Health Insurance as Social Protection in Latin America

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Why health insurance?

• 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 replaces, 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
From Camacho and Conover (2011)
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


Thank you!

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