Plans for the implementation of health benefits by the Social Security Corporation of Jordan

Observations and considerations in light of ILO's social security standards

Technical note

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Background

Over the past two decades, Jordan has made progress in access and utilization of health services, with a positive influence on health outcomes. This was accompanied by a sharp increase in the share of general government health expenditure in total health expenditure, which peaked in 2010 and allowed for a significant reduction in the share of out-of-pocket (OOP) payments from households in total health expenditure. Since 2015, the trend has reversed and OOP as a share of health expenditure has been increasing to reach 30 per cent in 2018, which is mostly captured by the private health sector. The demographic profile of the Jordanian population will also entail rising health costs on the medium to long term, translating into higher healthcare needs. Government spending on health as a share of government expenditure stabilized at around 12 to 13 per cent over the same period.

Notably, with a view to reduce OOP on health and to foster access and greater equity, the government of Jordan has put in place several social health protection schemes and programmes over the years. According to the Housing and Population Census of 2015, 64 per cent of Jordanians are insured by at least one type of health insurance, and 4.7 per cent receive free health care services, putting the total coverage at 68.7 per cent of Jordanians. The majority of insured Jordanians are covered through the Royal Medical Services (RMS) under the Jordan Armed Forces (38.1 per cent), the Civil Insurance Program (CIP) administered by the Ministry of Health (MoH) (34.4 per cent), and private insurances (12.1 per cent). In addition, UNWRA and UNHCR are covering part of the costs of accessing essential health care services for refugee populations under international protection. Non-insured Jordanians can access fee exemptions in cases of acute need through MoH and RMS on a case-by-case basis subject to funds availability. The Household Income & Expenditure Survey (2018) shows that health insurance coverage gaps are distributed almost equally across income deciles. Private health insurance coverage is concentrated amongst the wealthiest deciles.

As noted in the National Social Protection Strategy of 2019, the public social health protection system is characterized by "similar programs which have accumulated over time and result in inefficiencies, confusion about benefit entitlements and insurance contributions, and medical fee structure that is neither aligned with the true cost of service nor ability-to-pay." Several attempts at achieving unification in health financing approaches and harmonization of health insurance schemes have resulted in limited progress.

Social health protection coverage gaps remain. First, while there is a legal provision under the Social Security Law (2014) for private sector workers and their families to be covered by a public scheme, this provision was never enforced, therefore at present this category of the population remains largely unprotected. Second, like many middle-income countries, Jordan has seen important growth in the private health sector, while most social health protection mechanisms have focussed for a long time on public facilities, with reform in developing effective purchasing and providing mechanisms advancing at a slow pace. It means that in practice health care services sought in the private sector are largely paid out of pocket. In view of this situation, a number of companies – especially large companies representing a relatively small percentage of the population - and individuals have subscribed to private health insurance policies.

The Social Security Corporation (SSC) of Jordan currently provides benefits under four benefit branches, including pensions (old age, disability, and survivors), work injury benefits, maternity benefits, and unemployment benefits. The Jordanian Government, through the SSC, is planning to start the rollout of health benefits for private sector workers, pensioners and their families that are already under the scope of SSC coverage with a focus on inpatient care and cancer treatment.

In view of this context, this note articulates key considerations in light of international standards on social health protection.

Strategic plan to guarantee access to health care without hardship to the entire population

A third of the population that is uncovered relies on the case-by-case fee exemption programme, employer-led or individual private insurance policies, without a proper pre-financed mechanism based on solidarity in financing. ILO standards on social health protection, in particular the Social Protection Floor Recommendation No. 202 and the Medical Care Recommendation No. 69, provide for the universality of coverage through broad risk pooling and solidarity in financing. The initiative to implement the provisions of the Social Security Law (2014) on health benefits aims to cover the uncovered groups. Conservative estimates indicate that approximately 400,000 Jordanian workers who are already registered in SSC and their dependents would be covered by the new health benefits. The scheme would also represent means to provide financial health protection for migrant workers registered with SSC.

In practice, to maximise the effective impact on the extension of coverage, it would need to be accompanied by efforts to enforce the law in the informal economy. The latter goes hand in hand with a realistic consideration of the capacities of workers in the informal economy and their families to contribute to such schemes and subsidization to allow them to access social insurance mechanisms in general.

Depending on the specifics of the design of this initiative, it could also allow to replace some of the private health insurance coverage towards a publicly managed scheme where revenues from proportional contributions (and not risk-rated) would be pooled together. Lastly, it could relax the burden borne by the State budget of covering a number of dependents of workers registered with the SSC, future pensioners and beneficiaries of the case-by-case fee exemption programme.[1]

While closing the remaining coverage gap, securing the adequacy of social health protection benefits is a priority. The majority of the Jordanian population is covered by social health protection, but even for the ones that are covered, effective access to quality care remains affected by deeper issues along the six building blocks of the healthcare system. Therefore, coverage extension needs to go hand-in-hand with a well-structured, equipped and staffed supply of health services, only possible within a robust health system. Past benefit incidence analysis conducted by WHO and UNICEF on primary health care and maternal and child health care services have shown that public services cater to the most disadvantaged, but also that growth in private provision has been accompanied by an increase in OOP. Underlying factors related to the unequal availability of qualified staff and medical products in public and private facilities were highlighted by a number of authors. For any social health protection mechanism to meet its objective of adequate access to health care services without hardship when needed, those issues need to be addressed. Without adequacy of the benefits, the protection afforded by any social health protection scheme remains an empty promise. Further, lack of adequacy reduces the trust that people place in social health protection systems and public support to the scheme(s).

A long-term vision for reducing fragmentation is needed to increase the efficiency of health spending and ensure equity. Currently, the health financing systems are highly fragmented with many health purchasing schemes. The system is scattered, there is mandatory health coverage only for the military (RMS), civil servants (CIP) and older persons (over 60), children and the poor. The rest of the population is either not covered or covered through scattered voluntary schemes, the introduction of SSC health benefits may be able to catalyse some of the people covered by private voluntary insurance, but the system will still be very fragmented. It is therefore urgent to formulate a concerted vision on the way forward to ensure universal coverage of social health protection that will contribute to the goal of Universal Health Coverage.

There would be several benefits in having a vision for the progressive streamlining of the different fragmented mechanisms. From an operational perspective, this fragmentation creates barriers to the effective pooling of risks among the different groups of population and fosters a strategic approach to purchasing healthcare services - i.e.

[1] Since the decision to include the older persons aged 60 or above into CIP is relatively new, more and more older people will be joining the CIP in the coming years. All this means that pressures on public financing will only increase with time.

lower negotiation power and ability to adopt modern provider payment methods. It also limits the solidarity between the different groups. ILO social security standards on social health protection recommend broad risk pooling and solidarity in financing with a view to contributing to equity in access to health services. A roadmap for the streamlining and progressive integration of the different schemes into one harmonized system should be developed.

The proposed reform should contribute to the realization of a more comprehensive and integrated system for social health protection. To realize this objective, the following aspects should be considered:

- In view of the narrow scope of population coverage of the current proposal, it is important that the SSC health insurance scheme allows **over time gradual integration of all health financing approaches and reduces fragmentation** in the system. A concerted whole-of-government vision on the way forward to ensure universal coverage of social health protection is urgently needed. This should entail the harmonization of benefit packages across all schemes, effective means to monitor any overlap in coverage and the establishment of appropriate and formal contracting and reimbursement mechanisms across players.
- It is important to ensure access to a **comprehensive benefit package** in line with ILO standards, which entails good coordination between schemes financing different levels of care if they exist. Focussing mostly on hospital care alone is not recommended for cost containment and to secure continuity of care, adopting an approach based on primary health care can be most effective and cost-effective.
- Benefit packages, financial protection levels and networks of healthcare providers are design parameters that should be aligned for the entire population if the goal is to ensure **equity in access and aligned demand-side incentives**.
- The **participation of stakeholders** in the design and governance is a key principle that would ensure the responsiveness of any future architecture to actual needs.

Specific design considerations

The below key design considerations are based on the guidance and principles of international social security standards.

- Medical Care Recommendation, 1944 (No. 69)
- Social Security (Minimum Standards) Convention, 1952 (No. 102)
- Social Protection Floors Recommendation, 2012 (No. 202)
- Medical Care and Sickness Benefits Convention, 1969 (No. 130)
- Maternity Protection Convention, 2000 (No. 183)

The design considerations outlined here are selected ones in view of the current reform proposals, they are not exhaustive.

Coverage and opt-out clause

To ensure equity between all workers and to avoid perpetuating a two-tier system, it is recommended to avoid opt-out clauses for employers who already provide private health insurance coverage to their employees (or to ensure such a clause would be limited to a transition period). The contribution income forgone as a result of an opt-out clause could be substantial and may undermine the financial viability of the scheme.

Subjecting workers to different co-contribution rates depending on whether employers provided health insurance prior to the reform (opt-out), and whether employers intend to replace previous schemes with the new SSC scheme (opt-in) also raises equity concerns.

An alternative design could consist in not providing any opt-out option but rather having the insurance industry redesign their current health insurance products for companies to become supplementary packages. It should be

noted that private health insurance worldwide plays a very small role in covering health expenditures, and with few exceptions, it usually plays a supplementary or complementary role[2].

Financing

As per ILO Convention No. 102, when social security schemes are financed by way of contributions, the workers' share should not exceed 50 per cent of the total resources dedicated to protection including the cost of administration.[3] Therefore employers (which may be substituted by the government for the self-employed) are expected to contribute to the costs of such a scheme on the basis of a more equitable allocation of the financing burden between workers and employers to be agreed upon through social dialogue.

As recalled in the strategic considerations above, the extension of coverage to workers in the informal economy and their families also needs to be kept in mind when designing financing parameters. It is likely that extending the scheme to them will require the partial subsidization of their contributions and therefore will involve mobilizing further general government revenues.

Benefit package

ILO standards stipulate that the benefit package should be comprehensive and at a minimum cover (i) general practitioner; specialist care at hospitals for in-patients and out-patients, and such specialist care as may be available outside hospitals; (ii) the essential pharmaceutical; and (iii) hospitalization where necessary; and (iv) in case of pregnancy and confinement and their consequences: pre-natal, confinement and post-natal care either by medical practitioners or by qualified midwives; and hospitalization where necessary (convention no. 102 article 10). In addition, the care provided should be afforded with a view to maintain, restore or improve the health of the person protected and his ability to work and attend to his personal needs (i.e. promotional, preventive, curative and rehabilitative services).

While outpatient care at public (MoH) facilities is heavily subsidized in Jordan, it is not provided for free and may lead to financial hardship for patients with chronic diseases. Furthermore, access to free ambulatory care (in particular primary care) is generally recommended from a public health perspective since primary care is key for preventing diseases, for cost containment purposes and as a gate-keeping mechanism.

It is therefore important to ensure that all social health protection mechanisms contribute to effective access to a comprehensive package of services across the different levels of care. If the different levels of care are covered via different mechanisms and schemes, proper coordination needs to be secured and this needs to be reflected in the entitlements provided in the legal framework.

Network of healthcare providers

As mentioned in the context of this note, there is a growing private health sector in Jordan, including a number of for-profit providers. In pluralistic health systems, it is important to reflect on the impact of purchasing strategies on social health protection schemes. Focusing exclusively on private provision may be an important cost driver and calls for resonated cost containment and quality assurance processes. Promoting the primary care gate-keeping functions, ensuring the scheme can support the enhancement of health care delivery standards in public health facilities and exercising collective purchasing power and engaging the views of members in decision-making processes are key.

It is further recommended to consider adopting a referral system as a gate-keeping mechanism to channel patients to high-level facilities only if/when medically necessary. An effective gate-keeping mechanism is considered key to containing costs and achieving cost efficiency.

[2] WHO (2020). Global Spending on Health: Weathering the storm. https://www.who.int/publications/i/item/9789240017788

[3] While partial financing to the health insurance scheme is envisaged to be provided indirectly by employers through a reallocation of the surplus from the employment injury fund, it is noted that this is representing a very small portion of total financing, hence the proposed scheme will be primarily financed by workers.

Administration

Some countries have externalized some of the administrative functions related to social health insurance management to third-party administrators. It should be noted that there are inherent risks related to externalizing the management of public health insurance schemes – mainly due to regulating the private company contracted to ensure that public health priorities are linked to resource allocation and purchasing decisions. SSC as a purchaser should act on behalf of the population and therefore can ensure that there are mechanisms in place to reflect the population's needs, preferences, and values in purchasing and hold health providers accountable. International Social Security standards establish that where schemes are not administered by government authorities, representatives of the persons protected shall participate in the management or be associated in a consultative capacity. Further, they stipulate that in any instance the Government still has the overall responsibility to ensure the due provision of benefits and the good administration of the scheme.

Summary Recommendations

The extension of social health protection has been at the centre of the national debate for decades. Several attempts at developing a comprehensive master plan to reform and integrate the health insurance system in Jordan have been undertaken in the recent past, with limited progress effectively made. Social security institutions play an important role in supporting the extension of coverage in many countries. However, this has to happen in the context of a comprehensive approach that allows alignment and reduction in fragmentation, improve solidarity and equity in accessing healthcare, and ensures balanced and sustainable financing.

In further considering upcoming reforms, constituents should consider ensuring alignment of the fragmented social health protection schemes (and progressive integration). This has proven effective in several countries to improve coverage extension monitoring and purchasing practices (to align demand-side incentives). This should include a progressive alignment in benefit package, the development of common mechanism to monitor coverage, and the establishment of systems for reimbursement and contracting across schemes, under a central regulatory authority.

If tripartite partners in Jordan decide to go ahead with the implementation of the health benefits under the Social Security Act of 2014, the **following design features should be considered to ensure closer alignment with international social security standards**:

1) **Removing opt-out clauses and ensuring <u>all</u> private sector workers and employers participate in financing a common scheme on the basis of an equitable and unified contribution level, with no exceptions.** Mandatory coverage without opt-out clauses has proven to be more effective in extending coverage globally. When a mandatory scheme is created, pre-existing occupational private voluntary schemes can be redefined to become complementary.

2) **Introducing a comprehensive benefit package.** Social health protection schemes should contribute to the primary health care approach and align their incentives to providers and protected persons accordingly. A comprehensive benefit package needs to be guaranteed, including primary care and is crucial when it comes to gate-keeping.

3) **Ensuring through tripartite dialogue that a fair share of financing is established between workers and employers.** As per ILO Convention No. 102, when social security schemes are financed by way of contributions, the workers' share should not exceed 50 per cent of the total resources dedicated to protection including the cost of administration.

4) **Including public hospitals in the network of providers and ensuring a proper gatekeeping system through a public system is put in place.** In pluralistic health systems, it is possible for social health protection schemes to contract private health facilities, but it should not undermine the investment in public ones. A unified network of public and private providers can be considered in pluralistic health systems, excluding public facilities that would direct public funds exclusively to the private sector.

5) **Avoid outsourcing essential functions.** Any outsourcing or third-party administration is easier to manage when it excludes the core functions of risk pooling and definition of purchasing policies.

Administrative processes that may be outsourced should not hider accessibility and rights. Promote strategic purchasing modalities.

6) **Carefully monitoring the financial sustainability of the health insurance scheme** through actuarial valuations and establishing clear guarantees to avoid adverse financial impact on other social security branches, including by reaffirming the role of the state as ultimate guarantor for the financial stability of the social security system.

7) **Engaging in social dialogue** with employers and workers and other concerned national stakeholders can ensure proposed reform designs are based on broad consensus and responsive to needs.