3. Pooling Health Funds and Risks

**Highlights**

- Risk pooling is important to address equity and financial sustainability in health. Countries have multiple pooling arrangements, leading to unequal risk distributions across pools and to different pools for the various socioeconomic groups.
- World Bank support contributed to increased risk pooling in middle-income countries. Similarly, the International Finance Corporation supported risk pooling through public and private insurance.
- The World Bank Group built institutional, management, and technical capacity in government and insurance administration to manage funds and risks, and Bank analytical work informed policy decisions. However, Bank assistance to health insurance has been diminishing over time. Projects were less effective in countries with decentralized health systems.
- Equity in pooling has improved where the Bank helped subsidize coverage of the poor. But coverage did not always lead to pro-poor spending, improved service use, or greater financial protection. Fragmented pooling remains an issue and can affect efficiency. Success factors included strength in institutions, management, technical capacity, and information.

With the exception of user payments, all revenues for health are pooled in public and private health insurance and in central and local government budgets, and then transferred to providers. Pooled financing reallocates funds from healthy to sick individuals—that is, from individuals with a low risk of illness to those with a high risk who are more likely to occur higher health care costs. As countries grow economically, pooled health financing in national health systems and health insurance comes to dominate revenues from user payments.

The objective of pooling is to reduce the out-of-pocket price the patient pays when using services and to ensure financial protection against catastrophic health payments and equity in service use. But managing health revenues in a way that ensures equitable and efficient pooling is a major challenge (Gottret and Schieber 2006). Also, increased pooling contributes to higher health spending by increasing the demand for health care.

Increased pooling, in national health systems or through insurance, benefits consumers and providers. Individuals who are insured or covered in the public system will copay less when seeking care. They are thus expected to report greater service use and lower copayments than those who pay user fees. Increased pooling is also good for providers because user payments from patients are erratic revenues in low-income environments. Instead, contracted providers will receive a stable amount of revenues from the government and insurers to treat patients (Box 3.1).
Box 3.1. Risk Pooling Arrangements

Countries introduce different risk-pooling arrangements to protect individuals against the financial risk of illness. In health systems with automatic coverage, public revenues are pooled in the government’s health budget, and the public sector plays an insurance role, even if it is not formally constituted as an insurance plan (Kutzin 2007; Savedoff et al. 2012). The government transfers revenues from the central and local government budgets to providers to pay for health care services provided to the population. In countries with decentralized health systems (such as Argentina, Kazakhstan, and the Philippines), health revenues from the central and local governments are pooled at the local level (state or region) and transferred to providers to finance health care delivery to patients.

In addition, public and private health insurers pool health funds, including from individual contributions, premium payments, and government subsidized contributions, to pay for the financial risk of illness among their members.

Chapter 3 summarizes the challenges related to automatic coverage and to mandatory and voluntary pooling. It then describes support from the International Finance Corporation (IFC) and World Bank to countries in meeting them. It offers evidence on how this support to pooling affects equity in health financing and service use, financial protection, and efficiency.

Challenges

In most countries, multiple pooling arrangements coexist, leading to a risk of fragmentation. Generally, formal sector workers are covered under mandatory social insurance; higher-income groups can afford paying higher premium to enroll with private voluntary insurance (to access specialist care and private providers); and the government provides automatic coverage in public health facilities for those who are excluded from these insurance arrangements, mainly the lower-income and informal sector groups. As a result, different socioeconomic groups pool their health risk among themselves in different institutions with different revenue raising capacity and access to different health benefits. The resulting fragmentation raises concerns about equity in service use across different groups. It also raises concerns about the financial sustainability of small risk pools (Box 3.2).

One of the main challenges in government health systems (automatic coverage) in low- and middle-income countries is that government allocations are often not pro-poor. Instead, a higher share of funds is allocated to hospitals in urban areas, which are mainly used by the wealthier (Table 3.1). To improve pro-poor spending, some countries have earmarked transfers to providers mainly used by low-income groups. In Mexico, for instance, the Seguro Popular is an intergovernmental revenue transfer within the national health system from the center to the states. The transfer is
defined based on the number of low-income individuals affiliated with Seguro Popular and is cofinanced by the states.

**Table 3.1. Incentives and Challenges in Different Risk Pooling Arrangements**

<table>
<thead>
<tr>
<th>Risk Pooling</th>
<th>Pooling Institutions</th>
<th>Incentives</th>
<th>Challenge</th>
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<td>Automatic coverage</td>
<td>Government budget (central and local)</td>
<td>Governments allocate funds for political reasons (e.g., urban hospital)</td>
<td>Pro-rich spending; underfunded services in low-income areas</td>
</tr>
<tr>
<td>Mandatory pooling</td>
<td>Public health insurance Private health insurance&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Moral hazard among insured individuals</td>
<td>Exclusion of informal groups; inefficient service use; cost increase</td>
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<tr>
<td>Voluntary pooling</td>
<td>Private health insurance Community-based health insurance</td>
<td>Moral hazard; risk selection</td>
<td>Financial sustainability</td>
</tr>
</tbody>
</table>

<sup>a</sup> In some countries including Georgia, India, and Slovakia, private insurers offer mandatory insurance coverage.

Mandatory participation by law in public or private health insurance limits insurance coverage to all or a defined population group (e.g., formal sector employees). The excluded are mainly lower-income groups who work in the informal sector—the majority of the population in developing countries (Table 3.1). They receive automatic coverage through the public system; however, this is often less comprehensive. The small membership size of social insurance in countries with nascent formal sectors can endanger an insurer’s financial viability. A fiscal and equity problem can arise if the government has to finance the deficit caused by the medical service use of wealthier insurance members (Box 3.2).

**Box 3.2. Financial Incentives May Endanger the Sustainability of Risk Pools**

Risk pooling involves trade-offs between equity gains caused by reduced uncertainty about the financial consequences of ill health and efficiency losses created by financial incentives (Arrow 1963; Cutler and Zeckhauser 2000; Zeckhauser 1970). These incentives, which include adverse selection, moral hazard, and supply side–induced demand, can lead to higher costs for the risk pool and endanger its financial sustainability.

Adverse selection arises when those enrolling in voluntary risk pools are mainly high-risk individuals, resulting in high-cost pools that may not be financially viable. Moral hazard occurs when pool members overuse medical services because they copay at a reduced price for care, which can increase costs. Finally, providers who are reimbursed by the pool based on fee-for-service payments have a financial incentive to oversupply care, which also leads to higher costs.

Some governments introduced separate institutions to pool public funds and health risk for informal sector groups. Thailand, for example, has established the government-funded Universal Coverage Scheme, which uses tax revenues to
provide coverage for individuals not covered by formal sector social insurance. Benin and Cambodia created health equity funds to strengthen financial risk protection among the poor and informal sector groups. While they differ in design, these funds were set up to manage health care subsidies for eligible population groups.

The volume of voluntary pooling in private health insurance is inconsequential. Few people can afford voluntary private insurance, and there are generally not that many private providers to contract with in developing countries (appendix D). Private health insurance pays mainly for services not covered by social insurance or by the government (e.g., specialist care in the private sector) and is used to avoid waiting lists for elective treatment. To ensure their financial viability, private insurers have an incentive to enroll people at low risk of being ill.

Community-based health insurance (CBHI) is more prominent in Africa for informal sector groups. While members of such schemes often report better access than those who pay user fees, they tend to have access to a smaller benefit package than those with social health insurance (SHI). In addition, voluntary pooling in private insurance and CBHI may lead to adverse selection resulting in small, high-risk pools with predominantly sicker individuals, and may undermine pool finances (Box 3.2).

**Bank Group Support to Risk Pooling**

The World Bank Group has tried to help countries address challenges in pooling arrangements. About 40 percent of the Bank’s health financing operations support automatic coverage through national health systems or enrollment into mandatory health insurance in 36 countries.

The Bank Group does not take an ideological stance on risk pooling arrangements. It did not advocate for SHI or automatic coverage through national health systems, or promote private health insurance. Rather, it works within different country and risk pooling contexts. The Bank assisted Ministries of Health and local governments managing and implementing their health budgets. Management and information capacity was also built with Bank and IFC support in public and private health insurance.

**Analytical Work**

The Bank produced several analytical reports, mainly in middle-income countries, to inform governments about the challenges of different risk pooling arrangements in different contexts. Of the 70 economic and sector work activities, a relevant word search suggests that 15 have tackled pooling. In addition, the Bank conducted eight
impact evaluations on risk pooling in China and Vietnam (appendix Table A.8). It also carried out limited analysis on the welfare effect of increased pooling of domestic revenues and whether the poor benefit. Only 10 Bank poverty assessments examined the distributional aspects of public spending and conducted benefit incidence analysis (see chapter 5).

**Automatic Coverage through National Health Systems**

The Bank provided technical assistance to improve resource management in national health systems. Decentralization of funding to lower levels of government was supported in several countries including Cambodia, Indonesia, Kosovo, Pakistan, Rwanda, and Serbia. It helped build technical capacity to manage fund pooling and health resources in Afghanistan, Cambodia, and Vietnam. The Bank has helped countries target the poor through automatic coverage in national health systems. In Argentina it supported the introduction of the Plan Nacer program, which targets supply-side subsidies to health facilities used by the poor (IEG 2011).

Depending on the country context, Bank support to automatic health coverage was accompanied by public sector measures to strengthen the public management of health funds. In Afghanistan the Bank supported expenditure management through program-based budgeting which links health sector spending to the national strategy and to prioritize allocation. In Kenya and Tanzania it helped with public expenditure tracking to identify inefficiencies in spending. In Kenya the Poverty Reduction and Economic Management and Health, Nutrition, and Population (HNP) teams worked with the government to improve budget transparency by adding more detailed line items to track health expenditure.

**Public and Private Health Insurance**

The Bank has advised several low- and middle-income countries on the level of contributions paid to social insurers and on subsidized enrollment. The Bank also supported the strengthening of health insurance governance and management.

The IFC has made only two direct investments in private health insurance (both originating from the Financial Markets Group) and two investments in a health maintenance organization (HMO) provider network (appendix Table D.3). The IFC has supported the expansion of Nigeria’s largest integrated HMO provider network with two investments and one advisory services project (2007 and 2009), and provided funding through its Performance-Based Grants initiative to support a project under the Global Program on Output-Based Aid to support the HMO’s community-based health plan targeting the informal sector. And it has supported the expansion of private insurance providers in the Europe and Central Asia and the Middle East and North Africa Regions with two equity investments in 2011 and
2012, respectively. IFC has recently approved a micro health insurance advisory project in India (appendix D).

Two equity funds have been established as part of the Health in Africa Initiative (HiA)—the Africa Health Fund and the Investment Fund for Health in Africa. Both funds include insurance as target investments. They have invested in insurance companies and HMOs in Kenya, Nigeria, and Tanzania. The initiative has also supported governments in Kenya and Nigeria in strengthening their public health insurer through IFC’s advisory services. IFC support to the government of Uganda in reforming legal and regulatory frameworks aims to increase private sector participation in publicly funded health programs (appendix D).

**Effectiveness of World Bank Group Support to Pooling**

In practice, risk pooling may not work as expected for several reasons. This section examines how effectively Bank Group support to risk pooling has helped countries develop management and technical capacity, and improve equity in pooling, service use, financial protection, efficiency and financial sustainability of risk pools.

**Management and Technical Capacity**

Management and technical capacity is important to ensure that health budgets in central and local governments are effectively implemented. Although the Bank has supported governments in increasing their health budget, budget implementation is limited in some countries. Low budget-execution rates were reported in Afghanistan and the Democratic Republic of Congo because of constrained technical capacity, lack of financial authority, and complicated financial and procurement procedures. In Afghanistan, Bank analytical work also found no clear targeting of public funds to areas with worse health outcomes, and the funds spent by the government and donors on health were not coordinated across provinces (Belay 2010). More recently, the IEG case study found, the Bank played an effective coordinating role among donors and emphasized the use of M&E which supported the government in evidence-based fund management. In Brazil, Bank support to building the institutional foundations at municipality level—including budget management, accounting, monitoring, financial management, and managerial capacity—contributed to the timely execution of the health budget in a decentralized health system (IEG 2011).

Through its multisector analytic work, the Bank provides important information about public sector reforms (such as decentralization) that affect health financing. The Independent Evaluation Group (IEG) found that in Kenya, the Bank’s Health and Public
Sector teams have spearheaded several analytical products and policy discussions in health financing. The Public Sector team was supporting a fiscal space analysis to ascertain the efficiency of the health sector and determine the value for money aspect. Bank work through the 2012 Public Expenditure Review and a Public Expenditure Tracking Survey with sub-national analysis and frontier analysis helped identify inefficiencies and informed the government about challenges that need to be addressed in health sector devolution (appendix E). This type of Bank analysis helped inform policy makers in their management and technical decisions.

Health financing projects in decentralized health systems with automatic coverage performed worse than the average health financing projects in ratings of the IEG. Examples include projects in Brazil, the Dominican Republic, Ghana, and Mauritania, where the Bank overestimated the political commitment and technical knowledge in the government to decentralize, and failed to calibrate project design to local capacity.

In Indonesia, three Bank health projects assisted the government in shifting responsibilities for planning and management of resources to district authorities. While district health budgets tripled, the additional resources were insufficient and ineffectually allocated. Allocation formulas were not adequately poverty calibrated, and the limited own-revenue raising capacity of poorer districts negatively affected horizontal equity across districts. Few districts reached the target of allocating at least 15 percent of local government spending to health, and health service use among the poor and near-poor increased very modestly in some districts and decreased in others. IEG found several factors that limited the success of Bank-supported health sector decentralization in Indonesia, including insufficient attention to define roles and responsibilities at different government levels, inadequate information systems, and considerable overlap and duplication of tasks across government (including in management of human resources) that generated inefficiencies in the organization and delivery of services. The Bank did help introduce better planning and budgeting methods that over time have helped improve information systems for regional monitoring. IEG concluded that Bank support to health decentralization needs to be grounded in a realistic understanding of how institutions work, and how they can be expected to change in the political context in which projects operate (IEG 2013).

Bank technical assistance and lending helped governments develop new laws and administration to strengthen social insurance management, mainly in middle-income countries. Following Bank advice governments in Albania, the Dominican Republic, Serbia, and Vietnam introduced changes to health insurance laws and regulations. In Turkey it gave advice on the Social Security Administration law and hospital budgets.
Governments in European countries introduced measures to stem the deficit in health insurance as recommended in PERs and analytical work supported under policy lending. Bank loans financed beneficiary identification and medical claims management systems in Georgia, Montenegro, and Serbia, and improved efficiency in insurance management. In these countries, Bank Public Sector and Health teams worked closely on these reforms, which contributed to successful implementation.

Although the HNP strategy highlights the Bank’s comparative advantage in health insurance analytical capacity, Bank teams did not always maintain support to health insurance and address shortcomings in management and institutional capacity. In Tanzania in the 1990s and early 2000s, the Bank was instrumental in setting up the National Health Insurance Fund, the National Social Security Fund and the Community Health Fund. However, by the mid-2000s, the Bank reduced its engagement in these funds, partly because of changes in Bank resources as well as reduced demand for Bank assistance by the government as other donors increased their health financing technical assistance. By 2013, only about 8.6 percent of the population is insured in Tanzania, enrollment is highly unequal, and the National Health Insurance Fund has high financial reserves because investments are tied up, and because of a lack of understanding among health facility managers about how to submit a medical claim to the fund to get paid for care provided to insured patients. Little additional reforms were introduced to address these shortcomings. IEG finds that given the strong Bank involvement in the past, the Bank team could have provided further analysis and technical assistance to the funds to strengthen institutions and management capacity, especially since the government is now considering scaling-up insurance and raising labor taxes to finance enrollment. In Bolivia, IEG found that the Bank was instrumental in helping the government establish health insurance for mothers, children, and the elderly; however, this support was not maintained over time. Similar concerns were identified in Ghana and Rwanda, where Bank support to health insurance management has been reduced over time partly due to a shift in government priorities and Bank resources (appendix E).

In the Kyrgyz Republic the Mandatory Health Insurance Fund is nearly all funded from general government revenues and manages a state-guaranteed benefit package for the whole population. The fund is also the sole purchasing agency for health services within the health system (Kutzin 2013). The Bank has supported these reforms in collaboration with other donors, through analytical work and capacity building and as a convener of donor efforts. Health reforms have benefited from strong political commitment and technical capacity, which are important success factors. They include the 10-year (1996–2005) government health reform strategy, several champions in the government in support of the reforms, and effective use of
monitoring and evaluation (M&E) so that early successes could be publicized and used to generate support for subsequent reforms. In addition, Bank interventions and policy dialogue at key moments of political opposition sustained momentum for insurance reforms (IEG 2008).

Under the HiA, IFC has conducted a strategic review of Kenya’s National Hospital Insurance Fund (IFC 2011a) and a market assessment of prepaid plans (IFC 2011b). Its recommendations were accepted by the government and are now being implemented. Through a follow-on advisory project, IFC is assisting the government on integrating private hospitals into the national health system (e.g., regulatory framework for accreditation and contracting with private providers). The evaluation’s case study found the Bank is also working on recommendations made by IFC through a project on health insurance subsidies for low-income groups (appendixes D and E).

**Equity in Pooling**

Ensuring that pooling arrangements are equitable requires an effective way to cross-subsidize across pool members and to inject the pools with a sufficient amount of public funds that are sustainable. In health systems with automatic coverage, the Bank conducted a few incidence analyses to alert governments to issues in pro-poor allocation of funds. In Indonesia the Bank found that overall allocation of public spending on health is low and spending needs to be increased strategically to reach the poor effectively and to include demand-side measures. In Ghana the Bank identified increased pro-poor spending over time. However, in Nicaragua it found that public spending on social services is not pro-poor—it benefits all socioeconomic groups about equally.

The share of poor included in risk pools increased where the Bank helped governments subsidize their enrollment (Box 3.3). In Turkey insurance coverage for the poorest increased more than fourfold between 2003 and 2011, generating a coverage rate of 85 percent for the poorest (Atun et al. 2013). The public health insurance has recently incorporated the Green Card Program, which subsidizes health care for the poorest income group and is funded by general government revenues (Atun et al. 2013). Similarly, in Colombia the Bank’s development policy operation helped increase the enrollment of low-income groups in government-subsidized insurance from 10.7 million in 2002 to 18.2 million in 2007. By March 2014, about 43 million individuals or 90 percent of the population was insured in Colombia (www.sispro.gov.co). In Rwanda, IEG found that Bank support to the CBHI law makes insurance enrollment mandatory and increased CBHI enrollment to about 85 percent of the population by 2012. A Bank project in the Philippines
reached the poor in the National Health Insurance Indigent Program, but the percentage enrolled is unknown.

Box 3.3. Bank Analysis Informed Risk Pooling in China and Vietnam

Researchers have found that individuals enrolled with the voluntary Vietnamese Health Insurance (VHI) program were more likely to use outpatient care, and the poorest insured are 10 times more likely to seek care than the uninsured. But there were concerns that adverse selection and the use of unnecessary care would threaten the financial sustainability of VHI (Jowett et al. 2004). The Bank, using data from the late 1990s, confirmed improved health outcomes among VHI members (Wagstaff and Pradhan 2005). Informed by these studies, the Bank and other donors through the Second Poverty Reduction Support Credit in 2003 helped the government establish the Health Care Fund for the Poor (HCFP), which provides the same benefits as the VHI. In a follow-up study the Bank found that 60 percent of eligible households were covered by 2006, and the HCFP was well targeted to the poor; however, there was adverse selection (Wagstaff 2010). To address selection problems, Bank lending helped increase HCFP enrollment to 96 percent among the poor and 42 percent among the near-poor by 2011.

In China, based on data from the late 1990s up to 2004, the Bank found that the Rural Cooperative Medical Scheme diminished the risk of high user payments for households (Wagstaff and Lindelow 2005), and ill health can have a large impact on household income, labor supply, and medical expenditures, even for the insured, raising concerns about the effectiveness of the Scheme (Lindelow and Wagstaff 2005). This was followed up by an impact evaluation of the government-subsidized New Cooperative Medical Scheme (NCMS) established in 2003, which found lower enrollment among the poor and higher enrollment among the chronically sick, pointing to adverse selection. Service use increased, but the NCMS did not reduce user spending for the poor (Wagstaff et al. 2007). Informed by these studies, the Bank has supported the NCMS since 2009. Enrollment increased to 99 percent in 2012.

In some countries, Bank support was less successful in targeting the poor for inclusion in risk pools. In Tunisia only 9 percent of the eligible poor are covered under the government-funded Free Medical Assistance Program. The poor are not reached because of institutional constraints including nontransparent eligibility criteria that are subject to manipulation, and the Bank could in fact have addressed weak targeting of the poor in the policy dialogue (IEG 2014). In Georgia, despite means testing supported by the Bank, a significant proportion of eligible households were excluded from the Medical Insurance Program, mainly because of insufficient information (Bauhoff et al. 2011).

In Ghana the National Health Insurance System covers 40 percent of the population, which are predominantly the nonpoor. The Bank was instrumental in convincing the government to extend coverage to children and youths under the age of 18 and pregnant women to achieve the relevant Millennium Development Goals. It also
discussed a more generous definition of the poor, which according to the National Health Insurance System is only 1.7 percent of the population and far below the national poverty rate of 30 percent (appendix E). But reaching the poor requires commitment by government. IEG found that insufficient political and financial commitment by the government and limited implementation capacity were constraining factors to reforms as was weak M&E systems to track equity in access for insured and uninsured individuals (IEG 2007).

The IFC supported private and public health insurers that provide both mandatory and voluntary coverage mainly for formal sector employees. In IFC’s managed-care investments in Nigeria, HMO enrollees are primarily federal employees and employees of large corporations and members of the National Health Insurance Scheme. There is no evidence from the IFC’s Development Outcome Tracking System to suggest the 1.2 million HMO enrollees in Nigeria and 613,000 patients served as of FY13 were poor. In Kenya, IFC advisory support to the public insurer contributed to expanding coverage to civil servants. IFC support also resulted in the government’s decision to expand health insurance subsidies to the indigent population (poorest 9 million Kenyans). IFC assisted the government of Meghalaya (India) with the contracting of a private insurer to offer health insurance to low-income individuals. In Tanzania, the Investment Fund for Health in Africa invested in the largest private insurance company; its clientele is primarily corporate employees who are mainly higher- and middle-income individuals (appendix D). Dalberg (2012) finds that the equity investment through the Africa Health Fund in Kenya is reaching the poor but not the very poor.

**Service Use Relative to Need and Financial Protection**

Few Bank projects report how increased pooling of domestic revenues affects service use, particularly in automatic coverage systems. In Uzbekistan primary health spending to facilities mainly used by low-income groups rose from 41 percent in 2004 to 45.2 percent of public health expenditure in 2011, and the number of visits per person per year has increased from 3.8 in 2005 to 4.4 in 2010. In Tajikistan the reforms in public revenues had no effect on care seeking; as patients did not seek care, households also spent less on health. In Argentina service use of protected programs remained at a high level and increased for the treatment of tuberculosis and HIV vertical-transmission prevention (IEG 2011).

Risk pooling does not necessarily translate into improved service use and financial protection. In China no recent information is available on the impact of the use of care and how effectively the New Cooperative Medical Scheme protects households against the financial consequences of ill health. The Turkey insurance reform supported by the Bank contributed to improved equity in health financing across
income groups and substantially reduced catastrophic expenditures for the poor while increasing their service use (Atun et al. 2013). The Colombia health insurance for the poor lowers mean inpatient spending for patients and is associated with the use of preventive series and health gains for children. However, insurance does not affect spending for outpatient care nor does it increase utilization of curative care (Miller et al. 2013). In Georgia, insurance did not affect utilization of care (Bauhoff et al. 2011). Among the reasons why were low quality of care and the exclusion of pharmaceutical products from coverage (World Bank 2012). Bank analytical work should identify and address the reasons why pooling does not lead to the expected outcomes, as done in Georgia and Vietnam (Somanathan et al. 2014), for example.

Insufficient information about benefits is a limiting factor. In Vietnam a Bank impact evaluation finds that while the Health Care Fund for the Poor (HCFP) has reduced user payments for members, it did not affect their service use (Wagstaff 2010). Among the reasons were that HCFP members were not well-enough informed about benefits. Thus the Bank helped improve knowledge about HCFP benefits for 98 percent of members, and by 2011, 46 percent of the poor HCFP members used hospital and outpatient care. Similarly, service use among members of the Medical Insurance Program in Georgia was low because the program provided too little information on the benefit package; beneficiaries failed to receive vouchers for enrollment; and providers continued requesting under-the-table payments from patients (Bauhoff et al. 2011).

Some countries report substantial improvements for the poor insured, but this information is limited. Other researchers report improved utilization and reduced out-of-pocket spending for the insured in some Bank-supported risk pools. Based on 2006 household survey data, CBHI in Rwanda is associated with significantly increased utilization of health services when they are needed and with lower user payments. The incidence of catastrophic health expenditure was almost four times as high for noninsured households as for the insured (Saksena et al. 2011). In Ghana the insured poor have greater access to health care, lower copayments, and better health outcomes than the noninsured poor. Insurance has also reduced catastrophic spending on health and protected households against impoverishment (Nguyen et al. 2011). In Cambodia the health equity funds led to sharp gains in utilization of key services and reduced spending by the poor, and they significantly lowered copayments, catastrophic expenditures, and debt by the poor (Flores et al. 2013).

Little evidence of the impact of IFC’s support to health financing on improved service use or financial protection is due to the newness of the projects or scarcity of data (appendix D). As IFC investments in private health insurers do not monitor utilization of care and copayments by the insured, no information is on hand about
their effectiveness. Partly this is due to the transaction-like nature of some IFC’s advisory services; however, recent projects have recommended post-completion reporting on access to improved services.

**EFFICIENCY AND FINANCIAL SUSTAINABILITY**

Efficiency concerns arise where pooling is fragmented. In East Asian countries the Bank warned about high administrative costs, duplications of benefits, and loss of negotiating power with providers (Langenbrunner and Somanathan 2011). In European countries the Bank highlighted risk-equalization issues to address fragmentation (World Bank 2009a). Bank advice to the government of Turkey in 2003 cautioned about fragmented pooling (World Bank 2003). Since then, the government has consolidated the five insurance schemes into a unified general health insurance program with harmonized benefits (Atun et al. 2013). The government has also improved revenue allocation to primary care which reduced referral rates to more costly specialist care. In Hungary and Poland the Bank successfully advised against breaking up the social health insurer into multiple pools, which would have increased fragmentation. The Bank also warned about adverse selection in countries with multiple insurance funds, including China, the Slovak Republic (World Bank 2009a), and Vietnam. Achieving development results in IFC’s private insurance investments have been difficult. For example, an investment aimed at reaching underserved populations in a multiple pooling environment proved difficult.

Addressing fragmentation needs political commitment. In Bosnia and Herzegovina, Bank advice to consolidate various health insurers faced political resistance, and the government did not follow it. In Mexico a Bank study found that government-subsidized risk pooling among the poor through Seguro Popular incentivizes informality. While Seguro Popular improves access to care, it was associated with a 3.1 percentage point fall in the flow of workers into formality. The Bank also found that Seguro Popular has income effects. Members can avoid having to contribute to the formal SHI program by moving to the informal sector and receiving services under Seguro Popular (Aterido et al. 2011). Yet the government has chosen not to consolidate Seguro Popular with the formal SHI program to reduce fragmentation.

The findings of this evaluation show that almost half of the Bank’s health financing portfolio supported the strengthening of pooling through automatic coverage or mandatory public health insurance. The Bank helped strengthen regulatory frameworks, resource management, and institutional foundations for budget execution, and invested in M&E. Bank and IFC analytical work and technical assistance helped inform governments about fund management and the expansion of coverage to the uninsured. However, in some countries the Bank could have
provided further analysis and technical advice to help governments strengthen insurance institutions and address weaknesses, including in targeting the poor. Equity in pooling improved where the Bank helped subsidize enrollment of the poor. But coverage did not always lead to pro-poor spending, improved service use, or financial protection. The IFC supported private and public health insurers that provide both mandatory and voluntary coverage mainly for formal sector employees, but evidence that this has improved service use is missing. Fragmented pooling remains an issue in several countries and can reduce efficiency.

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CHAPTER 3
POOLING HEALTH FUNDS AND RISKS


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1 Of the 188 projects included in this evaluation, 42 supported decentralization. Their rating in the Independent Evaluation Group (IEG) review of the project implementation completion report is lower for monitoring and evaluation and for efficacy.

2 Eligibility in 2005 was determined based on visits by local social workers and included criteria such as family size, disability, age, capacity to work, and income.