CL 135/INF/7

May 2008

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منظمة الأغذية والزراعة للأمم المتحدة | 联合国粮食及农业组织 | Food and Agriculture Organization of the United Nations | Organisation des Nations Unies pour l'alimentation et l'agriculture | Продовольственная и сельскохозяйственная организация Объединенных Наций | Organización de las Naciones Unidas para la Agricultura y la Alimentación

COUNCIL

Hundred and Thirty-fifth Session

Rome, 17-18 November 2008

JIU/REP/2007/2: UNITED NATIONS SYSTEM STAFF MEDICAL COVERAGE

1. This JIU Report is accompanied by brief comments of the Director-General and more extensive joint comments of the UN system Chief Executives Board (CEB) for Coordination (UN/GA document A/62/541/Add. 1). Given the subject matter, it is drawn particularly to the attention of the Finance Committee.

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Comments of the Director-General of FAO

2. As FAO generally subscribes to the CEB comments formulated in relation to this report (presented in the accompanying UN/GA document A/62/541/Add. 1), in order to avoid duplication, the comments of the Director-General are restricted to providing as necessary clarifications from the perspective of FAO (e.g. when the CEB comments do not reflect unanimous or near unanimous opinions) or additional background information.

3. In relation to the group of recommendations: 1, 2 and 3, FAO is among the large number of Organizations which do not see the need of periodic reviews of health insurance arrangements by the ICSC, and of an additional advisory body. FAO also shares in the many reservations expressed in relation to recommendation 6. The ongoing efforts towards harmonization by the Rome-based institutions are duly underlined in the CEB comments.

4. As regards recommendations 4 and 5, the Finance Committee is fully aware that FAO is already pursuing means to address concretely the issue of after-service medical care (ASMC) liabilities.

JIU/REP/2007/2

UNITED NATIONS SYSTEM

STAFF MEDICAL COVERAGE

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Geneva 2007

United Nations

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Original: ENGLISH

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EXECUTIVE SUMMARY

United Nations system staff medical coverage
JIU/REP/2007/2

Objective

To provide Member States with an overview of the United Nations system staff medical coverage and to suggest ways to deal with the emerging problems faced by the health insurance schemes of the United Nations system, resulting from the soaring cost of medical coverage and the need to guarantee adequate medical coverage to their staff and retirees and their dependants, in the context of zero budget growth practices adopted within the United Nations system.

Main findings and conclusions

- Since the issuance of the original Joint Inspection Unit (JIU) note on this subject in 1977, the cost of providing health coverage to staff members, retirees and their eligible dependants has grown exponentially. Between 1975 and 2004, there was a 122 per cent increase in the number of contributors to the staff health insurance schemes. The cost of providing health insurance grew by 1,387 per cent for the same period, and the cost per person increased from US$ 540 to US$ 3,620 between 1975 and 2004.

- Several main factors continue to affect the increase in costs of the staff health insurance schemes: the rising cost of medical benefits worldwide, in particular hospital charges; the ageing of the international community demanding services to which they are entitled with their adverse financial consequences; the systematic increase in the frequency of access to medical care; and currency fluctuations.

- Although staff health insurance constitutes the third most important and costly element of the total compensation package in the United Nations system, after salary and allowances and pension, it is not considered a “common system” matter. As a result, United Nations system organizations have established, some individually and some collectively, health insurance schemes with wide disparities in the cost and scope of coverage, conditions for eligibility, rates of contribution and medical benefits. The health insurance schemes, initially at the level of the duty station, need to be harmonized. Member States do not exercise adequate oversight on health insurance related issues and do not play any role in determining the health insurance related conditions and benefits across the United Nations system.

- The fastest growing element in health coverage is the after-service health insurance (ASHI). The issues of determining, recognizing and funding the accrued liabilities for the ASHI is yet to be resolved. In the meantime, the present actuarial estimates of the accrued liability of future benefits (net of retiree contributions) at 31 December 2004 for United Nations system organizations is estimated at US$ 4.2 billion, out of which more than US$ 3.6 billion is unfunded.

- The United Nations General Assembly in its resolution 60/255 recognized the end-of-service accrued liabilities for the United Nations, and requested the Secretary-General

to disclose the liabilities in the financial statements. The United Nations system needs to embark on a long-term funding strategy to meet these long-term liabilities. Given the zero budget growth practices of the United Nations system, Member States should start funding specifically for the accrued liabilities.

- The option to establish a common fund, pooling the reserves already established/to be established by the individual organizations to cover ASHI long-term liabilities, and investing them under the responsibility of the United Nations Joint Staff Pension Fund (UNJSPF), needs to be explored. This would minimise investment risks, obtain managerial and financial advantage for the organizations and improve investment returns.

- The governing bodies of the United Nations system organizations should develop and adopt sound strategies to contain the costs of health insurance schemes. There are numerous options, inter alia, the extension of the network of preferred providers at negotiated tariffs, strengthening and expanding in-house medical facilities to provide primary care and referral services for staff members, retirees and their dependants, establishing in-house pharmacies, and facilitating access to national health services in conjunction with the health insurance schemes available to international staff.

- Listed below are the recommendations for consideration by the legislative bodies. Another recommendation (Recommendation 7), proposed for the consideration of executive heads, can be found in the main text of the report.

Recommendations for consideration by legislative organs

- **The legislative bodies of the United Nations system organizations should formally recognize staff health insurance as an important integral part of the common system. They should request the International Civil Service Commission (ICSC) to undertake periodic reviews with a view to making recommendations to the General Assembly.**

- **In this regard, the General Assembly should establish, initially, an ad hoc advisory body to assist ICSC in formulating broader principles, policies and standards for staff health insurance schemes. The advisory body should be composed of representatives of Member States, officials of the United Nations system organizations, elected representative(s) of the staff, and elected representative(s) of the retirees, and be assisted by experts in health and insurance matters from the private sector.**

- **The legislative bodies of each United Nations system organization should request their respective executive heads to harmonize the existing health insurance schemes, initially at the level of the duty station, and in the longer term across the common system, relating to scope of coverage, contributions and benefits and to establish periodic reporting on health insurance related information to the legislative bodies.**

- **The legislative bodies of each United Nations organization should request their respective executive heads to undertake periodic actuarial studies based on a uniform system-wide methodology to determine the extent of accrued ASHI liabilities and to disclose the liabilities in the financial statements.**

- **The legislative bodies of each organization should:**
  (a) Request their respective executive heads to put forward proposals for funding the ASHI liabilities;
  (b) Provide adequate financing to meet the liabilities and establish a reserve for this purpose.

- **The United Nations General Assembly should establish a common fund to pool the reserves (existing and to be established), which should be invested in a manner similar to the assets of UNJSPF.**

CONTENTS

ABBREVIATIONS

ACABQ	Advisory Committee on Administrative and Budgetary Questions
ACC	Administrative Committee on Coordination
ASHI	After-service health insurance
BMIP	Basic Medical Insurance Plan (FAO and WFP)
BOA	Board of Auditors
CCAQ	Consultative Committee on Administrative Questions
CEB	United Nations System Chief Executives Board for Coordination
FAO	Food and Agriculture Organization of the United Nations
FMIP	Full Medical Insurance Plan (UNOV and UNIDO)
GMIT	Group Medical Insurance for temporary staff (IAEA)
HIP	Health Insurance Plan for New York
HMO	Health Maintenance Organization
IAEA	International Atomic Energy Agency
ICAO	International Civil Aviation Organization
ICSC	International Civil Service Commission
ILO	International Labour Organization
IMO	International Maritime Organization
IPSAS	International Public Sector Accounting Standards
ITU	International Telecommunication Union
JIU	Joint Inspection Unit
JMS	Joint Medical Service
MIP	Medical Insurance Plan (UNHCR)
MMBP	Major Medical Benefit Plan (FAO and WFP)
PPO	Preferred Provider Option
SHI	Staff Health Insurance (WHO)
SHIF	Staff Health Insurance Fund (ILO)
SMIP	Supplementary Medical Insurance Plan (Vienna)
SSA	Special Service Agreements
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNJSPF	United Nations Joint Staff Pension Fund
UNOG	United Nations Office at Geneva
UNOV	United Nations Office at Vienna
UNSMIS	United Nations Staff Mutual Insurance Society against Sickness and Accident
UPU	Universal Postal Union
WFP	World Food Programme
WGKK	Wiener Gebietskrankenkasse (Austrian national health insurance scheme)
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WMO	World Meteorological Organization

I. INTRODUCTION

1. The Joint Inspection Unit (JIU) included a report on United Nations system staff medical coverage in its work programme for the year 2005.[1] The report was included on the basis of formal proposals by the International Atomic Energy Agency (IAEA) and the United Nations Industrial Development Organization (UNIDO). These organizations have asked for guidance on how to deal with the emerging problems faced by their health insurance schemes, resulting from the soaring costs of medical coverage and the need to guarantee medical coverage to their staff and retirees and their dependants, in the context of zero budget growth practices adopted within the United Nations system. Most of the United Nations organizations have from time to time encountered similar managerial, administrative and financial problems with their respective health insurance schemes.

2. Since the creation of the United Nations and its specialized agencies and IAEA, the question of health insurance for staff and their dependants has been the subject of many reviews by United Nations common system organs like the Administrative Committee on Coordination (ACC), now the United Nations System Chief Executives Board for Coordination (CEB), the Consultative Committee on Administrative Questions (CCAQ) and JIU. JIU conducted an in-depth review of the health insurance schemes of the organizations of the United Nations system in June 1977, the last such system-wide study on the subject. The 1977 review examined different key issues including types of schemes, structure of benefits, financial matters, and administrative and managerial issues.[2]

3. In 1977, the CCAQ set up a working group to prepare a common response to the recommendations contained in the JIU note. However, no information is available on the outcome of this working group. The findings, observations and recommendations of the 1977 JIU note remain relevant in today's context. Therefore, the Inspectors would like to recall some of them in this report, to draw the attention of the Members States and the United Nations system organizations to the persistent and continuing problems relating to the staff health insurance schemes.

4. The objective of this report is to provide Member States with an overview of United Nations system staff medical coverage, a comparison of it with the best practices in non-United Nations entities, and a number of viable options for more effectively controlling the concomitant budgetary outlays without negatively affecting this important element of the overall conditions of service in the United Nations system.

5. The methodology followed in preparing this report included questionnaires, interviews and in-depth analysis. Detailed questionnaires were sent to all participating organizations. On the basis of the responses received, the Inspectors conducted interviews with officials of the participating organizations, and also sought the views of other international organizations. As part of the review, the Inspectors visited organizations based in New York, Geneva, Vienna, Rome, London and Paris. The Inspectors also held discussions with officials of the World Bank, the International Monetary Fund, the European Commission, the Organisation for Economic Co-operation and Development and the European Space Agency, regarding the health insurance schemes in their organizations, for possible benchmarks and best practices. These discussions have been taken into consideration in finalizing the recommendations in this report. Comments on the draft report have been sought from participating organizations, as well as from the United Nations Joint Staff Pension Fund (UNJSPF) and the International Civil Service Commission (ICSC) and many organizations responded. Their comments were taken into account in finalizing the report.

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[1] A/60/34 (paragraphs 39 and 40).
[2] JIU/NOTE/77/2 Note on health insurance schemes in the United Nations system.

6. In accordance with article 11.2 of the JIU statute, this draft report has been finalized after consultation among the Inspectors so as to test its conclusions and recommendations against the collective wisdom of the Unit.

7. To facilitate the handling of the report and the implementation of its recommendations and the monitoring thereof, annex VII contains a table indicating whether the report is submitted to the organizations concerned for action or for information. The table identifies those recommendations relevant for each organization, specifying whether they require a decision by the legislative or governing body of the organization or can be acted upon by the executive head.

8. The Inspectors wish to express their appreciation to all who assisted them in the preparation of this report, and particularly to those who participated in the interviews and shared their knowledge and expertise.

II. HEALTH INSURANCE SCHEMES IN THE UNITED NATIONS SYSTEM

A. Growth of the cost of health insurance in the United Nations system

9. Since the establishment of the United Nations and its specialized agencies and IAEA, the staff regulations of these organizations have required that the executive head of the organization establish a scheme of social security for the staff, including provisions for health protection. An official, upon appointment to a post in the United Nations system, may become a member of a staff health insurance scheme. Such schemes provide them with insurance against medical expenses incurred as a result of illness, maternity or accident. In the early days of the United Nations, health insurance was made available to serving staff members only, and without benefit of any organizational subsidy. In resolution 1095 (XI) of 27 February 1957, the General Assembly authorized the sharing of the costs of health insurance by the organization on an approximately equal basis with participating staff members, subject to the provision that a larger subsidy would be granted to staff in the lower salary levels.

10. According to available information, the total number of contributors system-wide to these schemes was approximately 84,000 persons, and the annual cost exceeded US$ 305 million, as of 31 December 2004. The comparative percentage increase in the number of contributors and in the annual cost of the health insurance schemes to the organizations for 1997 and 2004 is shown in annex II. According to the JIU note of 1977, the number of contributors in 1975 was approximately 38,000, including 3,000 retirees, and the annual cost was approximately US$ 20.5 million. The percentage increase in the number of contributors since 1975 is about 122 per cent, whereas during the same period, the cost of health insurance schemes grew by 1,387 per cent. Based on the analysis, the Inspectors underscore the growing importance of health insurance coverage, the third most important element of the conditions of service after salary and allowances and pension, and caution that measures must be taken to contain the expected exponential growth in the cost of providing medical coverage for staff.

B. Lack of adequate oversight by Member States

11. Article 101 of the Charter of the United Nations establishes that, in determining conditions of service for its staff, the United Nations organizations should be guided by “the necessity of securing the highest standards of efficiency, competence and integrity”. Enjoying a decent and equal level of social security is part of the basic expectations of any staff member joining the United Nations system. According to established international principles, notably those featured in relevant International Labour Organization (ILO) Conventions and Recommendations, as well as in the International Covenant on Economic, Social and Cultural Rights, decent social security schemes should ensure protection against risks or contingencies such as old age, disability, sickness, required health and medical care, and responsibility for the maintenance of children and other dependent family members.

12. All the organizations in the common system have some kind of health insurance scheme or arrangement. The Inspectors note the apparent lack of oversight by Member States in establishing health insurance schemes across the United Nations system. While they play an active role in determining the salary scales and other benefits including pension, Member States have not played any direct role in determining the health insurance benefits for staff members and retirees. This has been delegated to the respective secretariats of the organizations. Hence there are wide disparities throughout the system. Existing health insurance schemes show noticeable differences, even within the same duty station (New York, Geneva and Vienna), between local and non-local staff, between headquarters and field staff, as well as disparities among the provisions governing the contribution and reimbursement rates.

13. Since the beginning, health insurance has not been considered a common system matter. United Nations system organizations have resisted attempts by ICSC to consider the social security aspects of the conditions of service, in developing a methodology for total compensation comparisons. Similarly, ICSC declined to take a position when the General Assembly, in 1982, requested ICSC to examine the need for raising the contributions provided by the organizations of the common system for health insurance schemes. During a meeting with the Inspectors, the former chairperson of ICSC confirmed that health insurance is not considered to be part of the common system.

14. The Inspectors believe that it is rational that health insurance for staff members, like other common system benefits such as salaries and emoluments, grades and pension benefits, should be governed by consistent regulations. The Inspectors believe that disparities in the health insurance schemes run counter to the accepted principle of a common system for personnel questions, and reiterate that "It is desirable … that the situation should be rectified in a way that makes for uniform treatment of the staff in the United Nations system in the matter of health insurance as part of the common system."[3] In this effort, Member States should play an active part in determining health insurance benefits, in order to ensure harmony among the various health insurance schemes, contain disparities and ensure economy in health insurance spending.

C. Comparative analysis of the health insurance schemes in the United Nations system

15. The United Nations system currently has 20 major health insurance schemes. A brief description of the important elements of these schemes is provided in annex I. The schemes are varied and differ substantially between organizations and duty stations, and sometimes within a duty station. There are different types of scheme:

- self-administered and self-financed schemes like the United Nations Medical Insurance Plan (MIP), the United Nations Staff Mutual Insurance Society against Sickness and Accident (UNSMIS) in the United Nations Office at Geneva (UNOG); the Staff Health Insurance (SHI) of the World Health Organization (WHO); the Staff Health Insurance Fund (SHIF) of ILO and the International Telecommunication Union (ITU); and the Medical Benefits Fund of the United Nations Educational, Scientific and Cultural Organization (UNESCO);
- self-financed schemes administered by third party commercial providers like Aetna, Blue Cross, Sun Life group and Vanbreda, as in United Nations Headquarters and field missions, the International Civil Aviation Organization (ICAO), the Food and Agriculture Organization of the United Nations (FAO), the World Food Programme (WFP) and the World Intellectual Property Organization (WIPO) respectively;
- national or state schemes like the Austrian national health insurance scheme (Wiener Gebietskrankenkasse - WGKK) for some categories of staff in some duty stations.

D. Scope of coverage

16. The scope of coverage provided by the health insurance schemes is varied. All the organizations of the United Nations system provide health coverage in a single pool, as in annex IV, to all active staff and their dependants (both primary and secondary), and to retirees and their dependants. However, the criteria for eligibility to participate in the health insurance schemes varies in terms of the minimum period of appointment necessary to be eligible for participation. For example, a three-month contract is the minimum necessary in ICAO, while a six-month contract is required in most other organizations. Similarly, the eligibility criteria for retirees and their dependants vary, as shown in annex VI. With the exception of a few organizations like IAEA, ICAO and the International Maritime Organization (IMO), short-term staff, consultants and special service agreements (SSA) holders are covered by the respective staff health insurance schemes.

[3] JIU/NOTE/77/2 (p. 30. para. 92).

17. Participation is compulsory in one of the basic health insurance schemes in most of the organizations. Exceptions are made for staff members who provide adequate evidence of coverage in any scheme outside of the United Nations schemes. Participation is voluntary in the supplementary schemes like the Major Medical Benefits Plan (MMBP) in Rome, or the Supplementary Medical Insurance Plan (SMIP) in Vienna. The supplementary schemes are designed to provide for expenses not covered under the basic schemes, and the staff member pays the full contribution. All the schemes provide global coverage with variations in benefits and reimbursement. However, the national schemes, like the Austrian national health insurance scheme (WGKK), provide coverage only in the European Union and in countries having a bilateral agreement on health insurance with the Republic of Austria.

E. Contributions

18. Currently, staff members pay a percentage or a fixed amount of the premium cost as their contribution, and the organizations subsidize the remainder of the cost. A comparative analysis of the share of the premium paid by staff members and retirees and by the organizations is provided in annex III. There are considerable differences between the staff/retirees and the organizations in the share of the premiums paid. Similarly, there are wide disparities in determining the cost of premiums. The Inspectors recognize that different medical cost environments determine the premium costs in a duty station, but in some duty stations e.g. Geneva, where similar benefits are offered by different organizations, there is no justification for differences in premium sharing between the staff member and the organization, and in the determination of premium costs. This is also true for some of the other duty stations where significant numbers of common system staff working for different organizations are stationed, and where those organizations operate their own healthcare schemes. The share of the premium paid and the premium costs should be harmonized within a duty station.

F. Benefits

19. In order to cope with increasing demands for benefits and services, health insurance schemes periodically revise their benefits structure. In this instance, the revision has mainly taken place in the level of benefits, for example long-term nursing services, dental care, optical appliances, etc. At the same time, new rules have been adopted with respect to benefits and medication. A comparative analysis of major benefits provided by the health insurance schemes across the United Nations system is provided in annex V.

20. All the schemes offer a free choice of providers, medical practitioners, pharmacists and medical establishments. There is no lifetime limit on reimbursement in any of the schemes, however there are limits to the annual reimbursement. The annual limit varies from US$ 1,000,000 provided by the FAO/WFP scheme to US$ 30,000 provided by WHO for its temporary staff during the first three months of their contract. In organizations like ICAO only certain benefits have ceilings or limitations per benefit year.

21. Most of the schemes provide 80 per cent reimbursement for fees for general practitioners, physicians, surgeons, psychiatrists, obstetricians and gynaecologists. Some schemes provide 100 per cent reimbursement and some offer 75 per cent. In any given duty station, the rates of reimbursement for specific services vary. In the New York schemes, 100 per cent is reimbursed under the Aetna Open Choice preferred provider organization (PPO) scheme (subject to annual deductible limits and co-insurance), whereas only 80 per cent is reimbursed in the other schemes. Similar disparities exist in the schemes in Geneva. For prescription drugs, the rate of reimbursement is 80 per cent. In some schemes, like in ICAO, brand name drugs are covered at 80 per cent and generic drugs are offered at 90 per cent.

22. Regarding outpatient services (laboratory tests, x-rays, artificial limbs, etc.) and institutional care, reimbursement rates vary from 75 to 100 per cent. Similar variations exist for

medical procedures like breast cancer screening, orthopaedics etc. The rates of reimbursement for nursing services show substantial variations among the schemes.

23. Hospital care, i.e. reimbursement of the daily charges for a stay in a hospital, clinic or other recognized medical institution, is a costly healthcare requirement, and there are wide differences between schemes. For example, in the United Nations, WHO, ILO and WIPO, 100 per cent is reimbursed for treatment in a public ward. The reimbursement for treatment in a private or semi-private room is varied, and ranges from 70 per cent in the Office of the United Nations High Commissioner for Refugees (UNHCR) MIP scheme, to 100 per cent in the WIPO scheme. Similarly, only some schemes provide the financial advances required by some hospitals for admission.

24. Reimbursement for dental care (routine periodic examinations, fillings, crowns, etc.) follows the established pattern of 80 per cent to 100 per cent among the schemes. However, the maximum annual rates of reimbursement show disparities. The WHO scheme provides a maximum of US$ 1,500 in a year, and US$ 30,000 if the dental care is required as a result of an accident. In the WIPO scheme, the reimbursement is 75 per cent up to a maximum of SwF 3,500 per year, whereas the reimbursement rate is 85 per cent if treated in France. Similarly, the reimbursements for orthodontics also show disparities.

G. Harmonization of the health insurance schemes

25. Considering the wide disparities in the contribution, benefits and scope of coverage among the various health insurance schemes, the Inspectors believe that harmonization of the health insurance regulations and benefits across the United Nations system is an option that needs to be taken up on a priority basis. The Inspectors are also concerned that the wide disparities may be an impediment to staff mobility among the organizations of the United Nations system.

26. The issue of harmonization of health insurance arrangements by United Nations organizations has been present from the early days of the United Nations system, when the organizations had to set up arrangements in this regard for their staff. In the 1950s and 1960s, the common system organs like CCAQ and ACC showed a continuing interest in the establishment of a common health insurance scheme for all the staff of the United Nations organizations. At its 13th session (September 1952), CCAQ "urged that consideration be given to the possibility, wherever an organization has a plan for its staff, of bringing into such a plan the staff of other member organizations in the same area. If two or more organizations … have individual plans applicable to their staff, the possibility of having a single plan to cover all such staff should be studied".

27. JIU, having reviewed the different key issues of the United Nations system health insurance schemes in 1977, and noting "the complexity of the schemes and the labyrinth of complex regulations that form the basis of the schemes", regarded it as "a desirable aim that there should be a single scheme covering all international civil servants belonging to all United Nations organizations … whether posted at the headquarters of the organizations or in the field". However, the Inspectors did not make this a recommendation as they believed that it could only remain an ideal, as practical problems had to be taken into consideration. Instead, they suggested that as a first step, the Geneva-based organizations could combine and provide a single health insurance scheme for all personnel serving in Geneva and in the field.

28. The Inspectors also advised "the creation of an Inter-Agency Health Insurance Committee to examine the findings outlined in [the note] and to devise a common system for health insurance which might be introduced first in Geneva, and later extended to other duty stations". The Inspectors suggested that the task of the proposed Committee would be to draw up plans for the creation of a joint health insurance self-administered scheme for all Geneva-based organizations, which should be the basis for an eventual European or regional scheme to include all United Nations organizations based in Europe. As a long- term objective, the Committee would establish

plans for designing a common benefits scheme, sufficiently flexible to take account of different health care patterns, with a view to establishing two schemes, one for North America and the other for the rest of the world.[4] As stated in paragraph 8 above, no concrete action was taken on the earlier JIU recommendations.

29. Reviewing the situation after 29 years, and based on numerous interviews and discussions with officials of various United Nations organizations in different duty stations, and the staff representatives of these organizations, the Inspectors conclude that it may still be feasible to establish a single global health insurance scheme for the entire United Nations system. This would be achievable in the long term after the harmonization of the schemes at the level of the duty station. In the course of interviewing for this report, the organizations stated that there are reasons for the existence of several schemes within the United Nations system. These reasons include the history of the organizations, the varying medical needs depending on the nature of the mandate and function of the individual organization, the cost-effectiveness of the individual schemes, and the medical practices and relevant legal regimes governing the medical profession in a duty station or host country.

30. Notwithstanding these reasons, the Inspectors are concerned at the disparities in the scope of coverage, benefits, level of reimbursement and the soaring cost of health protection, as illustrated in annex II, among the major health insurance schemes in the United Nations system. In the opinion of the Inspectors, all the schemes should provide staff members and their dependants with a comparable level of health security, irrespective of their category, level and duty station. The Inspectors also believe that the existence of so many schemes cannot continue to be justified on historical grounds and grounds of cost-effectiveness. Also, the existence of several schemes in the same duty station, as is the case in New York and Geneva, operating in the same medical and legal environment, cannot be justified. The Inspectors underscore the need to establish a single global health insurance scheme for the United Nations system, flexible enough to accommodate the varying needs of the organizations, and the medical and legal environments in which they operate. In this connection, the Inspectors wish to draw attention to the schemes provided by commercial providers with global coverage. As a first step towards achieving this objective, the Inspectors believe that the health insurance schemes across the United Nations system should be harmonized.

Recommendation 1

The legislative bodies of the United Nations system organizations should formally recognize staff health insurance as an important integral part of the common system. They should request ICSC to undertake periodic reviews with a view to making recommendations to the General Assembly.

Recommendation 2

In this regard, the General Assembly should establish, initially, an ad hoc advisory body to assist ICSC in formulating broader principles, policies and standards for staff health insurance schemes. The advisory body should be composed of representatives of Member States, officials of the United Nations system organizations, elected representative(s) of the staff, and elected representative(s) of the retirees, and be assisted by experts in health and insurance matters from the private sector.

[4] JIU/NOTE/77/2 (p. 34 recommendations).

Recommendation 3

The legislative bodies of each United Nations system organization should request their respective executive heads to harmonize the existing health insurance schemes, initially at the level of the duty station, and in the longer term across the common system, relating to scope of coverage, contributions and benefits, and to establish periodic reporting on health insurance related information to the legislative bodies.

III. AFTER-SERVICE HEALTH INSURANCE (ASHI) IN THE UNITED NATIONS SYSTEM

31. In the early 1950s, organizations like ILO extended the benefits of the medical insurance schemes, on an optional basis, to staff members upon their retirement from the service. Other United Nations organizations followed, and extended the medical insurance coverage to retired staff members and their dependants. In the United Nations, in a report submitted to the General Assembly at its twenty-first session (A/6491 and Corr. l), the Secretary-General noted that the automatic termination of the medical coverage to retiring staff was "unduly restrictive", and suggested that after-service health protection should be extended to all retiring staff of the United Nations, on similar lines to the prevalent common practice among Member States to provide after-service health protection for national civil servants and members of their families. The General Assembly, at its 1501st plenary meeting on 20 December 1966, approved the establishment of the after-service health insurance programme.

32. In the beginning, there was no matching contribution by the organizations for the retirees. There was no subsidy and the retirees were required to contribute in full. However, this position changed in 1965, when ILO argued that "many retired officials and their survivors, whose financial position was less favourable than that of the serving officials, were required to devote to health protection a quite disproportionate part of their income as compared with serving officials … the principle of social insurance which has been fully applied for active insured persons since 1958 and which implies the sharing of the costs, irrespective of whether those protected are good or bad risks, should be extended to retired officials and their survivors".[5] The ILO governing body approved the sharing of the cost of insuring the retired officials and subsequently other United Nations system organizations followed suit.

33. Currently, all the health insurance schemes in the United Nations system provide for cost-shared health insurance coverage to retirees and their dependants. In all the schemes, the health insurance coverage for retirees is optional, and available only as a continuation of previous coverage without interruption in a contributory health insurance plan of the United Nations system. In order to be enrolled in the after-service health insurance programme, the former staff member and his eligible dependants must all have been covered under such an insurance scheme at the time of the staff member's separation from service. At the time of separation, a staff member may switch from their current health insurance plan to another plan for retirement more appropriate to the location of his residence.

34. From its inception, the ASHI programme has grown substantially in the United Nations system in terms of both the number of participants and the cost. In the United Nations, the average after-service health insurance enrolment more than doubled in a period of ten years from 2,672 retirees in the biennium 1984-1985, to 7,105 retirees by the end of the 2002-2003 biennium. Over the same period, the United Nations share of the health insurance subsidy for retirees increased almost ten fold from US$ 6.9 million to US$ 67.7 million. Similar trends were noticed in the other organizations of the United Nations system. A combination of several elements, namely the demographic composition of the insured population; the growing proportion of the enrolled retirees; increased life expectancy; and the escalation of medical costs, has led to an inexorable cost-push impact on health insurance costs and the related contributions of participants and the organizations. In view of historical trends, the Inspectors estimate that enrolments and medical costs will continue to grow in the future.

[5] ILO G.B.162/FA/D.15/19/ 162 Session May 1965.

A. Financing the ASHI programme

35. In addition to the cost of the premiums paid by organizations to cover retirees, the major issue of the ASHI programme relates to its accrued liability and its funding. Accrued liability for ASHI represents the present value of future benefits for which active staff and retirees have already rendered service. In many United Nations organizations, the resources are appropriated biennially and after-service health benefits are accounted for on a "pay-as-you-go" or cash basis. In many organizations the expenditures relating to the ASHI schemes are not separately identified within staff costs. In other organizations the expenditures are specifically identified. Therefore it is difficult to ascertain the extent of the subsidy paid for ASHI on a system-wide basis. The Inspectors note that the amounts appropriated do not include funding for the accrued liability for after-service health benefits earned by staff members during active service.

36. The issue of funding for the accrued liabilities for after-service health benefits has been under discussion in the inter-agency bodies for some years. However, a solution on how to deal with this issue has not yet fully emerged. The Advisory Committee on Administrative and Budgetary Questions (ACABQ), in its review of the proposed programme budgets for the biennium 1998-1999,[6] raised the issue concerning the accrued liability for ASHI benefits. The Committee requested that the liability be addressed on a system-wide basis in a report of the Secretary-General. The Inspectors welcome the recent proposals put forward by the Secretary-General in his report A/61/730 "Liabilities and proposed funding for after-service health insurance benefits".[7]

37. The Board of Auditors (BOA) emphasized (A/57/201) the urgency for all organizations to recognize end-of-service benefit liabilities, and disclose them in the financial statements. Furthermore, the General Assembly requested the Secretary-General, in its resolution 58/249 A of 23 December 2003, to report on the full extent of the unfunded staff termination and post-service liabilities, and to propose measures towards fully funding such liabilities.

B. Extent of liability in the United Nations system

38. Although United Nations system organizations have undertaken actuarial studies, only some undertake them on a periodic basis, as shown in annex VI, to determine the extent of the accrued liability for ASHI. The liability is disclosed in the notes to the financial statements and updated in the subsequent biennial statements. Based on responses to the JIU questionnaire, the Inspectors note that organizations have engaged the services of private consultants and firms to undertake the actuarial studies. These private firms have uniformly adopted the International Accounting Standards (IAS 19) with variations in both the approach and assumptions used to determine the extent of the liabilities. The Inspectors believe that a uniform and consistent approach and assumptions for a system-wide actuarial study, on the same lines as UNJSPF studies, would be beneficial and cost-effective.

39. Based on the actuarial studies done by the organizations, the present value of the accrued liability of future benefits (net of retiree contributions) as of 31 December 2004 is estimated to be US$ 4.3 billion, as shown in annex VI. This estimate will increase once all the organizations complete the actuarial study of their liabilities and make projections as of December 2005.

C. Funding the ASHI liabilities

40. Given the significance of the liabilities involved, a number of organizations have recognized their ASHI liabilities and are attempting to identify ways and means to fund the accrued liabilities, as shown in annex VI. No organization in the United Nations system has established full

[6] Official Records of the General Assembly, Fifty-second session, Supplement No.7 (A/52/7/Rev.1) para. X.25.

[7] Covers the United Nations, the International Criminal Tribunal for the Former Yugoslavia, the International Criminal Tribunal for Rwanda and the United Nations Compensation Commission.

funding for the accrued liabilities. Ten organizations that had been accruing liabilities have not yet started allocating resources to fund these liabilities. In contrast, in recent years, organizations like the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), FAO and WFP have been allocating resources to partially fund these liabilities. UNDP has allocated US$ 54 million for the bienniums ended 31 December 2001 and 2003. UNICEF established a reserve of US$ 30 million in 2003 and intends to make annual contributions to fully fund its liability. Since 1998, FAO and WFP have been allocating a portion of their general reserve to after-service medical care schemes, which has been earmarked for the financing of all staff related schemes. The self-administered schemes of WHO and UNOG have established reserves, as required under their respective statutes, to cover the expected future cost of benefits to retirees. The funding set aside to cover the liability is some US$ 632 million and constitutes approximately 15 per cent of the recognized liabilities as shown in annex VI. In the United Nations system, the unfunded ASHI liabilities of the health insurance schemes remain significantly in excess of the funding provided so far.

41. The Inspectors also note the adoption of International Public Sector Accounting Standards (IPSAS) by the United Nations system and their planned phased implementation by 1 January 2010. One of the benefits of adopting internationally recognized accounting standards is that of fairly reflecting the obligations of the United Nations system arising from post-retirement benefits, particularly ASHI liabilities.

42. Considering the magnitude of the liabilities, the Inspectors believe that the United Nations system organizations should embark on a long-term funding strategy to meet their long-term liabilities. Given the zero budget growth practices adopted by most United Nations system organizations, it will be a continuing challenge for the organizations to identify funding. The Inspectors note that the Secretary-General, in his report[8] on liabilities and proposed funding for ASHI, recommended a funding strategy for the United Nations. The important features include: annual funding for the long term; establishing a charge equivalent of 4 per cent of salary costs for all budgets to be applied against the cost of salaries paid to staff; utilizing the unspent balance of any appropriations from the regular budget; and utilizing the excess of actual miscellaneous income over budget estimates. The Inspectors concur with the recommendations of the Secretary-General, and believe that all the organizations of the United Nations system must submit to their respective governing bodies the extent of their ASHI liabilities and establish a similar strategy to that proposed by the Secretary-General to meet their long-term liabilities.

43. The General Assembly, in resolution 60/255, recognized the end-of-service accrued benefit liabilities reported in the Secretary-General's report A/60/450, and requested that steps be taken to disclose these liabilities in the United Nations financial statements. The Inspectors believe that it is not sufficient that the liabilities merely be disclosed in the financial statements; adequate funding should be provided to meet such liabilities.

44. The Inspectors note that those organizations that have established a reserve, accumulating funds to meet their ASHI liabilities, have been investing the reserve individually in short- and long-term investments. The Inspectors suggest that it would be a reasonable option to establish a common fund, pooling the reserves established so far by some organizations, and reserves to be established by other organizations to cover future ASHI liabilities. The reserves of individual organizations should be maintained separately, to facilitate tracking and monitoring by each organization, but pooled for investment purposes. This would minimise investment risks, obtain managerial and financial advantage for the organizations and improve investment returns. The Inspectors believe that the common fund should be invested in a manner similar to the assets of UNJSPF.

[8] A/60/450 of 27 October 2005.

Recommendation 4

The legislative bodies of each United Nations organization should request their respective executive heads to undertake periodic actuarial studies based on a uniform system-wide methodology to determine the extent of accrued ASHI liabilities and to disclose the liabilities in the financial statements.

Recommendation 5

The legislative bodies of each organization should:
(a) Request their respective executive heads to put forward proposals for funding ASHI liabilities;
(b) Provide adequate financing to meet those liabilities and establish a reserve for this purpose.

Recommendation 6

The United Nations General Assembly should establish a common fund to pool the reserves (existing and to be established), which should be invested in a manner similar to the assets of UNJSPF.

IV. COST CONTAINMENT MEASURES

45. Confronted with the soaring costs of medical care, several organizations, individually and collectively, embarked in the 1990s on the development of proposals for cost containment programmes to control expenditures to the extent possible. Organizations have adopted various approaches, including imposing restrictions on certain types of benefits, or by rationalizing reimbursements, especially for hospital expenses (the imposition of ceilings; maximum reimbursable days; offers on common wards in public hospitals, etc.). All the health funds of the Geneva-based organizations together conducted negotiations with certain health providers, to attempt to achieve reduced charges. Individual organizations, like ILO, commissioned studies to find ways to contain the increasing costs of their health schemes, and to ensure sufficient resources for the volume and scope of health care required for its members. Despite these efforts, the increasing cost of the health insurance schemes, as shown in annex II, is a growing concern for the United Nations system organizations. The Inspectors believe that effective measures need to be taken to contain costs, otherwise there is a risk that access to a reasonable level of health care for the participants will be jeopardized.

46. The Inspectors note that there are periodic meetings between the medical and health insurance professionals in the United Nations system, and that there is coordination among them at the operational level. They share their experiences and a common concern relates to the containment of the costs of medical coverage. The options outlined below, in the opinion of the Inspectors, deserve the attention of the medical and insurance professionals involved in the cost containment exercise across the United Nations system:

- Extend the network of preferred providers, hospitals, clinics, laboratories and pharmacies at negotiated tariffs at an acceptable level;
- Attempt to identify, in a unified fashion, types of benefits that can be rationalized, and strive to obtain favourable tariffs in the various duty stations;
- Strengthen and expand in-house delivery systems within the medical and legal environment in the duty station, to provide primary care and a referral service for staff members, retirees and their dependants. In-house medical services in FAO in Rome provide primary care, physiotherapy and a pharmacy, whereas in-house medical services in United Nations Headquarters, New York; in UNOG, WIPO, WHO and ILO in Geneva; and IAEA in Vienna, provide only preventive care consultations and first aid, and attend to any medical emergencies of staff members. These services can be expanded using the available resources and facilities, to optimally utilize the resources and to contain costs;
- Establish in-house pharmacies for the supply and dispensing of drugs for staff members and retirees who are on regular regimens for chronic diseases;
- Undertake health education and health promotion activities, and provide patient counselling services on the rational use of health care.

47. Another cost containment measure the Inspectors suggest would be to explore the possibility of providing access to national health services in conjunction with the health insurance schemes available to international staff, and carry out a study to: determine the accessibility of national health schemes for their officials (active and retirees); ascertain in what way the organizational health schemes could be coordinated with national health schemes; ascertain what formalities officials may have to undertake during active life or after retirement to maintain health coverage under the national health schemes; and improve information-sharing with respect to the availability of such services to international staff, and the mechanisms and formalities to be completed in order to obtain them.

Recommendation 7

Executive heads should implement cost containment measures proactively in their respective organizations and ensure that these measures are taken in a coordinated manner among the various organizations in a duty station.

Annex I

BRIEF DESCRIPTION OF THE VARIOUS HEALTH INSURANCE SCHEMES AVAILABLE IN THE UNITED NATIONS SYSTEM

1. United Nations Headquarters, New York; UNDP, UNICEF and UNFPA; and international and national staff members working in designated duty stations:

(a) Aetna Open Choice, preferred provider option (PPO), administered by a commercial health insurance administrator, offers worldwide coverage for hospitalizations and surgical, medical and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network (US$ 10 per visit and without the need to file any claim) or out of network provider (100 per cent reimbursement for hospital expenses and 80 per cent reimbursement of "reasonable and customary" costs of other medical expenses).

(b) Empire Blue Cross PPO, also administered by a commercial health insurance administrator, offers in-network benefits, including an extensive network of participating providers covering most medical specialists, as well as out of network benefits. An extensive network of physicians both in New York (the city and metropolitan areas) and nationally participate in the plan. When treatment is rendered by an in-network provider a co-payment of US$ 10 is required. For services rendered by out of network providers the reimbursement is limited to 80 per cent.

(c) HIP Health Plan for New York is a health maintenance organization (HMO), and follows the concept of total prepaid group practice hospital and medical care. There is no out-of-pocket cost to the staff member for covered services provided by numerous participating medical groups in the Greater New York area. The plan also provides 100 per cent coverage for emergency treatment anywhere in the world.

(d) CIGNA dental PPO programme is provided by a commercial provider and offers a large network of participating providers in the Greater New York metropolitan area and nationally. The dental PPO functions like a medical PPO; the network of dentists accept payment at a fee schedule negotiated with CIGNA and the reimbursement is 100 per cent. For services rendered by out of network providers, the reimbursement is limited to 80 per cent of reasonable and customary charges and in all cases the current maximum annual reimbursement is US$ 2,250.

(e) In addition to the above plans, the MEDEX Assistance Corporation (MEDEX) is a facility available, at a small monthly subscription, to Aetna and Empire Blue Cross subscribers. The programme provides emergency medical assistance, including medical evacuation and repatriation and other travel assistance services, when the staff member is 100 or more miles from home.

With the exception of HIP, the United Nations Headquarters health insurance plans are "experience rated". The premiums in each year are based on the cost of the medical or dental treatment received by United Nations participants in the previous year, plus the expected effect of higher utilization and inflation, and an appropriate allowance for administrative expenses. In a year following a period of heavy utilization, premium increases are expected to be relatively high. Conversely, if the utilisation has been moderate, the increase in premiums will be moderate.

(f) Vanbreda medical, hospital and dental insurance programme for staff members away from headquarters, administered by a commercial provider, covers staff members and former staff members who reside in all parts of the world except the United States of America. The premium is based on the claims incurred by the participants in all parts of the world and reflects varying price levels. Accordingly, three different geographical regions have been established to enable the determination of premiums: rate group 1 for all duty stations other than Chile, Mexico and Western Europe; rate group 2 for Western Europe; and rate group 3 for Chile and Mexico. All

staff members holding appointments of three months and longer under the 100/300 series, and one month or longer under the 200 series, are eligible globally.

(g) Medical Insurance Plan (MIP) is a self-administered and self-financed plan offered to locally recruited staff of the General Service category and national professionals at duty stations away from headquarters, including field offices and peacekeeping missions. The MIP was established in accordance with General Assembly resolution 41/209. The MIP administration is completely delegated to the duty stations. The contributions were established when the plan was introduced in 1987 and have not changed since. The claims administration has been outsourced by UNDP to an independent administrative brokerage.

2. Geneva

(a) United Nations Staff Mutual Insurance Society against sickness and accident (UNSMIS) is a society established by UNOG staff members on the basis of a statute, and is a self-financed and self-administered programme. An Executive Committee consisting of seven members representing UNOG management and the staff coordinating council administers the society. The premium is fixed on the basis of the net pay of the staff member. The society provides health insurance to staff members of UNOG, UNHCR and WMO.

(b) Staff Health Insurance (SHI). This insurance plan, established by WHO, is a self-financed programme. The objective is to provide for the reimbursement of a major portion of the expenses for medically recognized health care incurred by staff members of WHO globally. The contributions of staff members are computed on the basis of their remuneration. The working and financial status of the programme is reviewed and monitored by surveillance committees in the headquarters and regional offices.

(c) Staff Health Insurance Fund (SHIF). This is a self-financed and self-administered health insurance fund for the staff members of ILO and ITU. It is financed by the contributions of the persons insured under the scheme, computed on the basis of their remuneration. The Management Committee, composed of eight titular members (three each representing the ILO staff and the Director-General of ILO, and one each representing the staff of ITU and the Secretary-General of ITU), is responsible for managing the fund.

(d) Group Medical Insurance. WIPO health insurance is provided on the basis of a contract concluded by Assurances Générales de France IART, a commercial provider. The contract is further delegated to Vanbreda International as a broker for the management, execution and implementation of the contract. The contributions are revised periodically and cover two groups: adults 21 years and over; and children under 21 years old.

(e) Group Insurance. A Swiss commercial firm, KPT Assurances SA, provides the main health insurance scheme for UPU permanent staff members, and Vanbreda International supplies health insurance for other personnel.

3. Vienna

(a) Group Medical Insurance is provided by Vanbreda International, a commercial provider, for UNOV/UNIDO. UNIDO is the policyholder and UNOV is a participating organization in the plan. The Full Medical Insurance Plan (FMIP) and Supplementary Medical Insurance Plan (SMIP) provide worldwide coverage and reimburse 80 per cent of the cost of medical, hospital and dental consultations/examinations. The premium rates are based on a comparison of the premiums paid and the reimbursements received over a 12-month review period.

(b) FMIP and SMIP plans are provided by Vanbreda for IAEA regular staff. Vanbreda also provides Group Medical Insurance for temporary staff (GMIT) for short-term staff.

(c) In addition to the two commercial schemes, the Austrian national health insurance scheme (WGKK), a social security insurance scheme, is also provided to staff members in Vienna.

4. Rome

WFP and FAO provide two medical insurance schemes to their staff. The Basic Medical Insurance Plan (BMIP) is compulsory for all staff employed globally. The Major Medical Benefit Plan (MMBP) is a voluntary scheme. The BMIP cost is shared between the organization and the staff, whereas MMBP premiums are fully paid by the staff. Vanbreda International provides the two schemes.

5. Paris

The Medical Benefits Fund of UNESCO is a self-financed and self-administered health insurance scheme providing global coverage. A Board of Management composed of five members manages the fund: the Chairperson, appointed by the Director-General; two members elected by the participants; and one representative each of Human Resources Management and the Controller respectively. The contributions of the participants are calculated on the basis of their annual remuneration and revised when the financial situation of the Fund is unfavourable.

6. Montreal

The Sun Life Group Medical Insurance plan of ICAO is a voluntary scheme, providing worldwide coverage on a commercial basis.

7. London

Vanbreda International provides health insurance to IMO staff.

Annex II

NUMBER OF CONTRIBUTORS AND ANNUAL COST OF HEALTH INSURANCE SCHEMES FOR 1997 AND 2004

Organization	Number of contributors under health insurance schemes (active and retirees)			Annual cost of health insurance schemes (thousands of US dollars)		
	1997[9]	2004[10]	2004 index 1997 =100	1997[11]	2004[12]	2004 index 1997=100
United Nations[13]	39,119	46,352	118	86,551	175,447	203
ILO	4,289	4,737	110	8,432	11,846	141
FAO[14]	9,097	9,833	108	16,809	24,342	145
UNESCO	4,285	4,600	107	6,723	15,932	236
ICAO	997	997		1,844	2,929	159
WHO	7,682	9,262	121	21,900	37,173	170
UPU	509	573	113	561	2,255	401
ITU	1,178	1,501	127	3,169	4,530	143
WMO	384	473	123	1,736	2,699	155
IMO	342	342		539	1,439	267
WIPO	783	1022	131	2,357	5,455	231
UNIDO	1,113	1102	100	2,767	4,316	156
IAEA	2,599	2,953	114	4,839	7,729	160
Total	**72,377**	**83,747**[15]	**116**	**158,227**	**296,092**	**187**

[9] Source – ACC/1999/FB/ R.13 – Biennial report on the cost of health insurance.
[10] Source: responses to JIU questionnaire.
[11] Source – ACC/1999/FB/ R.13 – Biennial report on the cost of health insurance.
[12] All currencies converted to US dollars according to December 2004 official exchange rate.
[13] United Nations includes health insurance programmes administered out of United Nations Headquarters office in New York, the staff and retirees of the Secretariat, UNDP, UNOPS, UNFPA and UNICEF. It also includes UNSMIS Geneva data comprising the staff and retirees of UNOG, all funds and programmes in Geneva, WMO, UNV, UNFCCC, UNCCD, and UNSSC.
[14] Includes WFP.
[15] Includes the estimated numbers for ICAO and IMO, based on 1997 figures.

Annex III

COMPARATIVE ANALYSIS OF PREMIUM SHARING

Cost share (basic plan)[16]				
Organization	**Staff**	**Organization**	**Retirees**	**Organization**
United Nations[17]	40	60	20	80
UNSMIS, Geneva	50	50	33	67
ILO[18]	50	50	33	67
FAO[19]	50	50	50	50
UNESCO	50	50	50	50
ICAO	P-65, G-50	P-35, G-50	50	50
WHO[20]	33	67	33	67
UPU	50	50	50	50
ITU[21]	50	50	33	67
WMO	50	50	33	67
IMO	33	67	25	75
WIPO	25 to 50	75 to 50	35	65
UNIDO	50	50	25	75
IAEA[22]	50	50	50	50

[16] Expressed in terms of percentage of total premium.

[17] Programmes outside the United States other than the UNSMIS plan have approximate cost sharing as follows: about 60 per cent covered by staff, 40 per cent by the Organization; about 30 per cent covered by retirees, 70 per cent by the Organization.

[18] In terms of percentage of salary or pension.

[19] Includes WFP, IFAD and ICCROM. Staff member's share limited to 5 per cent of gross salary. Any amount beyond that is paid by the Organization. For retirees, maximum 4 per cent of 32 per cent of monthly final average remuneration, or 4 per cent of full pension benefit, whichever is greater.

[20] For staff, computed on the basis of remuneration – net salary together with post adjustment or any non-resident allowance; for retirees computed on the basis of the full benefit granted to retired staff members.

[21] In terms of percentage of salary or pension.

[22] Premiums at IAEA are flat rates per insured person and not a percentage of salary. Therefore staff member shares vary from 20 per cent to 70 per cent (20, 30, 40, 50, 60 and 70) of the premium depending on their net monthly emoluments. Retiree shares vary from 15 per cent to 60 per cent (15, 25, 35, 50 and 60) of the premium depending on net emoluments during the last full month of service. Overall, the Organization's contribution is approximately 50 per cent.

Annex IV

COMPARATIVE ANALYSIS OF COVERAGE

Coverage									
Regular staff and dependants				**Retirees**			**Others**[23]		
	Regular staff	**Primary dependants**	**Secondary dependants**	**Retirees**	**Primary dependants**[24]	**Secondary dependants**[25]	**Short term**	**Consultants**	**SSAs**
United Nations[26]	Yes	Yes	Yes	Yes	Yes	Yes[27]	Yes	Yes	Yes
ILO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FAO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UNESCO	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
ICAO	No	No	No	Yes	Yes	No	Yes	No	No
WHO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UPU	Yes	Yes	Yes	Yes	Yes	Yes	N/A	N/A	N/A
ITU	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
WMO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
IMO	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
WIPO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
UNIDO	Yes	Yes	N/A	Yes	Yes	Yes	Yes	No	Yes
IAEA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No

[23] Coverage for the "others" category is extended under different insurance/compensation schemes to those for staff and retirees.
[24] Primary dependants are a spouse and children meeting the conditions under relevant staff rules.
[25] Secondary dependants cover parents and / or dependent siblings meeting the conditions under relevant staff rules.
[26] United Nations includes United Nations Headquarters, UNDP, UNFPA, UNICEF, UNHCR, UNOG, UNOV and UNODC.
[27] Only the UNSMIS plan provides for coverage of secondary dependants of staff or retirees.

Annex V
COMPARATIVE ANALYSIS OF BENEFITS

Organization	Annual limit (in United States dollars)	Lifetime limit	Free choice of providers[28]	Reimbursement formula (percentage of expenditure incurred)					
				Doctors fees and prescription drugs	Outpatient services[29]/ institutional care[30]	Medical procedures[31]	Hospital care[32]	Nursing services	Dental care[33]
United Nations[34]	N/A	No	[35]	See footnote 35	See footnote 35	See footnote 35	See footnote 35	See footnote 35	See footnote 35
ILO	$150,000	No	Yes	80	80	80	80	80	80
FAO[36]	$1,000,000	No	Yes	80	80	80[37]	100/80[38]	100	80[39]
UNESCO	[40]	No	Yes	75	75[41]	75	90	75	80
ICAO	[42]	No	Yes	80[43]	80	80	80/100[44]	80	80
WHO	$30,000[45]	No	Yes	80	80	80	80/100[46]	80	80[47]

[28] Medical practitioners, pharmacists and medical establishments.
[29] Includes outpatient services, e.g., laboratory tests, x-rays, artificial limbs, crutches, etc.
[30] Includes stay in sanatoria. Reimbursements for professional ambulance services are also included in this column.
[31] Includes breast cancer and other breast screenings, orthopaedics, orthotics etc.
[32] Reimbursement of daily charges. In most cases, expenses for services provided in a hospital (nursing, x-rays, operating room charges, etc.) included here.
[33] Routine dental care, e.g., periodic examinations, fillings, crowns, etc.
[34] Includes UNDP, UNFPA and UNICEF.
[35] Participants are free to choose in-network or out of network service providers. Out of pocket expenses for those going out of network would be generally higher. Rate of reimbursement (usually between 80 and 100 percent) varies by service provided and, more importantly, on the basis of service provided in-network or out of network.
[36] Includes WFP.
[37] Breast cancer screenings reimbursed at 100 per cent.
[38] For hospital care in Italy, 100 per cent up to 260 euros, 80 per cent of next 240 euros. Limits and percentages for areas outside Italy differ.
[39] Up to a maximum of US$ 700 per patient.
[40] Annual limits in monetary terms apply in cases of specific benefits.
[41] Chemotherapy, radiotherapy reimbursed at 100 per cent.
[42] In general 80 per cent reimbursement formula applies. Certain benefits have ceilings or limitations per benefit year.
[43] Brand name drugs covered at 80 per cent, generic drugs at 90 per cent.
[44] 80 per cent reimbursement up to US$ 20,000; 100 per cent thereafter.
[45] Applies to temporary staff and consultants.
[46] 80 per cent reimbursement for stay in a hospital, clinic or other recognized medical institution. 100 per cent reimbursement for treatment in a general ward.
[47] Within the limit of US$ 1,500 per year. In cases where dental care is required as a result of an accident, the limit of US$ 30,000 applies.

Organization	Annual limit (in United States dollars)	Lifetime limit	Free choice of providers[48]	Reimbursement formula (percentage of expenditure incurred)					
				Doctors fees and prescription drugs	Outpatient services[49] / institutional care[50]	Medical procedures[51]	Hospital care[52]	Nursing services	Dental care[53]
UPU	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
ITU	$150,000	No	Yes	80	80	80	80	80	80
WMO	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
IMO	No	No	Yes	80	80	80	100[54]	100	80
WIPO	See footnote 55	No	Yes	[55]	See footnote 55	See footnote 55	100[56]	See footnote 55	75[57]
UNIDO	No	No	Yes	80	90	80	100/90/70[58]	No	80[59]
IAEA[60]	No	No	Yes	80	90[61]	80	100/90/80[62]	80	80[63]

[48] Medical practitioners, pharmacists and medical establishments.
[49] Includes outpatient services, e.g., laboratory tests, x-rays, artificial limbs, crutches, etc.
[50] Includes stay in sanatoria. Reimbursements for professional ambulance services are also included in this column.
[51] Includes breast cancer and other breast screenings, orthopaedics, orthotics etc.
[52] Reimbursement of daily charges. [footnote 32 above has more information]
[53] Routine dental care, e.g., periodic examinations, fillings, crowns, etc.
[54] Up to £550 per day.
[55] All insured persons of 21 years and over must pay the first SwF 350 and 10 per cent of the expenses incurred beyond this amount per calendar year. However, these out of pocket expenses may not exceed SwF 2,000 per year per insured person falling in this category. For insured persons under 21, a limit of SwF 250 per annum for the 10 per cent share applies. Total out of pocket expenses pertaining to the 10 per cent share for all insured persons under 21 in the family may not exceed SwF 500.
[56] An insured person opting for hospital treatment in a private room bears 10 per cent of the cost of medical treatment up to a maximum of SwF 1,000. He/she also bears 10 per cent of the cost of accommodation up to a top price of SwF 850 per day, and 100 per cent of the cost beyond this limit.
[57] Up to a maximum of SwF 3,500 per year. In France, the reimbursement rate is 85 per cent.
[58] 100 per cent for general ward, 90 per cent for semi-private room and 70 per cent for single room.
[59] Subject to a maximum of euros 1,455 per calendar year.
[60] Relates to Full Medical Insurance Plan (FMIP). Reimbursement formulae are different under other plans.
[61] Refers to day surgery not requiring hospital stay.
[62] 100 per cent for a standard room, 90 per cent for a semi-private room and 80 per cent for a private room.
[63] 80 per cent up to 1,770 euros, none thereafter.

Annex VI

AFTER-SERVICE HEALTH INSURANCE (ASHI)

Organization	Eligibility requirement (number of years of participation at the time of separation)	Year of last actuarial study	Total ASHI liability[64] (in millions of US $)	Funded up to 2004 (in millions of US $)	Unfunded liability (in millions of US $)
United Nations	10 years	2002	1,484.9	25.0[65]	1,459.9
UNDP	10 years	2003	263.2	135.0	128.2
UNICEF	10 years	2003	182.5	40.0	142.5
UNFPA	10 years	2003	54.5	--	54.5
UNHCR	10 years	2002	136.1	--	136.1
ILO	10 years	2004	474.0	--	474.0
FAO[66]	10 years	2004	562.5	178.8	383.7
UNESCO	10 years	N/A	322.6	--	322.6
ICAO	5 years	2004	32.5	--	32.5
WHO	10 years	2003	371.2	252.2	119.0
UPU	No contributory service required	N/A	N/A	N/A	N/A
ITU	10 years	2004	185.1	--	185.1
WMO	10 years	2002	12.1	1.3	10.8
IMO	10 years	N/A	No information	No information	No information
WIPO	5 years	1999	43.2	--	43.2
UNIDO	10 years	2000	59.1	--	59.1
IAEA	5 years[67]	2002	80.9	--	80.9
TOTAL			4264.4	632.3	3632.1

[64] Figures mainly taken from A/60/450 (Report of the Secretary-General on Liabilities and proposed funding for after-service health insurance benefits).
[65] UNSMIS actuarial reserve for long-term risks.
[66] Includes WFP.
[67] Staff members separating at age 55 and above are eligible to continue to participate in ASHI provided they participated in the health insurance plan for a period of 5 years. However, to qualify for the Organization's subsidy towards the premium, the staff member must have 10 years of continuous service prior to separation. Staff members separating between age 50 and 55 are eligible to continue to participate in ASHI provided they participated in the health insurance plan for a period of 20 years, 10 of which were continuous prior to separation. In the latter case, the Organization's subsidy is only payable after they reach age 55.

Annex VII
UNITED NATIONS SYSTEM STAFF MEDICAL COVERAGE: OVERVIEW ON ACTION TO BE TAKEN ON RECOMMENDATIONS

		United Nations and its Funds and Programmes											Specialized Agencies and IAEA											
		United Nations *	UNCTAD	UNODC	UNEP	UN-HABITAT	UNHCR	UNRWA	UNDP	UNFPA	UNICEF	WFP	ILO	FAO	UNESCO	ICAO	WHO	UPU	ITU	WMO	IMO	WIPO	UNIDO	UNWTO	IAEA
Report	For action	X					X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	For information and review		X	X	X	X		X																	
Recommendation 1		L					L		L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
Recommendation 2		L																							
Recommendation 3		L					L		L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
Recommendation 4		L					L		L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
Recommendation 5		L					L		L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
Recommendation 6		L																							
Recommendation 7		E											E	E	E	E	E	E			E	E	E	E	E

Legend:
L: Recommendation for decision by legislative organ
E: Recommendation for action by executive head
Blank: Recommendation does not require action by this organization

* Covers all entities listed in ST/SGB/2002/11 other than UNCTAD, UNODC, UNEP, UN-HABITAT, UNHCR, and UNRWA.

United Nations A/62/541/Add.1

General Assembly

Distr.: General
14 January 2008

Original: English

Sixty-second session
Agenda items 126, 128 and 134

Review of the efficiency of the administrative and financial functioning of the United Nations

Programme budget for the biennium 2008-2009

Joint Inspection Unit

United Nations system staff medical coverage

Note by the Secretary-General

The Secretary-General has the honour to transmit herewith, for the consideration of the General Assembly, his comments and those of the United Nations System Chief Executives Board for Coordination, on the report of the Joint Inspection Unit entitled "United Nations system staff medical coverage" (see A/62/541).

08-20702 (E) 310108

Summary

The Joint Inspection Unit report, entitled "United Nations system staff medical coverage" (see A/62/541), examines the issues surrounding medical insurance coverage provided to staff members and notes the dramatic increase in cost to organizations associated with health insurance. Through a series of recommendations directed at executive heads, legislative bodies and the General Assembly, the Joint Inspection Unit seeks increased system-wide harmonization to reduce the costs of health insurance and to address funding issues related to after-service health insurance.

The present note presents the views of United Nations system organizations on the recommendations provided in the report of the Joint Inspection Unit. The views of the system have been consolidated on the basis of inputs provided by the member organizations of the United Nations System Chief Executives Board for Coordination (CEB). While CEB members appreciate the detailed survey of the health insurance schemes in place across the system, many believe that the subject matter deserves a more rigorous actuarial and financial analysis in order to ascertain the impact of a common system model, as proposed in the report. Many organizations note that they already report after-service health insurance liabilities and have begun to put measures in place to fund these, questioning the value of a common pool. They also agree to the need for cost-containment measures, and many noted that reviews of health insurance already take place.

I. Introduction

1. The Joint Inspection Unit report, entitled "United Nations system staff medical coverage" (see A/62/541), focuses on the issues surrounding medical insurance coverage provided to staff members, and observes two patterns that have developed over the past 30 years: (a) that the costs of providing health insurance have grown dramatically in that time; and (b) the continuing diversity of insurance schemes in place throughout the system. The report examines the history of the health insurance provided to staff members and, within the context of several recommendations, seeks more uniformity across the system. The report also explores the issues surrounding the financing and liability inherent in the after-service health insurance programme along with recommendations to agencies for staff health cost containment measures.

II. General comments

2. Organizations welcome the report and appreciate its comprehensive nature, which includes a detailed overview of the diverse health insurance schemes implemented by organizations across the United Nations system, including comparative analyses of annual cost, premium sharing, coverage and benefits. In general, organizations believe that the report contains some interesting ideas and suggestions that merit further exploration, even though some proposals might not meet with unanimous agreement.

3. However, they also indicate that the report did not go far enough in several aspects of its analysis. First, organizations note that the report suggests moving the system towards a common health insurance scheme and they take the view that the importance of the subject matter justifies development of complete actuarial and financial projections, structured organization per organization (with each of the schemes included under the single "United Nations" heading treated separately), in order to accurately ascertain the impact of a common system model on each organization.

4. Second, many organizations took issue with the statement in the executive summary referring to the "soaring cost of medical coverage" followed by statistics which state:

> Between 1975 and 2004, there was a 122 per cent increase in the number of contributors to the staff health insurance schemes. The cost of providing health insurance grew by 1,387 per cent for the same period, and the cost per person increased from US$ 540 to US$ 3,620 between 1975 and 2004.

5. Responding to this statement, several organizations note that a review of the data indicates that the nominal growth of medical costs over the 30-year period of the review (1975-2004) was approximately 6.5 per cent per year and, therefore, was no different from the average medical inflation costs for the general population at major headquarters duty stations during a similar period. In constant dollars, using the United States consumer price index as a deflator, the average cost increase would only be 2.1 per cent per year. Although any cost increase is undesirable, organizations believe that the Joint Inspection Unit should avoid such expressions as "soaring cost" as they are not commensurate with the cost increase observed during the period when calculated in real terms, net of inflation. Furthermore, they note that the growth in the cost of health insurance coverage, taken out of cost-of-living or cost-of-healthcare context, emerge as a United Nations-system phenomenon rather than as a broader reality impacting many national social security schemes. Although the increase in the cost of health insurance coverage is undeniable, external benchmarking would improve the system's ability to objectively assess the situation within the United Nations system.

6. CEB members also noted that the executive summary cites "several main factors" which "continue to affect the increase in costs of the staff health insurance schemes: the rising cost of medical benefits worldwide […]; the ageing of the international community demanding accrued services […]; the systematic increase in the frequency of access to medical care; and currency fluctuations". However, organizations questioned how a common system approach could contribute to reducing the effect of these main factors on escalating health care costs and note that a full actuarial and financial study would be required to determine how a common system approach would improve any individual organization's ability to mitigate the financial effects of workforce demographics, ageing, shifts in morbidity and mortality, geographic location, evolving medical technology, etc.

III. Specific comment on recommendations

Recommendation 1

The legislative bodies of the United Nations system organizations should formally recognize staff health insurance as an important integral part of the common system. They should request the International Civil Service Commission (ICSC) to undertake periodic reviews with a view to making recommendations to the General Assembly.

Recommendation 2

In this regard, the General Assembly should establish, initially, an ad hoc advisory body to assist ICSC in formulating broader principles, policies and standards for staff health insurance schemes. The advisory body should be composed of representatives of Member States, officials of the United Nations system organizations, elected representative(s) of the staff, and elected representative(s) of the retirees, and be assisted by experts in health and insurance matters from the private sector.

Recommendation 3

The legislative bodies of each United Nations system organization should request their respective executive heads to harmonize the existing health insurance schemes, initially at the level of the duty station, and in the longer term across the common system, relating to scope of coverage, contributions and benefits and to establish periodic reporting on health insurance related information to the legislative bodies.

7. As the report brings these three recommendations under one heading, many organizations responded to them as a group. While organizations generally support policy coherence within the United Nations system, including a common system approach to employee benefits, and while there exists across the system broad support for these recommendations, many organizations stated that the data provided in the report does not allow for a fully informed position regarding the level of support for these recommendations.

8. Regarding recommendation 1, organizations agree with the notion that staff health insurance should form “an important integral part of the common system”, however they did not express universal acceptance that ICSC should conduct “periodic reviews” on the subject. Many organizations note that this issue is already currently under consideration by individual organizations in the context of implementation of the International Public Sector Accounting Standards and in the context of the human resources network and the medical offices’ network.

9. For many of these same reasons many organizations did not see the need to have ICSC either establish another advisory body to undertake periodic reviews or look into medical insurance issues. Organizations generally agree with the sense of recommendation 2, that these policies should be reviewed, although they expressed concern about whether the proposed establishment of yet another ad hoc advisory body to ICSC for that purpose would be the best way of doing this, especially as its implications on United Nations governance are unclear.

10. Recommendation 3, requesting the executive heads of organizations to begin harmonizing health insurance schemes, elicited a variety of responses from organizations, many noting the challenges in achieving this even at a modest level. Some, especially the Rome-based organizations, noted that harmonization had already been accomplished on a limited basis. Many others expressed a concern that it would be very difficult to achieve even in the long term considering that the health insurance scheme of each organization depends on various factors such as the history of the organization, varying medical needs based on the nature of the mandate and the function of the organization, cost-effectiveness of the individual scheme and the medical practices and legal medical requirements in the country of the duty station.

11. In particular, many organizations do not view the establishment of a single fund as the only option for achieving system-wide equity with respect to health insurance, i.e., for achieving equal access to a defined set of covered health-care related goods and services for all active and retired staff members. Such equal access can be achieved either within the framework of a single fund or through separate funds operating on the basis of a minimum set of common rules. Furthermore, those organizations feel that the report does not discuss the various options for harmonizing insurance schemes, which range from a common (minimum) "basket" of goods and services with a common reimbursement schedule, to a "cafeteria" option within a common funding policy. Certain determining aspects of health insurance, such as service levels, proximity, governance and operating costs, have also not been addressed in the report.

Recommendation 4

The legislative bodies of each United Nations organization should request their respective executive heads to undertake periodic actuarial studies based on a uniform system-wide methodology to determine the extent of accrued after-service health insurance liabilities and to disclose the liabilities in the financial statements.

12. CEB members generally accept the concept of periodic actuarial studies and many indicate that they already perform these regularly. They note that with the development and implementation of the Institute for International Public Sector Accounting Standards, the system will begin to calculate and disclose this liability in a more uniform manner.

Recommendation 5

The legislative bodies of each organization should:

(a) Request their respective executive heads to put forward proposals for funding the after-service health insurance liabilities;

(b) Provide adequate financing to meet the liabilities and establish a reserve for this purpose.

13. Organizations across the system recognize the need to fund all liabilities related to after-service health insurance and many indicate that they already have programmes in place to accomplish this. Some organizations note that their after-service health insurance liabilities are already fully funded, while others have put in place mechanisms, implemented over the past several years, to calculate and fund

this liability. Most indicated they would welcome proposals from either their legislative bodies or the General Assembly on creative ways to cover this liability.

Recommendation 6

The United Nations General Assembly should establish a common fund to pool the reserves (existing and to be established), which should be invested in a manner similar to the assets of the United Nations Joint Staff Pension Fund.

14. Whereas some CEB members agreed with this recommendation in principle, many urged the General Assembly, to which this recommendation is addressed, to consider several important factors before proceeding with a common reserve fund, including the demographics of the staff and retiree base, the current funding status and the annual contribution policy across agencies. All of these factors will likely continue to be quite different, from agency to agency, in the medium term and therefore pooling the investments in one common fund may not provide the optimal asset/liability ratio for each agency. Furthermore, organizations note that they would need to weigh their current investment strategy and returns against any proposed alternative before agreeing to participate. Therefore, while organizations generally look favourably upon system-wide initiatives, they cannot judge the merits of this recommendation until the rules for a pooled investment have been made clearer.

Recommendation 7

Executive heads should implement cost containment measures proactively in their respective organizations and ensure that these measures are taken in a coordinated manner among the various organizations in a duty station.

15. Organizations of the system note that cost containment is an ongoing or regular exercise, with regular review of existing health insurance schemes to ensure its cost-effectiveness. However, organizations express difficulty with some of the measures mentioned in the report. For example, the suggestion that organizations provide a “referral service” to their staff members requires further clarification as, depending on the intent of the report, the suggestion either does not provide any economies of scale if the intent is to provide an optional referral service, or contravenes staff regulations regarding freedom of choice if the intent is to act as a “gatekeeper” and direct staff to specific providers. Another measure noted by organizations requiring further clarification is the suggestion of establishing in-house pharmacies, since the cost of hiring pharmacists and the risks associated with maintaining a stock of medicines, including the possible liabilities in the handling of drugs, does not seem to be justified. In general, organizations note that enhanced organizational delivery of health services will necessarily reduce the cost of health insurance premiums, which is the primary focus of the report.