



► Social Protection in Action: Building Social Protection Floors for All

2022

Costa Rica, Indonesia, Lao People's Democratic Republic, Rwanda, and Viet Nam: Integrating social health protection systems

Summary

Social health protection (SHP) designates a series of public or publicly organized and mandated private measures to ensure effective and affordable access to health care as well as income security in case of sickness (ILO 2008). Several countries have moved towards integrated SHP systems with a single pool or with a single institution managing different pools. This study summarizes the main features and lessons learned of the experiences of Costa Rica, Indonesia, Lao People's Democratic Republic (PDR), Rwanda, and Vietnam.

ILO standards provide guidance on ensuring financial protection and effective access to health care, including the Medical Care Recommendation, 1944 (No. 69) and the Social Security (Minimum Standards) Convention, 1952 (No. 102), as well as the Social Protection Floors Recommendation, 2012 (No. 202). These standards take account of the diversity of approaches to ensure financial

protection against the cost of medical care, as first defined in Recommendation No. 69: social health insurance and national health service, and combination of such models.

Main lessons learned

- Building a coherent SHP system that provides comprehensive coverage to all members requires coordination and harmonization across schemes and sectors, including reducing fragmentation and inefficiencies of existing programmes.
- Proven success factors for the establishment of comprehensive SHP systems include a strong political commitment, the existence of a conducive policy and legal framework, and the availability of subsidies to provide coverage to population groups with insufficient contributory capacities.

Social Protection Floors Recommendation, 2012 (No. 202)

SDG 1.3 aims to implement nationally appropriate social protection systems and measures for all, including floors, and by 2030, achieve substantial coverage of the poor and the vulnerable.

Social protection floors (SPFs) guarantee access to essential health care and basic income security for children, persons of working age and older persons.

187 countries have adopted the Social Protection Floors Recommendation, 2012 (No. 202), to achieve universal social protection.

Recommendation No. 202 recognizes the need to put universality of coverage as a central objective of social protection systems, using taxes, social security contributions or a combination of both. In practice, most countries rely on a combination of such mechanisms in order to extend coverage to all.

- ▶ While integrated systems facilitate risk-sharing between population groups, it is critical to design the system so that redistribution promotes equity.
- ▶ Integrating SHP schemes at the administrative and policy levels is helpful, but not sufficient to guarantee equity. Special efforts are required to ensure that the entire population is covered, especially the rural population and vulnerable groups.
- ▶ Ensuring that members of SHP are aware of their rights and obligations is often a challenge, especially in countries where a large part of the population live in rural areas and operate in the informal economy. Context-specific approaches can be effective in increasing awareness of their rights.

Context

In many countries, the historical processes of development of social health protection systems have not necessarily been comprehensive or uniform, leading to high fragmentation of schemes. To address fragmentation, several countries have moved, or are moving, towards a unified SHP system with a single pool or single institution managing different schemes. The benefits of moving towards a more integrated system and merging risk pools, such as a single social health insurance fund, have been demonstrated in countries such as Mongolia, the Philippines, and the Republic of Korea (Chu, Kwon, and Cowley 2019). In some countries, such as Costa Rica, Indonesia, Lao PDR, Rwanda, and Vietnam, the integration of SHP schemes has been used to extend coverage and reach a wider scope of populations covered (see table) regardless of their employment status. Building a coherent SHP system that provides comprehensive coverage to all members requires coordination and harmonization across schemes and sectors, including reducing fragmentation and inefficiencies of existing programmes.

Several reasons motivated the integration of SHP schemes. An integrated system can lead to more equitable access to health care when the benefit package is harmonized across population groups (Myint, Pavlova, and Groot 2019). A single integrated system replacing separate SHP programmes can reduce costs in the long-run because integrated programmes can share resources and because administrative costs are reduced due to economies of scale (BMZ 2019).

Integration facilitates strategic purchasing strategies that can contain costs while ensuring quality. An integrated

SHP system can simplify enrolment through unified procedures and facilitates support to beneficiaries, for example through one-stop windows or service centres, which reduce the opportunity costs for applicants, increase the accessibility and inclusiveness of the system and improve the cost-effectiveness of beneficiary service

▶ **Table. SHP coverage and health financing indicators**

Country	Protected persons (%) (affiliated to a SHP scheme)	UHC Service Coverage Index (SDG 3.8.1)	Incidence of catastrophic expenditure (%) (SDG 3.8.2)	Domestic government spending on health as % of GDP	Out-of-pocket (OOP) as % of current health spending
Costa Rica	89.9	78	7.4	5.3	22.3
Indonesia	81.3	59	4.5	1.4	34.8
Lao PDR	93.6	50	3.0	1.0	41.8
Rwanda	83.0	54	1.2	2.6	11.7
Vietnam	90.2	70	8.5	2.3	43.0

▶ Source: ILO World Social Protection Database, WHO Global Health Expenditure Database and UHC Data Portal.

The advantages of an integrated system can cut across the three financing functions of revenue-raising, pooling, and strategic purchasing:

- ▶ The **revenue-raising function** benefits from economies of scale in an integrated scheme. For contributory or partially contributory schemes, since contributions are collected from fewer schemes, the administrative cost of revenue raising can decrease. Contribution compliance can also be improved by strengthening administration and by tasking a single agency with the collection of contributions (ILO 2019a; ILO 2016a). For non-contributory (tax-financed) schemes, having a single institution responsible for SHP can facilitate transparent communication with the ministry of finance and avoid issues of coordination and tension over resource allocation between different programmes.
- ▶ **Pooling of revenues** is strengthened because there are fewer schemes to manage and cross-subsidization across population groups becomes easier. In Lao PDR, the National Health Insurance (NHI) scheme was launched in 2016 as part of reforms to integrate and expand SHP. One important feature of the SHP reform was to subsidize contributions for a wide range of population groups, including the poor and vulnerable. This supported the scale up of enrolment in the new scheme nationally rapidly, expanding coverage to almost the whole population (ILO 2019b). In Rwanda, the introduction of a centralized risk pool with electronic transfers and billing contributed to considerable improvements in financial management

(USAID 2016).

- **Purchasing of services** becomes more effective and efficient because of increased purchasing and negotiation power of the SHP authority. An integrated SHP system can also reinforce integration of service delivery. In Costa Rica, social health insurance and health care services are provided through a single, publicly funded, integrated purchaser-provider, the Caja Costaricense de Seguridad Social (CCSS). Responsibility for service delivery used to be divided: CCSS was responsible for providing hospital care and the Ministry of Health (MOH) was responsible for public health services and primary health care (Pesec, Ratcliffe, and Bitton 2017). During reforms in the 1990s, responsibility for providing primary health care was transferred from the MOH to the CCSS to facilitate the integration of primary, secondary, and tertiary care, and thus of preventive and curative services. The MOH retained the stewardship function of the overall health system to direct the system, lobby for new legislation where necessary, and set quality standards of care. The decision to integrate the primary health care functions of the MOH and the CCSS was a critical first step in creating a comprehensive primary health care system. The integration enabled all population health to be managed by one agency with one set of goals and one budget and also ensured that both preventive and curative services were equally represented in the new model.

Success factors

Political commitment

Bringing together a variety of stakeholders around a common vision and motivation for a unified SHP system is critical to successful integration. To do so requires navigating a landscape of actors with their own priorities and agenda and existing programmes that may resist integration into a single, comprehensive universal social protection (USP) system (BMZ 2019). In Vietnam, political leadership behind universal health care was inspired, among various factors, by the desire to prevent social unrest (The Economist 2014). Political support was leveraged to develop and enforce related laws and regulations and guarantee adequate funding for the SHP system in Vietnam (ILO 2019b). In Costa Rica, the President played an important leadership role in moving towards an integrated SHP system for universal health coverage (UHC) and managed to bring together the MOH and the agency responsible for health insurance (Vargas and Muiser 2013).

The political economy of health reform is highly complex and may generate diverging views between stakeholders. Therefore, social dialogue with government institutions, employers, workers, civil society, academics, and UN agencies and others, is fundamental to generate a broad political consensus for SHP reforms (Ortiz et al. 2019). Boxes 1 to 5 provide information on the integration of social health protection systems in Costa Rica, Lao PDR, Rwanda, Indonesia and Viet Nam.

Progress in SHP coverage in Rwanda was achieved through political commitment and a strong, decentralized network of health facilities and health workers, and the use of collective action and mutual support (ILO 2016b). The President harnessed political power to promote local accountability for advancing the UHC agenda by signing performance contracts with district mayors for meeting certain indicators (Rosenberg et al. 2015). The reform was an integral goal of the overall socio-economic development strategy of the Government.

Political commitment can also be generated through pressure from civil society. The merger of Indonesia's SHP system and move to a single-payer system started after citizens brought legal actions to hold the Government accountable to implement the 2004 law on the National Social Security System, which stipulated that benefits should be uniform for all members (Global Financing Facility & World Bank 2019). This example illustrates the importance of having a rights-based approach as a condition for the operationalization of the schemes and effective access.

► **Box 1. Integrating social health protection systems – the example of Costa Rica**

Social health insurance and health care services in Costa Rica are provided through a single, publicly funded, integrated purchaser-provider, the CCSS. Mandatory health insurance for city-dwelling, lower-income worker was introduced in 1941, followed by universal health insurance for all workers and their families in 1961, and extension of insurance to the uncovered subsidized by the national budget. The CCSS provides universal health care insurance by combining social security schemes for four groups into a single national pool: salaried workers and their families, self-employed workers and their families, pensioners and dependents, and fully subsidized beneficiaries. The CCSS also manages sickness and maternity benefits, disability, old age, and death benefits. Costa Rica was among the first countries to achieve UHC. CCSS currently covers 90 per cent of the population.

Legal framework

A conducive policy and legal framework are important catalysts of an integrated SHP system. In Vietnam, the first Health Insurance Law was adopted in 2008 and rendered coverage mandatory for children under six, the elderly, the poor and near-poor (ILO 2019b). The law stipulated that the Government should fully subsidize those groups identified vulnerable or with no contributory capacity and should partially subsidize near-poor and students. The law also integrated the Health Care Fund for the Poor in the social health insurance scheme, which created an integrated, single risk pool.

► **Box 2. Integrating social health protection systems – the example of Lao People's Democratic Republic**

The National Health Insurance (NHI) scheme was launched in 2016 as part of reforms to integrate and expand SHP in Lao PDR and was further reinforced in the National Health Insurance Strategy 2017–2020. The strategy provides a road map with timeframes guiding the gradual transfer of functional responsibilities from individual schemes to the National Health Insurance Bureau (NHIB), currently under the management of the MOH. The National Health Insurance Law was passed in 2018. Workers in the formal sector are enrolled in a mandatory system funded by contributions from employers and workers. Other groups of the population are subsidized by a taxed-based system. Members must pay a small co-payment at facility level, but the poor and mothers and children under five are exempt from this requirement. The management of the schemes covering the informal sector has been consolidated under the NHIB. With the launch of NHI, SHP coverage increased from 32 per cent in 2015 to 91 per cent in 2018, which is higher than the 80 per cent government target for 2020. However, out-of-pocket (OOP) expenditure still constitutes the largest proportion of revenues of health facilities, highlighting the need to assess the adequacy of benefits.

Policy and governance

Designing and implementing a robust policy framework is critical when moving to an integrated system. Governments with an explicit commitment in their health policies and strategies to expand SHP coverage, such as Indonesia, Rwanda, and Vietnam, have reached the highest population coverage (USAID 2018). In Lao PDR, the NHI scheme launched in 2016 was further reinforced in the National Health Insurance Strategy 2017–2020. The strategy provides

a road map with timeframes guiding the gradual transfer of functional responsibilities from individual schemes to the National Health Insurance Bureau (NHIB), currently under the management of the MOH.

Governance arrangements are also of vital importance since SHP mechanisms are complex systems to manage. One study found that Indonesia, Rwanda and Vietnam – countries with high population coverage – score high on governance, including reliable insurance supervision and legislation, political commitment and effective management (Global Financing Facility and World Bank 2019). Social dialogue and participation are also key to ensuring that SHP is responsive to the needs of the protected population and gives a voice to the stakeholders. Representation in the governance bodies of institutions in charge of SHP of workers and employers scheme members and those who represent the interests of patients is a key element of good governance (ILO 2019e).

► **Box 3. Integrating social health protection systems – the example of Rwanda**

The SHP system in Rwanda consists of the Rwandaise d'Assurance Maladie (RAMA), which provides medical insurance to civil servants and employees of state-owned enterprises, military medical insurance, which provides basic insurance coverage to military personnel, community-based health insurance (CBHI) schemes (Mutuelles de Santé) for formal and informal sector members. In 2010, Rwanda moved towards integration by setting up the Rwanda Social Security Board (RSSB), which oversees implementation of the SHP for the formal sector, informal sector, and the military, to improve the financial management and efficiency of the system. In 2014, it was decided that managerial responsibility for the CBHI programme would move from the MOH to RSSB. This transition began in July 2015.

Subsidized contributions

Governments in the countries that have integrated their SHP system and managed to substantially increase coverage have all allocated significant subsidies to the coverage of certain population groups with insufficient contributory capacities (ILO 2019c). In Lao PDR, the Government shifted to a tax-based financing model, complemented by direct co-payments, at the time of the merger of SHP schemes. Under this model, contributions from workers in the informal sector have been replaced by public subsidies that are

transferred to the NHI fund on behalf of workers in the informal sector and the poor and vulnerable.

Through these subsidies, the Government managed to scale up the new scheme very quickly and expanded coverage to almost the entire population. Indonesia, Rwanda and Vietnam made social insurance enrolment mandatory and subsidized – partially or fully – enrolment for low-income groups.

► **Box 4. Integrating social health protection systems – the example of Indonesia**

Indonesia's social protection system consists of contributory schemes (health insurance and employment insurance programs) and non-contributory schemes (tax-financed social assistance programmes). The national health insurance scheme Jaminan Kesehatan Nasional (JKN) was launched in January 2014 by consolidating previously fragmented health insurance schemes and assistance programs at national and provincial levels (ILO 2019c). An important factor in the launch of the integration national scheme was the pressure to integrate vertical programmes such as HIV/AIDS in a broader approach to financing the health system. JKN is funded predominantly by member contributions but also fully subsidizes contributions for the poorest 40 per cent of the population through the health insurance subsidy system. In May 2019, JKN covered 83 per cent of the population.

Integration within coordinated social protection systems

Connections with the rest of the social protection system are also fostered by integrated SHP systems. In Rwanda, there is a centralized social registry called Ubudehe, which is a household database constructed through periodic social censuses. Similarly, Indonesia has created a unified database for social protection called Basis Data Terpadu (Barca and Chirchir 2014). In Costa Rica, the CCSS administers both medical care benefits and social assistance benefits such as maternity benefits.

In this context, making use of performant information systems can also be, with the right design and protection of personal data, a useful tool.

► **Box 5. Integrating social health protection systems – the example of Viet Nam**

The national health insurance programme was introduced in 1992 at the same times as Viet Nam enshrined the right to health care and protection for all citizens in its Constitution for the first time. The Health Care Fund for the Poor was launched in 2003, a government financed SHP mechanism for the poor, ethnic minorities in selected mountainous areas, and all households living in communes officially designated as highly disadvantaged. The first Health Insurance Law of 2008 launched Vietnam's move towards an integrated SHP system. Following revision of the Health Insurance Law in 2014 and a series of policies and regulations aimed at expanding mandatory enrolment to the entire population, population coverage reached 87.7 per cent in 2018. According to the Asian Development Bank, 71.5 million people were covered by social health insurance in 2015.

Challenges and attention points

While there are several benefits of integrating SHP systems, a careful design is necessary. Although integrated systems facilitate risk-sharing between population groups, it is crucial to design the system so that redistribution promotes equity. In Vietnam, poorer rural provinces tend to indirectly subsidize the richer and more urban provinces, because health service utilization, and therefore costs, is lower in rural areas (Chu, Kwon, and Cowley 2019). In Lao PDR, utilization rates for members of the scheme for formal sector workers are significantly higher than for the informal sector and the former health equity funds, which means that a prerequisite for successful integration is to identify and address the root causes of inequities in utilization (Ministry of Health of Lao PDR 2018). In Rwanda, social health protection scheme members in the poorest quintile had significantly lower utilization rates and experienced higher catastrophic health spending than the better-off, which may be due to a co-payment level that is too high for the poor (Lu et al. 2012).

These examples demonstrate that integrating SHP schemes at the administrative and policy levels is helpful but not sufficient to guarantee equity. Special efforts are required to ensure that the entire population is covered, especially the rural population, vulnerable groups, and so on, and have (i) adequate access to service provision meeting the

requirements of availability, accessibility, acceptability and good quality, and (ii) equal information about their rights and how to access them. Integration may require revising the benefit package accordingly and making additional investments in infrastructure, equipment and training of personnel in order to foster equity. At the same time, it also requires that financing mechanisms are equitable, take account of contributory capacities of individuals and households, the progressivity of existing taxation systems, and are designed in a way that also takes into account broader policy objectives.

Ensuring that members of SHP are aware of their rights and obligations is often a challenge, especially in countries where a large part of the population live in rural areas and operate in the informal economy. For example, in Lao PDR, many poor people appear not to fully take advantage of their rights due to a lack of awareness (Ministry of Health of Lao PDR 2018). There are examples of effective approaches to increasing awareness on rights. The national health insurance scheme in Indonesia developed a mobile application that among other things provides information regarding the programme, member rights and obligations, relevant regulations, procedures to access services, and complaint mechanisms (ILO 2019d).

It is also important that SHP systems carry out regular beneficiary surveys to access to up-to-date information on what beneficiaries perceive is working well and which areas need improvement. Another challenge faced by several countries is geographic access to services. Rwanda has invested in its health system by building a decentralized and strong network of health facilities and health workers to increase effective geographical access to health care.

Impact

There are several examples of positive impact of integrated SHP systems. In terms of utilization of health

services, the integration of SHP to extend SHI coverage had a positive impact in Vietnam (M. Palmer et al. 2015). For example, in 2010–2012, the student health insurance and free health insurance programmes increased the number of health care visits of children by 13.6 per cent and 66.1 per cent, respectively (ILO 2019b). Another study found that social health insurance has significantly increased utilization of maternal health care services in Indonesia (Wang, Temsah, and Mallick, 2017). In terms of health outcomes, a study of Rwanda's compulsory CBHI scheme found that it contributed to dramatic reductions in under-five mortality, infant mortality and maternal mortality (Lu et al. 2012). A study of Vietnam's health insurance programme found that it had a positive impact on the height-for-age and weight-for-age of young school children, and body mass index of adults (Wagstaff and Pradhan 2005).

In terms of financial protection, a study of the CBHI scheme in Rwanda found that the scheme reduced annual per capita out-of-pocket spending by about 3,600 Rwandan Francs (about US\$12) (Sydavong et al. 2019). A study of Vietnam found that covered individuals with disabilities spent 84 per cent less on health care than those uncovered (M. G. Palmer and Nguyen 2012). Social health insurance increased the likelihood of using inpatient care and health centres and reduced health expenditure (M. Palmer 2014). In terms of cost containment, analysis found that some measures have already led to efficiency gains at central level in Vietnam. For example, the MOH and Vietnam Social Security (VSS), the health insurance implementer, jointly organized a national drug tender, which saved hundreds of billions of Vietnamese Dong (ILO 2019b).

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