With free health care at public facilities, the individual has more of a passive role

## Effects of insurance expansion

- Decrease in out-of-pocket health care expenditures
- Increase in preventive care
- Increase in curative care
- Improvements in health (for Mexico, first studies did not report such improvements in health but second wave studies do)
- See Miller, Pinto, Vera-Hernández. 2013, Knaul et al. 2012, Conti and Ginja 2014,

## Conclusions

- Mexico and Colombia have reached almost universal health coverage
- Mostly funded through taxation but providing choice of health care provider/insurer, possibly increasing accountability
- Preventive care offers possibilities of complementarities with other programs
- Studies have reported positive effects on out-of-pocket expenditures and health outcomes



# References

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**Thank you !**

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