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Review of the quality, effectiveness, efficiency and sustainability of health insurance schemes in the United Nations system organizations

Report of the Joint Inspection Unit

Prepared by Jesús S. Miranda-Hita

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Executive summary

Review of the quality, effectiveness, efficiency and sustainability of health insurance schemes in the United Nations system organizations

I. Introduction and review objectives

The review of the quality, effectiveness, efficiency and sustainability of health insurance schemes in the United Nations system organizations was included in the programme of work of the Joint Inspection Unit (JIU) for 2022 to address long-standing requests from the Independent Audit Advisory Committee of the United Nations Secretariat, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Office of the United Nations High Commissioner for Refugees (UNHCR), the International Maritime Organization (IMO) and the World Meteorological Organization (WMO). The overarching objective of this review is to identify areas for improvement and good practices with regard to the transparency, quality of service, coordination, harmonization, effectiveness, efficiency and long-term financial sustainability of the health insurance schemes of JIU participating organizations for their active and retired staff. Specifically, in the review, health insurance policies and management, including cost-containment policies and practices are assessed, financial and budgetary perspectives are explored, and the potential for strengthening coordination and cooperation among organizations, including staff mobility, is examined. In this connection, the review provides a comparative analysis of all 25 primary health insurance plans and 1 stand-alone dental health insurance plan for active and retired staff members that are directly or indirectly administered and co-sponsored by the JIU participating organizations (chapter II), and covers selected aspects related to the effectiveness and efficiency of such plans (chapter III), the adequacy of coverage and quality of their administration (chapter IV), and the status of disclosure and funding of after-service health insurance liabilities and their budgetary implications (chapter V).

Health insurance is an essential part of the compensation package provided to the staff and retirees of United Nations system organizations. Its coverage and financing are system-wide issues that are subject to continuous adaptation as a result of demographic trends among the insured populations and increasing costs stemming from technological advances and other developments in health. The number of active and retired staff insured under the primary health insurance schemes in the United Nations system grew from 84,000 people in 2004 to over 160,000 people at the end of 2022, with a total protected population of over 440,000 people when family members and other dependants are included. The annual cost increased from $296 million to $1.2 billion in the same period. Overall, the average annual cost of health insurance for the family of a United Nations staff member rose from $3,536 in 2004 (equivalent to $5,478 in 2022) to $7,259 in 2022, a rise of 32.5 per cent in real terms.

Although the right to social security is part of the staff compensation package, the scope of its consideration as a “common system” matter is limited; this is partially owing to a lack of policy coordination and common guidance that has given rise to the distinct historical development of each health insurance plan, and also owing to dissimilar supply conditions for health services in different countries and duty stations, which have resulted in significant variations in the coverage, cost and the degree of solidarity and mutualization of health risks inherent to each plan.

II. Main findings and conclusions

Comparative study of health insurance schemes for the active and retired staff of United Nations system organizations

As already noted by JIU in its previous report on the subject,[1] the review found that governing bodies and legislative organs remain largely inactive in health insurance policymaking. The organizations in the United Nations system have an obligation to establish a social security scheme for their staff, but in all cases except one, regulations are limited to recognition of the right to social security and the delegation to the executive heads of the organizations of full authority to establish relevant health insurance policies. This has resulted in the existence of 26 different health insurance schemes in the participating organizations (one of which is specific to dental insurance). Recognizing that having one health insurance scheme for all participating organizations is not feasible, a minimum set of principles, requirements or standards for an adequate health insurance scheme would assist policy design and enhance coherence.

The 26 health insurance schemes in the United Nations system can be categorized by the entity that underwrites risks and by the entity that administers the plans. The former is used to distinguish between self-insured and externally insured schemes, while the latter refers to self-administered schemes, in which the entire health insurance service is managed by the organizations, and to third party-administered schemes, in which an external company is engaged to provide administrative services. Half of the health insurance schemes within the United Nations system are self-insured or captive schemes. These schemes cover 82 per cent of the entire insured population.

Outsourcing is the prevailing mode of administration, even for self-insured schemes: 72 per cent of the beneficiaries are covered by schemes administered externally. Conversely, just over a quarter of the insured persons are under one of the existing four self-administered (and therefore self-insured) plans, all of which are headquartered in Geneva and feature a large clientele ranging from nearly 13,000 beneficiaries at the International Labour Organization (ILO) to more than 41,000 at the World Health Organization (WHO). The biggest single entity in terms of the population covered by its plans is the United Nations Secretariat in New York, with five plans and almost 150,000 protected persons.

Governance of health insurance schemes and engagement of insurance plan members

The engagement of beneficiaries in policymaking and the governance of health insurance plans is crucial. Representatives of active and retired plan members are formally engaged in health insurance policymaking in most schemes, but locally recruited staff and retirees outside headquarters locations are not sufficiently represented in the relevant committees.

Eligibility criteria

Health insurance packages often depend on the contract and duty station of staff members. Most participating organizations offer a specific health insurance package to their active staff based on their contractual status, whether they are internationally or locally recruited, and whether they are located at a headquarters location (such as New York, Geneva and Vienna).

The 26 health insurance schemes apply varying eligibility criteria for staff, retirees and their family members and associated protected persons. The unharmonized eligibility criteria, especially for those who receive subsidized premium rates from their organizations, create unequal access to health insurance coverage for active and retired staff and their family members, and demonstrate an inequitable use of public funding.

[1] JIU/REP/2007/2.

There is not always mutual recognition of prior participation in health insurance schemes across the system without reservations. Although the number of years of staff participation in contributory health insurance plans of other United Nations organizations are recognized by all schemes, ILO and WHO require that 5 of the 10 years required to be eligible for after-service health insurance need to be from their respective plans.

Premiums and shares of contribution between organizations and plan members

Under most schemes, the ability to pay and the intergenerational solidarity principle inherent in the notion of social security are the basis for allocating premiums among beneficiaries; as such, staff members with lower remuneration or larger families tend to receive a larger share of contributions from their organizations, whereas retired staff and their dependants contribute less, receive higher subsidies and potentially incur higher amounts of health insurance reimbursements. For its part, the principle of equivalence or cost causation, which usually characterizes private commercial insurance premiums, is also built into some schemes through the use of flat-rate premiums in absolute amounts, as in the case of the Basic Medical Insurance Plans of the Food and Agriculture Organization of the United Nations (FAO) and the World Food Programme (WFP). The health insurance plan of the Universal Postal Union (UPU) is the only plan that collects flat-rate contributions based exclusively on the age of plan members.

The level of organizations' contributions toward health insurance premiums ranges from 50 to 75 per cent across plans, with half of the schemes providing a higher level of subsidy to retired staff than to active staff, thus reinforcing the intergenerational solidarity principle embedded in the idea of the insurance or mutualization of health risks. However, in some organizations, overall, the staff bear a higher proportion of the cost of insurance than the organization itself, as is the case with the FAO Medical Insurance Coverage Scheme/After-Service Medical Insurance, the United Nations Secretariat's United Nations Worldwide Plan for active staff and the two United Nations Industrial Development Organization (UNIDO) schemes for retirees.

Regarding disparities in staff contributions, through a comparative case study of six duty stations, the review found that, within the same duty station, the cost of health insurance for internationally recruited staff in the same category can vary by a factor of up to 2.5, depending on the plan, and that they may vary by a factor of up to 4 in the case of locally recruited staff, which implies that staff members working under the same circumstances are treated differently solely, or mostly, on the basis of their affiliation with a particular health insurance scheme. This situation, along with other factors such as differences in coverage, clearly goes against the goal of a common system that avoids harmful competition between system organizations when recruiting personnel, while also providing equal working conditions to employees in the same duty station, irrespective of their employer.

Coverage and benefits

For the review, 11 key dimensions were selected to compare the level of coverage and benefits of different schemes: (a) choices of health-care providers and geographical coverage; (b) financial coverage and protection against catastrophic expenses through stop-loss measures and hardship provisions; (c) general outpatient care and pharmaceutical products; (d) hospitalization; (e) physical therapy; (f) preventive care for adults; (g) optical and dental care; (h) mental health care; (i) reproductive health, family planning and infertility treatments; (j) well childcare; and (k) long-term care.

All schemes allow a free choice of health-care providers for their plan members but some schemes, especially those designed for plan members in North America, offer significant preferential benefits from their in-network providers. As for geographical coverage, plans designed for staff and retirees worldwide, regardless of their recruitment status, offer worldwide coverage, but many provide limited coverage in the United States of America owing to high medical costs. The schemes designed specifically for locally recruited staff such as the Medical Insurance Plans of the United Nations Secretariat, the United Nations Development Programme (UNDP), UNHCR and the United Nations Children's

Fund (UNICEF) feature limited to no coverage outside the duty stations or places of residence of the plan members under normal circumstances.

Annual reimbursement limits vary significantly between plans within the same duty station and even within the same organization for different beneficiaries. For costs related to hospitalization, most schemes cover 100 per cent of the cost of a semi-private room or a bed in a public ward, but in some duty stations, especially in Europe and North America, a reimbursement ceiling amount may be indicated as a cost-containment measure.

For physical therapy, the level of benefits varies considerably among the schemes, including the types of care covered. For preventive care, four schemes do not provide coverage at all or provide coverage for dependants only, or do not have a specific provision for routine physical check-ups; for the schemes that cover such procedures, the level of coverage varies greatly even though preventive medicine is not only advisable on medical grounds, but also an integral part of the right to health in the broadest sense and a way of containing costs in the long run.

Coverage for optical devices and dental care also varies considerably among the schemes. Mental health is another area where there are major divergences in coverage between plans. For outpatient psychiatric therapy and psychotherapy, the schemes offered by the International Atomic Energy Agency (IAEA), the United Nations Office at Vienna, the United Nations Secretariat (Aetna plan), UNIDO and the World Tourism Organization (UNWTO) impose no ceiling for the reimbursement amount for staff and retirees, and their plans have no overall financial limits. The two schemes established by FAO and WFP for their locally recruited staff outside headquarters feature the lowest financial coverage, as their annual limit for outpatient psychiatric therapy and psychotherapy is set at $800.

The 25 schemes with this coverage provide similar protection for maternity-related expenses, most at 80 per cent, but family planning coverage is also uneven and would benefit from closer harmonization. For medically necessary infertility treatments, 17 plans offer varying coverage, while 8 do not provide coverage at all.

Long-term care is generally not covered by health insurance and remains an unmet need. Long-term care is usually covered under a separate insurance policy and is not part of a health insurance package. Out of the 25 health insurance schemes reviewed, only 8 include some long-term care coverage.

The review did not find specific limitations or exclusions to coverage based on age, race, gender, sexual orientation or any other personal characteristics.

Protection of health-related data of staff

All of the third-party administrators and commercial insurers used by health insurance plans are based in either the United States or Europe, which requires them to comply with the Health Insurance Portability and Accountability Act, for the former, or the General Data Protection Regulation for the latter. However, the level of maturity of data protection policies varies greatly among the participating organizations.

Effectiveness and efficiency of health insurance schemes

Financial performance of health insurance schemes

On average, contributions from employing organizations for active staff were 17 per cent higher than those made by these beneficiaries, and 83 per cent higher than the amount contributed by retirees. All in all, contributions per insured person, both from beneficiaries and their employers or former employers, amounted to $3,079 in 2022. For serving staff and their dependants, contributions reached a total of $845.7 million, while for retirees and their dependants the amount came to $367.5 million. Consequently, the combined sum of contributions amounted to $1.2 billion for the year.

The average of the full loss ratios[2] of all plans for which data were provided reached 88.1 per cent in 2022, indicating a good balance between contributions and expenses. The loss ratios[3] of the 25 plans with complete information amount on average to 83.1 per cent.

Of the 21 plans with relevant information, 14 have an effective reimbursement ratio (share of medical expenditure effectively borne by the insurer) above 80 per cent. The highest value corresponds to the World Intellectual Property Organization (WIPO) plan (88.8 per cent). Regarding the financial self-coverage ratio (the portion of the cost of health-care needs, including premiums, borne by the beneficiaries themselves), seven plans have ratios below 50 per cent, implying that their schemes cover more than half the actual cost of health services needed during the year. Subsidies for retirees (equivalent to 61 per cent of their health insurance and medical costs) were twice as much as those of active staff.

Fraud prevention and control

The JIU participating organizations reported 226 presumptive and decided health insurance fraud cases between 2019 and 2022, with a combined fraud amount of $2.2 million, of which approximately $142,000 has been recovered to date. Available data suggest that, across global health-care systems, fraud accounts for between 3.3 and 10 per cent of health-care expenditure. In the case of the health insurance plans in the United Nations system organizations, which incurred a total reimbursement amount of $1.05 billion in 2022, the reported fraud amount was much lower than under other plans.

A multitude of tools are applied by the United Nations health insurance administrators to detect and prevent fraud, from cash payment limits to random sampling of claims to the use of indicators to flag possible fraud. In the case of the four self-administered plans, the policyholders set up their own system to monitor potential fraud and devise measures to minimize fraud risks, while schemes administered externally rely on the third-party administrator or insurer to do so.

Active staff who are found to have committed health insurance fraud through their organization's investigation system face different disciplinary actions depending on the organization, which are not always based on the principle of proportionality to the gravity of the misconduct.

Cost containment

Most plan administrators do not have a clear plan of action on cost containment. Third-party administrators or insurers do not usually report on the financial savings (or costs avoided) as a result of their cost-containment measures. Moreover, the review did not find evidence that there had been any tangible results from the 2018 recommendation of the inter-agency Working Group on After-Service Health Insurance that "all avenues of health insurance cost containment [are] to be explored in the context of inter-agency discussions under the auspices of the High-Level Committee on Management" or even that such system-wide inter-agency collaboration had taken place.

As more engagement from sponsoring organizations is needed, the reinforcement of the role of their audit function in cost containment, fraud detection and overall improvement of health insurance policies and practices is suggested.

Procurement

Apart from existing and historic inter-agency collaboration on joint procurement, such as cooperation between the administrators of the Medical Insurance Plans, there have been limited inter-agency collaboration, exchanges of good practices and lessons on procurement in health insurance and administration since the Working Group on After-Service Health Insurance recommended that the United Nations system organizations

[2] [(medical expenses + administrative expenses) x100/contributions]
[3] [medical expenses x100/contributions]

collectively negotiated with providers of such services and considered aligning their requirements for third-party administrators to best practices; such practices included achieving harmonization on various key aspects, such as key performance indicators, pricing methodology, reporting and controls and audits. In interviews, several plan administrators highlighted the difficulties of such an endeavour owing to the lack of in-house expertise and access to good examples from other organizations.

Adequacy and quality of services

The review conducted a large-scale online survey between 4 May and 20 June 2023, which, ultimately, received responses from 23,163 people, representing 14.7 per cent of the total number of insured active and retired staff members. The survey asked for the respondents' perceptions on: (a) the extent to which their health insurance scheme has met their health-care needs; (b) access to health care and other related services at their duty station or place of residence; and (c) the quality and effectiveness of the administration of their health insurance scheme.

Of the 11 areas of coverage enquired about in the survey, hospitalization, outpatient care and preventive care were rated the highest as most often "fully" or "mostly" meeting the needs of the respondents. On the other hand, long-term care, mental health care[4] and optical care received the lowest number of positive responses, coupled with other areas deserving of particular attention, such as outpatient care for locally recruited staff, conditions related to physical disabilities and medications for chronic illnesses, physical therapy, routine health check-ups, dental care and reproductive health care.

The respondents' level of agreement with the effectiveness of the claim dispute resolution mechanism varies considerably between schemes. Only 43–51 per cent of the respondents insured under the United Nations Secretariat's United States-based plans, the Medical Insurance Plans of UNHCR and the United Nations Office for Project Services (UNOPS), and the United Nations Staff Mutual Insurance Society against Sickness and Accident plan of the United Nations Office at Geneva agreed that their claim dispute resolution mechanisms[5] were effective, compared with 94 per cent of the respondents insured under the UNWTO plan and 83 per cent of the respondents under the IAEA plan. Over 80 per cent of the respondents were satisfied with the ease of submission of claims, but the level of satisfaction with the accuracy in processing claims varied between plans, even when the third-party administrator is the same for different plans.

About 67 per cent of the respondents were satisfied with the speed at which they received their reimbursements, with locally recruited respondents being significantly less satisfied (63 per cent) than their internationally recruited counterparts (73 per cent). Comparing plans, respondents insured under the UNHCR Medical Insurance Plan were the least satisfied (34 per cent).

Disclosure, funding and budgetary implications of after-service health insurance liabilities

The introduction of the International Public Sector Accounting Standards (IPSAS) as the accounting standard for the United Nations system organizations has been a major step forward in terms of the comprehensiveness and transparency of their financial statements and, in particular, of the visibility of liabilities associated with the right to post-retirement health care for staff members, which is acquired progressively during their working lives. However, as important as this is, the recognition of the liabilities is insufficient in view of the persistent lack of funding.

[4] See also "Review of mental health and well-being policies and practices in United Nations system organizations" for a comprehensive study of related policies and practices (JIU/REP/2023/4).

[5] For a comprehensive analysis of the formal dispute resolution mechanisms in the JIU participating organizations, see "Review of the internal pre-tribunal-stage appeal mechanisms available to staff of the United Nations system organizations" (JIU/REP/2023/2).

A system-wide common valuation approach was developed in 2018 to ensure consistency across organizations in determining long-term after-service health insurance liabilities. In addition to some plan-specific assumptions, most JIU participating organizations follow the same set of basic actuarial assumptions to determine their respective after-service health insurance liability, which allows for meaningful comparison in the accounting for the liabilities across the system and externally.

As at December 2021, after-service health insurance liabilities amounted to $20.3 billion, with 5 participating organizations accounting for two-thirds of the total and 11 for 90 per cent. More than a quarter of the total liability belongs to the United Nations Secretariat.

Even though after-service health insurance liabilities have been on the agenda of governing bodies, the United Nations System Chief Executives Board for Coordination (CEB) and external auditors as a system-wide issue since the 1990s, funding those liabilities remains an unachieved goal, with only 31 per cent already funded. The United Nations Secretariat, ILO and WHO account for 61 per cent of the total unfunded liabilities ($14 billion), while UNDP, the United Nations Population Fund (UNFPA), UNOPS, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and WFP have their after-service health insurance liabilities fully or partially funded at a rate of around or over 85 per cent; five organizations (the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF, the United Nations Office on Drugs and Crime (UNODC), WHO and FAO) have accumulated a reserve of 40–60 per cent of their liabilities; and four (IMO, the United Nations Environment Programme (UNEP), UNHCR and WIPO) between 20 and 40 per cent. The remaining 13 participating organizations have not set aside any significant funding to this end.

The choice of the pay-as-you-accrue method is not only a matter of sound financial management or long-term financial sustainability, but also of transparency and efficiency in legislative budget discussions. There are two reasons for this: (a) not budgeting for the new portion of the long-term costs of after-service health insurance that will arise each year is tantamount to taking a cost that is inevitable out of the budget proposal and the related discussions; and (b) this lack of transparency and the misalignment of costs and programme activities create a fiscal illusion of freeing up resources for other budget programmes, shift budgetary priorities or needs from the present to the future or vice versa, or simply leave contributions below the level that would correspond to real costs (in the absence of a shift in priorities).

III. Recommendations

A. Formal recommendations

The recommendations are listed below, with the corresponding paragraph number in the present report.

Recommendation 1

The executive heads of United Nations system organizations administering a health insurance plan should ensure that, by the end of 2026, arrangements are made for the representation of all groups of plan members, including locally recruited staff in the field and retirees, in their health insurance plan management, oversight or advisory committee. (Para. 43)

Recommendation 2

The executive heads of United Nations system organizations who have not yet done so should, by the end of 2026, explore discontinuing the practice of subsidizing premiums for secondary dependent family members, non-dependent family members and

unrelated household members, and the practice of mutualizing their risks with those of primary members. (Para. 59)

Recommendation 3

The executive heads of United Nations system organizations who have not yet done so should, by the end of 2026, ensure that the right of family members of staff to participate in after-service health insurance is conditional on a minimum of five years of participation in a United Nations contributory health insurance scheme, without prejudice to duly justified exceptions based on life events. (Para. 68)

Recommendation 4

The General Assembly of the United Nations should request the International Civil Service Commission to propose guidelines to enhance coherence in the application of the principles of intergenerational solidarity, ability to pay and family protection in health insurance schemes co-sponsored by the United Nations common system organizations. (Para. 77)

Recommendation 5

By the end of 2026, the executive heads of United Nations system organizations who have not yet done so should ensure that the highest level of protection is given to all beneficiaries' health insurance-related data, including medical reports, prescriptions, tests and reimbursed amounts, and that the disclosure, transmission, processing and storage of health insurance-related personal data be subject to the written consent of the person concerned and any possible exception be unequivocally spelled out in relevant policies. (Para. 123)

Recommendation 6

From 2026, the executive heads of United Nations system organizations who have not yet done so should ensure that voluntary contributions cover future after-service health insurance liabilities corresponding to staff working on programmes or projects funded from such contributions as they accrue. (Para. 224)

Recommendation 7

The legislative organs and/or governing bodies of United Nations system organizations that have not yet approved a plan to fund after-service health insurance liabilities as they accrue for posts funded from assessed contributions should establish a long-term strategy to that end, at least to cover future after-service health insurance liabilities for all newly recruited staff. (Para. 234)

B. Informal recommendations

The formal recommendations are complemented by 33 informal recommendations, indicated in bold in the text, as additional suggestions to the executive heads. These soft recommendations are listed below with the corresponding paragraph number in the present report and the necessary context as appropriate.

1. (Inadequate dissemination of plan conditions adds to the inherent complexity of health insurance.) **The Inspector proposes that the United Nations system organizations administering a health insurance plan should ensure that the information about the plan's coverage and benefits, including limitations and ceilings, is made available to the public online.** (Para. 31)

2. (Mutual recognition of prior participation in health insurance schemes across the system without reservations is not always fully granted. ILO and WHO require that 5 of the 10 years required to be eligible for after-service health insurance need to be from their respective plans.) The Inspector believes that such a precaution runs counter to the need to comply with and strengthen the inter-agency mobility policy and combat ageism. **The Inspector thus recommends that this restriction be removed.** (Para. 63)

3. (On the use of an amount other than actual pensions for calculating contributions from retirees.) **The Inspector suggests that, whenever data are available, actual pensions (or a uniform proportion thereof) and not any proxy be used as the basis for calculating retirees' contributions to their respective health insurance schemes in order to better align such contributions with retirees' ability to pay.** (Para. 78)

4. (Harmonization of the number of years considered when estimating the theoretical pension on which basis the retirees' contributions are calculated as a way of reducing the share of premiums borne by the participating organizations for retirees with limited contributory participation in the plans.) **The Inspector therefore suggests that the basis for calculating contributions takes into account, apart from the ability to pay (ideally, the actual pension), the need to minimize excessive subsidies for retirees whose contributory participation in the scheme while in active service was low.** (Para. 82)

5. **The Inspector is also of the view that the entitlement to social security and, in particular, health insurance implies that, at the bare minimum, organizations shoulder no less than half the cost of the schemes.** (Para. 88)

6. (Staff members working under the same circumstances are treated differently based solely, or mostly, on their affiliation with a particular insurance scheme.) **The Inspector suggests that United Nations system organizations coordinate their efforts at the duty station level to avoid disparities in contributions and coverage to the extent possible.** (Para. 92)

7. **The Inspector suggests that the participating organizations adapt their health insurance policies and contracts to ensure that stop-loss or hardship provisions are based on the principle of equivalent financial support for all participants and that support is granted only when there is actual financial hardship in terms that are relative to the insured person's ability to pay.** (Para. 100)

8. **The Inspector suggests that the United Nations-sponsored health insurance plans provide coverage for preventive care, including routine health check-ups.** (Para. 106)

9. (Several schemes allow unspent amounts for optical devices to be carried over to the following year.) **In the Inspector's view, this practice should be replaced by an annual coverage sufficient to meet actual medical needs when they arise, thus maintaining the temporal correlation between contributions and risk coverage and avoiding beneficiaries being compelled to postpone the purchase of necessary devices until they have accumulated the maximum credit available.** (Para. 107)

10. (Within the same duty stations, the level of financial coverage varies significantly between schemes.) **The Inspector recommends that differences in ceilings within the same duty station be reduced or eliminated progressively as a matter of priority through the coordination and harmonization of policies.** (Para. 108)

11. **While, owing to their different nature, the Inspector advises against adding long-term care to health insurance policies or plans, he suggests that United Nations system organizations engage with active staff and retirees' representatives with a view to establishing a separate insurance scheme covering these types of risks and care in a coordinated and affordable manner.** (Para. 116)

12. **The Inspector recommends that a clear segregation of duties be maintained between human resources units and health insurance claims and complaints management functions to ensure the highest level of protection of health and health insurance personal data.** (Para. 121)

13. **It is suggested that whatever the type of service provision (self-administered or outsourced), organizations should strengthen their commitment to monitoring the performance of the health insurance service and that they do so in a systematic and measurable way.** (Para. 130)

14. (Customer service charters are issued by insurers or third-party administrators, not by the administration.) **The Inspector suggests that customer service charters should be**

issued and published by the organizations themselves, regardless of the way health insurance services are provided. (Para. 131)

15. (The four self-insured and self-administered plans have less comprehensive customer service-related objectives than the plans that are externally administered.) **While all of these are good examples of customer-centred objectives, the Inspector proposes that they be operationalized through relevant key performance indicators.** (Para. 132)

16. (Key performance indicators are used for performance monitoring but with varying quality and comprehensiveness.) **In the Inspector's view, these indicators constitute a good practice that should be replicated and possibly harmonized across all schemes, whatever their modality, and made part of the customer service charters, as applicable.** (Para. 133)

17. **Considering the fact that health insurance costs are co-contributed by both the active and retired staff and that health insurance is an essential element of their social security rights, it is imperative for the plan members to be provided with periodic reporting, irrespective of the entity administering the plan.** (Para. 134)

18. **The Inspector suggests that United Nations system organizations liaise with third-party administrators or insurers to request regular information on the financial performance of their plans so that they can evaluate their results and use them to promote changes to policies and contracts when appropriate.** (Para. 141)

19. (Cash payments to health service providers and pharmacies should be strictly limited to reasonable and customary amounts of the country of residence as the higher the amount, the lower their impact on fraud prevention.) **The Inspector suggests that cash limits be updated and lowered whenever possible for all kinds of health insurance.** (Para. 153)

20. (Random sampling of claims to detect fraudulent cases based on set thresholds.) **The Inspector proposes that the effectiveness of these thresholds be reviewed periodically to ensure that they are valid and yield the expected results.** (Para. 154)

21. **The Inspector suggests the use of indicators to monitor fraud risk, but indicators linking the likelihood of fraud to the salary of the beneficiary should be discontinued and replaced by others that better capture the risks considered.** (Para. 155)

22. **For self-administered schemes, the Inspector recommends that their programmes of work include a sustained emphasis on fraud prevention and detection training for staff involved in the processing of claims, and that schemes be kept up to date with, or adopt, the latest fraud detection technologies, comprising generative artificial intelligence tools.** (Para. 156)

23. (Disciplinary measures must be proportional to the gravity of the misconduct while the right to social security is upheld.) **The Inspector recommends that sanctions arising from cases of health insurance fraud, as with any other fraud or misconduct, always be graduated according to the severity of the misconduct, in line with the relevant staff regulations and rules.** (Para. 158)

24. (The Working Group on After-Service Health Insurance issued a recommendation in 2018 stating that "all avenues of health insurance cost containment to be explored in the context of inter-agency discussions under the auspices of the High-Level Committee on Management.") **The Inspector suggests that participating organizations revitalize inter-agency discussions with a view to implementing that recommendation.** (Para. 159)

25. **The Inspector recommends that audits be conducted periodically to assess, inter alia, the accuracy of eligibility records and claim adjudications, and whether the performance of the administrator meets agreed standards.** (Para. 166)

26. A good practice that the review found is the inclusion in some contracts of a clause requiring the contractor to be certified in the field of fraud risk management, as well as provisions to conduct audits of the insurer or third-party administrator's internal control systems.) **The Inspector suggests that the contractual arrangements of externally administered or insured plans be revised whenever possible to introduce such conditions and ensure that their auditing authority is exercised effectively.** (Para. 167)

27. **The Inspector proposes that participating organizations reassess their health insurance plan coverage with a view to filling the most important gaps and aligning their coverage with prevailing models in a phased and sustainable manner, always in close consultation with participants' representatives to ensure that their priorities and the financial stability of the schemes are taken into account. Areas of particular attention, according to the JIU global survey, should be: outpatient care, especially for locally recruited staff; long-term care; conditions related to physical disabilities and medications for chronic illnesses; physical therapy; routine health check-ups; dental care; optical care; mental health; and reproductive health care.** (Para. 187)

28. (The satisfaction levels with the accuracy in processing claims by third-party administrators vary considerably between plans even when the third-party administrator is the same.) **The Inspector suggests the harmonization of service-level agreements, including monitoring and reporting thereon, across the system.** (Para. 195)

29. (Locally recruited respondents to the JIU global survey are significantly less satisfied with the speed of reimbursement than their internationally recruited counterparts.) **The Inspector proposes that the organizations concerned review their policies and practices for providing advances or direct payments to expedite processes and prevent undue financial hardship for beneficiaries, in particular in emergency situations and in relation to hospitalization and long-term care.** (Para. 196)

30. (Only 52 per cent believed that their health insurance administrator was knowledgeable about coverage related to sexual orientation, gender identity, gender expression and sex characteristics.) **The Inspector believes that this points to an area for improvement in the training of staff working in client relations. He therefore suggests that administrators address this as a regular subject in their training programmes.** (Para. 201)

31. **To avoid planning in advance the use of savings as part of the after-service health insurance funding mechanism, the Inspector recommends that all possible allocations of unspent funds for after-service health insurance purposes be approved by the relevant legislative organ on an ad hoc basis.** (Para. 222)

32. (Budgetary transparency is as important as transparency in financial statements.) **It is recommended that the full and true cost of the workforce be disclosed and taken into account in each budgetary cycle when deciding on budgetary priorities.** (Para. 229)

33. (Application of the pay-as-you-accrue method is independent of any health insurance adjustments.) **The Inspector is of the view that providing for after-service health insurance liabilities as benefits accrue should not be conditional on the design and enactment of any health insurance policy changes.** (Para. 233)

Contents

Abbreviations and acronyms

CEB	United Nations System Chief Executives Board for Coordination
FAO	Food and Agriculture Organization of the United Nations
IAEA	International Atomic Energy Agency
ICAO	International Civil Aviation Organization
ILO	International Labour Organization
IMO	International Maritime Organization
IPSAS	International Public Sector Accounting Standards
ITC	International Trade Centre
ITU	International Telecommunication Union
JIU	Joint Inspection Unit
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UN-Habitat	United Nations Human Settlements Programme
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
UNWTO	World Tourism Organization
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
UPU	Universal Postal Union
WFP	World Food Programme
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WMO	World Meteorological Organization

Glossary of key terms

Anti-selection	Anti-selection, also known as adverse selection, is a term used in the insurance industry to describe a situation where an individual's appetite for insurance is positively correlated with the risk of loss and the insurer is unable to allow for this correlation in the price of insurance. This can destabilize the insurance pool and lead to higher premiums for all policyholders.
Co-insurance	Co-insurance is a percentage of medical services received that must be borne by the insured person (e.g. 20 per cent of the consultation fee).
Commercially insured scheme	A commercially insured scheme is a plan in which risks and administration have been outsourced to a private insurance company. Commercial health insurance plans are structured as a preferred provider organization, a health maintenance organization or a combination of both modalities. The main difference between these two types of plans is that a health maintenance organization requires patients to use providers and facilities within the network if they want insurance to cover the costs, while a preferred provider organization allows patients to go outside the network.
Contribution	A contribution is the portion of the insurance premium that is paid by each party, i.e. the beneficiaries and the employing organization responsible for providing the insurance, either directly or through an external insurer.
Co-payments	Co-payments, or co-pays, are fixed amounts that beneficiaries must pay towards the cost of medical services received (e.g. $20 per consultation).
Deductible	A deductible is the amount that an insured person must pay out of pocket every year for eligible health-care services before the insurance plan begins to cover the costs.
Out-of-pocket expenses	Out-of-pocket expenses are expenses for medical care that are not reimbursed by a health insurance scheme. This usually includes deductibles, co-insurance and co-payments.
Premium	A premium is the cost of insurance coverage, which includes contributions from employers, employees and retirees.
Self-insured scheme	Self-insured health insurance is a type of plan in which the employer assumes the financial risk for providing health-care benefits to its employees.
Third-party administrator	A third-party administrator is an entity that processes insurance claims and handles the day-to-day administration of self-insured plans, including customer service.

I. Introduction

A. Context

1. Rationale

1. **Health insurance and its financing as a system-wide concern.** The review of the quality, effectiveness, efficiency and sustainability of health insurance schemes in the United Nations system organizations has been included in the programme of work of the Joint Inspection Unit (JIU) for 2022 to address long-standing requests from the Independent Audit Advisory Committee of the United Nations Secretariat (2021), the United Nations Educational, Scientific and Cultural Organization (UNESCO) (2021), the Office of the United Nations High Commissioner for Refugees (UNHCR) (2019), the International Maritime Organization (IMO) (2018) and the World Meteorological Organization (WMO) (2018). Health insurance and its financing is a system-wide issue[1] – but not entirely a common system matter – that has been on the agenda of the United Nations system organizations on an ongoing basis over the decades and is subject to continuous adaptation as a result of demographic trends among the insured population and increasing costs stemming from technological advances and other developments in health.

2. **Staff health insurance constitutes a momentous condition of service.** Health insurance has been an essential part of the compensation package provided to the staff of United Nations system organizations since the creation of the United Nations in 1945 and even before, as in the case of the Staff Health Insurance Fund of the International Labour Organization (ILO), which was established in December 1922, before the first international labour standard on "sickness insurance" had even been adopted. However, although staff health insurance constitutes a momentous condition of service and the third most important and costly element of the total compensation package in the United Nations system, after salaries and allowances and pensions, the scope of its consideration as a "common system" matter is limited, partly because of a lack of policy coordination and common guidance that has given rise to the distinct historical development of each plan, and also because of dissimilar supply conditions for health services in different countries or duty stations and the demographic profiles of the organizations. This has resulted in a variety of health insurance schemes being adopted over time across United Nations system organizations with significant variations in their coverage, cost, eligibility criteria and the degree of solidarity and mutualization of health risks inherent in each plan.[2] This diversity of policies was recognized as an established practice rather than a goal by the International Civil Service Commission.[3]

3. **Social security: not only a staff entitlement but also a human right.** Social security was established as a basic human right in the Declaration concerning the aims and purposes of the International Labour Organization and the ILO Income Security Recommendation, 1944 (No. 67). This right is upheld in the Universal Declaration of Human Rights and in the International Covenant on Economic, Social and Cultural Rights. The World Health Organization (WHO) defines the right to health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity". This right encompasses, according to the Committee on Economic, Social and Cultural Rights, access to adequate, namely scientifically and medically appropriate, and good-quality health-care

[1] See CEB/2002/5.

[2] At its twenty-third session, held in March 1962, the Consultative Committee on Administrative Questions heard an interim report from WHO on its experience with its worldwide health insurance scheme. The Committee agreed that any organization might develop a similar scheme, but "should not make major departures from the WHO plan, so as not to prejudice the possibility of an eventual common scheme". Nonetheless, 10 years later, at a special session in July 1972, the Committee concluded that the development of a single worldwide inter-organization scheme was not practicable (see https://unsceb.org/health-insurance).

[3] "United Nations common system of salaries, allowances and benefits", February 2022, p. 13, available at https://icsc.un.org/Resources/SAD/Booklets/sabeng.pdf.

facilities and services, including medicines and equipment, without discrimination on any prohibited ground, and with contributions based on the principle of equity.[4] Consequently, the right to health goes beyond the formal availability of health insurance and calls for the effective provision of adequate physical and mental health services, irrespective of the duty station.

2. Key developments since the JIU review of United Nations system staff medical coverage in 2007

4. **An increase in the number of insured staff members and growing costs for health insurance.** The number of active and retired staff members insured under the primary health insurance schemes of JIU participating organizations grew from 84,000 people in 2004 to over 160,000 people at the end of 2022.[5] The annual cost increased from $296 million[6] in 2004 to $1.2 billion in 2022.[7] Overall, the average annual cost for the family of a United Nations staff member increased from $3,536 in 2004 (or an equivalent of $5,478 in 2022, accounting for inflation) to $7,259 in 2022, an increase of 32.5 per cent in real terms.

5. **Changes to laws and behavioural patterns influence changes to needs and demands related to health insurance.** In recent decades, the mean age of mothers at the time of birth of their first child has increased globally and people are choosing to start families later in life. In Organisation for Economic Co-operation and Development (OECD) countries, for example, between 1995 and 2016, the mean age at first birth rose by almost three years on average, from 26.0 to 28.9 years of age,[8] whereas in the United States of America, the age rose from 24.9 years in 2000 to 27.3 years in 2021.[9] This has increased the demand for fertility-related health care. In addition, more than 30 countries have legalized same-sex marriage. Many same-sex spouses are now insured under United Nations-administered health insurance schemes. The advancement of medical technology, such as the availability of telehealth and other Internet-based services, including in relation to health insurance administration, also influences policy and operational changes for health insurance schemes.

6. **The introduction of the International Public Sector Accounting Standards (IPSAS) has led to increased attention on the accrued liability arising from after-service health insurance.** The introduction of IPSAS as the accounting standard for the United Nations system organizations has been a major step forward in terms of the comprehensiveness and transparency of their financial statements and, in particular, of the visibility of liabilities associated with the right to post-retirement health care for the staff of those organizations, which is acquired progressively during their working lives. However, as important as this is, the recognition of the liabilities is insufficient in view of the persistent lack of funding, implying both a growing financial imbalance, which has a negative impact on the financial position of the organizations, and an increased budgetary risk, which, in the long term, may have an impact on the fulfilment of mandates if funds are not provided in a timely manner.

7. **The establishment of a Working Group on After-Service Health Insurance has guided key changes in policies and practices.** At the request of the General Assembly, the Finance and Budget Network of the High-level Committee on Management of the United Nations System Chief Executives Board for Coordination (CEB) established a Working Group on After-Service Health Insurance in 2015 to study after-service health insurance practices and even some major aspects of insurance policies in the United Nations system,

[4] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health.

[5] The figure from 2004 did not include plan members from UNHCR (10,170 people in 2022) and the World Tourism Organization (UNWTO) (260 people in 2022).

[6] Or an equivalent of $459 million in 2022, accounting for inflation.

[7] The 2004 figure did not include the annual costs of UNHCR ($19.6 million in 2022) and UNWTO ($1.7 million in 2022).

[8] OECD, *Society at a Glance 2019: OECD Social Indicators* (Paris, OECD Publishing, 2019).

[9] T.J. Matthews and Brady E. Hamilton, “Mean age of mother, 1970–2000”, National Vital Statistics Reports, vol. 51, No. 1 (Hyattsville, Maryland, National Center for Health Statistics, 2002); and Michelle J.K. Osterman and others, “Births: final data for 2021”, National Vital Statistics Reports, vol. 72, No. 1 (Hyattsville, Maryland, National Center for Health Statistics, 2023).

and explore options to sustainably fund after-service health insurance liabilities. Its findings and recommendations, including those related to funding modalities for after-service health insurance liabilities and standardized after-service health insurance liability valuations, offered guidance and good practices to the participating organizations, and served as benchmarks for this review.[10]

B. Objectives and scope

1. Objectives

8. **An independent assessment of health insurance schemes to find opportunities for greater efficiency.** The purpose and overall objective of the review is to provide a system-wide, comparative and independent assessment of the 26 health insurance schemes for active[11] and retired staff members of the participating organizations, focusing on their coverage and quality, effectiveness, efficiency and financial sustainability, with a view to identifying good practices and potential areas for improvement and standardization.

9. **The review is also aimed at finding opportunities for further harmonization.** Although having a single universal scheme is neither practicable nor desirable, key aspects of health insurance where greater harmonization can be achieved are explored in the review; this would enable more equitable and affordable health insurance coverage for everyone. For that purpose, in the review, insurance policies and management, including cost-containment policies and practices, are assessed, financial and budgetary perspectives are explored, and the potential for strengthening coordination and cooperation among organizations, including on staff mobility, is examined.

2. Scope and focus

10. **The review covers all JIU participating organizations.** The review was carried out on a system-wide basis and included all JIU participating organizations, namely the United Nations Secretariat, its departments and offices, the United Nations funds and programmes, other United Nations bodies and entities and the United Nations specialized agencies, as well as the International Atomic Energy Agency (IAEA).

11. **Focus on co-sponsored, primary health insurance plans administered by the participating organizations.** With regard to insurance policies, all primary health insurance plans in force at the time of preparation of the present report and administered and co-sponsored by the JIU participating organizations have been thoroughly reviewed. However, the review does not cover national schemes (Austria, Canada, the United Kingdom of Great Britain and Northern Ireland and the United States) that can be accessed by staff and retirees residing in those countries. Supplementary health insurance plans offered by some participating organizations have also been excluded from the review.

12. **Health insurance for non-staff personnel not covered by the review.** Only the insurance schemes for active and retired staff members and their eligible dependants and non-dependants are considered in this analysis. Consequently, health insurance schemes intended for non-staff personnel or staff on special leave without pay and similar situations are excluded.

13. **Time frame.** The time frame of the review spans the period between 2018 and 2022, and varies depending on the matters under consideration.

14. **Key areas of analysis.** The review is focused on the four key areas of analysis outlined in table 1.

[10] More information can be found in annex III to the present report.

[11] Active staff are those with fixed-term, continuing or temporary appointments and include both internationally and locally recruited personnel.

Table 1
Key areas of analysis in the review

Area of analysis	*Scope*
Health insurance policies	Comparative analysis of plans' modalities, coverage, exclusions, limitations, contributions and portability rights
Effectiveness and efficiency	Assessment of major aspects of the effectiveness (objectives, service charters and key performance indicators) and efficiency (financial performance, fraud prevention, cost containment and procurement)
Service quality	Analysis of clients' perceptions of coverage, access to health care and the effectiveness of the administration of their health insurance scheme
Disclosure, funding and long-term implications of after-service health insurance liabilities	Status of liability disclosure; independent valuations; harmonization of financial and demographic assumptions; funding status and sources; and long-term budgetary implications of current funding strategies

Source: Prepared by JIU.

C. Intended impact

15. **Enhanced transparency, efficiency, effectiveness, quality and sustainability.** The expected impact is an improvement in the visibility of good practices throughout the system and the introduction of substantive, organizational and management reforms aimed at increasing the transparency, efficiency, effectiveness, quality and sustainability of health insurance services provided to staff and retirees. The review also provides ideas for the further harmonization or coordination of the different modalities of health insurance provision, as well as proposals to improve the portability of health insurance rights to facilitate the inter-agency mobility of active staff.

D. Methodology

16. **Content of the report.** Following this introductory chapter, chapter II is focused on a comparative study of health insurance schemes for active and retired United Nations staff; chapter III is devoted to the analysis of the effectiveness and efficiency of such schemes, including monitoring and reporting on plan objectives, financial performance, fraud prevention and cost containment, and the procurement and management of contracts with third-party administrators and commercial insurers; chapter IV is focused on quality of service through analysis of feedback from a global staff survey conducted in 2023; and an examination and discussion of the state of disclosure, funding and long-term budgetary implications of post-retirement health insurance liabilities are provided in chapter V.

17. **Data collection methods.** In accordance with the JIU Norms and Standards and Internal Working Procedures, the present review was conducted by means of a range of qualitative and quantitative data collection methods involving different sources to ensure the consistency, validity and reliability of the findings. While the accuracy of some of the information provided by the participating organizations and gathered through interviews with the relevant functions and staff and retirees' representatives could not be verified, the team triangulated and reviewed the information collected for internal consistency and reasonableness, whenever necessary, and systematically requested further information or clarifications where appropriate.

18. **Research tools.** Evidence used in the preparation of the present report was current as at 30 September 2023 and included the following:

- Desk review of relevant documents and literature**.** The team conducted a comprehensive review of relevant policy and management documents, including: all

co-sponsored health insurance policies and related contracts with external insurers or third-party administrators; reports of the Secretary-General and the Advisory Committee on Administrative and Budgetary Questions on managing after-service health insurance, and General Assembly resolutions thereon; audited financial statements and actuarial valuations of after-service health insurance liabilities submitted by the participating organizations; and varied documentation shared by the associations and representatives of staff and retirees. The team also consulted relevant documents and websites of private and public sector institutions and health insurance literature.

- Questionnaires. A corporate questionnaire requesting qualitative and quantitative data and supporting documentation was provided to all 28 JIU participating organizations. The questionnaire included 68 questions on the following five areas: (a) health insurance regulations and policies; (b) the effectiveness and efficiency of policies and their administration; (c) service quality; (d) disclosure, funding and long-term implications of after-service health insurance liabilities; and (e) follow-up information on the recommendations made by JIU in its previous report.[12]
- Global staff survey. A global survey for all serving staff and retirees benefiting from health insurance schemes sponsored by their employing organizations was prepared to obtain their feedback on key aspects of coverage, including mental health, gender-affirming care and the coronavirus disease (COVID-19), as well as the quality of administrative services and access to health care in their duty stations. A total of 23,163 responses was received, accounting for 14.7 per cent of the total number of active and retired staff members enrolled in the health insurance schemes reviewed.
- Interviews. Based on the responses to the corporate questionnaire, from February to August 2023, the team conducted a total of 48 interviews (16 in-person and 32 virtual) with 147 people representing the participating organizations that administer the health insurance schemes within the United Nations system, the relevant staff and retirees associations, the International Civil Service Commission and the United Nations Joint Staff Pension Fund.
- Follow-up requests for information on, inter alia, demographics and the financial performance of plans were sent to plan administrators after the interviews to enable them to complete the required information.
- Case studies. As part of the review, case studies were conducted to compare the size of contributions to health insurance premiums as a percentage of the salaries of staff who are at the same grade and step in the same duty stations but insured under different health insurance plans. Six duty stations (Bangkok, Brasilia, Cairo, Geneva, Juba and Nairobi) were chosen for the case studies.

19. **Internal peer review and external quality control.** In accordance with article 11.2 of the Statute of the Joint Inspection Unit and for quality assurance purposes, the draft report was subjected to an internal peer review in order to obtain comments from all JIU inspectors to test the recommendations against the collective wisdom of the Unit. The revised report was then circulated to the organizations reviewed to allow them to correct any factual errors and provide comments on the findings, conclusions and recommendations. The report was finalized taking into consideration all the comments received, although the final responsibility for the review rests solely with the author.

20. **Limitations.** Owing to the unavailability of the required survey tool, which was being replaced by another platform at the time the survey was scheduled to be launched, the survey had to be postponed several times. The progress of the project was also hindered by the intermittent unavailability of key human resources from its inception in May 2022 to the end of December of the same year.

21. **Ethical safeguards.** The review was conducted in accordance with the JIU Statute and its internal regulations. Due consideration was given to protecting the confidentiality of the stakeholders who responded to the corporate questionnaire, participated in interviews and

[12] JIU/REP/2007/2.

filled out the online survey. In fulfilling its professional and ethical obligations, the team was not subject to any external influence that could have affected its independence, fairness, neutrality or professional integrity during the planning, execution and drafting phases of the present report.

22. **Recommendations.** The present report contains seven formal recommendations, of which two (recommendations 4 and 7) are addressed to the legislative organs and governing bodies, and five are to the executive heads of the JIU participating organizations. The timely and effective implementation of the recommendations addressed to the executive heads would be greatly facilitated by the explicit support of the legislative organs and governing bodies, and their follow-up with the said executive heads to verify implementation. The formal recommendations are complemented by 33 informal recommendations, which are suggestions for effecting further improvements and are indicated in bold in the report. To facilitate the handling of the report, as well as the implementation of the recommendations and the monitoring thereof, annex IV provides an indication of whether the recommendations are for action or for information only.

23. **Acknowledgements.** The Inspector and the team wish to express their appreciation to all the officials of the United Nations system organizations and representatives of active staff and retirees associations and other organizations who assisted with the preparation of this report, particularly those who provided responses to the corporate questionnaire and the online survey and participated in the interviews and the preparation of responses to follow-up requests for information, willingly sharing their knowledge, expertise and views.

II. Comparative study of health insurance schemes for active and retired staff

24. Key findings from a comparative study of the 26 health insurance schemes for active and retired staff administered by the JIU participating organizations are presented in this chapter, with the aim of highlighting the similarities and differences among these schemes and, where relevant, identifying any possible shortcomings and opportunities to enhance transparency, coordination and cooperation, coherence and harmonization, and efficiency. Section A concerns the relevant policies within the JIU participating organizations that govern the provision of staff health insurance benefits; an overview of how these health insurance schemes are arranged and administered is provided in section B; section C contains an examination of the eligibility criteria for active staff and for after-service health insurance, including the eligibility of dependants, family members and other associated persons; a review of the shares of contributions to the health insurance premiums of the plan members and their organizations is provided in section D; and the health insurance benefits and coverage offered by all plans are compared in section E.

25. In conducting the analysis that follows, findings are assessed against, inter alia, the three broad tenets enshrined in the United Nations common system, namely, the need to: (a) avoid serious discrepancies in terms and conditions of employment; (b) avoid competition in recruitment of personnel; and (c) facilitate the interchange of personnel among common system organizations.[13]

A. Health insurance policies and their alignment with staff regulations

26. **The governing bodies and legislative organs remain largely inactive in health insurance policymaking.** The organizations in the United Nations system have an obligation to establish a social security scheme for their staff, including provision for health protection, as enshrined in their respective staff regulations and other legal instruments. However, in all but one case, regulations are limited to the recognition of the right to social security and the delegation to the executive heads of the organizations of full authority to establish relevant health insurance policies, as in the case, for example, of United Nations Staff Regulation 6.2,[14] which merely states that "the Secretary-General shall establish a scheme of social security for the staff, including provisions for health protection".[15]

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[13] See https://www.un.org/Depts/OHRM/salaries_allowances/common.htm.

[14] ST/SGB/2018/1. The organizations that apply the Staff Regulations and Rules of the United Nations are the International Trade Centre (ITC), the United Nations Conference on Trade and Development (UNCTAD), the United Nations Development Programme (UNDP), the United Nations Environment Programme (UNEP), the United Nations Population Fund (UNFPA), the United Nations Human Settlements Programme (UN-Habitat), UNHCR, the United Nations Children's Fund (UNICEF), the United Nations Office on Drugs and Crime (UNODC), the United Nations Office for Project Services (UNOPS) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women).

[15] Similar content can be found in other legal instruments regulating the right to social security in the participating organizations that do not apply the Staff Regulations and Rules of the United Nations, such as the Food and Agriculture Organization of the United Nations (FAO) ("The Director-General shall establish a scheme of social security for the staff and eligible retirees and their dependants recognized by the Organization, including provisions for health protection"); ILO ("The objective of the Staff Health Insurance Fund of the International Labour Office (ILO) … shall be to provide, to the extent prescribed by these Regulations and by the Administrative Rules made thereunder, reimbursement of the expenses which may be incurred for health protection – including medical care in case of illness, accident and maternity and personal preventive care – by persons protected by the Fund."); IMO ("The Secretary-General shall establish a scheme of social security for the staff, including provisions for health protection"); the International Telecommunication Union (ITU) ("The Secretary-General shall establish a scheme of social security for the staff … including provisions for health protection"); UNESCO ("The Director-General shall operate a system of social security for the staff, including provisions for the preservation of health"); the United Nations Industrial Development Organization (UNIDO) ("The Director-General shall establish a scheme of social security for the staff, including provisions for health insurance"); UNWTO ("health insurance scheme shall be

27. **As a result, a great variety of plans still coexist.** The Inspector notes that United Nations regulation 6.2 and the equivalent regulations of the other JIU participating organizations only present a broad commitment from the organizations to provide health protection. As such, the right to social security can be put into effect in many different ways and to varying degrees. This has resulted in the existence of 26 different health insurance schemes in the JIU participating organizations, as already noted by the Unit in its previous report on the subject,[16] in which it already underscored a "lack of oversight by Member States in establishing health insurance schemes across the system", in stark contrast with the role Member States play "in determining the salary scales and other benefits including pensions".

28. **Divergence between plans is not always based on compelling reasons.** A common argument against a one-size-fits-all approach to a United Nations-wide health insurance scheme is that the organizations of the United Nations system have different mandates, operate in different geographical areas, and their staff (and retirees) have different risk profiles and health-care needs, which would call for differentiated eligibility criteria and coverage, and thus differentiated premiums and contributions. Although in some cases compelling reasons to do so (for instance, the cost and availability of health care vary greatly across duty stations or places of residence) were found during the review, in others, it was not possible to find them, as the only reason given by interviewees was that the differences were a result of the divergent paths taken by the schemes over time. This is very likely because of a lack of coordinated system-wide guidance, in other words, the lack of control by Member States in establishing such policies across the system, which was noted by JIU in 2007. An exceptional case worth noting in this regard is that of IAEA, under whose staff regulation 8.03 the Director General must request "the approval of the Board of Governors" in establishing a scheme of health insurance for IAEA staff.[17]

29. **Commendable efforts to harmonize or coordinate some aspects of health insurance plans can be found, but more can be done.** The United Nations Secretariat, the United Nations Development Programme (UNDP), UNHCR and the United Nations Children's Fund (UNICEF) meet regularly through a working group to discuss possible harmonization of their Medical Insurance Plans. Similarly, the Geneva-based self-insured plan administrators – ILO, the United Nations Office at Geneva and WHO – work together on a regular basis to negotiate preferential prices with health service providers in Geneva and share information about any changes in health insurance policies, whereas the International Telecommunication Union (ITU) recently joined the United Nations Office at Geneva plan and discontinued its own commercially insured plan. For their part, the Vienna-based organizations – IAEA, the United Nations Office at Vienna/the United Nations Office on Drugs and Crime (UNODC) and the United Nations Industrial Development Organization (UNIDO) – discussed and shared their experiences of administering full-commercial plans, albeit not systematically. On the other hand, since the previous JIU review on the topic in 2007, four new health insurance plans have been launched, creating further divergences. One is a new plan at the Food and Agriculture Organization of the United Nations (FAO) that was designed for its locally recruited staff in the field, and two are from the World Food Programme (WFP), which has decided to leave the two FAO-administered plans and start its own. The United Nations Office for Project Services (UNOPS) has also designed its own

arranged by the Secretary-General with a reputable insurance company, including provisions for health protection"); the Universal Postal Union (UPU) (" Subject to the conditions provided in the Staff Rules, the Director General shall establish a scheme of social security for the staff members, including provisions for health protection"); WHO ("the Director-General shall establish a scheme of social security for the staff, including provisions for health protection"); the World Intellectual Property Organization (WIPO) ("In addition to the provision made pursuant to Regulation 6.1, the Director General shall establish a scheme of social security for staff members and other WIPO employees designated by the International Bureau, which shall provide in particular for health protection"); and WMO ("The Secretary-General shall establish a scheme of social security for the staff, including provisions for health protection").

[16] JIU/REP/2007/2.

[17] IAEA staff regulation 8.03 states that: "The Director General may, with the approval of the Board of Governors, establish, either by a fund financed by the Agency or by contracting with a commercial organization, a scheme of insurance for medical and hospital expenses for staff members who may not be covered by any other scheme of health insurance. Membership in such an Agency scheme may be made compulsory for all staff members, who may also be required to contribute all or part of its costs."

Medical Insurance Plan for locally recruited staff in the field, leaving the UNDP Medical Insurance Plan.

30. **A minimum set of principles, requirements or standards for the United Nations-sponsored health insurance scheme is absent.** The Inspector recognizes that having one health insurance scheme for the United Nations system is not feasible at the present time and could not be effective or adequate to meet the differing needs or preferences of the staff. However, there is no minimum set of principles, requirements or standards to determine the adequacy of a health insurance scheme. Such guidance would not only assist policy design and enhance coherence, but would also help to determine whether the existing 26 health insurance schemes adequately fulfil the commitment made under the relevant – albeit brief and often concise – regulations and rules. Through a comparative analysis of the key aspects of these health insurance schemes, including eligibility criteria, level of benefits and coverage, and premium-setting rules, in this review attention is drawn to both the consistencies and divergences between these schemes that could make it possible to understand their differences and support further harmonization, if found to be feasible[18] and advisable.

31. **The inadequate dissemination of plan conditions adds to the inherent complexity of health insurance.** Besides the commitment to provide health-care protection to staff, the Inspector found that detailed and easy-to-understand information on most health insurance schemes is not readily available to the public. Prospective staff may not realize that the level of coverage and benefits of the health insurance scheme to be received as part of their compensation package may not adequately meet their needs and those of their dependants. For the participating organizations, this inhibits any effort to compare and improve their health insurance schemes, hindering possible harmonization. Among the 26 health insurance schemes under review, only the 9 schemes administered by ILO, the United Nations Secretariat, UNDP and the World Intellectual Property Organization (WIPO) are available online. **Therefore, the Inspector proposes that the United Nations system organizations administering a health insurance plan should ensure that the information about the plan's coverage and benefits, including limitations and ceilings, is made available to the public online.**

B. Plan modality, administration and governance

1. Plan modality and claims management

32. **Three modalities of insurance and administration exist.** The 26 health insurance schemes in the United Nations system can be categorized by the entity that assumes the associated financial risks and by the entity that processes claims and reimbursements. The former is used to distinguish between self-insured and externally insured schemes, while the latter refers to self-administered schemes, in which the entire health insurance service is managed by the organization itself, and third party-administered schemes, in which an external company is engaged to provide administrative services, such as: processing enrolment, disenrolment and beneficiary variations; managing claims and reimbursements; providing information to the policyholder (the organization) on the overall management, control and results of the scheme; and providing access to their network of health-care providers. The modalities of service provision are as follows:

- Self-insured and self-administered plans.
- Self-insured and externally administered schemes.
- Externally insured schemes, which always involve external administration, normally by the underwriter.

33. **The vast majority of the insured population is under self-insured plans.** Half of the health insurance schemes within the United Nations are self-insured or captive schemes, in which the organizations underwrite all the risks related to health-care costs, which is usually cheaper and more efficient. In addition, self-insured schemes are not profit-oriented

[18] The degrees of freedom in the formulation of health insurance policies are always limited because of the legal risks associated with the potential impact of changes on the acquired rights of participants (A/68/353, paras. 59 ff; A/68/550, para. 22; and A/70/590, paras. 29 ff).

plans and, therefore, they do not have to provide financial returns for the performance of the insurance activity, which externally administered schemes would need to do. The self-insured schemes have a total of 365,303 beneficiaries, 82 per cent of the entire insured population covered by the 26 reviewed plans (447,869 people)[19] in the United Nations system organizations.

34. **In the United Nations Secretariat, 99 per cent of staff and retirees are covered by self-insured plans.** Within the United Nations Secretariat, three entities manage their own plans, namely: the United Nations Secretariat in New York, with all its five self-insured and externally administered plans (148,899 clients); the United Nations Office at Geneva, which operates the second biggest self-insured, self-administered plan in the system, with more than 36,000 members; and the United Nations Office at Vienna/UNODC, whose plan, serving 2,710 beneficiaries, is outsourced.[20]

35. **Self-insured plans are generally larger than outsourced ones.** The self-insured schemes tend to be larger in size; 11 of the 13 such schemes have over 10,000 plan members each, and 9 have over 25,000, which is mostly because of the need to have sufficient critical mass both to adequately manage risks and, for the self-administered plans, to be able to absorb the cost of plan administration. In absolute numbers, the largest scheme is the United Nations Secretariat's United Nations Worldwide Plan (61,665 plan members), which is administered by Cigna.[21]

36. **Outsourcing is the prevailing mode of administration, even for self-insured schemes.** The population covered by externally administered schemes represents 72 per cent of the entire protected population. Conversely, just over a quarter of the insured persons are under one of the existing four self-administered (and therefore, self-insured) plans, all of which [22] are headquartered in Geneva and have a large clientele, ranging from 13,000 beneficiaries at ILO to more than 41,000 at WHO. The biggest single entity in terms of the population covered by its plans is the United Nations Secretariat in New York, with 148,899 people protected (33 per cent of the total) under five plans, all of which are self-insured and third party-administered.

37. **Commercially insured plans tend to be smaller in size.** With the exception of the WFP Medical Insurance Coverage Scheme, with over 40,000 members, and the FAO Basic Medical Insurance Plan, with almost 16,000 users, the fully commercially insured schemes, under which 82,566 people (18 per cent of the total) are protected, tend to be smaller in size, with an average of 6,353 members. Of these 13 outsourced plans, 9 have fewer than 5,000 members, and 6 have 1,000 or fewer. The main reason why these plans are externally insured is their size and their insufficient critical mass for risk-pooling, which may lead, inter alia, to an inability to cope with possible financial tensions from annual variations in expenditure owing to unexpected morbidity or exceptionally expensive claims.

38. **Some organizations feature more than one plan, while others subscribe to plans established by others.** Of the JIU participating organizations, only 17 are the policyholders of health insurance schemes,[23] while the remaining 11 organizations[24] have their staff and retirees protected under one of the nine schemes that also cover members from other

[19] The number of plan members insured under the United Nations Secretariat's Cigna Dental plan is not included to avoid double counting.

[20] UNIDO is the policyholder.

[21] Overall, Cigna administers 17 of the 26 plans, comprising 307,512 people, 64 per cent of the total. For 10 of those plans, Cigna is also the insurer.

[22] The ILO Staff Health Insurance Fund, the United Nations Office at Geneva United Nations Staff Mutual Insurance Society, the UNHCR Medical Insurance Plan and the WHO Staff Health Insurance.

[23] FAO, IAEA, the International Civil Aviation Organization (ICAO), ILO, IMO, the United Nations Secretariat (including the United Nations Office at Geneva), UNDP, UNESCO, UNHCR, UNICEF, UNIDO, UNOPS, UNWTO, UPU, WFP, WHO and WIPO.

[24] ITC, ITU, the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNCTAD, UNEP, UNFPA, UN-Habitat, UNODC, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), UN-Women, WMO, UNDP, UNICEF, UNHCR and UNOPS are policyholders of the health insurance plans designed for locally recruited staff outsides the headquarters location. Their internationally recruited staff are insured by the schemes administered by the United Nations Secretariat.

organizations.[25] This is a good practice, typically related to economies of scale resulting from the pooling of risks and shared administrative resources, as exemplified by ITU, whose personnel have been insured under the United Nations Staff Mutual Insurance Society against Sickness and Accident since 2020. Organizations that offer multiple insurance plans usually do so in order to cater to the specific market conditions in which they operate. For instance, the United Nations Secretariat has separate plans for insured persons within and outside the United States. Similarly, eight health insurance schemes are specifically designed for locally recruited staff outside headquarters locations.

39. The table and chart below set out the detailed distribution of the health insurance schemes of United Nations system organizations by their insurance and administration modalities.

Table 2

Modality and claim management of 26 health insurance schemes in the United Nations and the number of plan members[a]

	Self-insured		*Fully commercially insured*	
	Plan Administrator-Plan (third-party administrator)	*No. of plan members*	*Plan Administrator-Plan (third-party administrator)*	*No. of plan members*
Self-administered	**ILO** Staff Health Insurance Fund	12 984	Not applicable	
	United Nations Office at Geneva United Nations Staff Mutual Insurance Society	36 560		
	UNHCR Medical Insurance Plan	34 517		
	WHO Staff Health Insurance	41 359		
	Total beneficiaries	**125 420**		
Third party-administered	**ICAO** Medical Benefits Plan (Cigna)	3 106	**FAO** Basic Medical Insurance Plan/After Service Medical Coverage (Cigna)	15 975
	United Nations Secretariat Aetna (Aetna)	8 471	**FAO** Medical Insurance Coverage Scheme/After-Service Medical Insurance (Cigna)	501
	United Nations Secretariat Cigna Dental (Cigna)	32 813	**IAEA** Full Medical Insurance Plan/After-Service Medical Insurance Plan (Cigna)	4 326
	United Nations Secretariat Empire Blue Cross (Empire Blue Cross)	26 628	**IMO** Group Medical Plan (Cigna)	1 000
	United Nations Secretariat Medical Insurance Plan (Cigna)	52 135	**United Nations Office at Vienna/UNODC** Group Headquarters Medical Insurance (Allianz Care)	2 710
	United Nations Secretariat United Nations Worldwide Plan (Cigna)	61 665	**UNIDO** Medical Expenses Insurance for General Service Staff and National Officers in Field Duty Stations (Field General Service Plan) (Allianz Care)	403
	UNDP Medical Insurance Plan (Cigna)	36 567	**UNIDO** Group Headquarters Medical Insurance (Allianz Care)	2 187
	UNESCO Medical Benefits Fund (MSH International)	7 371	**UNOPS** Medical Insurance Plan (Cigna)	515
	UNICEF Medical Insurance Plan (Cigna)	43 940	**UNWTO** Health and Accident Insurance Plan (Cigna)	481
			UPU Health Insurance Fund (Cigna)	791
			WFP Basic Medical Insurance Plan (Cigna)	9 614
			WFP Medical Insurance Coverage Scheme (Cigna)	10 160
			WIPO Group Medical Insurance Plan (Cigna)	3 903
	Total beneficiaries	**239 883**[b]	**Total beneficiaries**	**82 566**

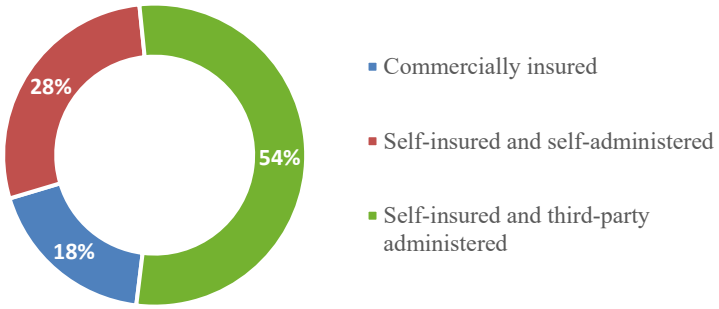
Source: Data received from the participating organizations. Table prepared by JIU.

[a] Data as at 31 December 2022.

[b] Excluding the number of plan members insured under the United Nations Secretariat's Cigna Dental scheme, as this is a supplementary plan.

[25] The United Nations Secretariat's Aetna, Cigna Dental, Empire Blue Cross, Medical Insurance Plan and United Nations Worldwide Plan, the United Nations Staff Mutual Insurance Society (administered by the United Nations Office at Geneva) and the UNDP Medical Insurance Plan.

Figure I
Percentage of the insured population covered in the United Nations system, by modality of insurance



Source: Prepared by JIU.

2. Engagement of insurance plan members in the governance of health insurance schemes

40. **The engagement of beneficiaries in policymaking and in the governance of health insurance plans is crucial.** 20 of the 26 health insurance plans have a governance and administration mechanism that enables the representatives of plan members to formally participate in policy decisions related to health insurance. Such a mechanism is organized either as a stand-alone body established to oversee the relevant health insurance plan(s), as in the case of the ILO Staff Health Insurance Fund, or as a subsidiary body of a larger joint staff-management administration mechanism, such as the United Nations Secretariat's Health and Life Insurance Committee, which is a standing advisory committee of the Joint Negotiation Committee. While their mandates and functions may vary in their details, their responsibilities usually include overseeing the financial health of the plan(s), especially in the case of self-insured schemes, ensuring compliance with the relevant rules and regulations, reviewing the overall performance and providing management with inputs related to policy changes, coverage, premium amount and procurement-related issues.

41. **Overall satisfaction with the level and scope of interactions.** The representation of plan members is either through nominations from the relevant staff and, in some cases, retirees associations or through election by plan members. Interviews with representatives of staff and retirees associations found that most were satisfied with their ability to engage with their organizations at the policy level through these mechanisms, especially with their ability to provide inputs to the decision-making process. While in several cases, representatives of retired plan members can only be observers owing to their non-staff status, the workings of most of these bodies are geared towards considering inputs from both members and observers, and towards seeking consensus, which is a good practice.

42. **Locally recruited staff and retirees outside headquarters locations are not sufficiently engaged or represented.** Since all health insurance plans are administered at the headquarters level, nominated representatives of the staff are usually those based at the headquarters location, in which case the receipt of inputs from staff outside headquarters is largely dependent on the engagement mechanism of individual staff associations. The oversight bodies of the WHO Staff Health Insurance are the only ones that guarantee the representation of staff from both the headquarters and regional offices. Otherwise, for the participating organizations with field offices, the Inspector found that staff members in the field, especially locally recruited ones, are not well represented. For example, the United Nations Secretariat's locally recruited staff outside New York who are insured under the Medical Insurance Plan are not represented on the Health and Life Insurance Committee. Similar committees at FAO and WFP, while guaranteeing seats for representatives from the FAO/WFP Union of General Service Staff, do not guarantee representation for locally recruited representatives in the field. The Medical Insurance Plans for locally recruited

UNDP[26] and UNOPS staff in the field do not have a formal mechanism to engage their plan members in the decision-making process of the plan at all. The existing governance and management mechanisms are outlined by health insurance plan in table 3.

Table 3
Formal mechanisms to engage plan members in health insurance policymaking

Health insurance plan	*Governance/ Management mechanism*	*Formal engagement of insured persons*
FAO Basic Medical Insurance Plan/After-Service Medical Coverage, Medical Insurance Coverage Scheme/After-Service Medical Insurance	FAO Advisory Committee on Medical Coverage	Nominated representatives from the associations of General Service Staff, Professional Staff and retirees
IAEA Full Medical Insurance Plan/After-Service Medical Insurance Plan	Joint Advisory Committee Sub-Committee on Health and Life Insurance	Nominated representatives of plan members by the staff association, which include representatives of retired plan members
ICAO Medical Benefits Plan	Health and Insurance Committee	Nominated representatives of both the staff and retirees associations
ILO Staff Health Insurance Fund	Management Committee	Elected representatives of the plan members, which may include representatives of retired staff
IMO Group Medical Plan	No formal mechanism	No formal engagement
United Nations Office at Geneva-United Nations Staff Mutual Insurance Society	United Nations Staff Mutual Insurance Society Executive Committee	Nominated representatives from the staff and retirees associations
United Nations Office at Vienna/UNODC Group Headquarters Medical Insurance	UNIDO/United Nations Office at Vienna Joint Advisory Committee Standing Committee on Health and Life Insurance	Nominated representative from the staff and retirees association
United Nations Secretariat Aetna, Empire Blue Cross, Cigna Dental, United Nations Worldwide Plan, Medical Insurance Plan	Health and Life Insurance Committee	Nominated representatives from the staff association Nominated representatives from the retirees association as an observer
UNDP Medical Insurance Plan	UNDP Medical Insurance Plan Board	Nominated from representatives from the staff associations of UNDP, UNFPA and UN-Women
UNESCO Medical Benefits Fund	Board of Management	Elected representatives of the insured persons, which may include retired staff members; nominated representatives from the staff and retirees associations as observers; insured persons also engaged through an annual General Assembly
UNHCR Medical Insurance Plan	Management Committee of the Medical Insurance Plan	Nominated representative from the staff association
UNICEF Medical Insurance Plan	UNICEF Medical Insurance Plan Committee	Nominated representatives from the staff association

[26] The UNDP Medical Insurance Plan also includes UNFPA and UN-Women locally recruited staff in the field.

Health insurance plan	*Governance/ Management mechanism*	*Formal engagement of insured persons*
UNIDO Field General Service Plan, Group Headquarters Medical Insurance	Joint UNIDO/United Nations Office at Vienna JAC Standing Committee on Health and Life Insurance	Nominated representatives from the staff and retirees associations
UNOPS Medical Insurance Plan	No formal mechanism	No formal engagement
UNWTO Health and Accident Insurance Plan	No formal mechanism	No formal engagement
UPU Health Insurance Fund	Ad hoc Working Group	Representatives from the staff association engaged with changes to be made to the health insurance policy, such as during the tendering process
WFP Basic Medical Insurance Plan, Medical Insurance Coverage Scheme	WFP Health Insurance Board	Nominated representatives from the three recognized staff representative bodies: associations of General Service Staff, Professional Staff and retirees
WHO Staff Health Insurance	Staff Health Insurance Global Oversight Committee	Nominated representatives from the headquarters and regional staff committees; members elected by retired plan members
	Staff Health Insurance Global Standing Committee	Nominated representatives from the headquarters and regional staff committees; members elected by retired plan members
WIPO Group Medical Insurance Plan	Collective Staff Insurance Management Committee	Nominated representatives from the staff association, including both active and retired staff members

Source: Prepared by JIU.

43. The following recommendation is expected to enhance the effectiveness of the decision-making processes related to health insurance policy and management control to ensure that the needs of different groups of plan members are formally taken into account in the policymaking process.

Recommendation 1

The executive heads of United Nations system organizations administering a health insurance plan should ensure that, by the end of 2026, arrangements are made for the representation of all groups of plan members, including locally recruited staff in the field and retirees, in their health insurance plan management, oversight or advisory committee.

C. Eligibility criteria

44. **Inequalities in access to health insurance remain an issue.** The 26 health insurance schemes apply varying eligibility criteria for staff, retirees and their family members, and associated or specially protected persons, as outlined in this section. The different eligibility criteria, especially for those receiving subsidized premium rates from their organizations, create inequitable access to health insurance coverage among active and retired staff and their family members and demonstrate an inequitable use of public funding by the organizations in the United Nations system.

1. Eligibility criteria for active staff

45. **Health insurance packages often depend on contractual modalities and duty stations.** Most participating organizations offer a specific health insurance package to their active staff based on their contractual status, whether they are internationally or locally recruited, their duty station and whether they are at the headquarters location or outside. The table in annex I outlines the eligibility criteria for active staff based on their contract type and location.

46. **Exceptions to mandatory enrolment do not apply to locally recruited staff.** Enrolment in the organization's health insurance schemes is mandatory at most participating organizations. Some of them, such as the United Nations Office at Geneva United Nations Staff Mutual Insurance Society, grant an exemption for staff members who can prove that they have adequate health insurance coverage through another scheme, whether public or private. However, such exemptions are not available for the schemes that are designed specifically for locally recruited staff, such as the Medical Insurance Plans of the United Nations Secretariat, UNDP, UNHCR and UNICEF.[27] Under these schemes, staff enrolment is mandatory, automatic and irrevocable.

47. **National schemes are available in London, Montreal and Vienna.** In those three duty stations, active staff have access to national health insurance schemes. In Vienna, staff are able to opt out of their organization's health insurance scheme and enrol in the national scheme (Östereichische Gesundheitskasse), where the participating costs are subsidized by their organizations (IAEA, UNIDO, UNODC and the United Nations Office at Vienna). In Montreal, Canadian residents can also opt out of the ICAO scheme if enrolling in the Quebec Health Insurance Plan. At IMO, staff are automatically enrolled in the National Health Service of the United Kingdom, whose coverage could be used as to complement the IMO health insurance plan.

48. **The review found no eligibility limitations based on previous or existing health conditions.** The eligibility criteria for each plan are inclusive of active staff members regardless of their pre-existing health conditions, health habits and gender, which is a good practice.

2. Eligibility criteria for family members and associates of active staff

49. **The eligibility of family and household members varies considerably among plans.** Staff members can enrol their family members in all 26 schemes and, in some cases, other persons associated with them under the same scheme, mostly on an optional basis. The eligibility criteria vary considerably, especially regarding whether these associated members would also be entitled to a subsidy for the premiums from their organization.

50. **Most plans subsidize premiums for non-dependent spouses.** All health insurance schemes except six subsidize the health insurance premium of one recognized spouse of the staff member in the same scheme, regardless of their dependency status. The six schemes that offer subsidized premiums to recognized dependent spouses only are those administered by IAEA, ILO, the United Nations Office at Geneva, UNESCO, the United Nations World Tourism Organization (UNWTO) and the Universal Postal Union (UPU). However, non-dependent spouses are eligible to enrol without organizational subsidies under the IAEA, ILO, United Nations Office at Geneva, UNWTO and UPU schemes. UNESCO does not offer a full-paying option. Divorced or legally separated spouses are eligible to continue to enrol in the IAEA scheme with a subsidized premium, but they are required to prove their dependency status. Under the WHO scheme, only the divorced spouses of retired members are eligible to continue to enrol.

51. **Dependent spouses from the legally recognized same-sex marriages of ITU staff members are not eligible to enrol in its health insurance plan.** On 26 June 2014, the Secretary-General of the United Nations issued a bulletin[28] stating that the personal status of staff members, for the purpose of entitlements under the Staff Regulations and Rules, is to

[27] For Medical Insurance Plans, a waiver of participation can be granted to specific duty stations.
[28] ST/SGB/2004/13/Rev.1.

be determined by reference to the law of the competent authority under which the personal status has been established. This means that a same-sex spouse of a staff member is to be recognized if the marriage (or union) is legally recognized by the staff member's country of nationality or the country where the marriage or union was concluded. Depending on the eligibility criteria of a particular health insurance plan, a dependent or non-dependent spouse from a recognized same-sex marriage or union should be able to enrol in the plan and, if eligible, receive organizational subsidies for the premiums. The review found that ITU is the only participating organization that does not recognize spouses of staff members from same-sex marriages or unions, even if the marriages are legally recognized.[29] This results in the dependent spouses not being able to enrol in the health insurance plan offered and subsidized by the organization (which, in the case of ITU, is the United Nations Office at Geneva plan). Other participating organizations that enrol their staff in the United Nations Office at Geneva plan, such as the United Nations Secretariat, UNHCR and WMO, recognize and allow the enrolment of dependent same-sex spouses whose marriages or unions are legally recognized. In 2022, the ITU Secretary-General proposed to the ITU Council that the Staff Regulations be amended[30] to allow the recognition of domestic partnerships in line with the 2014 bulletin of the Secretary-General of the United Nations. However, the Council did not reach a consensus and the ITU Secretariat was requested to further consult with Member States and report back at a future session of the Council.

52. **Different eligibility age limits apply to dependent children from 18 to 30 years of age.** The dependent children of a staff member are eligible to enrol in the same health insurance scheme and receive organizational subsidies. The criteria for a dependent child are similar across the participating organizations, which recognize a child under 18 years of age, or under 21 years of age if in full-time attendance at an educational institution, or with no age limit if physically or mentally incapacitated to work under most plans. However, all but four schemes allow children older than 21 years of age (without a disability) to enrol and receive organizational subsidies, with differing upper age limits ranging from 25 to 28 years of age, provided that they are dependent, i.e. unemployed and unmarried. The age limit of 25 years is associated with the upper age limit for the provision of education grants. Other age limits beyond 25 years of age are not associated with any of the existing benefits or allowances and exist only in the context of the eligibility criteria for health insurance. The different age limits of children eligible to enrol in the subsidized health insurance applied by the participating organizations are shown in table 4.

Table 4
Age limits of the children of a staff member or retired staff member who are eligible to enrol in the same health insurance scheme and receive organizational subsidies

Age limit of children (years)	*Policyholders of health insurance schemes*
Up to 21	IAEA, ICAO, ILO, United Nations Office at Geneva, UNWTO
Up to 25	ICAO, IMO, United Nations Secretariat, UNDP, UNESCO, UNHCR, UNICEF, UNIDO, UNODC, UNOPS, United Nations Office at Vienna, UPU, WIPO
Up to 26	FAO, WFP
Up to 28	WHO

Source: Prepared by JIU.

[29] In ILO Administrative Tribunal Judgment No. 2643, 27 April 2007, it is cited that the ITU Staff Regulations and Staff Rules explicitly define "spouses" as denoting husband and wife. The Tribunal then recommended that the matter of recognition of domestic partnerships be referred to the ITU Council, with a view of the amendment of the rules "so as to afford the requisite protection against any form of discrimination based on family status and sexual orientation". See https://www.ilo.org/dyn/triblex/triblexmain.fullText?p_lang=en&p_judgment_no=2643&p_language_code=EN.

[30] "Report by the Secretary-General: personal status for the purpose of ITU entitlements", document C22/47-E, available at https://www.itu.int/md/S22-CL-C-0047/en.

53. **Non-dependent children are also eligible, subject to varying upper age limits and other conditions.** The schemes that offer subsidized premiums to dependent children up to the age of 21 years allow children to enrol after this age but without organizational subsidies, provided that the children are unemployed and unmarried; this is a good practice. However, the upper age limits under this practice vary. IAEA, ILO and the United Nations Office at Geneva allow children to enrol up to the age of 30 years, while UNWTO allows them to enrol up to the age of 25 years. The United Nations Office at Vienna and UNODC do not impose any age limit on children over 25 years of age, so long as they remain unemployed, unmarried and financially dependent on the active or retired staff members.

54. **The review found no eligibility limitations based on previous or existing health conditions.** The eligibility criteria for each plan are inclusive of dependants regardless of their pre-existing health conditions, health habits and gender so long as they enrol within the time frame required.

55. **Secondary dependants are eligible, with or without a subsidy, in nine plans.** Of the 26 health insurance schemes, 9 allow one secondary dependant to enrol in the same scheme as the active staff member with a subsidized premium. These are the schemes of FAO, IAEA, UNIDO, UNODC, the United Nations Office at Vienna, WFP, WHO and WIPO. The definition of secondary dependants is similar across these schemes; it refers to a parent or a sibling who receives more than half of the total financial support from the staff member, compared with other sources, and the amount provided by the staff member is more than twice the amount of the dependency allowance. Only one secondary dependant is recognized at a given time and this is only the case in the absence of a recognized dependent spouse. The schemes of ILO, the United Nations Office at Geneva and UNWTO allow secondary dependants to enrol with unsubsidized premiums. With the exception of the Medical Insurance Coverage Schemes under FAO and WFP, none of the health insurance schemes exclusively designed for locally recruited staff outside headquarters locations allow the enrolment of secondary dependants.

56. **Vienna-based organizations allow the enrolment of non-family household members.** Besides the family members of active and retired staff, IAEA allows up to two people residing in the same household to enrol, but without subsidies. Similarly, the United Nations Office at Vienna and UNODC allow persons who are financially dependent on the staff member, are non-Austrian and live in the staff member's household to enrol without subsidy.

57. **The enrolment of non-dependent family or household members and secondary dependants should not be subsidized and their risks should not be mutualized.** The Inspector finds the admittance of non-dependent spouses and children and secondary dependants to be a good and beneficial practice both for the staff member's family and the sustainability of the plan, if only because increasing plan membership may have a positive effect on the bargaining power of the organizations in negotiations with insurers or health providers, while making it easy and perhaps more affordable for staff members' families to get protection against health risks. What the review could not find are the reasons, based on social security principles, why health insurance premiums are subsidized for such persons under some plans, other than the historical development of the schemes over time. The Inspector, therefore, is of the view that the admission of non-dependent family or household members and secondary dependants should not be subsidized and their risks not mutualized (especially if their profile is different from the average) alongside subsidized members of the plan; this is the case under the United Nations Office at Geneva United Nations Staff Mutual Insurance Society plan, which represents, in the view of the Inspector, a best practice. By mutualizing or commingling the health risks of theoretically unsubsidized plan members with those of explicitly subsidized members, participating organizations assume the risk of subsidizing the former if their risk profile deviates from the average profile of the subsidized population owing to age or other determinants of health-care spending. On the contrary, if these individuals form a separate group, as in the case of the United Nations Staff Mutual Insurance Society, their health risks will be shared exclusively among that group, and the premiums they pay should be sufficient to cover the entire cost of the health services received by the group members in each period considered.

58. **Current asymmetries in subsidies may be considered an obstacle to staff mobility.** This is to the detriment of plans or locations where no subsidies are available for non-dependent and secondary dependent family members. Such asymmetries should be eliminated as they constitute a competitive advantage for some organizations over others, which is against the notion of a common system of entitlements for the United Nations personnel.

59. Based on the findings of the review, the following recommendation is expected to result in financial savings for plans in which secondary dependants and non-dependent family members are entitled to enrol and receive a subsidy towards their premiums, while their health risks are mutualized alongside the primary participants. It is also made to facilitate inter-agency mobility and prevent harmful competition between participating organizations based on their health insurance plans.

Recommendation 2

The executive heads of United Nations system organizations who have not yet done so should, by the end of 2026, explore discontinuing the practice of subsidizing premiums for secondary dependent family members, non-dependent family members and unrelated household members, and the practice of mutualizing their risks with those of primary members.

3. Eligibility criteria for retired staff and their associated members

60. **Differences in seniority requirements to access after-service health insurance persist for staff recruited on or after 1 July 2007.** After-service health insurance enrolment is always optional and available only as an immediate continuation of the coverage in the same contributory health insurance plan of the United Nations system in which the retiree was enrolled during active duty.[31] In its resolution 61/264, the General Assembly specified, inter alia, that to be eligible for after-service health insurance, the staff members recruited on or after 1 July 2007, upon retirement, must have participated in a United Nations health insurance plan for a minimum of 10 years. All[32] except four health insurance schemes apply this minimum requirement of contributory participation. The two schemes at FAO and WFP that are designed specifically for locally recruited staff outside their headquarters location require only five years of participation, as do the WIPO and UPU plans for all staff.

61. **Early retirement after limited contributory participation**. While the General Assembly, in its above-mentioned resolution, eliminated the buy-in provision after five years of participation, this option is still available in several schemes. This is where a staff member who separates from their organization at least at an early retirement age and who has participated in a contributory United Nations health insurance scheme for more than 5 but less than 10 years is still eligible for after-service health insurance without organization subsidy. Once the contribution reaches 10 years, the health insurance premiums will be subsidized. This option is available for staff participating in the Medical Insurance Plans of the United Nations Secretariat, UNDP, UNHCR, UNICEF and UNOPS, and the Medical Benefits Plan of the International Civil Aviation Organization (ICAO).

62. **Staff separating before early retirement age.** After-service health insurance is meant to extend health insurance coverage for United Nations staff into their retirement, including those who were separated from service, other than by summary dismissal, either with a disability benefit under the United Nations Joint Staff Pension Fund rules, at an early

[31] Depending on the organizations under which the active staff member serves, there may be an option to switch to another retirement plan more appropriate to the location of their residence. Such a change is usually a one-time event and irreversible.

[32] It is noted that while the United Nations Secretariat has incorporated this requirement into its Staff Regulations, the actual implementation has been postponed until 2024 owing to technical complexities (see A/78/7).

retirement age [33] or the normal retirement age. [34] However, in several participating organizations, staff who separate before early retirement age may also be eligible for after-service health insurance with or without an organizational subsidy. These are all offered to staff who separate between the ages of 50 and 55 years and have elected to receive a deferred pension. Only WFP and WHO specify the corresponding early retirement age based on the date of entry to duty of the staff members, which is either 55 or 58 years of age (see Table 5).

Table 5
Minimum number of years of contributory participation in a United Nations contributory health insurance scheme required for after-service health insurance for staff separating between the ages of 50 and 55 years, entering on duty on or after 1 July 2007

Minimum number of years	*Health insurance scheme*	*With organizational subsidy*
20	FAO After-Service Medical Coverage	No
20 (10 of which are continuous)	IAEA After-Service Medical Insurance Plan	Yes, from the age of 55 years
20	UNIDO Field General Service Plan	No
20 cumulative	WFP Basic Medical Insurance Plan[a]	No
20 (in the WHO plan only)	WHO Staff Health Insurance[a]	Yes, from early retirement age
15 cumulative	WFP Medical Insurance Coverage Scheme[a]	No
15 cumulative[b]	UNDP Medical Insurance Plan	Yes
10	FAO After-Service Medical Insurance (for locally recruited staff outside the Headquarters location	No
10	ICAO Medical Benefits Plan	No
5	UNDP Medical Insurance Plan	Yes, after 10 years
	UNHCR Medical Insurance Plan	
	UNOPS Medical Insurance Plan	

Source: Prepared by JIU.

[a] For those entering the United Nations Joint Staff Pension Fund after 1 January 2014, separating between the ages of 53 and 58 years.

[b] For those who were on agreed termination or abolition of post.

63. **The mutual recognition of prior participation in health insurance schemes across the system without reservations is not always fully granted.** All schemes recognize the number of years of staff participation in the contributory health insurance plans of other United Nations organizations, in line with the Inter-Organization Agreement concerning Transfer, Secondment or Loan of Staff among the Organizations applying the United Nations Common System of Salaries and Allowances, under which a "transferred staff member and his or her dependants will … be entitled to participate in any health or group life insurance arrangements of that organization without new medical reservations or waiting periods".[35]

[33] At the age of 55 years or after for staff joining the United Nations Joint Staff Pension Fund before 1 January 2014 or at the age of 58 years or after for those joining after 1 January 2014.

[34] At the age of 60 years for staff who joined the United Nations Joint Staff Pension Fund before 1 January 1990; at the age of 62 years for staff who joined between 1 January 1990 and 31 December 2013; or at the age of 65 years for staff who joined on or after 1 January 2014.

[35] See https://hr.un.org/sites/hr.un.org/files/handbook/Mobility%20Agreement_2019.pdf.

However, ILO and WHO require that 5 of the 10 years needed to be eligible for after-service health insurance need to be from their respective plans, which constitutes an objective barrier to staff inter-agency mobility,[36] which has especially intense effects when the persons involved are 60 years of age or older. It is not difficult to understand that this measure has no purpose other than to prevent the arrival in these two organizations of officials from other organizations who are in their final years of professional activity, on the assumption that accepting such mobility would be importing an undue financial burden on the part of the receiving organization in connection with the right to after-service health insurance of the staff concerned.[37] It is no coincidence that this restriction, which does not exist in all the other insurance schemes examined, is present in two of the plans with the highest and most comprehensive coverage in the system (and a relatively high share of retirees compared with staff members, as these plans are among the most long-standing in the system). The Inspector believes that such a precaution, while reasonable from a financial point of view, runs counter to the need to comply with and strengthen the inter-agency mobility policy and combat ageism, which is sponsored by WHO, among other United Nations organizations.[38] **The Inspector thus recommends that this restriction be removed.**[39]

64. **The family members of retired staff are generally eligible for after-service health insurance.** Generally, the eligible family members who are enrolled in the same health insurance scheme as staff members prior to their retirement are eligible to continue with the same plan, with the exception of secondary dependants under the plans administered by UNIDO, UNODC and the United Nations Office at Vienna.

65. **The review found no eligibility limitations based on previous conditions.** The eligibility criteria for each plan are inclusive of retired staff members and their dependants, regardless of their pre-existing health conditions, health habits and gender.

66. **Some plans do not require a minimum amount of contributory participation for family members to qualify for after-service health insurance.** In its resolution 61/264, the General Assembly introduced the condition that dependants must have participated in a United Nations contributory health insurance plan for at least five years at the time of retirement of the staff member to be eligible for subsidized after-service health insurance.[40] In total, 14 of the 26 schemes follow this prerequisite. The health insurance schemes that apply a different standard, ranging from not imposing any minimum to enforcing a requirement of 10 years, are outlined in table 6. If family members do not meet the minimum number of years needed, they can enrol for unsubsidized after-service health insurance until they meet the requirement, from which time their premium will be subsidized.

[36] See the JIU review entitled "Review of staff exchange and similar inter-agency mobility measures in United Nations system organizations" (JIU/REP/2019/8) for a comprehensive analysis of related policies and practices.

[37] A/73/792.

[38] WHO, *Global Report on Ageism* (Geneva, 2021).

[39] When the issues of inter-agency mobility and after-service health insurance were discussed within the inter-agency Working Group on After-Service Health Insurance established by the Secretary-General under the auspices of the Finance and Budget Network of the High-Level Committee on Management of CEB pursuant to resolution 68/244, in which the General Assembly requested the Secretary-General to undertake a survey of health insurance plans across the system and explore efficiency and cost-containment options, it was agreed that "agencies of the United Nations system should accept the transfer of certain accrued health insurance benefits and entitlements, as well as of the after-service health insurance liability, without the administratively onerous transfer of funding". That view was supported, reportedly, "by inter-agency mobility statistics covering 38 agencies provided by the CEB secretariat for the 2013–2016 period, [which showed] that any difference between the number of received staff members and the number of released staff members is immaterial when compared with the agencies' total workforces" (A/73/662, paras. 50–54).

[40] Or two years if the spouse has coverage with an outside employer or a national Government, except when the dependent is newly acquired within this period and is enrolled within 30 days of the effective date of the dependent relationship.

Table 6
Minimum number of years (other than five years) of participation in a United Nations contributory health insurance scheme required for family members of staff entering on duty on or after 1 July 2007 to be eligible for after-service health insurance

Minimum number of years	*Health insurance scheme*
10	FAO After-Service Medical Coverage
	UNESCO Medical Benefits Fund
	WFP Basic Medical Insurance Plan
	WHO Staff Health Insurance
2	IAEA After-Service Medical Insurance Plan
	UNIDO Field General Service Plan and Full Medical Insurance Plan
No minimum requirements as long as they are insured at the time of the staff member's separation	ICAO Medical Benefits Plan
	ILO Staff Health Insurance Fund
	IMO Group Medical Plan
	UNDP Medical Insurance Plan (including UNFPA and UN-Women)
	UNHCR Medical Insurance Plan
	UNOPS Medical Insurance Plan
	UNWTO Health and Accident Insurance Plan
	UPU Health Insurance Fund

Source: Prepared by JIU.

67. **There is a risk of anti-selection in the late enrolment of family members.** In the Inspector's view, the possibility of gaining access to after-service health insurance without the requirement of having previously participated in the insurance plan lends itself to anti-selection, as individuals with a higher risk of experiencing a negative event are more likely to seek to enrol in a United Nations-administered scheme when the risk has materialized or is about to materialize, which tends to increase with age. This is, after all, the reason for setting a minimum period of contributory membership as a prerequisite for after-service health insurance, which has already been adopted in 18 United Nations plans.

68. The following recommendation is expected to result in financial savings and a more equitable allocation of risks related to the right to after-service health insurance of family members for schemes that do not require a minimum number of years or require a very low period of participation before the right to after-service health insurance is acquired, in accordance with General Assembly resolution 61/264. It is also expected to help to level the playing field with regard to inter-agency staff mobility, avoiding unnecessary competition between organizations by means of more generous conditions for eligibility for after-service health insurance for such family members.

Recommendation 3

The executive heads of United Nations system organizations who have not yet done so should, by the end of 2026, ensure that the right of family members of staff to participate in after-service health insurance is conditional on a minimum of five years of participation in a United Nations contributory health insurance scheme, without prejudice to duly justified exceptions based on life events.

D. Premiums and shares of contributions between organizations and plan members

1. Equity and solidarity as a basis to determine contributions[41]

69. **There needs to be greater alignment in the solidarity models underpinning the United Nations-sponsored health insurance schemes to ensure equitable distribution of premiums and risks.** Private health insurance premiums are generally determined on the basis of risk and other cost factors of the insured persons, such as pre-existing health conditions, lifestyle, age and geographical location, all of which are intended to strike a balance between the principle of mutualization of risks inherent to all insurance modalities and personal responsibility. With the same level of coverage, a young and healthy individual can expect to pay a lower health insurance premium than an older, less healthy person, while the latter will receive less comprehensive coverage if their premiums are the same as those paid by younger participants. Conversely, in the context of social security, such as in the case of national health insurance schemes or those of the United Nations system and other international organizations, the principle of solidarity, based on the ability to pay and the age of beneficiaries, is key, with the other component (featured in any insurance, whether public or private) being the mutualization of risks among participants regardless of their age, health conditions and level of income. That way, the application of both the solidarity and the mutualization of risks principles promotes equitable health-care coverage for all as this is considered both a private and a public good and a fundamental human right.[42] However, this is not applied equally across plans, as will be discussed later in the report.

70. **The two basic principles of health insurance contributions were established by the General Assembly in 1957.** It should be recalled that, under General Assembly resolution 1095 A (XI), the Secretary-General is authorized to finance medical and hospital care schemes for staff in such a way that "a larger measure of financial assistance" be granted to "staff in the lower salary levels than to staff in the higher salary levels". This means that, although the total contributions of the organization and the group of beneficiaries should be equal (in 1957, 50 per cent of the premiums were paid by the organization and 50 per cent were paid by its staff), staff contributions must be a (proportional or even more than proportional, but always positive) function of their respective salaries. The two main principles governing the financing of this part of social security policy, as enshrined in the resolution, are, that health care, like pensions, is a shared responsibility of both parties, employer and employees, and that the apportionment of contributions among the participants should be based on the ability to pay, although there are many different ways of complying with the mandate of the legislative body in this regard (through a proportional rate or a progressive or sliding scale, for instance).

[41] For more details on health insurance premiums, see the complementary paper for this review.

[42] The human right to health is recognized in numerous international instruments. Article 25 (1) of the Universal Declaration of Human Rights affirms that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services", although the International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In addition, the right to health and social security is recognized in ILO conventions, inter alia, the Social Security (Minimum Standards) Convention, 1952 (No. 102); the Equality of Treatment (Social Security) Convention, 1962 (No. 118); the Employment Injury Benefits Convention, 1964 [Schedule I amended in 1980] (No. 121); the Invalidity, Old-Age and Survivors' Benefits Convention, 1967 (No. 128); the Medical Care and Sickness Benefits Convention, 1969 (No. 130); the Maintenance of Social Security Rights Convention, 1982 (No. 157); and the Maternity Protection Convention, 2000 (No. 183). Several regional human rights instruments also recognize the right to health, such as the European Social Charter, art. 11; the African Charter on Human and Peoples' Rights, art. 16; and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, art. 10. Similarly, the right to health has been proclaimed by the Commission on Human Rights as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments (general comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights, para. 2).

71. **Most schemes feature the ability to pay and intergenerational solidarity principles as the basis for allocating premiums among beneficiaries.** Of the 26 health insurance schemes, 21 collect the contributions for health insurance premiums from plan members based on a fixed percentage of the plan member's emoluments,[43] with variations according to family size, except UNWTO, which applies a flat-rate percentage regardless of family size. In the view of the Inspector, the design of these proportional rates of contribution is a good practice as it is simple and easy to understand, while incorporating solidarity based on the ability to pay and on age (intergenerational solidarity principle). This multiprincipled kind of solidarity is sometimes reinforced by means of sliding scales (as in the case of the United Nations Secretariat and IAEA schemes),[44] therefore making contributions to health protection progressive, mimicking national progressive income taxes or the United Nations common system rate structure applied to determine the staff assessment. As a result, solidarity not only is proportional to the staff income but becomes even more than proportional as salaries increase.

72. **The family dimension of solidarity is also present to varying degrees.** For their part, simpler structures of contributions, such as that of UNWTO where all enrolled family members, with no numerical limit, are exempt from contributions, present a new family-centred dimension of solidarity. In this case, the UNWTO subsidy covers 100 per cent of the premium corresponding to the eligible family members of all staff members (i.e. dependent spouse and children), integrating health insurance as an element of the organization's policy of family protection.

73. **The principle of equivalence or cost causation, which usually characterizes private commercial insurance premiums, is also built into some schemes.** The use of flat-rate premiums in absolute terms is another method for contribution calculation that fails to consider solidarity based on the ability to pay and replaces it with a restricted version of the principle of equivalence or expense causation that usually characterizes private commercial insurance premiums. Akin to a poll tax, flat-rate premiums are based on family size rather than emoluments, to which an element of individual risk profile within the family can be added, leading to different contributions for children and adults. Under the FAO and WFP Basic Medical Insurance Plans, a fixed amount is collected from their plan members, but with the caveat that contributions are capped at 5 per cent of emoluments. Although easy to understand at first glance, this arrangement may result, in practice, in differences in contributions that range from 1 to 5 per cent of emoluments, bigger subsidies for families with many dependent children (as in the case of UNWTO), and employees with lower salaries paying more in relative terms (5 per cent of their salaries in the worst-case scenario) compared with those with higher emoluments (for whom the same fixed amount certainly represents a lower proportion of their income).

74. **Plans with limited or no solidarity based on the ability to pay.** The UPU health insurance plan is the only plan under which flat-rate contributions are collected based on the age of plan members, regardless of their level of income, as is the usual practice of the private insurance industry. This implies that, on the one hand, there is no cross-subsidy between insured persons (or more subsidies from the organization) based on their ability to pay and, on the other hand, that the degree of risk mutualization is more limited, as people with higher risks, such as age, pay more (i.e. self-insure a bigger portion, at least in absolute terms, of their risks). Under the ICAO model, for its part, different percentages are applied to the premiums for internationally and nationally recruited staff, possibly creating cross-subsidies among participants or an unequal apportion of subsidies from the organization between both groups based on a condition extraneous to the basic principle of the ability to pay.

75. **The diversity of solidarity models incorporated into the way insured persons' contributions are assessed sometimes yields startling results.** For the purpose of illustrating the effects associated with these different methods of calculating contributions, the percentage of the staff's net remuneration based on the amount contributed to their

[43] These are the schemes whose policyholders are ILO, the United Nations Office at Geneva, the United Nations Office at Vienna, UNODC, the United Nations Secretariat in New York, UNDP, UNESCO, UNHCR, UNICEF, UNIDO, UNOPS, WFP and WHO.

[44] A/61/730, paras. 11, 12 and 13.

organization's health insurance plan are shown in table 7, comparing, as case studies, a 35-year-old staff member holding a job at the P-3 grade, step V, and a staff member of the same age holding a job at the GS-5 grade, step V. The analysis from the case studies demonstrates that in these cases, a staff member at the GS-5, step V level who earns less than a staff member at the P-3, step V level at the same duty stations (Geneva, Bangkok, Rome) could contribute a higher percentage of his or her income to the premium under the same health insurance scheme.

Table 7

Percentage of a staff member's net remuneration apportioned to the health insurance premium: comparison between an internationally recruited 35-year-old staff member at the P-3, step V level and a locally recruited 35-year-old staff member at the GS-5, step V level at the same duty station (regardless of sex)

	Staff member only		*Staff member + one adult*		*Staff member + one adult +one child*	
Health insurance scheme/ Duty station	*P-3, step V*	*GS-5, step V*	*P-3, step V*	*GS-5, step V*	*P-3, step V*	*GS-5, step V*
Bangkok						
ICAO: Medical Benefits Plan	1.79	2.20	3.38	4.35	3.29	4.24
Geneva, Bern						
UPU: Health Insurance Fund	2.34	3.02	4.42	5.54	5.41	6.50
WIPO: Group Medical Insurance Plan	2.32	2.51	4.38	4.71	5.23	5.39
Rome						
FAO: Basic Medical Insurance Plan	2.02	3.56	3.71	5.00	4.54	5.00
WFP: Basic Medical Insurance Plan	1.61	2.84	3.06	5.00	3.77	5.00

Source: Prepared by JIU.

76. **More transparency and coordination are needed in shaping solidarity across schemes.** The underlying solidarity model chosen by each plan to determine staff contributions is usually based on a long-standing and well-established tradition. However, sometimes the complexity of the formulas utilized and their consequences were hardly understood by beneficiaries and even by plan administrators, as evidenced during the interviews and the collection of data from the corporate questionnaire. The Inspector believes that more transparency and discussion between the organization and staff representatives are needed to ensure that there is a clear understanding of the scope and impact of such arrangements on the level of mutualization of risks and the intergenerational and interpersonal solidarity enshrined in the schemes. Further to that, in the view of the Inspector, there is also room for a system-wide approach to this topic to create a set of contribution-setting principles that could foster harmonization and comparability and reflect a shared approach to what is one of the most important elements of the notion of social security, beyond coverage and the apportionment of premiums between serving and retired staff and their employing organizations.[45]

[45] Models can be: market type, in which solidarity is limited to risk-pooling among a large group of people and contributions are based not on income or the ability to pay, but on foreseeable risks or expenditure (age and number of family members, and even health condition); moderately redistributive, in which payments are determined in direct proportion to income and irrespective of the age and size of families, so that, *ceteris paribus*, those who earn more subsidize those who receive less, and larger families are subsidized by smaller families and, in particular, singles with equivalent income; highly redistributive, in which, in addition to not taking into account age or family composition, a sliding scale is applied to income to determine contributions, thus reinforcing the cross-subsidies described in the previous case; and regressive, in which a rate inversely proportional

77. The absence of common guidance on the solidarity model underpinning the share of contributions could exacerbate divergences in the level of subsidy provided by the organizations to plan participants and an inequitable apportionment of contributions within the group of beneficiaries. The following recommendation is expected to enhance policy coherence and harmonization and therefore, transparency, comparability and the inter-agency mobility of staff across participating organizations' health insurance plans.

Recommendation 4

The General Assembly of the United Nations should request the International Civil Service Commission to propose guidelines to enhance coherence in the application of the principles of intergenerational solidarity, ability to pay and family protection in health insurance schemes co-sponsored by the United Nations common system organizations.

2. Basis for calculating contributions of retired staff

78. **Actual pensions are the most accurate way of assessing retirees' ability to pay, as salaries are for serving staff.** While for active staff the basis for the charge is usually their net base monthly salary plus post adjustment (for internationally recruited staff) and other allowances, such as language and non-resident allowances, for retirees, that basis varies from actual pensions to an amount deemed to be functionally equivalent, such as a percentage of their last salary during active service. This is mainly done to simplify calculations and avoid depending on data from the United Nations Joint Staff Pension Fund, yet a fairer measurement of the ability to pay, and the most accurate one, remains actual pensions, as attested by the use of salaries in the case of serving staff and as decided by the General Assembly in its resolution 1095 A (XI) of 27 February 1957.[46] For that reason, as well as to foster the comparability and harmonization of schemes across JIU participating organizations, **the Inspector suggests that, whenever data are available, actual pensions (or a uniform proportion thereof) and not any proxy be used as the basis for calculating retirees' contributions to their respective health insurance schemes in order to better align such contributions with retirees' ability to pay**, without prejudice to the use of a theoretical pension for the same purpose, as described in the paragraphs below.

79. **A theoretical pension as a basis for calculating after-service health insurance contributions can reinforce solidarity and help to contain costs.** The use of a theoretical pension equivalent to a minimum number of years of membership for the determination of after-service health insurance contributions is another form of solidarity with members with longer careers when contributions are calculated on the basis of actual pensions,[47] as well as a way of containing costs. In its resolution 61/264, the General Assembly approved the application of a theoretical pension of a minimum of 25 years of service as the basis of assessing contributions from pensioners with fewer years of contributory participation in a United Nations-administered health insurance plan so that they must pay the contribution corresponding to higher pensions than those they actually receive, resulting in the organization (and the rest of the retirees) paying lower contributions.[48] Considering the origin

to income is applied (a flat rate, poll tax-like contribution would be the simplest expression in this category).

[46] The General Assembly "authorizes the Secretary-General to broaden the existing medical and hospital care schemes applicable to the staff, with effect from 1 June 1957 … these schemes to be financed on the basis of an over-all sharing of the costs by the participating staff and the Organization on an approximately equal basis in such a manner that a larger measure of financial assistance will be granted to staff in the lower salary levels than to staff in the higher salary levels".

[47] A portion of the pension, rather than the full actual pension, is sometimes used for the purpose of calculating retirees' contributions, with the intent of proportionally reducing those contributions. As long as the proportion applied to pensions is the same for all pensioners, e.g. 50 per cent for all, the effect of rebalancing contributions from members with shorter careers through the use of a theoretical pension and those with longer careers remains the same.

[48] Although the use of the theoretical pension was approved by the General Assembly in its resolution 61/264, the provision was only put into effect in July 2017 for all staff recruited since 1 July 2007 as

of this initiative, it must be noted that it has nothing to do with the ability-to-pay principle, but is related to the acquisition of the entitlement to a subsidy for after-service health insurance.

80. **The theoretical pension is applied by just a handful of participating organizations.** Out of the 26 health insurance schemes, 8 are in compliance with or follow the above-mentioned resolution. These are the schemes whose policyholders are ILO, the United Nations Office at Geneva, the United Nations Secretariat in New York and UNIDO. The schemes under UNESCO and WHO also apply a similar basis, but the former uses a theoretical pension amount of 20 years, while WHO enforces a period of 30 years. None of the other schemes use any theoretical pension to limit their subsidies for retirees, although the use of actual emoluments at the time of separation may yield similar effects in terms of increasing retirees' contributions.

81. The application of different bases for retired staff members who are eligible for after-service health insurance and for organizational subsidies for health insurance premiums is outlined in table 8.

Table 8
Basis for calculating a retired staff member's contribution to health insurance premiums

Basis for calculation	*Participating organizations and health insurance scheme*
A theoretical pension of a minimum of 10 years (unless the full actual pension amount is higher)	UNWTO Health and Accident Insurance Plan
A theoretical pension of a minimum of 20 years	UNESCO Medical Benefits Fund
A theoretical pension of a minimum of 25 years (unless the full actual pension amount is higher)	ILO Staff Health Insurance Fund
	United Nations Office at Geneva United Nations Staff Mutual Insurance Society
	United Nations Office at Vienna Full Medical Insurance Plan
	United Nations Secretariat Aetna, Cigna Dental, Empire Blue Cross, United Nations Worldwide Plan
	UNIDO Full Medical Insurance Plan and Field General Service Plan
A theoretical pension of a minimum of 30 years or the full pension amount if retiring with more than 30 years of contribution to the United Nations Joint Staff Pension Fund	WHO Staff Health Insurance
A full periodic benefit from the United Nations Joint Staff Pension Fund (recalculated to include any portion that may have been commuted into a lump sum), including cost-of-living adjustments; or 46 per cent of the Final Average Remuneration[a] as calculated by the United Nations Joint Staff Pension Fund	FAO After-Service Medical Coverage and After Service Medical Insurance

its full implementation was deferred pending the consideration of alternative accrual mechanisms by the Working Group on After-Service Health Insurance. In the light of the lack of consensus by the Working Group related to such alternatives, the provision approved by the General Assembly was put into full effect as of 1 January 2023 (A/76/373, para. 63).

Basis for calculation	*Participating organizations and health insurance scheme*
A full periodic benefit from United Nations Joint Staff Pension Fund (recalculated to include any portion that may have been commuted into a lump sum), including cost-of-living adjustments; or 32 per cent of the Final Average Remuneration[a] as calculated by the United Nations Joint Staff Pension Fund	WFP Basic Medical Insurance Plan
Net monthly emoluments during the last full month of service (fixed throughout the lifespan of the retirees) to determine the percentage to which the plan member will contribute towards the premium amount	IAEA After-Service Medical Insurance Plan
The higher amount between one third of the remuneration used for calculating the contribution at the date of separation or the full United Nations Joint Staff Pension Fund periodic benefit (recalculated to include any portion that may have been commuted into a lump sum)	IMO Group Medical Plan
50 per cent of the current net salary corresponding to the grade and step of the retired staff at the time of separation, adjusted periodically by the global cost-of-living increases declared by the United Nations Joint Staff Pension Fund	United Nations Secretariat Medical Insurance Plan UNDP Medical Insurance Plan UNHCR Medical Insurance Plan UNICEF Medical Insurance Plan WFP Medical Insurance Coverage Scheme
The current net salary corresponding to the grade and step of the retired staff at the time of separation[b]	UNOPS Medical Insurance Plan
Not applicable, flat-rate amounts of contribution regardless of level of income	ICAO Medical Benefits Plan UPU Health Insurance Fund WIPO Group Medical Insurance Plan

Source: Prepared by JIU.

[a] The average of pensionable remuneration for the highest 36 months of the last five years of service.

[b] However, the contribution rates for retired staff members are 50 per cent of those for active staff members.

82. **Reducing the contributions made by the participating organizations for retirees with limited contributory participation in the plans is a good practice.** As shown, a variety of approaches have been developed over time in all plans to calculate the contributions of retirees based on their ability to pay or the alternative criterion of expense causation. These approaches range from actual pensions – the closest approximation to the ability to pay – to the last remuneration while still in active service, to the current net salary amount corresponding to the last grade and step of the retired staff, or even a flat-rate contribution unrelated to income. Except for the flat-rate amount, all other approaches are based on income and, thus, on the basic principle of the ability to pay usually applied to social security schemes and adopted by Member States in 1957; the Inspector is of the view that all of them are acceptable, an idea corroborated by representatives of the staff associations interviewed who did not raise any concerns in this regard. However, what lends itself to closer harmonization is the number of years taken into account when estimating the theoretical pension used to calculate the retirees' contributions as a way of reducing the share of the premiums borne by the participating organizations for retirees with limited contributory participation in the plans. **The Inspector therefore suggests that the basis for calculating contributions takes into account, apart from the ability to pay (ideally, the actual pension), the need to minimize excessive subsidies for retirees whose contributory participation in the scheme while in active service was low.**

3. Shares of premiums between plan members and organizations

83. **The General Assembly's premium-sharing principles require the employer to cover 50 per cent or more of the cost, with beneficiaries' contributions based on their emoluments.** In its resolution 1095 A (XI), adopted on 27 February 1957, the General Assembly established that the medical and hospital care schemes applicable to staff were to be financed "on the basis of an over-all sharing of the costs by the participating staff and the Organization on an approximately equal basis", albeit in 1983,[49] it introduced a maximum ratio of 2 to 1 between the share of the organization and that of the plan members on an experimental basis for United States-based health insurance schemes owing to the high cost of health care in that country.[50] While the overall distribution of contributions follows those ratios, they are not flatly applied as, according to the above-mentioned resolution, plan members' contributions are a function of their net remunerations, making the organization's contributions, which cover the outstanding balance of each individual premium, inversely proportionate to salary levels. In addition, also based on the premium amounts and percentages set for staff contributions, the Organization's share is slightly higher for those with larger families, thus incorporating into contribution-setting a factor of family protection that is also linked to the differentiated risk profile of families according to their size.

84. **The actual level of organizations' contributions to health insurance premiums is between 50 per cent and 75 per cent.** A group of participating organizations – ILO, ICAO (for internationally recruited staff), the United Nations Office at Geneva, the United Nations Office at Vienna, UNESCO, UNIDO and UPU – keeps the share of contribution at around 50 per cent for active staff members. Under the health insurance schemes that cater solely to locally recruited staff away from headquarters, the organizations provide the highest level of contributions, ranging from 50 per cent to 75 per cent, as in the case of the Medical Insurance Plans administered by the United Nations Secretariat, UNDP, UNHCR, UNICEF and UNOPS, the Medical Insurance Coverage Scheme administered by FAO and the Medical Benefits Plan administered by ICAO. The WHO Staff Health Insurance is the only scheme that has a 2 to 1 ratio of contribution between the organization and eligible plan members and is applicable to plan members worldwide.

[49] General Assembly resolution 38/235.

[50] The latest affirmation of this decision was granted in 2014 by the General Assembly in its resolution 69/251, which was to maintain the existing ratios for the apportionment of health insurance premiums between the Organization and the active and retired staff participating in the health insurance plans.

85. **Only half of the schemes provide a higher level of subsidy for retired staff than active staff**, reinforcing the intergenerational solidarity principle embedded in the idea of insurance or the mutualization of health risks. Several schemes set fixed percentages for the shares of contribution. The shares of contributions in the ILO and United Nations Office at Vienna schemes, for example, is a 50 to 50 ratio between the organization and staff and a 67 to 33 ratio between the organization and retired staff, as shown in table 9. More details on the arrangement for the share of contributions can be found in the complementary paper for this review.

86. **In some organizations, overall, staff pay a higher proportion of the premium than the organization.** As can be seen in table 10, this is the case with the FAO Medical Insurance Coverage Scheme, the United Nations Secretariat's United Nations Worldwide Plan (for active staff) and the two UNIDO schemes for retirees.

87. **While the principles of interpersonal and intergenerational solidarity are present in most plans, there are inequalities in the apportionment of premiums.** The Inspector found that the current arrangements for sharing the costs of health insurance premiums between organizations and plan members are generally aligned with the relevant General Assembly resolutions and the interpersonal and intergenerational solidarity principles that are inherent to the notion of social security, insofar as staff members with lower rate of remuneration and those with larger families tend to receive a larger share of contributions from their organizations, whereas retired staff and their dependants contribute less, receive higher subsidies and potentially incur higher amounts of health insurance reimbursements. However, as mentioned previously, comparative inequalities in sharing the cost of health insurance abound, as shown in table 9 and detailed in the next subsection.

Table 9
Aggregate shares of contributions by health insurance scheme in 2022[a]

	Shares of contribution (%)	
Health insurance scheme	*Organization: Active staff*	*Organization: Retired staff*
FAO Basic Medical Insurance Plan/After Service Medical Coverage	61:39	63:37
FAO Medical Insurance Coverage Scheme /After-Service Medical Insurance	39:61	Not applicable
IAEA Full Medical Insurance Plan /After-Service Medical Insurance Plan[b]	40:60	44:56
ICAO Medical Benefits Plan	48:52	52:48
ILO Staff Health Insurance Fund	52:48	67:33
IMO Group Medical Plan	63:37	83:17
United Nations Office at Geneva-United Nations Staff Mutual Insurance Society	47:53	65:35
United Nations Office at Vienna/UNODC Full Medical Insurance Plan	56:44	77:23
United Nations Secretariat Aetna	51:49	75:25
United Nations Secretariat Cigna Dental	55:45	71:29
United Nations Secretariat Empire Blue Cross	59:41	78:22
United Nations Secretariat United Nations Medical Insurance Plan	79:21	67:33
United Nations Secretariat United Nations Worldwide Plan	34:66	61:39
UNDP Medical Insurance Plan	77:23	75:28

Health insurance scheme	*Shares of contribution (%)*	
	Organization: Active staff	*Organization: Retired staff*
UNESCO Medical Benefits Fund	50:50	50:50
UNHCR Medical Insurance Plan	78:22 (disaggregated data not available)	
UNICEF Medical Insurance Plan	79:21	Data not available
UNIDO Field General Service Plan	53:47	30:70
UNIDO Full Medical Insurance Plan	53:47	30:70
UNOPS Medical Insurance Plan	77:23	89:11
UNWTO Health and Accident Insurance Plan	Data not available	
UPU Health Insurance Fund	Data not available	
WFP Basic Medical Insurance Plan	52:48	57:43
WHO Staff Health Insurance	67:33	69:31
WIPO - Group Medical Insurance Plan	47:53	48:52

Source: Prepared by JIU based on the financial information submitted by the participating organizations.

[a] Contributions from organizations also include additional payment for a third-party administrator's fee or an in-house claim-related administrative fee, if applicable.

[b] The amounts of contributions from active and retired staff included unsubsidized amounts. This has a slight impact on the calculation of the ratio.

88. **Common standards on the sharing of health insurance costs are needed.** In line with recommendation 4 of the present review, the Inspector considers that, regardless of differences in coverage, there is no clear reason, other than varying medical costs in each location, to apply diverging rates for premium-sharing between organizations and beneficiaries across schemes. **The Inspector is also of the view that the entitlement to social security and, in particular, health insurance implies that, at the bare minimum, organizations shoulder no less than half the cost of the schemes.**

4. Comparative study of staff contributions to the health insurance premiums in six duty stations

89. **The review used case studies to examine the payments for health insurance premiums made by active staff**, selecting six duty stations from different regions: Bangkok, Brasilia, Cairo, Geneva, Juba and Nairobi. Different United Nations entities are hosted in these duty stations, meaning that there is a good number of different health insurance schemes. The case studies reviewed the percentage of the remuneration of an internationally recruited staff member at the P-3, step V level and a nationally recruited staff member at the GS-5, step V level[51] apportioned to the health insurance premium.

90. **Within the same duty station, the cost of health insurance for staff in the same category can vary by a factor of up to 2.5**, depending on the organization and the plan. The data from the case studies show that there can be a variation by a factor of up to 2.5 between the lowest and the highest premium amounts for staff members at the P-3, step V level within the same duty stations. For example, in Bangkok, a staff member at the P-3, step V level

[51] The data are based on the salary scales, post adjustment rates and operational United Nations exchange rates as at 31 July 2023.

insured under the United Nations Secretariat's United Nations Worldwide Plan would pay $121.73 per month for their share of the insurance premium contribution (for the staff member only), or 1.48 per cent of their net remuneration, whereas if insured under the ILO Staff Health Insurance Fund, the staff member would pay $291.99 per month, or 3.55 per cent of the same net remuneration. Similarly, for a family of three (one staff member, one spouse and one child) in Nairobi, a staff member under the United Nations Worldwide Plan would pay $309.01 per month, or 3.6 per cent of their net remuneration, compared with $541.25 per month, or 6.31 per cent of the net remuneration, if insured under the UNIDO Group Headquarters Medical Insurance.

91. **There can be significant variations in the case of staff in the General Service category.** For a staff member at the GS-5, step V level, there can be as much as a fourfold difference in the contribution to the premiums between two schemes. For example, in Nairobi, the monthly premium contribution for one staff member and one adult family member is $18.27, or 1.35 per cent of the net remuneration, for the Medical Insurance Plans of the United Nations Secretariat and UNHCR, and $77.65, or 5.74 per cent of the same net remuneration, for the ICAO Medical Benefits Plan. The size of the monthly premium and the percentage of the net remuneration allotted to the premium of a staff member at the P-3, step V level in Bangkok is illustrated in table 10. A similar set of data for a staff member at the GS-5, step V level at the same duty station is provided in table 11. The data from the six duty stations selected for the case studies can be found in the complementary paper for this review.

Table 10
Amount of monthly health insurance premiums and percentage of the net remuneration of a staff member at the P-3, step V level in Bangkok

	Monthly premium amount ($) *(Percentage of the staff member's salary allocated for insurance premium)*		
Health insurance scheme	*Staff member only*	*Staff member + one eligible family member*	*Staff member + two eligible family members*
Duty station: Bangkok			
FAO Basic Medical Insurance Plan	176.43 (2.15)	344.63 (3.95)	432.27 (4.82)
ICAO Medical Benefits Plan	147.12 (1.79)	294.44 (3.38)	294.44 (3.29)
ILO Staff Health Insurance Fund	291.99 (3.55)	402.80 (4.62)	446.34 (4.98)
United Nations Secretariat United Nations Worldwide Plan for staff under the United Nations Secretariat, UNDP, UN-Women, UNFPA and UNOPS	121.73 (1.48)	199.66 (2.29)	322.66 (3.60)
UNESCO Medical Benefits Fund	259.91 (3.16)	414.30 (4.75)	496.53 (5.54)
UNIDO Full Medical Insurance Plan	259.35 (3.15)	412.35 (4.73)	565.15 (6.31)
United Nations Office at Vienna United Nations Staff Mutual Insurance Society for UNHCR	279.65 (3.40)	383.62 (4.40)	430.21 (4.80)
WFP Basic Medical Insurance Plan	141.64 (1.72)	285.13 (3.27)	359.92 (4.02)
WHO Staff Health Insurance, also for UNAIDS staff	209.74 (2.55)	444.65 (5.10)	488.47 (5.45)

Source: Prepared by JIU.

Table 11
Amount of monthly health insurance premiums and percentage of the net remuneration of a staff member at the GS-5, step V level in Bangkok

	Monthly premium amount ($) *(Percentage of staff member's salary allocated for insurance premium)*		
Health insurance scheme	*Staff member only*	*Staff member + one eligible family members*	*Staff member + two eligible family members*
Duty station: Bangkok			
FAO Medical Insurance Coverage Scheme	29.81 (1.43)	38.08 (1.82)	56.10 (2.61)
ICAO Medical Benefits Plan	45.82 (2.20)	91.13 (4.36)	91.13 (4.24)
ILO Staff Health Insurance Fund	74.00 (3.55)	96.67 (4.62)	107.05 (4.98)
United Nations Secretariat Medical Insurance Plan	21.89 (1.05)	28.25 (1.35)	39.77 (1.85)
UNDP Medical Insurance Plan	22.93 (1.10)	29.29 (1.40)	42.99 (2.00)
UNESCO Medical Benefits Fund	65.87 (3.16)	99.02 (4.73)	119.08 (5.54)
UNICEF Medical Insurance Plan	22.93 (1.10)	29.29 (1.40)	40.84 (1.90)
UNHCR Medical Insurance Plan	21.89 (1.05)	28.25 (1.35)	39.77 (1.85)
UNIDO Full Medical Insurance Plan	38.57 (1.85)	58.06 (2.78)	119.08 (5.54)
UNOPS Medical Insurance Plan	22.93 (1.10)	29.29 (1.40)	42.99 (2.00)
WFP Basic Medical Insurance Plan	25.22 (1.21)	32.22 (1.54)	47.29 (2.20)
WHO Staff Health Insurance, also for UNAIDS staff	53.16 (2.55)	106.71 (5.10)	117.15 (5.45)

Source: Prepared by JIU.

92. **Greater coordination is needed to avoid harmful competition and ensure more comparable conditions of service.** In view of the data shown in tables 10 and 11 and the results of the interviews conducted, it appears that there are no valid reasons for the disparities observed, other than the existence of multiple insurance schemes with varying coverage (see section E below) and administrative expenses in the same location. Even though this explanation may be acceptable in terms of understanding differences, the outcome is debatable, as it implies that staff members working under the same circumstances are treated differently based solely, or mostly, on their affiliation with a particular insurance scheme. This situation, along with other situations mentioned earlier and the differences in coverage set out in section E below, is clearly counter to the goal of a common system that avoids harmful competition between system organizations when recruiting personnel while providing equal working conditions to employees in the same duty station, irrespective of their employer. **The Inspector suggests that United Nations system organizations coordinate their efforts at the duty station level to avoid disparities in contributions and coverage to the extent possible.**

E. Coverage and benefits

93. **Eleven key dimensions were selected to compare the level of coverage and benefits between schemes.** There are no internationally recognized benchmarks or standards for the level of health insurance coverage for employees that this review could use to evaluate the adequacy of the health insurance schemes within the United Nations system. In addition, finer details on what different schemes offer in terms of their coverage and benefits coupled with different premium amounts make it impractical to judge whether one scheme provides better coverage than the others. Nonetheless, in this review, 11 key dimensions were selected to compare the level of coverage and benefits of these schemes and to offer some insights for

further harmonization. The dimensions were selected by considering the most common features and areas of coverage of most health insurance plans and those most utilized by plan members. A summary of the key findings is provided in this section, while more detail is available in the complementary paper for this review. In addition, feedback from plan members on the extent to which the coverage and benefits meet their needs is discussed in chapter IV of the report.[52]

1. Choice of health-care providers and geographical coverage

94. **All schemes allow the free choice of health-care providers** for their plan members, but some schemes, especially those designed for plan members in North America, offer significant preferential benefits from their in-network providers. The United Nations Secretariat's Aetna and Empire Blue Cross schemes, for example, offer plan members full coverage with no deductibles and lower maximum out-of-pocket payments for most services with their in-network providers. Outside North America, most schemes offer no significant advantages among different providers, except in cases where negotiated prices are concluded with specific providers in certain cities.

95. **There is worldwide coverage, except for most locally recruited staff in the field.** As for the geographical coverage, the schemes that are designed for staff and retirees worldwide, regardless of their recruitment status (internationally or locally recruited), provide worldwide coverage at a "reasonable and customary cost" where the service is received, but many schemes offer limited coverage in the United States owing to the high costs of services in that country. The schemes that are designed specifically for locally recruited staff, such as the Medical Insurance Plans of the United Nations Secretariat, UNDP, UNHCR and UNICEF, feature limited to no coverage outside the duty stations or places of residence of the plan members under normal circumstances.[53] This could pose a significant challenge for plan members residing in the duty stations where access to health care is limited; this situation deserves closer and constant attention to avoid shortfalls in the adequate provision of health insurance as part of the right to social security of staff and retirees.

2. Financial coverage and protection against catastrophic expenses

96. **Annual reimbursement limits vary significantly between plans within the same duty station and even within the same organization**. Among the 26 schemes, the overall annual reimbursement limit varies from $60,000 per person to unlimited. Within the same scheme, the overall ceiling amount is offered equally for all plan members at the same duty station regardless of their recruitment status and job grade. It is therefore noted that the level of financial coverage within the scheme applies the solidarity principle, enabling plan members with different levels of income, age and health conditions to benefit equally from the scheme according to their health needs rather than their salary or recruitment category. However, between plans, within the same duty station, the financial coverage can vary significantly, including where, within the same participating organization, different health insurance schemes are assigned to internationally and locally recruited staff and retirees. Further details on the annual reimbursement limits of these plans are provided in the complementary paper for this review.

97. **There is additional protection from financial hardship arising from unusually high health-care costs**. As health insurance is considered part of the social security protection offered by the United Nations to its staff, retirees and their eligible family and associated members, most of its health insurance schemes provide additional protection from financial hardship that may arise from high or catastrophic health-care costs. These are in the form of a stop-loss measure and/or a hardship provision. Stop-loss measures put a ceiling to the amount of out-of-pocket expenses (co-insurance, i.e. a percentage of medical costs for

[52] It is noted that the data presented here are based on the policy documents available at the time of writing of this report. Certain benefits and coverage may be subject to prior authorization and/or certain conditions by the responsible scheme. For comparison purposes, these finer details are not included in the analysis.

[53] It is noted that for the Medical Insurance Plans, members may be able to access medical services not available in their duty station in nearby duty stations through the Regional Area of Care arrangement.

each consultation or treatment) for the health-care costs of the plan member. Once such a ceiling is reached, the health insurance scheme would cover the remaining costs at a full or a higher rate, irrespective of the overall financial ceiling of the plan.

98. **Protection against catastrophic expenses should be based on the notion of equal financial effort for all participants.** Of the 26 schemes, a stop-loss measure is offered in 22schemes, but with different ceiling amounts for out-of-pocket expenses. In several plans, the amount of out-of-pocket expenses is determined as a percentage of the primary plan member's monthly or annual remuneration, whereas others use a flat and equal amount for everyone. Considering the purpose of this clause, which is to prevent participants from having to face significant financial hardship as a result of illness, the Inspector is of the view that the stop-loss clause should always be determined in relative terms rather than absolute amounts, for the simple reason that, for instance, $1,000 has greater financial significance to someone whose salary is $1,000 a month than it does to someone who earns 10 times as much.

99. **There is exceptional coverage for when the plan ceiling is reached and extraordinary expenses are incurred.** The hardship provision offers additional financial coverage on an exceptional basis for plan members whose reimbursement amounts have reached the overall financial coverage of the plan. The hardship provision is therefore not applicable for the schemes that have no ceiling limits, such as the schemes administered by IAEA, the United Nations Office at Geneva, the United Nations Office at Vienna, UNODC, UNIDO, WHO and WIPO. Of the schemes that have a limit to their reimbursement level, 10 schemes offer a hardship provision. Further details on stop-loss measures and hardship provisions are provided in the complementary paper for this review.[54]

100. **Stop-loss and hardship clauses, combined with overall ceilings for reimbursement, are good practices.** Based on the differences in the overall financial coverage and in the availability and scope of stop-loss and hardship provisions, it is evident that the level of social protection in health insurance varies significantly between schemes. The Inspector is of the view that stop-loss and hardship clauses, combined with overall ceilings for reimbursement, are good practices for containing costs while ensuring full protection in cases of need, especially to allow coverage for the most serious and costly health risks. **The Inspector suggests that the participating organizations adapt their health insurance policies and contracts to ensure that stop-loss or hardship provisions are based on the principle of equivalent financial support for all participants and that support is granted only when there is actual financial hardship in terms that are relative to the insured person's ability to pay.**

3. General outpatient care and pharmaceutical products

101. **Reimbursement rates range from 75 to 100 per cent of medical and pharmaceutical expenses.** Of the health insurance schemes that are not based in North America, nearly all schemes reimburse 80 per cent of expenses for outpatient care without deductibles, with the exception of the scheme under UNESCO that reimburses 75 per cent of them, the scheme under UNWTO that covers 100 per cent for in-network providers in Spain and 90 per cent elsewhere, and the schemes under UPU and WIPO that cover 90 per cent of the expenses after the annual deductible. For the North America-based schemes, the coverage is 100 per cent from in-network providers with a small amount ($15–20) for a co-payment per visit and 80 per cent after deductibles for out-of-network providers. Similarly, for prescribed pharmaceutical products, the reimbursement rates are mostly at 80 per cent, with only a few schemes at 90 per cent.[55] More details can be found in the complementary paper for this review.

[54] In the global staff survey conducted by the review, 13 per cent of the respondents (2,580 people) reported that they had made a request for exceptional reimbursement in the previous four years and 56 per cent of these respondents reported that their requests had been granted.

[55] There are some differences in the details of what is covered under pharmaceutical products, but most schemes do not cover vitamins and minerals even when prescribed. For this aspect of the health insurance coverage, there is not much difference between the schemes.

4. Hospitalization

102. **For costs related to hospitalization (room and board), most schemes cover 100 per cent for a semi-private room or a bed in a public ward.** In some duty stations, especially in Europe and North America, a reimbursement ceiling amount may be indicated as a cost-containment measure, which is considered a good practice. A lower reimbursement level, such as 80 per cent instead of 100 per cent, is offered for a private room, which is another good practice for cost containment. The UNWTO scheme is the only one that covers 100 per cent of expenses for all types of rooms from its in-network providers in Spain. For more details, see the complementary paper for this review.

5. Physical therapy

103. **For general physical therapy, the level of benefits varies significantly between the schemes**, including the types of care covered. While most schemes cover different types of physical therapy, such as physiotherapy, occupational therapy and osteopathy, at 80 per cent of the costs, the ceiling limits are considerably different, with up to $4,000 per year under the ILO scheme compared with up to $600 per year under the FAO Basic Medical Insurance Plan. Several schemes limit the cost per session or the number of sessions, or both, but without a ceiling amount per year. Some schemes, such as the one under IAEA, also cover alternative therapies, such as shock wave therapy, and the scheme under WIPO covers kinesitherapy and shiatsu (at 90 per cent) while most other schemes do not. The detailed comparison is provided in the complementary paper for this review.

6. Preventive care for adults

104. **Four schemes do not provide coverage for routine physical check-ups and, among the schemes that cover such procedures, the level of coverage varies greatly.**[56] For routine physical check-ups, four schemes under IMO,[57] UNESCO, WFP (Basic Medical Insurance Plan) and WIPO do not provide coverage at all, do not provide coverage for staff or do not specifically mention this in the benefits information. For the schemes that cover routine check-ups, the reimbursement ceiling varies from, for example, $300 biennially (FAO Basic Medical Insurance Plan) to $1,050 per annum (the United Nations Secretariat's United Nations Worldwide Plan) to no specific ceiling (e.g. the FAO Medical Insurance Coverage, the United Nations Office at Geneva United Nations Staff Mutual Insurance Society and the United Nations Secretariat's Aetna and Empire Blue Cross).

105. **For routine screenings for breast cancer, cervical cancer and prostate cancer, almost all schemes provide coverage for between 80 and 100 per cent of expenses**, in some cases in addition to the ceilings for routine physical check-ups. Eleven schemes offer specific coverage for colonoscopy as a routine check-up for colorectal cancer. Further details are provided in the complementary paper for this review.

106. **Preventive medicine is part of the right to health and a way to contain costs.** The Inspector is of the opinion that the health-care services provided to an individual for the purpose of preventing disease, disability or other adverse health conditions, or the early detection of such conditions, are not only advisable on medical grounds, but are also an integral part of the right to health in the broadest sense and a way of containing costs in the long run.[58] As stated by the Secretary-General of the United Nations in his fourth report on managing after-service health insurance liabilities,[59] "the rationale [for including preventive

[56] The Cigna dental scheme of the United Nations Secretariat is not relevant to this aspect.

[57] IMO directly covers annual medical check-ups for staff over 50 and biennial check-ups for staff over 40, not through its health insurance plan. For dependants aged 40 years and over, there is 100 per cent reimbursement of up to a maximum of $580 and up to a maximum of one routine physical exam every two calendar years. For retirees and their spouses, there is 100 per cent reimbursement of up to $580 and up to one routine physical exam every two calendar years.

[58] According to WHO, for each dollar invested in preventive interventions for non-communicable diseases, such as heart disease, diabetes, cancer and respiratory disease, a return of up to $7 could be generated through reduced health costs and improved productivity ("Saving lives, spending less: the case for investing in noncommunicable diseases" (Geneva, 2021).

[59] A/68/353.

care in policies] is that it is more cost-efficient than treatment. Early identification of chronic and serious conditions enables participants to take steps to better manage their health. Early management of such conditions may also result in lower rates of absenteeism and higher productivity among active staff, costs that are not easily reflected in the insurance programme costs." **The Inspector suggests that the United Nations-sponsored health insurance plans provide coverage for preventive care, including routine health check-ups.**

7. Optical and dental care

107. **The coverage for dental care and optical devices varies significantly between the schemes.** The ceiling amounts for dental care vary greatly, ranging from $500 per annum (the Medical Insurance Coverage Schemes under FAO and WFP, designed especially for locally recruited staff in the field) to $4,469 per annum under the UPU Health Insurance Plan (but reimbursed at 75 per cent). Regarding eye care, the IMO Group Medical Plan[60] is the only plan that does not cover eye tests to determine the dioptre, whereas other plans reimburse 80 per cent of the expense. The ceiling amount for optical devices varies from $102 per annum at IMO to $1,117 per annum under the WIPO Group Medical Insurance Plan. Dental and optical coverage between the relevant health insurance schemes is compared in the complementary paper for this review. Under several schemes, the unspent amount is allowed to be carried over to the following year, including the schemes under ILO, the United Nations Office at Geneva, the United Nations Office at Vienna, UNWTO, UPU and WHO, which is something akin to a premium rebate (if expenses are actually incurred in the following year) as this coverage was against a risk to be materialized, if any, during the year when such contributions were made. **In the Inspector's view, this practice should be replaced by an annual coverage sufficient to meet actual medical needs when they arise, thus maintaining the temporal correlation between contributions and risk coverage and avoiding beneficiaries being compelled to postpone the purchase of necessary devices until they have accumulated the maximum credit available.**

108. **Ceilings should not mean that insured persons are prevented from getting what is medically necessary and reasonable.** The varying ceilings of some health insurance schemes for optical and dental care reflect the high cost of living of the duty stations where most of the plan members reside (such as in Geneva, New York, Paris and Rome). However, within the same duty stations, the level of coverage could vary significantly between schemes, and this could create significant differences in the out-of-pocket expenses of the members of different plans. Ceilings for optical and dental care, as for other benefits of social security, are understandable considering the need to keep expenses within reasonable and affordable boundaries. However, this should not imply that limits prevent insured persons from getting what it is medically necessary to cure their illnesses and prevent their deterioration, at least according to the prevailing conditions in the place or country of residence. **The Inspector recommends that differences in ceilings within the same duty station be reduced or eliminated progressively as a matter of priority through the coordination and harmonization of policies.**

8. Mental health care

109. **Coverage of mental health services is also one of the areas where there are major divergences between plans.** As in other dimensions examined, the level of coverage for this important aspect of health insurance varies greatly among the health insurance schemes.[61] Most schemes reimburse at 80 per cent except UNESCO, at 75 per cent, WIPO, UNWTO and UPU at 90 per cent, and the United Nations Secretariat's Aetna and Empire Blue Cross, at 100 per cent for in-network providers (with a small amount of co-payment). In addition, under most schemes, a financial limit for the reimbursement amount, a ceiling amount per counselling session and/or a maximum allowable number of sessions per year are also imposed. For outpatient psychiatric therapy and psychotherapy, the schemes offered by IAEA, the United Nations Office at Vienna/UNODC, the United Nations Secretariat

[60] Class 3 and 5.

[61] See JIU report "Review of mental health and well-being policies and practices in United Nations system organizations" (JIU/REP/2023/4) for more details on mental health and well-being policies and practices in JIU participating organizations.

(Aetna plan), UNIDO and UNWTO impose no ceiling for the reimbursement amount for staff and retirees, and their plans also have no overall financial limits. This means that the plan members under these schemes have the highest (and unlimited) coverage for psychiatry/psychotherapy services. The two schemes offered by FAO and WFP for their locally recruited staff in the field provide the lowest financial coverage as their annual limit for outpatient psychiatric therapy and psychotherapy, at $800 per annum. Mental health-related coverage between different schemes is compared in the complementary paper for this review. The Inspector welcomes the United Nations System Workplace Mental Health and Well-being Strategy for 2024 and beyond of the High-Level Committee on Management, which calls upon United Nations system organizations to review their health insurance coverage in relation to mental health care.

110. **Several plan administrators adjusted their mental health-related plan coverage in response to the coronavirus disease (COVID-19) pandemic.** From interviews, several plan administrators reported that new services or better coverage had been introduced to support plan members affected by the pandemic. These included the introduction of telehealth services with therapists and mental health professionals (IMO, UNDP and UNICEF), an increase of up to 24 psychotherapy sessions without prescription, a broader definition of mental health experts based on the local context and the lifting of the ceiling limit for treatments for substance abuse (WHO).

9. Reproductive health, family planning and infertility treatment

111. **The 25 health insurance schemes offer similar coverage for maternity-related expenses**, most at 80 per cent, but family planning coverage is uneven and would benefit from closer harmonization. For family planning procedures and contraceptive devices, the coverage varies from none at all (for the schemes under FAO,[62] UNESCO, UNIDO,[63] UNOPS[64] and UNWTO) to reimbursements of 80–100 per cent of costs of the termination of pregnancies, sterilizations and contraceptive devices.

112. **Infertility treatments are only available under 17 schemes.** For medically necessary infertility treatments, which are considered high-cost procedures, varying levels of coverage are provided under 17 schemes, while no coverage is provided under 8 schemes. For those with coverage, an upper age limit on women is imposed under several plans, varying from 40 to 46 years of age. The number of attempts and the ceiling amount per lifetime are limited under some schemes, whereas a limit per successful pregnancy is imposed under some others. It is noted that infertility treatments are available to eligible women regardless of their marriage status, including those in a same-sex marriage, which is commendable. Surrogacy is not covered in any of the schemes. Further details on the coverage for infertility treatment by scheme are provided in the complementary paper for this review.

10. Well childcare

113. **Most schemes provide coverage for routine, preventive care services for children**, also known as well childcare, from birth up to a certain age. The IMO Plan is the only plan that does not cover well childcare, including immunizations, as the National Health Service of the United Kingdom covers child wellness and care and immunizations. Coverage for well childcare is not specifically indicated in several schemes, but their preventive care coverage may cover these related expenses. For the schemes that explicitly include well childcare, the number of routine exams allowed varies in accordance with the age of the child. More details can be found in the complementary paper for this review.

[62] Medical Insurance Coverage Scheme for locally recruited staff outside the headquarters location.
[63] Field General Service Plan for locally recruited staff outside the headquarters location.
[64] Medical Insurance Plan for locally recruited staff outside the headquarters location.

11. Long-term care

114. **Long-term care is generally not covered by health insurance and remains an unmet need.** The main purpose of long-term care insurance is not to prevent or cure illnesses, but to help the insured person to meet everyday needs that they are unable to cope with because of health problems, injuries, accidents or age. Consequently, long-term care mainly refers to non-medical assistance with routine daily activities both at home or health-care establishments, such as nursing home care and assisted living facilities. While long-term care is often associated with geriatric care, young people suffering from extended or indefinite physical or mental conditions may also need it. Long-term care is usually covered under a separate long-term care insurance and not provided as part of a health insurance package. Out of the 25 health insurance schemes in the United Nations system, only 8 schemes offer some long-term care coverage. More details can be found in the complementary paper for this review.

115. **The provision of long-term care as part of the United Nations social security system has long been discussed, but a conclusion has not been reached owing to funding constraints.** In 1994, a proposal for obtaining a global voluntary group insurance for long-term care in the common system was proposed to the Consultative Committee on Administrative Questions by UNIDO, the Federation of Associations of Former International Civil Servants and the Association of Former International Civil Servants (New York); the discussions on this topic have been ongoing ever since. The rationale for the provision of long-term care insurance, in particular for internationally recruited staff, is based on the mobility of the staff, which makes many of them ineligible for social protection schemes provided by their home country and possibly deprived of the safety net of close kin. Several options have been explored, including through a working group on long-term care under the joint human resources and finance and budget networks. However, similar to the arrangements for health insurance schemes, no joint effort has been established.

116. **UNIDO protection against this risk is a good example to follow.** While the UNIDO Group Headquarters Medical Insurance plan does not cover long-term care, the organization has made available a specific insurance plan for long-term care in which their health insurance plan members are automatically subscribed (with an opt-out option). The premium ($65.7 per annum per person) is co-sponsored by UNIDO (25 per cent) and the UNIDO Staff Council (25 per cent). The main coverage is the provision of a lump sum of $986 per month for the plan members when they are recognized by the insurer, for medical reasons, as being in a state of dependence. **While, owing to their different nature, the Inspector advises against adding long-term care to health insurance policies or plans, he suggests that United Nations system organizations engage with active staff and retirees' representatives with a view to establishing a separate insurance scheme covering these types of risks and care in a coordinated and affordable manner.**

F. Protection of medical and health-related data of staff

117. **No plan requires active staff to disclose their health and medical status when joining**, including when transitioning to after-service health insurance upon retirement. However, how the data received through claim submissions are handled and protected largely depends on the plan's claim administration modality and the personal data protection policy of the participating organization.

118. **Externally administered health insurance plans follow a comprehensive data protection legal framework.** For the 22 health insurance plans that are administered by a third party or are fully commercially insured (see Table 2), an agreement related to the protection of personal data of plan members, including medical and health-related data, was reached as part of a service-level agreement or contract. In addition, all of the third-party administrators and commercial insurers used by these health insurance plans are based in either the United States or in Europe, which require them to comply with the Health Insurance Portability and Accountability Act of 1996, for the former, or the General Data Protection Regulation, for the latter. From interviews with both the participating organizations and the

representatives of staff and retirees associations, isolated cases of disclosure of personal data by third-party administrators or insurers had been reported but subsequently addressed.

119. **The level of maturity of data protection policies varies greatly among the participating organizations.** The extent to which the medical and health-related data of the plan members is protected largely hinges on each organization's personal data protection policy and regulations. While it is beyond the scope of this review to examine these policies in depth, the interviews showed that the level of maturity of such policies varies greatly among the participating organizations. While the majority of the claims submitted under these 22 health insurance plans are processed externally, in certain cases, the claim-related medical data of a plan member was disclosed to the organizations, including for the application of a hardship provision, claim disputes and investigations of potential health insurance fraud. The Inspector was informed that, in such cases, files were reviewed without disclosing the plan member's identity, but it is unclear if the practice was governed by adequate personal data protection policies.

120. **The centralization of claims administration offers greater assurances regarding data protection-related risks.** For the four self-insured and self-administered plans under ILO, the United Nations Office at Geneva, UNHCR and WHO, the handling of the medical and health-related data of the plan members is subject to the internal rules of these organizations. For the plans under ILO, the United Nations Office at Geneva and WHO, the claims administration is handled by a centralized unit at their headquarters location, which provides an additional layer of protection for the medical data of plan members in structural terms. In the case of ILO, personal data related to its health insurance are governed under a directive[65] whereby an individual's personal health status is classified as "sensitive personal data" that cannot be released to third parties without the explicit written consent of the individual concerned. The data protection policy of the United Nations Office at Geneva United Nations Staff Mutual Insurance Society includes a statement that the personal data of the plan members will not be shared, but it also refers to exceptions where the personal information of the plan members may be disclosed. These exceptions are not clearly defined, and the consent of the plan members prior to disclosure is not required. In the case of WHO, personal information, including medical records, is governed under its information disclosure policy and is regarded as "confidential information". Under this category, the disclosure of information reflects what is necessary to preserve legitimate public or private (including personal privacy) interests. However, how medical data related to claim submissions and disputes will be handled is not clearly stated in the health insurance rules.

121. **There are risks associated with staff members' health-related data being handled directly by local human resources units.** The UNHCR Medical Insurance Plan is the only plan where the majority of claim reviews and approvals are handled locally at the country and regional office levels. The Plan's claims procedure requires the submission of a receipt of payment that includes detailed costs of the services or treatment rendered or a prescription that includes details of the diagnosis. A human resource associate at these offices is designated to handle the claims. While the staff handling the claims are required to sign a confidentiality agreement, the fact that these claims are handled directly by a local human resources unit, then subsequently approved by the head of the office, poses a serious concern, especially in terms of the risk of staff's medical- and health-related data being potentially misused. **The Inspector recommends that a clear segregation of duties be maintained between human resources units and health insurance claims and complaints management functions to ensure the highest level of protection of health and health insurance personal data.**

122. **Reimbursing the health insurance claim amounts through payroll does not add to data protection but increases the risk of disclosure of that information.** Regardless of the entity handling the claims, the two Medical Insurance Plans under the United Nations Secretariat and UNHCR reimburse the health insurance claim amounts through payroll, potentially exposing private information closely linked to health conditions to unrelated

[65] ILO Office Directive IGDS No. 457 (version 1), "Protection of personal data".

entities, as in the case where the person concerned needs to prove his or her remuneration to a third party or in connection with banking transactions involving loans or bank guarantees.

123. The following recommendation is expected to strengthen data protection policies and enhance control and compliance.

Recommendation 5

By the end of 2026, the executive heads of United Nations system organizations who have not yet done so should ensure that the highest level of protection is given to all beneficiaries' health insurance-related data, including medical reports, prescriptions, tests and reimbursed amounts, and that the disclosure, transmission, processing and storage of health insurance-related personal data be subject to the written consent of the person concerned and any possible exception be unequivocally spelled out in relevant policies.

124. **Acknowledging reality without renouncing improvement.** The differences in coverage mainly arise from the evolution of the schemes and the varying dynamics of negotiations with staff representatives. This is a fact that cannot be overlooked when considering whether further harmonization of policies is possible. It would be challenging to eliminate differences in coverage as this would imply an increase in costs for schemes with limited coverage or an unacceptable reduction in coverage for those schemes that offer more protection. Indeed, it is for this reason that no benchmarking framework has yet been developed on the question of health insurance coverage.

125. Coordination of all future major modifications to health insurance among all the entities, always in close cooperation with the beneficiaries, is needed. Moving towards greater harmonization, both through specific and concrete changes to certain aspects (as suggested in this report) and narrowing the gap between schemes should remain the ultimate goal. Both strategies should be based on transparency and the availability of detailed information to allow policyholders to assess their relative position in the system at any given moment in order to determine whether or not there is a need for change. On the basis of that information, it would be possible to chart a long-term convergence path, which, in the Inspector's view, would involve the strictest possible coordination of reforms among all the entities, at least at the level of the duty station where the health insurance policies are administered (i.e. Geneva, New York, Rome and Vienna).

III. Effectiveness and efficiency of health insurance schemes

126. This chapter is divided into three parts: section A is focused on monitoring of and reporting on the objectives and performance of health insurance schemes; section B is focused on the financial performance of plans; and section C deals with fraud prevention, cost containment and procurement of third-party administrators and health insurance providers.

A. Monitoring of and reporting on the objectives and performance of health insurance schemes

127. **Achievement of high-level policy goals is not measured.** As already mentioned, all participating organizations indicate, in their respective staff regulations and rules, their commitment and obligation to establish and run a scheme of social security for their staff and retirees. However, such rules are generally drafted in very broad terms, which does not allow for a precise understanding of the extent of the commitments and makes it difficult to monitor compliance. Some examples of such statements are highlighted in table 12.

Table 12
High-level organizational objectives related to health insurance for staff and retirees

Participating organization	*High-level objective*
FAO	To provide high quality, efficient health insurance coverage to all FAO personnel worldwide, fulfil its duty of care to personnel, while maintaining [its] financial sustainability.
ILO	The objective … shall be to provide, to the extent prescribed by these Regulations and by the Administrative Rules made thereunder, reimbursement of the expenses which may be incurred for health protection –including medical care in case of illness, accident and maternity and personal preventive care – by persons protected by the Fund.
United Nations Secretariat	The Secretary-General shall establish a scheme of social security for the staff … [to] provide the most comprehensive health insurance coverage to staff members, retirees and their eligible dependants … [to] ensure that all plan participants (staff members, retirees and their eligible dependants) enrolled in health plans administered by the Health and Life Insurance Committee have access to benefits, and products that provide adequate protection against sickness and loss.
UNHCR	Medical Insurance Plan is part of the scheme of social security for staff, established by the Secretary-General in accordance with regulation 6.2 of the Staff Regulations. The Plan provides protection against the high cost of health care involving preventive care, chronic condition management, maternity or catastrophic events resulting in serious illness or injury. The Plan is not, however, intended to cover all types of medical or dental expenses or to cover such expenses at full cost.
UNOPS	The objective of the Medical Insurance Plan is to assist subscribers and their eligible family members in meeting expenses incurred for certain health services, facilities and supplies arising from sickness, accident or maternity and which should be reimbursed within the limits laid down in the UNOPS Medical Insurance Plan rules.
UPU	To ensure staff members and retirees' well-being through the provision of good health care for them and their families.

Participating organization	*High-level objective*
WFP	To provide WFP employees, retirees, and their dependants worldwide with sustainable and cost-effective access to quality health care and financial protection through affordable insurance services, so as to mitigate health risks and promote a corporate culture of health and an enabling and supportive workplace.
WHO	The mission of Staff Health Insurance is to provide access to quality, safe, effective, and affordable health-care services and medicines and ensure financial risk protection at an affordable cost, while serving participants with efficiency, dignity and integrity.

Source: Compiled by JIU based on documents submitted by the participating organizations.

128. **Performance against high-level goals is sometimes gauged through satisfaction surveys.** The Inspector could find a few instances where these broad objectives are monitored and measured. Some examples are highlighted in table 13; these are not yet considered optimal, but the effort is commendable. WFP is the only organization found that clearly links the provision of health insurance with its Wellness Strategy[66] and its People Policy,[67] which is an additional good practice.

Table 13
Examples of indicators to monitor the achievement of health insurance objectives

Participating organization	*Output/Activity*	*Key performance indicator*
UNDP Occupational Health, Safety and Well-Being Strategy 2021–2023	Developing, delivering and evaluating evidence-based programmes, tools and staff-care resources at the corporate and local level to help personnel and their eligible dependants to maintain their safety, health and well-being and ensuring they have access to these services upon joining UNDP and for the entire duration of their work in the organization	Percentage of staff aware of the various entitlements, as well as resources and services for health and well-being that are available in UNDP Percentage of staff feeling that the organization takes adequate measures to protect health and well-being (measured through an annual global staff survey)
WFP Wellness Strategy 2020–2024	Access to service: expanded provider network of the WFP Corporate Insurance Plan; cost-effective design and administration of health insurance benefit schemes for all employees	Satisfaction rate of locally recruited employees in the field with insurance benefits and services (measured through a yearly satisfaction survey)

Source: Compiled by JIU.

129. **Claim data could be used to monitor high-level goals.** Anonymized claims data are a valuable source of information about the state of health and well-being of staff, but they are severely underutilized. Staff health insurance is largely perceived as a stand-alone staff benefit and is almost never linked to the organization's strategy for staff health and well-being. As a result, the review has not found any good examples of anonymized claims

[66] See https://executiveboard.wfp.org/document_download/WFP-0000127406.
[67] See https://executiveboard.wfp.org/document_download/WFP-0000127449.

data being used for policymaking related to staff's health and well-being or an overall assessment of schemes.

130. **Organizational commitment and monitoring of externally administered health insurance schemes are lacking.** As mentioned earlier, most health insurance services are outsourced, either fully or only with respect to their administration.[68] This sometimes weakens ownership and leads organizations to act, to varying degrees, as if their responsibility for providing health insurance has also been outsourced. This deficiency was in evidence in interviews with many participating organizations; when asked how they assessed their achievement of health insurance goals, the respondents simply referred to the absence of complaints from plan members as an indicator that the health insurance provided was effective and adequately met their needs. Stakeholders in the field also reported that the quality of services provided by third-party administrators is not always monitored at the regional or subregional level. The Inspector believes that more engagement with policyholders and plan members across geographical locations is needed to better understand the challenges that both staff and management face with regard to the provision of quality and comprehensive coverage, and also to demonstrate that health insurance is an essential part of organizational policies for the well-being of staff.[69] **It is therefore suggested that whatever the type of service provision (self-administered or outsourced), organizations should strengthen their commitment to monitoring the performance of the health insurance service and that they should do so in a systematic and measurable way.**

131. **Customer service charters should be defined and published by the organization.** Most health insurance plans have a customer service charter or agreement to demonstrate their service commitment to the plan members, but this is mainly expressed through their third-party administrator or commercial insurer and not by any official policy instrument, which conveys the idea that it is a concern that has been externalized. **The Inspector suggests that customer service charters should be issued and published by the organizations themselves, regardless of the way health insurance services are provided.**

132. **The four self-insured and self-administered plans have less comprehensive customer service-related objectives than the plans that are externally administered.** This is partly because the rules governing these plans were established long ago, whereas commercial insurers and third-party administrators continue to update service objectives for their customers. For example, the United Nations Office at Geneva United Nations Staff Mutual Insurance Society states that its customer service objective is "to reimburse, within the limits laid down in the Society's Internal Rules, the expenses incurred by its members arising from sickness, accident or maternity." In comparison, the customer service objectives of the IAEA health insurer (Cigna) are based on ensuring access to quality health care at a preferential rate, promoting free choice of health-care providers, facilitating direct payments of medical expenses, and processing medical claims swiftly. **While all of these are good examples of customer-centred objectives, the Inspector proposes that they be operationalized through relevant key performance indicators.**

133. **Key performance indicators are used for performance monitoring, but with varying quality and comprehensiveness.** The health insurance plans that have a third-party administrator or a commercial insurer usually establish a list of key performance indicators with their contractors through a service-level agreement.[70] This list is not standardized, even though in some cases these agreements were concluded with the same company. It is evident

[68] Some organizations' schemes are doubly outsourced, first to another organization in the system that administers the organization's insurance policy on its behalf, and then to a third-party administrator contracted to manage reimbursements, the network of providers and other related activities. This is the case of UNDP, UNFPA, UNICEF and UNOPS, whose internationally recruited staff are members of the plans administered by the United Nations Secretariat; and the United Nations Office at Vienna/UNODC with UNIDO.

[69] One of the recommendations of the previous JIU report (JIU/REP/2007/2) on United Nations system staff medical coverage was precisely that "the legislative bodies of the United Nations system organizations should formally recognize staff health insurance as an important integral part of the common system", which has not been implemented so far.

[70] A list of key performance indicators from existing service-level agreements is consolidated in annex II.

that there was little coordination or exchange of experience and information between the plan administrators.[71] Most plan administrators do not have in-house expertise to negotiate effective terms and closely monitor the agreed indicators to hold the health insurance contractors fully accountable for their service performance, while others were more successful in doing so, even imposing fines on contractors who failed to meet the agreed targets. Key performance indicators from service-level agreements concluded by JIU participating organizations with third-party administrators are compiled in annex II. **In the Inspector's view, these indicators constitute a good practice that should be replicated and possibly harmonized across all schemes, whatever their modality, and made part of the customer service charters, as applicable.**

134. **There is a need for more transparency for beneficiaries on the results of plans.** Regular reporting on health insurance is mainly focused on the operational performance of the plans, such as the number and value of claims made and the average duration of the claims process. These reports were mainly prepared by the organizations or companies administering the plans and the main target audiences are either the executive heads or the governing body, or both. Only eight entities prepare a report for the plan members, which is commendable (FAO, ICAO, ILO, UNESCO, the United Nations Office at Geneva, UNWTO, WFP and WHO). **Considering the fact that health insurance costs are co-contributed by both the active and retired staff and that health insurance is an essential element of their social security rights, it is imperative for the plan members to be provided with periodic reporting, irrespective of the entity administering the plan.**

B. Financial performance of health insurance schemes

1. Definitions and methodological information

135. **Four indicators to analyse health insurance financial performance from the perspective of the schemes and their beneficiaries.** The present analysis is based on the calculation of four key indicators, which, taken together, can be used to describe the overall financial performance of insurance plans from the point of view of both the insurer and the insured persons. The first two indicators are the "loss ratio" and "full loss ratio" and represent the results from the perspective of the insurance provider,[72] while the "effective reimbursement ratio" and the "financial self-coverage ratio" reflect the financial impact of a health insurance plan on its participants.

136. **Loss ratios to gauge financial performance from the insurer's perspective.** The loss ratio measures how far contributions are sufficient to meet expenses, or more generally, when viewed from the insurer's long-term perspective, the schemes' financial sustainability. When analysing the loss ratios, it is important to understand that they compare the expenses incurred[73] with the resources or income of the scheme.[74] The loss ratios thus express the surplus attained in the period under review if the ratio is less than 100 per cent, or the excess of expenditure over income (deficit) if the ratio is greater than 100 per cent.[75]

[71] Some collaboration existed, such as the joint tendering process of the United Nations Secretariat, UNDP and UNICEF to procure a third-party administrator for their Medical Insurance Plans, which allowed for a harmonized list of key performance indicators, but this is an exception to the norm.

[72] While the loss ratio only computes medical expenditures as "expense", the full loss ratio adds to the expense side (the fraction's numerator) not only reimbursements, but also the associated administrative costs.

[73] To simplify the collection of data and calculations, the expenses accounted for herein correspond to medical reimbursements only (for the loss ratio) and to medical reimbursements plus administrative expenses for the full loss ratio.

[74] For the purpose of the study, the income of a scheme is composed of contributions from beneficiaries and the organization, be the latter in cash or in kind (administrative services provided by the scheme without charging their cost to the contributions to be paid by the insured population).

[75] Consequently, for self-insured schemes, very low ratios imply that contributions could be reduced or reserves increased. For outsourced schemes, a very low loss ratio implies, *ceteris paribus*, that premiums are too high or that there are obstacles to the proper use of health-care services and that, in principle, there is room to renegotiate the terms of the contract with the insurance provider or to improve compliance with the contracts.

137. **The effective reimbursement ratio measures the share of actual medical expenditure incurred by beneficiaries that the insurer had effectively reimbursed.** The effective reimbursement ratio compares the reimbursements made and the value of the invoices corresponding to the reimbursements claimed or expenses incurred. It is, therefore, a measurement of the share of medical expenditure actually incurred by beneficiaries that the insurer had effectively reimbursed during the period, which is the latest period for which data were available when they were provided to JIU, namely 2022.[76]

138. **The financial self-coverage ratio expresses the actual cost of insurance borne by beneficiaries.** To calculate the financial self-coverage ratio, it is assumed that the total health expenses ("gross expenses") of each insured person consist of the sum of their contributions to the insurance scheme plus the cost of medical care received during the year, namely the amount that they paid for health-care bills or the amounts that were paid on their behalf by the insurer in the case of direct payments (usually for in-network consultations and for hospitalization). The net expenses are then calculated by deducting the reimbursements obtained from the gross expenses. The net expenses represent, in absolute value, how much the insured person has spent on health in net terms in the period. The financial self-coverage ratio thus indicates the proportion of net expenses in comparison to actual health-care needs (medical expenses incurred). By definition, when this ratio exceeds 100 per cent it means that the beneficiaries paid more than they received in monetary terms, normally because their contributions exceeded their medical needs. Conversely, the further this ratio is below 100 per cent, the higher the subsidy obtained by the insured persons is.

Table 14
Key indicators to gauge the financial performance of schemes

Indicator	*Description*	*Formula*
Loss ratio (%)	Sufficiency of contributions and other organizational subsidies to meet medical expenses	Total medical expenses x 100 / Income of the scheme
Full loss ratio (%)	Sufficiency of contributions and other organizational subsidies to meet medical and administrative expenses	(Total medical expenses + administrative expenses) x 100 / Income of the scheme
Effective reimbursement ratio (%)	Share of medical expenditure effectively borne by the insurer	Total amount of reimbursements made x 100 / Total amount of invoices or medical expenses incurred
Financial self-coverage ratio (%)	Portion of the cost of health-care needs (including health insurance premiums) borne by the beneficiaries themselves	(Contributions from beneficiaries + cost of medical care received – reimbursements received) x 100 / Cost of medical care received = (Net expenses) x 100 / Medical expenses incurred

Source: Prepared by JIU.

[76] In the absence of incurred but not reimbursed claims from past periods, this ratio's highest possible value is 1 (100 per cent) for schemes with no co-payments or co-insurance. Given that most plans have co-insurance for most services, which means that the insured have to pay a percentage (usually 20 per cent) out of their own pocket for each consultation or treatment, it is to be expected that this ratio will take values at or below 80 per cent, as 80 per cent would normally be the maximum amount reimbursed. Thus, the higher the effective reimbursement rate is above 80 per cent for such schemes in a given year, the higher the amounts owed (and now settled) by the insurer from previous periods and the longer the average reimbursement turnaround time. For schemes with no significant co-payments or co-insurance, and therefore with higher reimbursement rates (typically 90 per cent or 100 per cent), the effective reimbursement rate would indicate a problem with the time taken to process reimbursements only if its value was well above 100 per cent.

139. **Methodological caveats.** In interpreting the results that follow, it should be kept in mind that the main aim of this analysis is to provide a limited set of key performance indicators to homogeneously describe plans for benchmark purposes and to further policy harmonization. This is why, in the light of the workload involved for the participating organizations in collecting complete, multi-year time series data on the demographics and financial results of their schemes, information beyond 2022 was not requested for the review;[77] it therefore cannot be ruled out that if the same data were analysed over a longer period of time, covering several years in the business cycle, different results could be obtained.[78] Another methodological restriction to bear in mind is that, for the same reason – to avoid an excessive workload in data collection – the required reimbursement data are cash-based, so they include all payments made in the year, irrespective of the date of their accrual; in the same vein, the amount of expenses incurred is the value of invoices received in 2022, even if the services to which they refer were rendered earlier.[79]

140. **Administrative costs must be considered additional income of the plan when such costs are not factored into contribution calculations.** For schemes where the plan or the sponsoring organization provides administrative services (such as enrolment, collection of contributions, supervision and liaison with the third-party administrator or external insurer) whose value is not considered in the calculation of contributions from beneficiaries, an estimate of that value was also requested in order to add it as income in kind to the scheme. The amount paid by the organization to an external administrator, provided that this cost is also not subsumed into the calculation of contribution from beneficiaries, was also included as income of the scheme for the purposes of this analysis. The total income of each plan is thus the sum of the contributions in cash of both parties and the estimated or exact value of the administrative services not factored into participants' contributions, irrespective of whether these services were provided internally (as in the case of ILO) or through an external administrator (such as UNIDO). For reasons related to simplifying data collection, financial income and any other income that may exist in practice have therefore not been considered.

141. **The data provided have limitations that could be addressed through closer monitoring of plan performance**. Among those schemes for which data were received, 11 provided complete information[80] and 11 schemes lacked information on the cost of in-house health administration services, which leads to an underestimation of the total cost, and therefore to an underestimation of the full loss ratio.[81] Five schemes lacked substantial information, mostly regarding the total expenses submitted for claims,[82] which indicates a lack of oversight over the external administrator or insurer. **The Inspector suggests that United Nations system organizations liaise with third-party administrators or insurers**

[77] One participating organization provided data from 2021 as 2022 data were not readily available when the information was requested.

[78] In particular, as attested by interviewees, the data for 2022 were clearly affected by the COVID-19 pandemic as much of the medical expenditure that would normally have been incurred in 2021 was postponed to 2022 owing to the restrictions prevailing in the first year of the pandemic in most countries. This resulted in a direct negative impact on the individual results of all schemes, in particular on loss ratios. However, since this negative effect is equally distributed across the range of plans, the comparative analysis still stands as a (point-in-time) measurement of the relative health and generosity of each plan.

[79] In a time-series analysis, the differences resulting from these timing mismatches tend to offset each other, but this is not the case when only one year is analysed (cross-sectional analysis), as in the present study.

[80] FAO Basic Medical Insurance Plan and Medical Insurance Coverage Scheme, ILO Staff Health Insurance Fund, IMO Group Medical Plan, United Nations Office at Geneva United Nations Staff Mutual Insurance Society, UNDP Medical Insurance Plan, UNESCO Medical Benefits Fund, WFP Basic Medical Insurance Plan and Medical Insurance Coverage Scheme, WHO Staff Health Insurance and WIPO Group Medical Insurance Plan.

[81] IAEA Full Medical Insurance Plan, ICAO Medical Benefits Plan, United Nations Secretariat Aetna, Cigna Dental, Empire Blue Cross, Medical Insurance Plan and United Nations Worldwide Plan, UNICEF Medical Insurance Plan, UNIDO Field General Service Plan and Full Medical Insurance Plan and UPU Health Insurance Fund.

[82] United Nations Office at Vienna Full Medical Insurance Plan, UNHCR Medical Insurance Plan, UNIDO Field General Service Plan and Full Medical Insurance Plan and UNOPS Medical Insurance Plan.

to request regular information on the financial performance of their plans so that they can evaluate their results and use them to promote changes to policies and contracts when appropriate.

2. Results of the analysis[83]

142. **Active staff and their families comprise 83 per cent of the insured population, with retirees making up the remainder.** Overall, information was provided on 26 plans covering a population of 447,869 people,[84] of whom 373,707 are serving staff and their family members and 74,162 are retirees and their protected relatives. The former amounts to 83 per cent of the entire insured population, while the latter represents the remaining 17 per cent.

143. **On average, organizations in the United Nations systems contributed 17 per cent more than the active staff and 83 per cent more than retirees.** In 2022, for each insured person from active staff families, the staff contributed an average of $1,349, while the organizations contributed $1,576 (17 per cent more), bringing the total contribution to $2,926 per person for the year. For each insured person from a retired staff member's family, the retirees contributed an average of $1,388, while the organizations contributed $2,540 – 83 per cent more. The total average annual contribution per insured member of the retiree's family was $3,928 in 2022. This is 34 per cent more than the average contribution for an active staff family member. In total, the 2022 annual contributions[85] per insured person, both from beneficiaries and the organizations, amounted to an average of $3,079. For serving staff and their dependants, the total contributions for the 24 schemes in the United Nations system organizations with available data amounted to $845,770,821 in 2022, while for retirees and their dependants, it was $367,528,901, bringing the combined sum of contributions to $1.2 billion in the year.

144. The following table shows the estimated financial indicators corresponding to the 2022 data provided by the participating organizations.

Table 15
Financial ratios by health insurance plan (2022)

Policyholder and scheme	*Modality*	*Full loss ratio (%)*	*Loss ratio (%)*	*Effective reimbursement ratio (%)*	*Financial self-coverage ratio (%)*
FAO Basic Medical Insurance Plan	Commercially insured	97.6	93.5	85.4	49.3
FAO Medical Insurance Coverage Scheme	Commercially insured	169.0	127.1	77.3	59.8
IAEA Full Medical Insurance Plan	Commercially insured	Data not available	99.0	80.8	67.1
ICAO Medical Benefits Plan	Self-insured	Data not available	89.3	78.5	65.6
ILO Staff Health Insurance Fund	Self-insured	93.5	96.8	82.7	53.93

[83] To develop the analysis presented below, information was requested from the participating organizations on the insured personnel (number, distinguishing between active and retired staff and including their respective family members also covered by the insurance in each group); the income of each scheme, including the contributions received from active participants, retirees and employers, in the latter case with detail of contributions in favour of each of the two subgroups of beneficiaries and the estimated value of the administrative services not considered in the calculation of contributions from beneficiaries; the amount of the expenses corresponding to the health care received by beneficiaries in the year considered; the reimbursements and direct payments made by the insurers; and the administrative costs incurred.

[84] The number of plan members insured under the United Nations Secretariat's Cigna Dental plan is not included to avoid double counting.

[85] In-kind contributions and amounts directly paid to third-party administrators (not included in the calculation of contributions from beneficiaries) by the organization are not accounted for here.

Policyholder and scheme	*Modality*	*Full loss ratio (%)*	*Loss ratio (%)*	*Effective reimbursement ratio (%)*	*Financial self-coverage ratio (%)*
IMO Group Medical Plan	Commercially insured	85.9	85.5	87.6	41.8
United Nations Office at Geneva United Nations Staff Mutual Insurance Society	Self-insured	81.1	77.8	77.8	70.4
United Nations Office at Vienna Full Medical Insurance Plan	Commercially insured	72.2	65.2	Data not available	Data not available
United Nations Secretariat Aetna	Self-insured	Data not available	87.9	64.9	60.9
United Nations Secretariat Cigna Dental	Self-insured	Data not available	90.5	48.3	73.0
United Nations Secretariat Empire Blue Cross	Self-insured	Data not available	97.7	33.6	78.8
United Nations Secretariat Medical Insurance Plan	Self-insured	Data not available	107.2	87.5	30.1
United Nations Secretariat United Nations Worldwide Plan	Self-insured	Data not available	87.9	87.2	72.4
UNDP Medical Insurance Plan	Self-insured	169.8	148.9	84.4	29.0
UNESCO Medical Benefits Fund	Self-insured	66.7	64.1	87.7	80.6
UNHCR Medical Insurance Plan	Self-insured	59.8	55.0	Data not available	Data not available
UNICEF Medical Insurance Plan	Self-insured	Data not available	63.5	85.7	44.6
UNIDO Field General Service Plan	Commercially insured	Data not available	83.2	Data not available	Data not available
UNIDO Full Medical Insurance Plan	Commercially insured	Data not available	68.7	Data not available	Data not available
UNOPS Medical Insurance Plan	Commercially insured	68.3	53.4	Data not available	Data not available
UPU Health Insurance Fund	Commercially insured	Data not available		86.9	Data not available
UNWTO Health and Accident Insurance Plan	Commercially insured	28.6	28.5	86.9	Data not available
WFP Basic Medical Insurance Plan	Commercially insured	86.0	81.9	84.8	64.2
WFP Medical Insurance Coverage Scheme	Commercially insured	88.8	75.4	84.9	41.8
WHO Staff Health Insurance	Self-insured	58.5	54.6	73.7	69.8
WIPO Group Medical Insurance Plan	Commercially insured	94.9	94.8	88.8	44.4

Source: Prepared by JIU.

145. **The simple arithmetic mean of the full loss ratio is 88.1 per cent, indicating, in general, a good fit between contributions and expenses.** With regard to table 15, of the 15 plans with complete information on the calculation of the full loss ratio, 6 have values between 85 and 100 per cent, denoting a particularly good alignment between contributions and expenses for claims and administration, while another group of 6 also has healthy ratios between 50 and 85 per cent.[86] Regarding loss ratios, the simple arithmetic mean for the 25 plans with complete information amounts to 83.1 per cent. Overall, 21 schemes, 84 per cent of the total, have healthy loss ratios.

146. **In total, 14 of the 21 plans with information have an effective reimbursement ratio, ranging from 80 to 88.8 per cent.** There are five plans with a ratio of between 65 per cent and 80 per cent, whereas two of the United Nations Secretariat's plans have ratios below 50 per cent. The WIPO Group Medical Insurance Plan has the highest values (88.8 per cent), closely followed by the IMO Group Medical Plan, the UNESCO Medical Benefits Fund, the United Nations Secretariat Medical Insurance Plan and the United Nations Worldwide Plan, the UNWTO Health and Accident Insurance Plan and the UPU Health Insurance Fund, all of which have ratios of around 87 per cent.

147. **Of the 19 plans for which there are data, 17 have financial self-coverage ratios below 75 per cent.** As for the financial self-coverage ratio, data were received from 19 schemes (see Table 16). Of these, seven show ratios below 50 per cent, implying that their schemes cover more than half the actual cost of health services needed during the year. The plans with the highest levels of financial protection in 2022 were the Medical Insurance Plans under UNDP and the United Nations Secretariat, followed by the IMO Group Medical Plan and the WFP Medical Insurance Coverage Scheme. In particular, beneficiaries of these two Medical Insurance Plans had a financial self-coverage ratio as low as 30 per cent and, therefore, obtained the highest subsidy (around 70 per cent of their expenses) to meet their health needs in 2022. For the schemes with financial self-coverage ratios above 50 per cent, the subsidy received by beneficiaries was less than their contributions and out-of-pocket medical expenses. The simple arithmetic mean of the financial self-coverage of this group of 19 plans is 57.7 per cent.

148. **A closer look at the financial self-coverage ratio confirms that intergenerational solidarity is firmly rooted in the United Nations health insurance plans.**[87] With reference to Table 16, the ratio corresponding to the serving staff of the 19 schemes for which data were provided averages 75.3 per cent, whereas for retirees it is 39 per cent, which means that subsidies for the latter (61 per cent) were 14 percentage points higher than those of active staff (24.7 per cent).

[86] Four schemes (FAO Medical Insurance Coverage Scheme, UNIDO Full Medical Insurance Plan, UNESCO Medical Benefits Fund and UNWTO Health and Accident Insurance Plan) have unusually low or high loss ratios, which might suggest a possible problem with the quality of the information provided.

[87] Part of the additional subsidy that retirees receive is aimed at covering taxes on pensions, as recognized by the latest Secretary-General report on after-service health insurance, A/76/373, para. 57 ("Since January 1974, [health insurance] costs have been apportioned between retired and active staff, with the result that the contribution rate for retirees is approximately one half that of active staff members, while maintaining the mandated sharing ratios between the Organization and the participants as a group. This arrangement takes into consideration that pensions are taxable, whereas contributions by staff members are based on net income. It is achieved by transferring a portion of the Organization's share of premium from active staff members to retirees, resulting in a cross-generational subsidy from active to retired staff").

Table 16
Financial self-coverage ratio (percentage) by health insurance plan and by type of insured member (2022)

Policyholder and scheme	*Modality*	*Active staff + dependants*	*Retirees + dependants*	*Overall ratio*
FAO Basic Medical Insurance Plan	Commercially insured	72.0	38.4	49.3
FAO Medical Insurance Coverage Scheme	Commercially insured	59.8	Not applicable	59.8
IAEA Full Medical Insurance Plan	Commercially insured	93.2	48.8	67.1
ICAO Medical Benefits Plan	Self-insured	66.9	64.4	65.6
ILO Staff Health Insurance Fund	Self-insured	94.2	35.3	53.93
IMO Group Medical Plan	Commercially insured	65.3	24.8	41.8
United Nations Office at Geneva United Nations Staff Mutual Insurance Society	Self-insured	107.8	40.1	70.4
United Nations Office at Vienna Full Medical Insurance Plan	Commercially insured			Data not available
United Nations Secretariat Aetna	Self-insured	75.3	29.8	60.9
United Nations Secretariat Cigna Dental	Self-insured	75.5	68.6	73.0
United Nations Secretariat Empire Blue Cross	Self-insured	75.2	84.2	78.8
United Nations Secretariat Medical Insurance Plan	Self-insured	35.5	13.2	30.1
United Nations Secretariat United Nations Worldwide Plan	Self-insured	99.9	31.2	72.4
UNDP Medical Insurance Plan	Self-insured	30.6	24.8	29.0
UNESCO Medical Benefits Fund	Self-insured	144.8	50.5	80.6
UNHCR Medical Insurance Plan	Self-insured			Data not available
UNICEF Medical Insurance Plan	Self-insured	48.9	26.1	44.6
UNIDO Field General Service Plan	Commercially insured			Data not available
UNIDO Full Medical Insurance Plan	Commercially insured			Data not available
UNOPS Medical Insurance Plan	Commercially insured			Data not available
WFP Basic Medical Insurance Plan	Commercially insured	89.5	34.1	64.2
WFP Medical Insurance Coverage Scheme	Commercially insured	44.3	21.7	41.8
WHO Staff Health Insurance	Self-insured	91.4	42.0	69.8
WIPO Group Medical Insurance Plan	Commercially insured	60.7	24.4	44.4

Source: Prepared by JIU.

C. Fraud prevention, cost containment and procurement

1. Fraud prevention and detection

149. **Fraud awareness is uneven across organizations.** Committing health insurance fraud not only goes against the standards of conduct of staff in the United Nations system, but also can lead to higher premiums or other policy changes to the detriment of policyholders and beneficiaries, regardless of whether plans are self-insured or commercially insured. However, the review found that the degree of fraud awareness is uneven across organizations, with the organizations with commercially insured plans generally the least active in this area. One good practice noted in this respect is the inclusion in contracts with commercial insurers of a formula whereby savings resulting from a lower level of expenditure are shared between the policyholder and the insurer up to a certain limit, which, at least in theory, creates an incentive for cost containment and fraud control from both sides.[88]

150. **The prevalence of health insurance fraud cases reported is lower than average, but vigilance must be maintained**. The JIU participating organizations reported 226 cases of presumptive and decided health insurance fraud between 2019 and 2022, with a combined fraud amount of $2.2 million, of which approximately $142,000 was recovered.[89] Available data suggest that across health-care systems globally, fraud accounts for between 3.29 and 10 per cent of health-care expenditure.[90] In the case of the health insurance plans in the United Nations system organizations, which incurred a total reimbursement amount of $1.05 billion in 2022, the reported fraud amount was much lower than these global benchmarks. However, this does not mean that the prevalence of fraud is lower, but rather that the number of officially known fraud cases might be low. In this sense, some respondents mentioned possible fraudulent practices in certain regions (such as collusion between medical service providers or pharmacists and insured persons, unusually high fees charged to United Nations staff or the use of insurance cards by uninsured family members) that go unnoticed or are not acted upon owing to a weak control system.

151. **Detecting health insurance fraud is a technical area requiring specialized expertise and resources.** The health insurance plans that have a third-party administrator or are commercially insured rely mainly on their health insurance contractors to set up a system to detect and investigate potential fraud. In such cases, the participating organizations benefit from the expertise of the contractors as monitoring and detecting health insurance fraud requires specialized expertise usually not available in-house except for self-administered schemes; however, this should not prevent them from engaging in fraud control activities. An example of a fraud detection system of an international health insurance provider is shown in figure II.

[88] This is the case of article 25 of the contract that UNIDO has with its insurer.

[89] Several cases are still under investigation.

[90] Jim Gee and others, “The financial cost of healthcare fraud” (MacIntyre Hudson LLP and Centre for Counter Fraud Studies, University of Portsmouth, 2010).

Figure II
A fraud, waste and abuse detection system of an international health insurance provider

Dedicated resources: clinicians, data scientists, auditors and investigators

Examples of multifaceted triggers to examine submitted claims

- Automated rules which identify unusual combinations of diagnoses and procedure codes
- Clinical audit and pricing scrutiny for out-of-network claims
- Claim amounts over a particular threshold
- Intellectual property-protected rules of known fraudulent scenarios or schemes
- Flagging of known fraudulent health-care providers
- Use of suspicion index
- Data mining exercises of post-payment fraud analysis to uncover emerging threats and trends

Source: Prepared by JIU.

152. **All four self-administered schemes detected and reported presumptive fraud cases, whereas 9 of the 22 schemes administered externally did not.** While it is clear that commercial health insurers or third-party administrators are highly experienced in fraud detection as it is part of their core business expertise, the review did not undertake a detailed comparative analysis to determine the effectiveness of the systems implemented by the self-administered schemes. Nonetheless, scheme administrators detected and reported presumptive fraud cases in all four self-administered schemes (64 cases between 2019 and 2022), whereas no fraud cases at all were reported under 9 of the 22 third party-administered or commercially insured schemes.

153. **Cash payment limits to prevent fraud.** In the case of the four self-insured and self-administered plans, the policyholders set up their own system to monitor potential cases of fraud or devise measures to minimize fraud risks. The WHO scheme, for example, limits the amount of cash payments made by plan members to health-care providers to $250 for Geneva and neighbouring France and $2,000 for the rest of the world, while the ILO scheme limits cash payments to $1,000 and the United Nations Office at Geneva United Nations Staff Mutual Insurance Society limits them to $500. Although these organizations deserve recognition for their anti-fraud policies, the significant difference in the amounts is striking, in particular as they are all located in Geneva. This suggests that there is room for improvement in the coordination of policies and practices in this area. The Inspector is of the view that cash payments should be strictly limited to amounts considered reasonable and customary in the country of residence as the higher the amount, the less of an impact it will have on fraud prevention. **The Inspector suggests that cash limits be updated and lowered whenever possible for all kinds of health insurance.**

154. **Random sampling of claims to detect fraudulent cases.** In the ILO and United Nations Office at Geneva schemes, an in-depth check of samples of claims with an amount over a specific threshold is conducted every month, which is also considered a good practice although its effectiveness depends on keeping the threshold low enough to discourage adaptative or opportunistic behaviour. **The Inspector proposes that the effectiveness of these thresholds be reviewed periodically to ensure that they are valid and yield the expected results.**

155. **Use of indicators to flag possible fraud.** The claim administration systems of the United Nations Staff Mutual Insurance Society, ILO and WHO include certain indicators that could flag anomalies, such as the use of the ratio of claims amounts to salary as a triggering factor for claim reviews in the case of ILO. Although the use of indicators is strongly encouraged to monitor fraud risk, in the Inspector's view, linking the likelihood of fraud to the salary of the beneficiary implies assuming that claims from lower-paid employees are

also expected to be low, as if the cost of treatments or the probability of materialization of health risks were a function of personal income. **The Inspector suggests the use of indicators to monitor fraud risk, but indicators linking the likelihood of fraud to the salary of the beneficiary should be discontinued and replaced by others that better capture the risks considered.**

156. **Training and coordination also add to fraud prevention effectiveness.** Some plans rely on the competency and expertise of their claim reviewers in country and regional offices to detect potential fraud. While the decentralization of this function does not, in itself, pose a risk to the integrity of the claims review process, it is necessary that the people charged with carrying out this function are adequately trained and coordinated to ensure the utmost objectivity, professionalism and fairness in the application of appropriate screening and control measures. **For self-administered schemes, the Inspector recommends that their programme of work include a sustained emphasis on fraud prevention and detection training for staff involved in the processing of claims, and that schemes be kept up to date with, or adopt, the latest fraud detection technologies, comprising generative artificial intelligence tools.**

157. **Disciplinary actions for proven fraud cases vary between the schemes.** Active staff who are found, by their organization's investigation system, to have committed health insurance fraud face different disciplinary actions; such actions vary depending on the organization. For a proven case, the disciplinary actions range from dismissal regardless of the amount of money involved in the fraud, as in the case of UNOPS and UNHCR, to disciplinary actions tailored to the severity of the case at ITU, the United Nations Secretariat, UNESCO, UNIDO and UNDP. Proven fraud cases involving retired staff usually result in the termination of their after-service health insurance enrolment.

158. **Disciplinary measures must be proportional to the gravity of the misconduct.** While the Inspector agrees that cases of suspected fraud must be investigated thoroughly and systematically, it should also be borne in mind that not all infringements deserve the same response. One of the principles of law, which must be applied in all areas concerning infringements of prohibitions or mandatory rules, is that the sanction must be proportionate to the degree of seriousness of the misconduct ("Any disciplinary measure imposed on a staff member shall be proportionate to the nature and gravity of his or her misconduct", in line with United Nations staff rule 10.3 (b)), as it is self-evident that not all breaches are equally damaging.[91] On the other hand, the right to social security is a right that staff should not be deprived of unless they are separated from service either voluntarily or as a consequence of a disciplinary process, as that right is an entitlement intimately linked to the employment relationship. **The Inspector recommends that sanctions arising from cases of health insurance fraud, as with any other fraud or misconduct, always be graduated according to the severity of the misconduct, in line with the relevant staff regulations and rules.**

2. Cost containment

159. **There have been very limited inter-agency discussions and collaboration on cost containment.** In 2018, the inter-agency Working Group on After-Service Health Insurance issued a recommendation that "all avenues of health insurance cost containment continue to be explored in the context of inter-agency discussions under the auspices of the High-Level Committee on Management".[92] The recommendation was aimed at reducing United Nations system organizations' costs related to health insurance plans, including after-service health insurance liabilities. It appears from interviews and discussions with JIU participating organizations that such system-wide inter-agency collaboration has not taken place. Nevertheless, some sporadic location-based effort was found, especially through the exchanges and discussions between Geneva-based organizations (ILO, the United Nations

[91] Improperly claiming a reimbursement of $30 is not the same as claiming one of $30,000. While in the first case, in addition to the refusal of reimbursement, the claimant should be liable to a petty penalty, in the second case he or she should be subject to a much more serious measure, comprising, where appropriate, disciplinary dismissal. See https://www.un.org/internaljustice/oaj/en/proportionality-sanction for jurisprudence on the principle of proportionality by the United Nations Appeals Tribunal.

[92] A/73/662.

Office at Geneva and WHO)[93] and the United States-based organizations (the United Nations Secretariat, UNDP and UNICEF for their Medical Insurance Plans).[94] **The Inspector suggests that participating organizations revitalize inter-agency discussions with a view to implementing that recommendation.**

160. **Most plan administrators do not have a clear plan of action on cost containment.** In interviews, many plan administrators stated that they did not have any plans for cost containment, while the rest explained that some measures have been pursued. Those with a third-party administrator or an insurer rely mainly on the expertise of these commercial enterprises, which, through shared examples, demonstrated that they were able to implement an array of actions to lower or avoid unnecessary costs. It is noted, however, that in the contractual arrangements with these companies, a target for cost containment is never included as part of their performance monitoring system. Similarly, cost containment is not part of the key performance indicators of the self-insured plans. In addition to the plan administrators, retirees associations have played a significant role in raising awareness of cost-saving measures among their members, which is commendable.

161. **Modifications to plan designs and eligibility criteria promote long-term cost reductions, but may come at the expense of inequitable coverage for staff.** FAO launched a new health insurance plan specifically designed for locally recruited staff in the field who joined the organization on or after 1 October 2016. Previously, FAO had only had one plan, the Basic Medical Insurance Plan, for all staff worldwide, which provided equitable coverage for all. The new plan, the Medical Insurance Coverage Scheme, has lower coverage than the original plan overall, and a significantly lower annual premium amount of $39.93 per person for 2023, compared with $143.53 for the original plan. The launch of the new plan, therefore, has lowered the organization's health insurance costs, including the future cost of after-service health insurance. It is noted that having two separate plans, one for staff at the headquarters and for internationally recruited staff in the field and one for locally recruited staff in the field, is a common modality used by most participating organizations.[95] The newer of the two plans at FAO is still small (223 active staff members were participating as at the end of 2022). It remains to be seen to what extent this plan would adequately meet the needs of the target staff.

162. **Some cost-containment measures require long-term planning.** In 2023, IAEA lowered the age of non-dependent children of after-service health insurance plan members from 30 to 25 years of age as a cost-containment measure.[96] This will also help to limit the number of after-service health insurance plan members of the organization in the long run. The result of this cost-containment measure still remains to be seen, but it demonstrates that long-term cost reduction measures may require long-term planning.

163. **The use of national health insurance schemes has successfully lowered costs, but it is not applicable everywhere.** In 2011, the United Nations Secretariat required its United States-based retired staff who received after-service medical insurance to enrol in Medicare Part B, a United States federal programme whose premium is reimbursed by the organization. Medicare Part B serves as the primary coverage[97] for the retired staff, while the United Nations plans serve as a secondary coverage. In essence, there is no change to the coverage for the plan members, but the United Nations is able to save costs owing to lower amounts of reimbursements made under its own plans. For the financial period ending on 31 December 2020, the consulting actuaries estimated that the projected savings from this initiative lowered the valuation of accrued after-service health insurance liabilities by 8 per cent,

[93] The joint effort among Geneva-based organizations is focused on price negotiations with medical service providers in Switzerland.

[94] The United States-based organizations jointly procured a third-party administrator for their Medical Insurance Plans.

[95] Among the 28 participating organizations, only IAEA, ILO, UNESCO, UNWTO, UPU, WHO and WIPO have one health insurance plan for all staff. It is noted that among these organizations, only ILO, UNESCO and WHO have a substantial number of staff in the field.

[96] This is applicable only to staff members whose entry on duty was on or after 1 March 2023.

[97] Medicare Part B covers two types of services: (a) services or supplies that are needed to diagnose or treat medical conditions; and (b) preventive care.

translating to an estimated reduction of $600 million in accrued liabilities at the time.[98] WHO has modified its health insurance rules for its United States-based retired staff accordingly. FAO is currently considering this option.

164. **National plans are available in Austria, Canada, Switzerland and the United Kingdom.** In the United Kingdom, IMO staff have access to the country's National Health Service. While the use of National Health Service services is considered complementary, IMO health insurance plan provides financial incentives for the plan members using the National Health Service, which is a good practice. In other countries, such as Austria and Canada, staff have an opportunity to opt out of the organizations' own plans and enrol, with an organizational subsidy, in the national plans. No data are available on how this has resulted in cost-saving for the organizations. For UPU retirees who opt to be insured under the national health insurance of Switzerland, regulated by the Federal Act on Health Insurance, UPU subsidizes the premiums and provides a subsidized supplementary health insurance plan. The organization reported no cost-saving as a result of this arrangement.

165. **Most plan administrators were not able to demonstrate tangible results of their cost-containment measures.** The review found very few examples of third-party administrators reporting on the financial savings (or costs avoided) as a result of their cost-containment measures. For the UNDP Medical Insurance Plan, for example, its third-party administrator reported in 2021 on the cost avoidance/reduction of $1.06 million through its negotiation with health-care providers, the provision of clinical services and case management and fraud, waste and abuse measures. Under the WHO Staff Health Insurance, cost-savings are tracked through their case management activities, which in 2022, also resulted in savings of $1.06 million. Otherwise, the Inspector found that the overall effort on cost containment for health insurance has not been pursued rigorously and systematically. Current cost-containment practices are as follows:

- Monitoring of claim amounts to ensure reasonable and customary costs
- Negotiation of preferential rates with local and in-network health service providers
- Provision of financial incentives when plan members are able to demonstrate cost-saving, such as utilizing national health insurance services, seeking services from less expensive providers and using generic drugs
- Provision of direct medical services in the duty stations whose access to quality services is not available
- Engagement with plan members, especially on the financial situation of the plan
- Promotion of preventive care
- Clinical consultations and case management, especially for chronic conditions
- Strengthening fraud prevention and control
- Raising awareness among plan members

166. **Most health insurance schemes are not regularly audited by the organizations.** The audit function plays an irreplaceable role in cost containment, fraud detection and the overall improvement of health insurance policies and practices. Control activities, such as the planned audit of medical claims and policy evaluation for the United Nations Headquarters-administered health insurance schemes, are of paramount importance to ensuring an adequate control environment and stimulating cost containment and fraud prevention and detection for all types of plans. **The Inspector recommends that audits be conducted periodically to assess, inter alia, the accuracy of eligibility records and claim adjudications, and whether the performance of the administrator meets agreed standards.**

167. **Contracts should allow plan owners to audit administrators and insurers.** Another good practice the review found is the inclusion in some insurance or administration contracts of a clause requiring the contractor to be certified by an external entity accredited

[98] See A/76/373.

in the field of fraud risk management, detection and prevention, as well as provisions to allow the participating organization to conduct on-site or off-site audits of the insurer or third-party administrator's internal control systems, procedures and practices relating to claim management and fraud prevention, control and remediation. **The Inspector suggests that the contractual arrangements of externally administered or insured plans be revised whenever possible to introduce such conditions and ensure that their auditing authority is exercised effectively.**

3. Procurement

168. **Limited inter-agency collaboration and exchanges of good practices and lessons on procurement of commercial health insurers and third-party administrators have taken place.** In 2015, the Secretary-General reported[99] on the need for the United Nations system organizations to collectively negotiate with health insurance third-party administrators and commercial health insurers to optimize pricing and network access. In his subsequent report,[100] it was recommended that the organizations consider aligning their requirements for third-party administrators with best practices, which include achieving harmonization on various key aspects, such as key performance indicators, pricing methodology, reporting structure and frequency and controls and audits. The Inspector did not find any efforts arising from this recommendation, besides existing and historic inter-agency collaboration on joint procurement, such as collaboration between the plan administrators of the Medical Insurance Plans.

169. **The lack of inter-agency coordination means missed opportunities for the United Nations system organizations to enhance negotiating power in the health insurance market where there are only a few vendors.** Nearly 240,000 United Nations plan members are insured under third party-administered health insurance plans, and nearly 83,000 people are insured under commercially insured plans. Despite this, procurement for health insurance services was conducted separately, including for the UNOPS, UNWTO and UPU plans, each of which cover fewer than 1,000 people (these three plans are under the same health insurer). It is noted that joint procurement cannot be easily executed owing to divergences in procurement cycles, operational rules and enterprise management systems, to name but a few reasons. Past efforts to promote the alignment of requirements for procurement, including the use of a template agreement that reflects industry best practice, has not been picked up owing to the absence of a central coordinating body and a repository for knowledge management, following the discontinuation of the Working Group on After-Service Health Insurance. In interviews, several plan administrators highlighted difficulties in preparing the terms of reference owing to the lack of in-house expertise and access to good examples from other organizations. Some participating organizations hired an external health insurance consultant to support the tendering process, which is a good practice. Another challenge is the scarcity of qualified vendors to enter the competitive bidding process. For the 19 third party-administered and commercially insured plans outside the United States, only three companies have been used: Cigna (15 plans), Allianz Care (3 plans, but one policyholder) and MSH International (1 plan). While this poses a challenge, it also presents an opportunity for collective negotiations and the harmonization of service-level agreements, especially with Cigna.

[99] A/70/590.
[100] A/73/662.

IV. Adequacy and quality of services

170. **Global survey on health insurance coverage with more than 23,000 responses.** The perceptions and feedback of active staff and retirees on the relevance, adequacy and effectiveness of the health insurance schemes in which they are enrolled are presented in this section. For the review, data were gathered and analysed, mainly from a large-scale online survey conducted between 4 May 2023 and 20 June 2023, which, ultimately, received responses from 23,163 active and retired staff members worldwide. The number of survey respondents constituted 14.7 per cent of the total number of active and retired staff who were insured under the 25 health insurance schemes of the United Nations (157,266 persons).[101] Although, as a result of the methodology used, it cannot be claimed that the survey results are statistically representative of the population consulted, the volume of responses received allows valid conclusions to be reached for the purposes of this analysis, the primary goal of which is to identify shortcomings and areas for improvement.

171. **The survey covered sufficiency of coverage, access to health care and the effectiveness of the administration of health insurance plans.** Respondents were asked for their perceptions of the aspects related to: (a) the extent to which their health insurance scheme has met their health-care needs and those of their dependants; (b) the level of access to health care and other related services at their duty station; and (c) the effectiveness of the administration of their health insurance scheme. A summary of the findings is provided in this section. The overall survey results can be found in the complementary paper for this review.

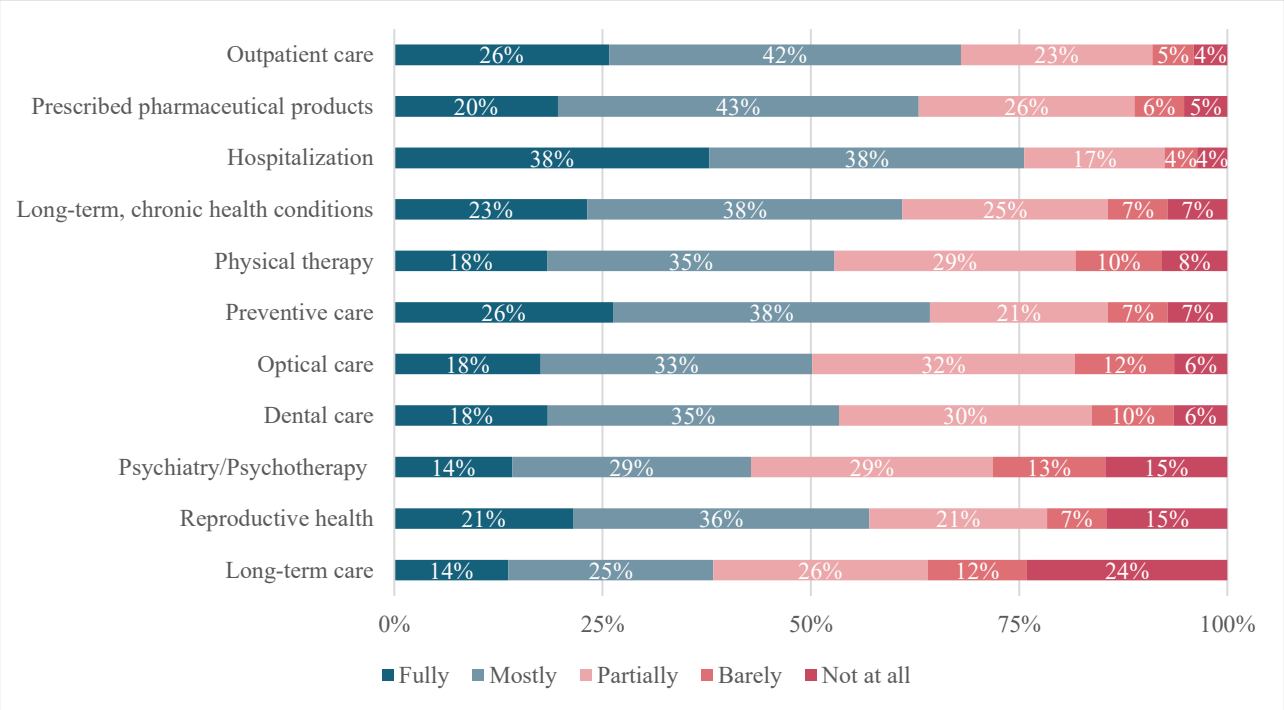
A. Coverage and cost

172. **Coverage not fully satisfactory in several areas of care.** The survey respondents were asked to rate the extent to which the coverage of their health insurance scheme cosponsored by their organizations has met their needs, including the needs of their dependants enrolled in the scheme. Of the 11 areas of coverage about which respondents were asked, hospitalization, outpatient care and preventive care were rated the highest as "fully" or "mostly" meeting the needs of the respondents. On the other hand, long-term care, mental health care (psychiatry and psychotherapy) and optical care received the lowest number of responses that their coverage "fully" or "mostly" meets the needs of the respondents. The overall results from the survey are shown in figure III.

[101] Number of staff and retirees who are plan members, not including protected family members.

Figure III

Perceptions of survey respondents on the extent to which the primary health insurance scheme co-sponsored by their organization met their needs, including those of their dependants



Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

173. **In total, 68 per cent of respondents find that outpatient care meets their needs.** For outpatient care, between the 25 health insurance schemes, the respondents insured under the health insurance plans of UPU, UNWTO and WIPO gave the highest rating in terms of the coverage "fully" or "mostly" meeting their needs. The respondents insured under the UNESCO Medical Benefits Fund, the Medical Insurance Plans of UNOPS, UNDP, UNICEF and UNHCR and the Field General Service Plan of UNIDO gave the lowest rating to the question on whether the coverage "fully" or "mostly" meets their needs. Apart from the UNESCO plan, the latter four schemes cater specifically to locally recruited staff outside headquarters locations.

174. **Hospitalization coverage fully or mostly meets expectations for 76 per cent of respondents**. For hospitalization, the majority of respondents (over 60 per cent for each scheme) reported that the coverage of their health insurance plans "mostly" or "fully" met their needs, with the WIPO plan receiving the highest rating (97 per cent) and the UNESCO plan the lowest rating (62 per cent).

175. **About 63 per cent of respondents believe that medication coverage is satisfactory**. On the subject of prescribed medications, while 63 per cent of the respondents believed their needs were "fully" or "mostly" met, over 2,000 comments were received stating that these needs were unmet, including in relation to certain pharmaceutical products, such as vitamins and minerals, not being covered despite being prescribed by physicians. From the analysis of the responses by plan, the lowest number of responses on the needs being "fully" or "mostly" met came from respondents insured under the WFP Medical Insurance Coverage Scheme, the Medical Insurance Plans of the United Nations Secretariat, UNDP, UNHCR, UNICEF and UNOPS for locally recruited staff outside the headquarters locations, and the UNESCO plan.

176. **While 61 per cent of the respondents found that their health insurance adequately met their needs in relation to long-term, chronic health conditions, the survey results vary considerably between plans.** Over 90 per cent of WIPO respondents believed their health insurance plan "fully" or "mostly" met these needs, compared with only

50 per cent of UNESCO respondents and locally recruited UNICEF staff in the field. Comparing the locally recruited and internationally recruited respondents, 57 per cent of the former found their health insurance coverage in this area of care adequate compared with 66 per cent of the latter. There was no significant difference between female and male respondents.[102] From the comments received, the top concerns were related to the inadequate coverage or limited reimbursement ceilings for long-term elderly care, extended physical therapy, conditions related to physical disabilities and medications for chronic illnesses, such as diabetes, high blood pressure, cancer and chronic pain.

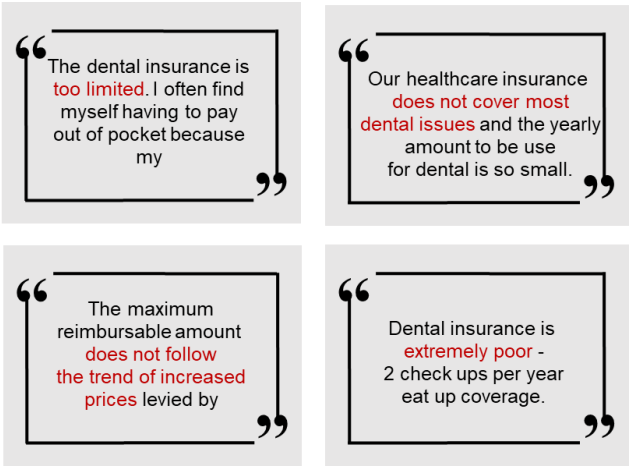
177. **Only 53 per cent of respondents rated physical therapy as fully or mostly meeting their needs.** For physical therapy, about 53 per cent of all the survey respondents reported that their needs were "fully" or "mostly" met. The analysis of the responses by health insurance plan shows that the schemes under ILO, UNWTO and WIPO received the highest number of responses for "fully" or "mostly" meeting the needs of the respondents (each over 70 per cent). UNWTO and WIPO offer the highest reimbursement rate in this area (100 per cent reimbursement rate for in-network providers in Spain for UNWTO and 90 per cent reimbursement rate for WIPO). Other than these two schemes, there appears to be no strong correlation between the level of coverage and the survey responses, except for the UNESCO scheme, which received the lowest rating (only 30 per cent of the respondents insured under this scheme believed their needs for physical therapy were "fully" or "mostly" met). This plan is among those that offer the lowest level of coverage, with a reimbursement rate of 70 per cent with up to $15 per session and up to 50 sessions per annum. In addition, similar to the response pattern in other areas of care, the Medical Insurance Plans of the United Nations Secretariat, UNHCR, UNICEF and UNDP also received some of the lowest ratings, with under 50 per cent of respondents reporting that their needs were "fully" or "mostly" met.

178. **Good preventive care coverage according to 64 per cent of respondents.** Preventive care is an area that received a decent response rate overall, with respondents stating that their needs were "fully" or "mostly" met (64 per cent), despite a varying level of coverage among the plans. Similar to other areas of care, respondents insured by UNESCO and under the Medical Insurance Plans of UNDP, UNHCR and UNICEF gave the lowest response rate of their needs being "fully" or "mostly" met (between 50 and 52 per cent). For plan members who identify themselves or their dependants as having a sexual orientation other than heterosexual, the most frequently raised concerns were related to the lack of coverage for routine testing for sexually transmitted diseases other than HIV and the coverage for pre-exposure prophylaxis for HIV prevention.

179. **Dental care coverage is insufficient for 46 per cent of respondents, with significant differences between schemes.** For dental care, 54 per cent of all respondents found their coverage to "fully" or "mostly" meet their needs, but the percentage of the responses varies considerably by health insurance scheme, ranging from 37 per cent (UNESCO and the WFP Medical Insurance Coverage Scheme) to 80 per cent (WIPO). Respondents insured under the Rome-based plans of FAO and WFP (Basic Medical Insurance Plan) gave the next lowest rating (40 per cent and 41 per cent, respectively). This may suggest that the current level of coverage does not correspond well to the costs incurred in the country. In the responses in the survey's open comment box about unmet needs, dental care was one of the topics most mentioned as insufficient (over 1,700 comments). Some examples of the comments can be found in Figure IV.

[102] For the 17 respondents who identified themselves as having another designation for their sex, 12 found that their health insurance coverage did not meet or only partially met their needs.

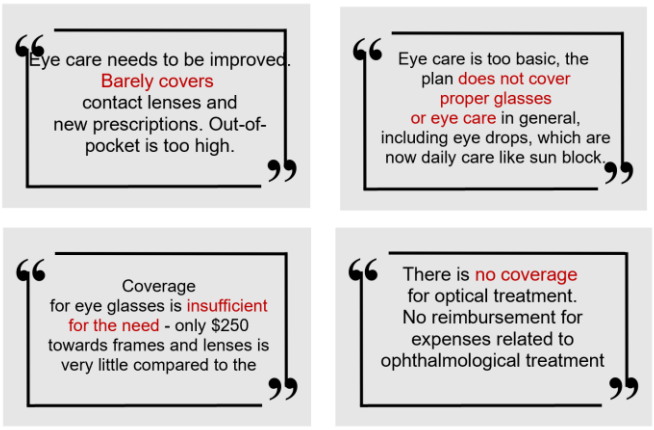
Figure IV
Examples of comments related to dental care coverage



Source: Prepared by JIU.

180. **Optical care coverage is not adequate for 49 per cent of respondents, with huge differences between plans**. For optical care, 51 per cent of the respondents found that the coverage under this area "fully" or "mostly" met their needs. In the responses by plan, more than half of the plans received a low rating (under 50 per cent for "fully" or "mostly" meeting the needs of the respondents), indicating significant unmet needs. About 30 per cent of the respondents insured under the Medical Insurance Plans of UNDP and UNOPS and the IMO plan reported that the coverage "barely" or "not at all" met their needs. This corresponds to a low level of coverage provided by these plans in this area. On the other hand, the two plans that received the highest ratings, those of ILO and WIPO, offer a much higher level of coverage. This is an area that over 1,200 respondents specifically mentioned in the open comment box in the survey as an unmet need. Some examples of the comments can be found in Figure V.

Figure V
Examples of comments related to optical care coverage



Source: Prepared by JIU.

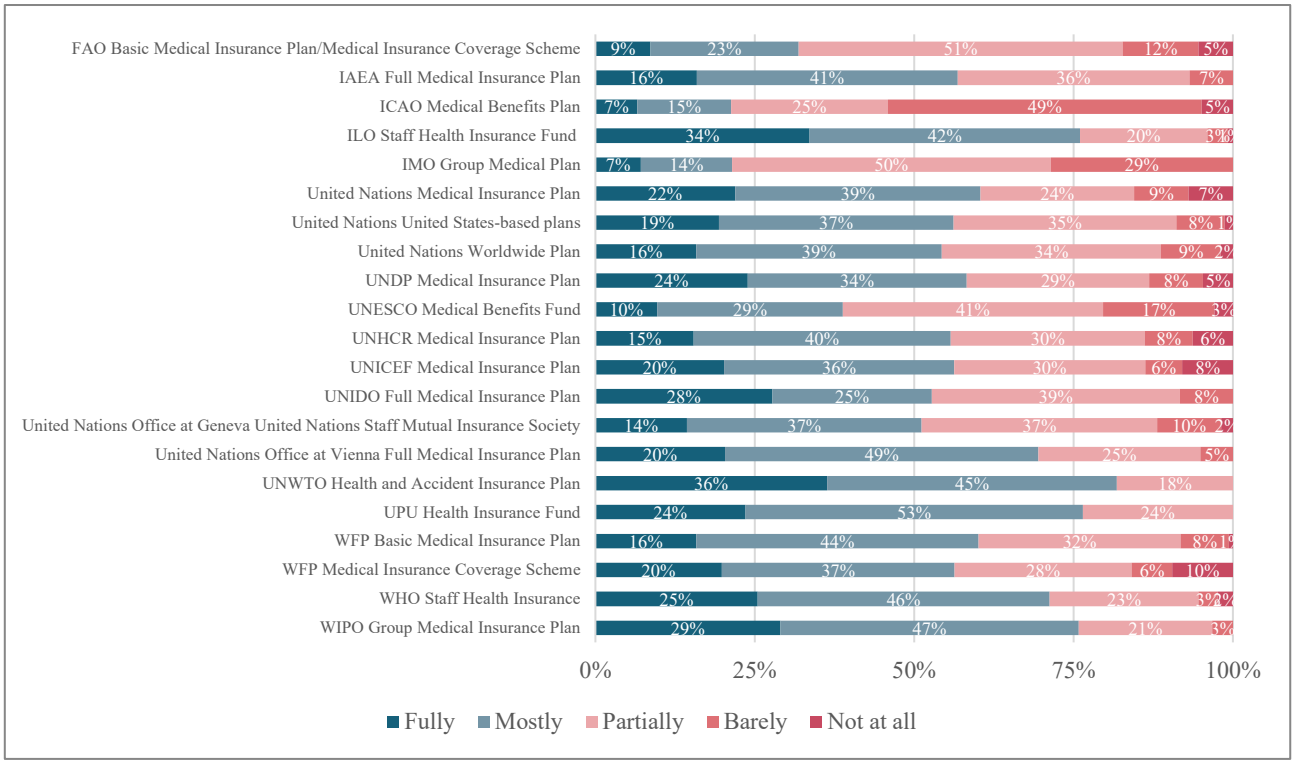
181. **Only 43 per cent of respondents found mental health-care coverage adequate**. Mental health care (psychiatry and psychotherapy) is an area where the survey responses indicated serious unmet needs.[103] More than 50 per cent of the respondents indicated that

[103] This finding is consistent with the conclusion reached by JIU in its review of mental health and well-being policies and practices in United Nations system organizations (JIU/REP/2023/4), which contains the following recommendation: "Participating organizations are encouraged to utilize existing guidance made available by the Implementation Board and to conduct a comprehensive

their coverage "fully" or "mostly" met their needs for only seven health insurance plans.[104] These are the two United States-based schemes of the United Nations Secretariat and the schemes of ILO, UNWTO, UPU, WHO and WIPO. The three plans that received the lowest ratings (between 22 per cent and 28 per cent of respondents said that their needs were "fully" or "mostly" met) are the plans of FAO, ICAO and UNESCO. The survey results related to mental health-care needs by health-care scheme are shown in figure VI.

Figure VI

Perception of the survey respondents on the extent to which the health insurance benefits related to psychiatry and psychotherapy (mental health care) met their needs, including those of their dependants



Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

182. **About 44 per cent of respondents who needed mental health-care services found coverage to be insufficient over the previous three years.** The survey found that 18 per cent of the respondents (or 3,797 of the 21,051 people who responded to this question) had made use of the health insurance claims related to psychiatric, psychological or mental health care in the previous three years either for themselves or their dependants. Among these respondents, 56 per cent indicated that the coverage "fully" or "mostly" enabled them to receive the mental health care that they or their dependants needed, while 32 per cent said "partially", 9 per cent "barely" and 3 per cent "not at all". The analysis found no significant differences in the responses between male and female respondents and between those who were locally recruited and internationally recruited active and retired staff. Geographically, respondents whose duty stations or main countries of residence are in Africa found the coverage to meet their needs less than those from other regions.

review of their schemes. That will contribute to the stated strategic goal that it is imperative that the United Nations review, simplify and standardize its health insurance schemes as related to mental health, well-being and disability. Reassessing health insurance schemes system-wide also offers opportunities to develop a common approach, ensuring basic coverage for personnel mental health and well-being – in turn, increasing access to psychosocial support services."

[104] The number of respondents insured under the UNIDO Field General Service Plan is not sufficient for the analysis.

183. **Reproductive health-care coverage is also considered uneven between schemes, with an average of 57 per cent of respondents rating it as satisfactory.** For reproductive health care, about 57 per cent of the respondents indicated that their needs were "fully" or "mostly" met. From the breakdown analysis, less than 50 per cent of respondents covered by the plans of FAO, ICAO and UNESCO and the UNHCR Medical Insurance Plan gave these responses, whereas the WIPO plan received such ratings in over 85 per cent of responses. For plan members who identify or whose dependants identify with a sexual orientation other than heterosexual, the coverage related to infertility treatments was the main challenge raised. The concerns range from their plans not offering infertility treatments at all to barriers to accessing the coverage as a same-sex couple.

184. **The level of satisfaction with long-term care coverage was very low.** Long-term care is the area that received the lowest responses in terms of the needs of the respondents being "fully" or "mostly" met (38 per cent). In interviews with the representatives of retirees associations, this was the area most frequently raised as not sufficiently covered by most health insurance schemes in the United Nations system.[105]

185. **About 65 per cent of the respondents believed that their needs related to COVID-19 were "fully" or "mostly" met.** The major area of unmet needs, as raised in over 1,350 comments from the respondents, is related to COVID-19 tests, which were not reimbursable even though they might be required for work or travel. One of the challenges was to obtain a doctor's prescription at the height of the pandemic, which also affected the reimbursable costs for medical care and prescribed medications. The majority of the comments related to the difficulties of receiving health insurance reimbursements came from respondents insured under the Medical Insurance Plans of UNDP, UNICEF and UNHCR and those insured under the United Nations Worldwide Plan.

186. **Gender-specific needs were well-met by health insurance coverage, with over 80 per cent of the respondents having "strongly agreed" or "agreed".** Female respondents were less in agreement (82 per cent) than male respondents (87 per cent). For those who identify or whose dependants identify with a sexual orientation other than heterosexual, 79 per cent agreed that their gender-specific needs were well met by their health insurance coverage.

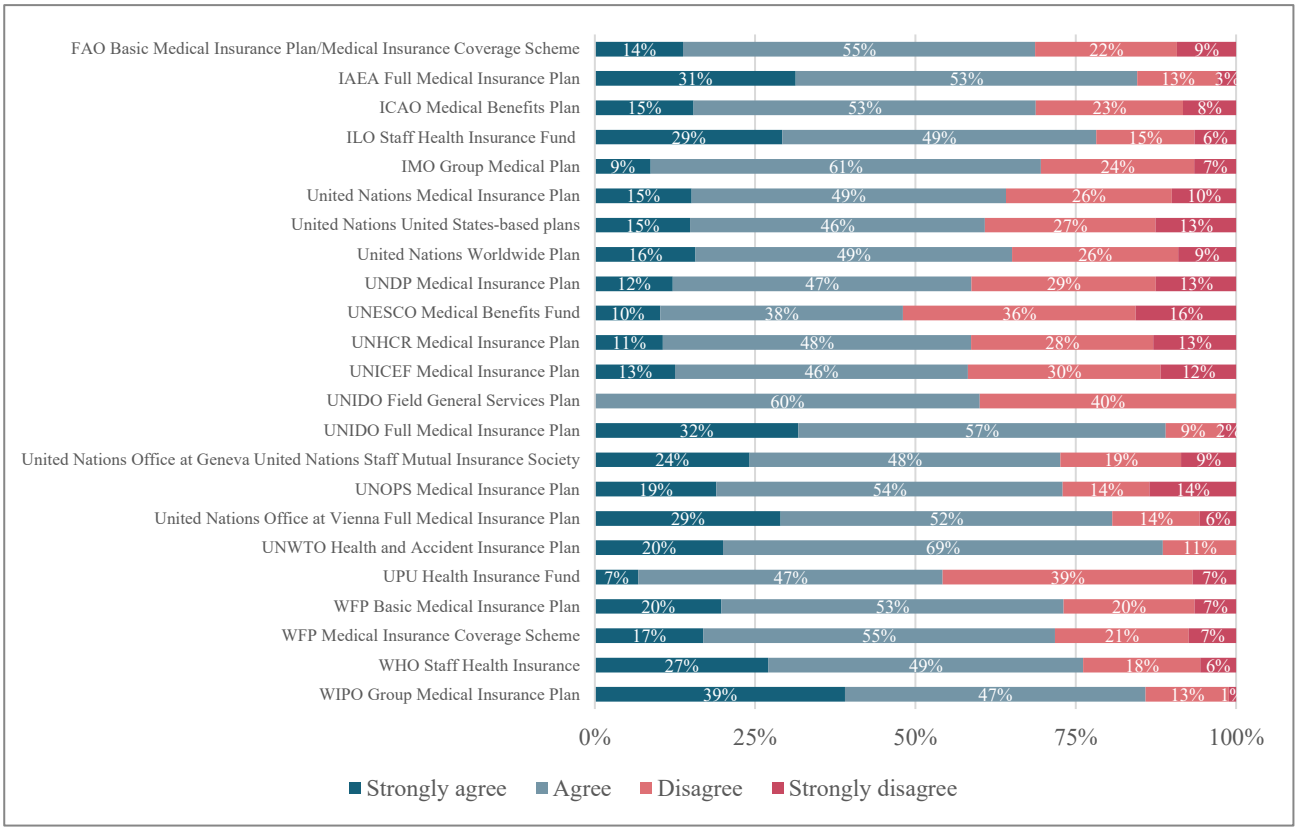
187. **The Inspector proposes that participating organizations reassess their health insurance plan coverage with a view to filling the most important gaps and aligning their coverage with prevailing models in a phased and sustainable manner, always in close consultation with participants' representatives to ensure that their priorities and the financial stability of the schemes are taken into account. Areas of particular attention, according to the JIU global survey, should be: outpatient care, especially for locally recruited staff; long-term care; conditions related to physical disabilities and medications for chronic illnesses; physical therapy; routine health check-ups; dental care; optical care; mental health; and reproductive health care.**

188. **The majority of respondents were satisfied with the availability of information related to coverage, but with varying views on the value for money of the insurance premiums.** Only about 48 per cent of UNESCO respondents "strongly agreed" or "agreed" that the health insurance premiums co-paid by them and their organization offered good value for money. This corresponds with the analysis in the review of the plan's premium amounts, which is at the high end of the range in relation to the level of coverage, where the reimbursement level for most costs is at 75 per cent. Feedback from the respondents insured under the rest of the schemes ranged from 54 per cent who "strongly agree" or "agree" (UPU respondents) to 89 per cent who do so (UNIDO and UNWTO respondents). The survey results by plan are shown in figure VII.

[105] See paras. 114–116 above.

Figure VII

Level of agreement of the respondents on the extent to which the health insurance premium co-paid by them and their organizations offers good value for money

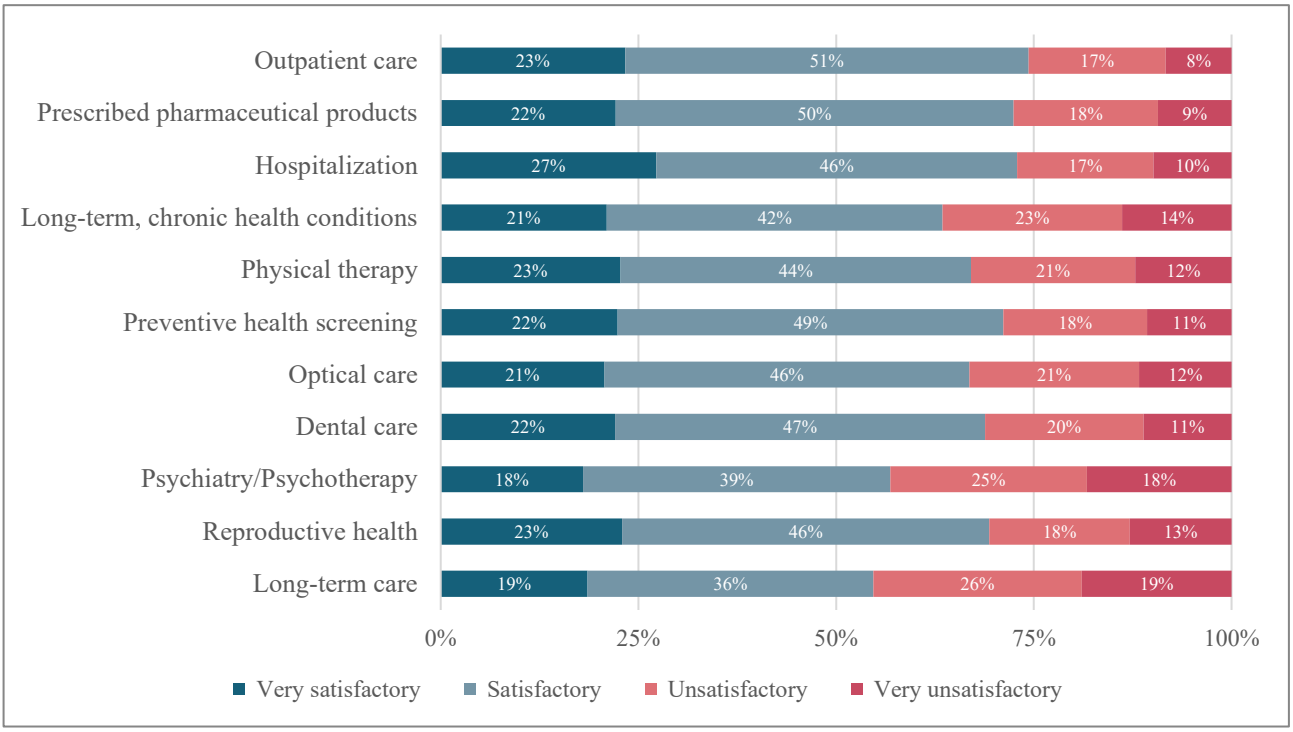


Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

B. Access to health care

189. **Having insurance is not enough; adequate health services must also be available.** As part of the survey administered under this review, feedback was also sought from active staff on their satisfaction level with access to health care in their duty stations. Among the 11 key areas of coverage examined, access to outpatient care, hospitalization, medicines and preventive health screening services were rated as satisfactory or very satisfactory by more than 70 per cent of respondents, while access to long-term care and mental health care received the highest level of unsatisfactory feedback, with 45 per cent and 43 per cent, respectively. The survey results are shown in figure VIII.

Figure VIII
Perception on access to health care at the duty stations of the respondents



Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

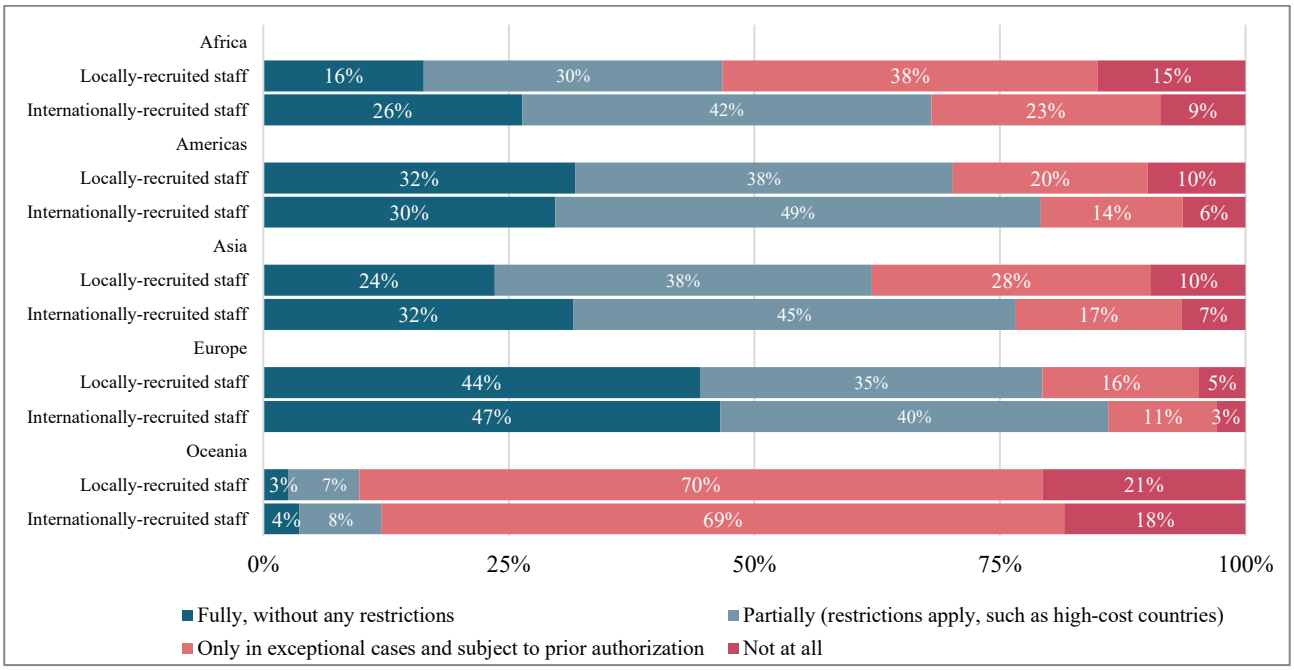
190. **Of the five regions considered,[106] respondents working in Africa were the least satisfied with their access to most areas of care**. In Africa, access to dental and optical care, physical therapy, long-term care, treatments related to chronic health conditions and mental health are the areas that received the lowest level of satisfaction (all below 50 per cent).[107] Respondents from the duty stations in Asia were largely satisfied with most areas of care, except for access to mental health care for those in Central Asia,[108] South Asia[109] and West Asia[110] (all received a satisfaction rate below 50 per cent). The detailed survey results related to access to health care can be found in the complementary paper for this review.

191. **Satisfaction with access to health care outside duty stations varies across regions and according to the type of contract**. When asked about the extent to which their health insurance schemes have enabled them to access health care and other related services not available in their duty stations (for staff) or in their primary residence (for retirees), responses from those in Africa were slightly more positive, but more than half of the respondents who were locally recruited active and retired staff stated that their health insurance scheme helped them to access health care outside their duty stations or primary residence only in exceptional cases and subject to prior authorization (38 per cent) or that they did not help at all

[106] The five regions are Africa, the Americas, Asia, Europe and Oceania.
[107] In Oceania, respondents working in the duty stations in Micronesia (such as Kiribati and the Marshall Islands) and Polynesia (such as Samoa and Tonga) were least satisfied with access to preventive care (25 per cent), outpatient care (32 per cent), hospitalization (17 per cent), eye care (18 per cent), mental health care (6 per cent) and long-term care (0 per cent). However, the representativeness of these data is limited because only 14 to 22 respondents provided ratings for different areas of care from these two subregions.
[108] Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.
[109] Mainly those in Afghanistan, Bangladesh and Pakistan.
[110] Mainly those in Lebanon, Türkiye and Yemen.

(15 per cent).[111] The survey results by region and by recruitment category of respondents are shown in figure IX.

Figure IX
Perception of the extent to which the health insurance schemes have enabled the respondents to access health care not available in their duty stations (for staff) or in their primary residence (for retirees)



Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

192. **Less than half the respondents insured under the UNESCO plan and the Medical Insurance Plans of UNDP and UNHCR found the out-of-pocket expenses or co-payments affordable.** Regionally, less than half of the respondents whose duty stations or primary countries of residence were in Oceania and Africa "strongly agreed" or "agreed" that the out-of-pocket expenses were affordable. Those in other regions gave a higher rate of agreement with this statement (52 per cent for Asia, 63 per cent for Americas and 67 per cent for Europe). Overall, internationally recruited respondents found the out-of-pocket expenses more affordable than their nationally recruited counterparts (61 per cent compared with 56 per cent who "strongly agreed" or "agreed").

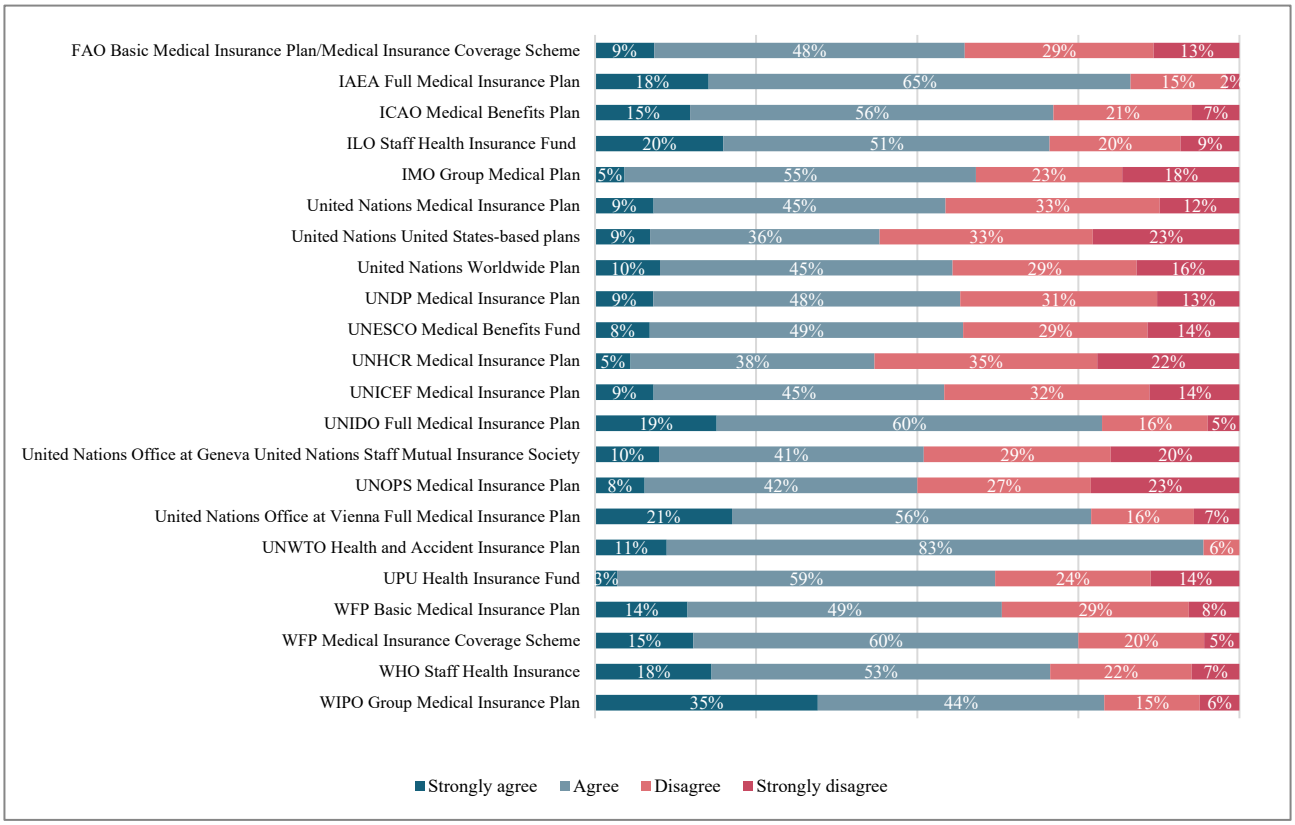
C. Quality of health insurance administration

193. **The level of agreement with the effectiveness of the claims dispute resolution mechanism varies considerably between schemes.** Only 43 per cent to 51 per cent of the respondents insured under the United Nations Secretariat's United States-based plans,[112] the Medical Insurance Plans of UNHCR and UNOPS and the United Nations Office at Geneva United Nations Staff Mutual Insurance Society agreed that their claims dispute resolution mechanisms were effective, compared with 94 per cent of the respondents insured under the UNWTO plan and 83 per cent of the respondents under the IAEA plan. The survey results by scheme are shown in figure X. These findings correspond with the survey results on the level of satisfaction with the clarity of reasoning given in cases of partial or non-settlement of claims, the responsiveness to these enquiries and the outcomes of any claim-related disputes.

[111] Only 3 per cent of the respondents based in Oceania said "fully, without any restrictions" and 8 per cent said "partially (restrictions apply, such as high-cost countries)".
[112] United Nations Secretariat Aetna, Empire and Cigna Dental.

Figure X

Level of agreement of the respondents on the extent to which they found the claims dispute resolution mechanism facilitated by their organizations to be effective[113]



Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

194. **Over 80 per cent of the respondents were satisfied with the ease of submission of claims.** However, the satisfaction rate drops to less than 60 per cent for the respondents insured under the UNHCR Medical Insurance Plan. Otherwise, there are no noted differences in the results, irrespective of whether the claim submissions are handled by the participating organizations or by a third-party administrator. On the language requirements for the submission of the claims, over 90 per cent of the respondents rated them as "very satisfactory" or "satisfactory".

195. **The level of satisfaction with the accuracy in processing claims varies somewhat between the health insurance plans, even when the third-party administrator is the same.** Respondents insured under the Medical Insurance Plans of UNHCR and UNOPS were the least satisfied (63 and 65 per cent were satisfied). On the other hand, over 90 per cent of the respondents insured under the IAEA, ICAO, UNIDO (Full Medical Insurance Plan), UNWTO and WIPO plans were satisfied with the accuracy of claims processing. According to these responses, there is no correlation between who administers claims (either in-house or outsourced to a third-party administrator) and the satisfaction level with the accuracy of claims handling. Strikingly, as the levels of satisfaction with the accuracy of claims processing by third-party administrators vary considerably between plans even when the third-party administrator is the same, **the Inspector suggests the harmonization of service-level agreements, including monitoring and reporting thereon, across the system.**

[113] An insufficient number of responses was received from respondents insured under the UNIDO Field General Service Plan.

196. **The speed of reimbursement is a major challenge raised by plan members.**[114] In the survey, overall, 67 per cent of the respondents were satisfied with the speed at which they received their reimbursements, with locally recruited respondents being significantly less satisfied (63 per cent) than their internationally recruited counterparts (73 per cent). Between plans, respondents insured under the UNHCR Medical Insurance Plan were the least satisfied (34 per cent), while 94 per cent of those insured under the WIPO plan were satisfied. In interviews, staff in Africa raised concerns over the lack of options for health establishments, including those where the health insurance plans could directly pay their share of reimbursement. Moreover, having to pay upfront and wait for reimbursement was repeatedly mentioned as a factor that generated financial hardship for staff, especially locally recruited staff. According to the survey results, there is no correlation between the level of satisfaction with the speed of reimbursements and whether the administrator is in-house or external. Moreover, as in the case of accuracy in processing claims, satisfaction levels vary considerably between plans even when the third-party administrator is the same. **The Inspector proposes that the organizations concerned review their policies and practices for providing advances or direct payments to expedite processes and prevent undue financial hardship for beneficiaries, in particular in emergency situations and in relation to hospitalization and long-term care.**

197. **Reimbursements processed through payroll are believed to cause unnecessary delays.** The staff interviewed also reported that the recent change to the administrative rules of the United Nations Secretariat's Medical Insurance Plan for claim reimbursements to be paid through payroll has also lengthened the time taken to receive reimbursements and distorted the interpretation of payslips as they now include not only emoluments, but also compensations for medical expenses incurred.

198. **About 80 per cent of the respondents were satisfied with the overall professionalism in communications from the health insurance plan administrators.** The respondents insured under the IAEA, United Nations Office at Vienna, WHO and WIPO plans had the highest rate of satisfaction (over 90 per cent), whereas those insured under the UNHCR Medical Insurance Plan were the least satisfied (66 per cent).

199. **Only 62 per cent felt safe to ask their health insurance administrator questions about gender-affirmative care.**[115] About 8 per cent of the survey respondents (1,846 people) indicated that they and/or their dependants identified with a sexual orientation other than heterosexual; 62 per cent of these respondents felt safe asking questions about coverage related to sexual orientation, gender identity, gender expression and/or sex characteristics (for example, gender-affirming care or inclusive reproductive support). In the survey responses by health insurance plan, less than half of the respondents insured under the WFP Basic Medical Insurance Plan, the United Nations Secretariat's United Nations Worldwide Plan, the IAEA Basic Medical Insurance Plan and the United Nations Office at Geneva United Nations Staff Mutual Insurance Society felt safe to enquire about coverage related to sexual orientation, gender identity, gender expression and/or sex characteristics, compared with the respondents insured under the United Nations Office at Vienna and ILO plans (90 per cent and 85 per cent respectively). For the respondents insured under the ICAO Medical Benefits Plan, 5 of the 7 respondents did not agree that they felt safe asking questions related to sexual orientation, gender identity, gender expression and/or sex characteristics. The review notes that the respondents' perception of this issue could be related to the organizational culture at large, rather than just being limited to health insurance administration.

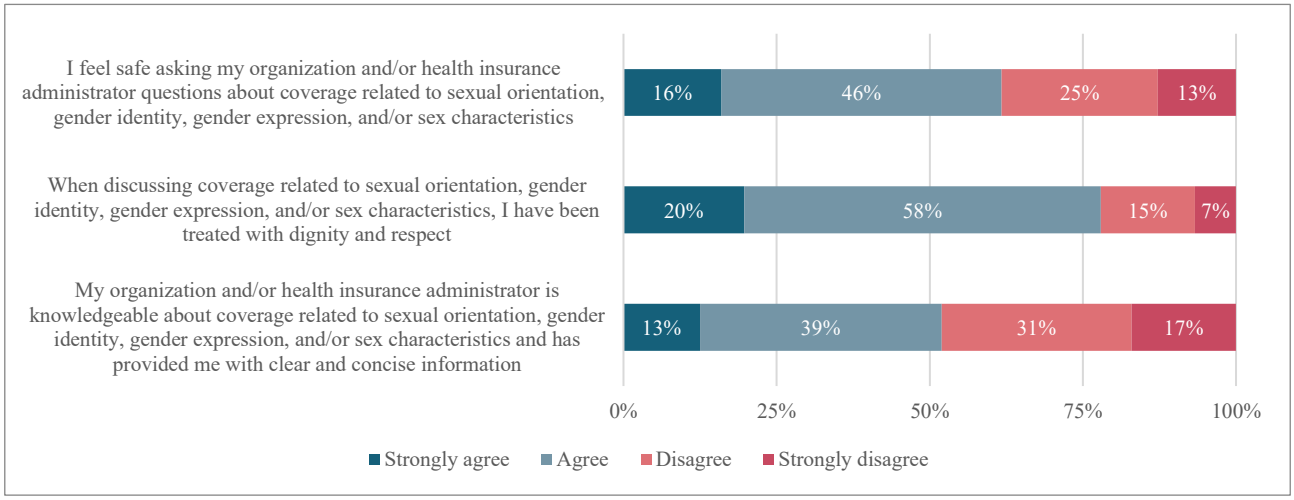
[114] It is noted that the turnaround time for claim processing might be affected by backlogs owing to the postponement of treatments and consultations during the COVID-19 pandemic, which might have impacted the level of satisfaction of respondents.

[115] In line with the definition in the WHO international classification, gender-affirmative health care includes any single or combination of a number of social, psychological, behavioural or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity. See https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd.

200. **In total, 78 per cent of respondents believed that they were treated with dignity and respect when discussing coverage related to sexual orientation, gender identity, gender expression and/or sex characteristics.** From their interactions with the organization and/or health insurance administrator, a high percentage of the respondents for each plan felt that they were treated with dignity and respect, with the United Nations Secretariat's United States-based plans receiving the highest ratings (94 per cent) and the FAO Basic Medical Insurance Plan/Medical Insurance Coverage Scheme receiving the lowest rating (65 per cent).

201. **Only 52 per cent believed that their health insurance administrator was knowledgeable about coverage of sexual orientation, gender identity, gender expression and/or sex characteristics.** Beneficiaries insured under the UNESCO Medical Benefits Fund, the United Nations Office at Geneva United Nations Staff Mutual Insurance Society and the United Nations Secretariat's United Nations Worldwide Plan gave the lowest rating (27 per cent, 30 per cent and 34 per cent, respectively) in this regard. **The Inspector believes that this points to an area for improvement in the training of staff working in client relations. He therefore suggests that administrators address this as a regular subject in their training programmes.** The survey results are shown in figure XI.

Figure XI
Perception of survey respondents of the ability of their organization and/or health insurance administrator to handle enquiries related to gender-affirmative care



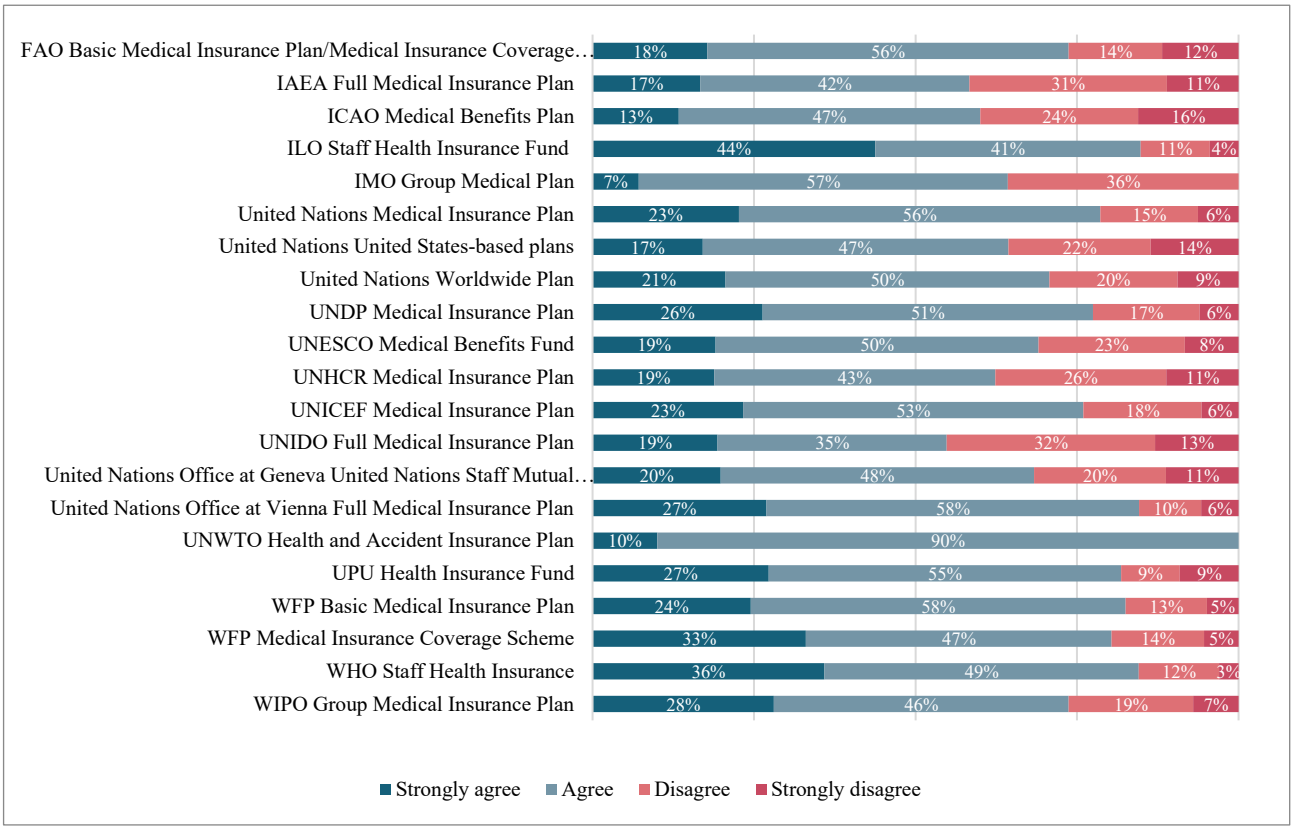
Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

202. **In total, 73 per cent of respondents felt safe asking questions about coverage and reimbursements related to mental health care.** About 18 per cent of the respondents (3,797 people) had received health insurance reimbursements related to mental health care in the previous three years. Overall, 73 per cent of the respondents "strongly agreed" or "agreed" that they felt safe asking their organization or health insurance administrator questions about coverage and reimbursements related to psychiatric, psychological or mental health care. However, comparing female and male respondents, the former are less positive (70 per cent in agreement) than the latter (78 per cent). Between nationally and internationally recruited staff, the former are more positive (77 per cent in agreement) than the latter (70 per cent). Comparing the schemes,[116] respondents insured under the plans of UNIDO (Full Medical Insurance Plan), IAEA and ICAO were the least in agreement (55, 58 and 60 per cent respectively). The survey results by health insurance plan are shown in figure XII.

[116] Excluding the analysis from the UNIDO Field General Service Plan and the UNOPS Medical Insurance Plan, owing to insufficient number of respondents.

Figure XII

Level of agreement of respondents when asked if they felt safe asking their organization or health insurance administrator questions about coverage and reimbursements related to mental health care



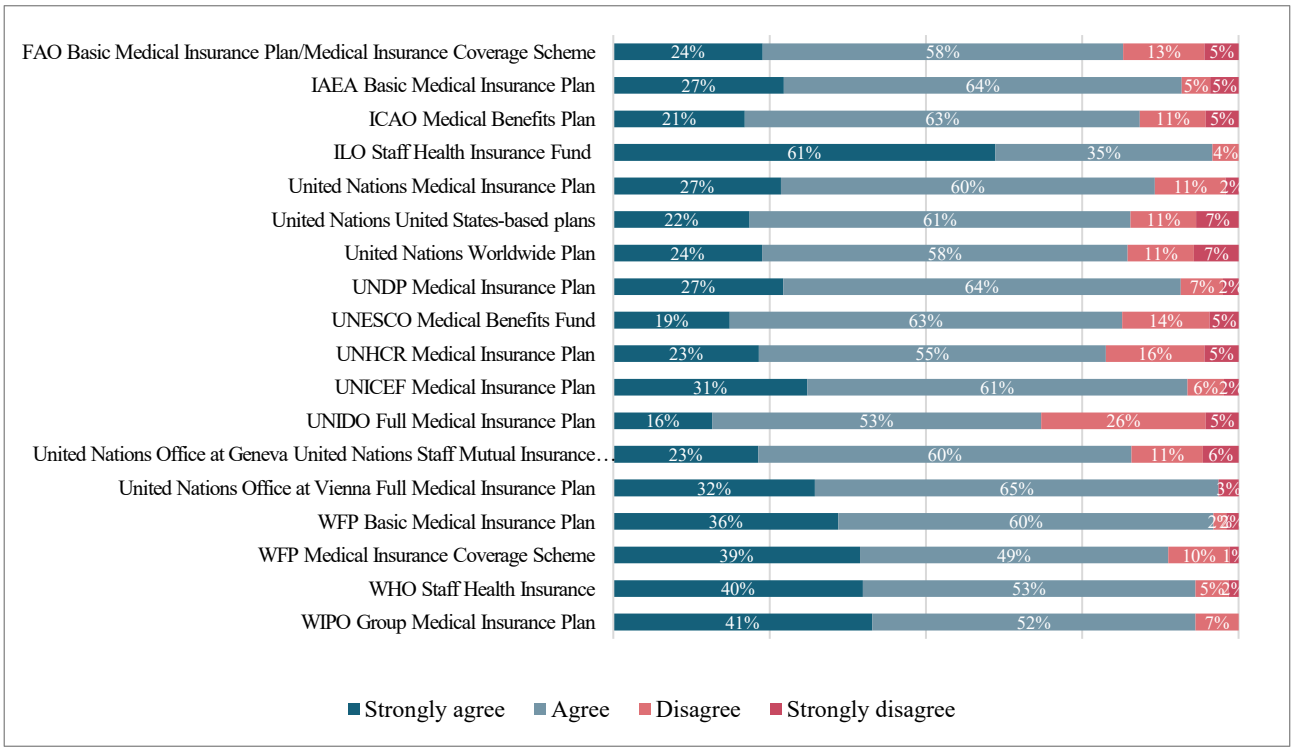
Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

203. **About 83 per cent of the respondents felt that when discussing reimbursement related to mental health care, they were treated with dignity and respect, with no significant difference between female and male respondents.** Nationally recruited respondents were slightly more in agreement (89 per cent) than their internationally recruited counterparts (85 per cent). All[117] schemes received over 75 per cent of positive responses, except the UNIDO Full Medical Insurance Plan, for which only 68 per cent of respondents were in agreement. The survey results by health insurance plan are shown in figure XIII.

[117] Excluding the analysis from IMO, the UNIDO Field General Service Plan, the UNOS Medical Insurance Plan, UNWTO and UPU, owing to an insufficient number of respondents.

Figure XIII

Level of agreement of respondents when asked if they were treated with dignity and respect when discussing reimbursements related to mental health care



Source: JIU global staff survey on health insurance schemes in the United Nations system 2023.

V. Disclosure, funding and budgetary implications of after-service health insurance liabilities

204. This chapter is divided into two parts: the evolution and current disclosure and accounting status of the long-term liabilities arising from after-service health insurance are briefly presented in section A; and section B is focused on the funding and budgeting for such liabilities to ensure the long-term financial sustainability of health insurance schemes. The possible funding sources, strategies and rationale, and the impact of the pay-as-you-go approach on the transparency of the budgetary process are also discussed.

A. Disclosure status of after-service health insurance liabilities

205. **The right to after-service health insurance is a contractual obligation that generates long-term liabilities for the employing organizations.** In December 1966, the General Assembly, at its 1501st plenary meeting, approved the establishment of the after-service health insurance programme as a defined benefit obligation[118] consisting of providing subsidized health insurance coverage to retired staff of international organizations and their family members, all of whom must meet certain eligibility criteria, as discussed elsewhere in this report. Since then, the after-service health insurance entitlement has been a contractual obligation that is part of the compensation package provided to United Nations staff and a vital component of their social security rights. After-service health insurance generates long-term liabilities for the employing organizations corresponding to their share of future payments for health insurance premiums or claims submitted by beneficiaries as they are considered a form of deferred compensation. Similar to pensions and other after-service entitlements, these are the amounts that an organization owes to its employees or beneficiaries for health insurance benefits earned during active service but not payable until retirement.

206. **Recognition of after-service health insurance liabilities in the financial statements is now a common practice system-wide.**[119] Disclosure responds to the need to provide transparent information to users of financial statements, namely governing bodies and legislative organs, Member States, donors and staff members, about the nature and level of accrued after-service health insurance benefits and how they affect the reporting entity's financial position. In its resolution 58/249, the General Assembly requested the Secretary-General to report on the full extent of unfunded staff post-service liabilities in the United Nations and its funds and programmes.[120] When considering the report of the Secretary-General[121] and the related report of the Advisory Committee on Administrative and Budgetary Questions,[122] the General Assembly, in its resolution 60/255, asked the Secretary-General to "take the necessary steps to disclose [end-of-service accrued benefit] liabilities", and thus after-service health insurance liabilities, in the United Nations financial statements, which was done for the first time in the statements for the biennium that ended

[118] Under IPSAS, post-employment benefit plans are classified as either defined contribution plans or defined benefit plans. Under a defined contribution plan, the entity's obligation is limited to the amount that it agrees to contribute to the fund. For a defined benefit plan as after-service health insurance, the obligation is to provide agreed benefits to retired staff members according to the relevant rules. A defined contribution plan and a defined benefit plan differ in terms of risk allocation. In a defined benefit plan, the employer or plan bears the actuarial risk (the possibility of benefits costing more than expected) and investment risk (the likelihood of losses occurring in relation to the expected return on after-service health insurance fund investments). In contrast, a defined contribution plan places all risks on the employees.

[119] Full disclosure of after-service health insurance liability in the financial statements was recommended by the Board of Auditors well before the United Nations system organizations adopted IPSAS as their accounting standards (see A/57/201).

[120] At the time, liabilities were disclosed only in the notes to the financial statements (as opposed to being accounted for on the face of the statement of financial position).

[121] A/60/540 and A/60/450/Corr.1.

[122] A/60/7/Add.11.

on 31 December 2007.[123] At the whole system level, the recognition of liabilities in the financial statements, which began in 2008, gained momentum with the implementation of IPSAS and is now a common practice.

207. **After-service health insurance liabilities are estimated using an actuarial valuation method and a set of commonly agreed assumptions.** Since payments are uncertain in terms of their timing and amount, being dependent on various factors such as mortality and medical cost inflation rates, medical innovation and health-care utilization patterns, after-service health insurance liabilities must be estimated to account for them. To that end, liabilities are calculated using an actuarial valuation method[124] and some assumptions[125] to estimate the present value[126] of the benefits that employees have earned as a result of their service in the current and prior periods.

208. **Financial and demographic assumptions.** As encouraged yet not required by IPSAS,[127] all plans involve qualified actuaries in measuring after-service health insurance obligations. To ensure consistency and comparability across the system, the standardization of assumptions was sought as part of the survey of the United Nations health insurance plans undertaken by the Working Group on After-Service Health Insurance established by the Secretary-General pursuant to a request of the General Assembly.[128] Assumptions are based on market expectations for the period over which the obligations are to be settled and must be mutually compatible and unbiased, i.e. neither imprudent nor excessively conservative.[129] Assumptions are disclosed in the financial statements in accordance with IPSAS and comprise the following elements:

- Financial and economic assumptions, such as discount rates, exchange rates, salary increases, benefit levels, inflation rates and medical trend rates, representing projected price inflation, technology advances, utilization patterns and cost-shifting from or to social programmes
- Demographic assumptions, such as mortality and disability tables, retirement rates, withdrawal rates and pension adjustment rates. (These tables were developed in the same manner as the those of the United Nations Joint Staff Pension Fund)

209. **A system-wide common valuation approach was developed in 2018 to ensure consistency across organizations.** In accordance with the "Memorandum of the Chair of the United Nations System Task Force on Accounting Standards: Common Actuarial Assumptions for ASHI Liabilities Financial Year 2022", dated 17 January 2023, the demographic assumptions used for the valuation of after-service health insurance are currently the same as those used by the United Nations Joint Staff Pension Fund (for example,

[123] A/63/5 (Vol. I).

[124] *IPSAS 39: Employee benefits* prescribes a specific actuarial technique to calculate and account for after-service health insurance liability, the so-called projected unit credit method (paras. 59 (a) (i) and 69). It is based on the assumption that each employee's health insurance benefit is earned throughout their employment, so each period of service gives rise to an additional unit of benefit entitlement. The method estimates the present value of each employee's future health insurance benefit by discounting the expected future payments using an appropriate discount rate.

[125] IPSAS 39, paras. 77–100.

[126] Obligations are measured in terms of present value by means of a discount rate because they may be settled many years after the staff members rendered the services that gave rise to the accrued right to after-service health insurance.

[127] IPSAS 39, para. 61.

[128] In that sense, it was recommended in 2015 (A/70/590, para. 54) that the "Task Force on Accounting Standards develop a common actuarial valuation approach in relation to after-service health insurance liabilities across the United Nations system", a recommendation that was subsequently endorsed by the General Assembly in its resolution 70/248 B and completed through the third report of the Secretary-General report on after-service health insurance (A/73/662), issued on 19 December 2018. The inter-agency Working Group on After-Service Health Insurance was established by the Secretary-General under the auspices of the Finance and Budget Network of the CEB High-level Committee on Management, pursuant to General Assembly resolution 68/244.

[129] The review did not address compliance with these and other accounting requirements and standards as auditors are solely responsible for validating the liabilities reported in the financial statements.

mortality rates, withdrawal rates, retirement rates and marital status).[130] In addition to some plan-specific assumptions, such as spousal coverage rates, plan participation rates and staff turnover rates, all JIU participating organizations, except UPU, follow the same set of basic actuarial assumptions to determine their respective after-service health insurance liability, which allows for meaningful comparison in the accounting for the liabilities across the system and externally, as required by IPSAS.

210. **As at December 2021, after-service health insurance liabilities amounted to $20.3 billion,[131] with 5 participating organizations accounting for nearly two thirds of the total and 11 for 90 per cent.** The most recent (2021) after-service health insurance liability estimates as reported by JIU participating organizations are presented in the following table. As can be seen, more than a quarter of the total liability belongs to the United Nations Secretariat, and the first five organizations account for two thirds of the total.

Table 17
After-service health insurance liabilities as at 31 December 2021[a]

Participating organization	*Total ($)*	*Percentage of total*	*Cumulative percentage*
United Nations Secretariat (including UNCTAD and UNRWA[b])	5 414 808 000	26.6	26.6
WHO	2 555 000 000	12.6	39.2
ILO	1 991 875 000	9.8	49.0
UNICEF	1 648 546 000	8.1	57.1
FAO	1 362 312 000	6.7	63.8
UNHCR	1 200 464 000	5.9	69.7
UNDP	1 168 732 000	5.7	75.4
WFP	892 000 000	4.4	79.8
WIPO	633 538 547	3.1	82.9
ITU	609 649 162	3.0	85.9
UNESCO	606 585 000	3.0	88.9
UNFPA	362 836 000	1.8	90.7
IAEA	345 937 568	1.7	92.4
UNIDO	243 424 973	1.2	93.6
UNAIDS	236 436 768	1.2	94.8
UNEP	232 250 000	1.1	95.9
ITC	164 783 000	0.8	96.7
ICAO	119 997 726	0.6	97.3
UN-WOMEN	103 042 000	0.5	97.8
UNODC	101 562 000	0.5	98.3
UNOPS	87 600 000	0.4	98.8
WMO	83 235 754	0.4	99.2
IMO	54 216 255	0.3	99.4
UPU	46 986 439	0.2	99.7
UN-HABITAT	34 513 000	0.2	99.8
UNWTO	33 960 703	0.2	100.0

[130] A/61/730, para. 21.
[131] Based on the 2021 financial reports of the participating organizations, using non-current after-service health insurance liabilities (if available).

Participating organization	*Total ($)*	*Percentage of total*	*Cumulative percentage*
UNRWA	771 000	0.0	100.0
Grand total	**20 335 062 895**	**100.0**	**100.0**

Source: Prepared by JIU.

[a] As reported in the 2021 financial reports of the participating organizations. Based on the United Nations operational exchange rate as at 30 June 2023.

[b] For internationally recruited staff posts funded under the regular budget of the United Nations.

211. **Valuations should be considered with caution as they are highly sensitive to changes in assumptions.** It should be underscored that valuations, because of their sensitivity to changes in assumptions, must be treated with prudence and considered only as the best estimate of an entity at the end of each reporting period and thus as an indication of future payments to be made and, as the case may be, a guide to take decisions on the overall strategy towards allocating funds to meet such obligations. From this it follows that, in the Inspector's view, the funding of long-term after-service health insurance liabilities does not need to be aimed at reaching 100 per cent when funded through assessed contributions; this is both to avoid unnecessary overbudgeting and overfunding and because more realistic and affordable rates can also be valid in achieving the ultimate goal of funding these long-term liabilities, which is basically to prevent serious financial or budgetary constraints when the payments fall due and, concurrently, Member States' ability or willingness to make good shortfalls is limited.[132] However, for programmes funded from voluntary contributions, the full cost of after-service health insurance should be factored into such contributions as it accrues, given that donors have no financial responsibility over the entities concerned once the programme or project for which they provided funds has been completed.

212. **The recent financial market evolution has confirmed the sensitivity of valuations to changes in assumptions, as a steady increase in discount rates has positively impacted plans.** This is reflected in the relevant statements of the financial positions and the related after-service health insurance liability studies consulted.[133] However, as the global economy stabilizes and inflation and interest rates fall, the opposite trend can be expected, increasing after-service health insurance liabilities accordingly. This volatility should be considered when assessing action to be taken if after-service health insurance funds or assets are close to or in excess of the amount of associated liabilities for a period of time, as in the case of the plans that have already reached 100 per cent of funding.

B. Funding and budgeting for after-service health insurance

1. Funding status

213. **While the disclosure of after-service health insurance liabilities is no longer an issue, their funding remains an unachieved goal, with only 31 per cent of liabilities**

[132] This approach was adopted by the Secretary-General in his report on managing after-service health insurance (A/76/373), as clarified in paragraph 26 of the report of the Advisory Committee on Administrative and Budgetary Questions (A/76/579) ("the Committee was informed [by the Secretariat] that the [suggested] partial funding [of 75 per cent] of future after-service health insurance cash-flow requirements was proposed owing to the sensitivity of the estimation of future costs related to changing demographic and economic assumptions associated with actuarial projections, and that the proposal was not made for full funding so as to mitigate against the possibility of overfunding"). The same concern over the instability of such calculations was previously raised by the Advisory Committee on Administrative and Budgetary Questions (A/73/792, para. 24), and is behind the proposed revision of the payroll charge every three years made by the Secretary-General in his reports on after-service health insurance (e.g. A/76/373, para. 77 (c)).

[133] According to the Board of Auditors (A/78/5 (Vol. I)), after-service health insurance liabilities for the United Nations peaked in 2020 and have been declining since. In 2022 only, the liabilities declined by 23.3 per cent compared with 2021, from $7.24 billion to $5.55 billion. Similar findings are found in the annual financial reports and actuarial studies of other participating organizations.

already funded. It is crucial to note that the recognition of after-service health insurance liabilities in financial statements is not dependent on the organizations' funding sources or even on the mere existence of resources to fund them: even if the organizations do not have a specific reserve or designated stream of revenue to fund their liabilities, these liabilities must still be recognized, namely, entered in the accounts, based on the benefits earned by the employees during the reporting period. However, while the disclosure of after-service health insurance liabilities is no longer an issue, their funding remains an unachieved goal for most of the JIU participating organizations as only 31 per cent of the combined liabilities are currently funded,[134] as shown in table 18. Nevertheless, compared with the figures reported in the previous JIU review on the same topic in 2007, the funded portion of after-service health insurance liabilities for most participating organizations, where data was available, has improved.

Table 18
Status of funding of after-service health insurance liabilities as at 31 December 2021[a] compared with the amounts reported in the 2007 JIU review of United Nations system staff medical coverage[b]

Participating organization	*After-service health insurance liability in the 2007 JIU Report ($)*	*Disclosed after-service health insurance liability ($) as at end of 2021*	*Amount of funding reserved for after-service health insurance liabilities in 2021 ($)*	*Percentage of after-service health insurance liabilities funded in 2021 (%)*	*Percentage of after-service health insurance liabilities funded as reported in the 2007 JIU Review*
FAO	562 200 000	1 362 312 000	600 925 000	44.1	32.0
IAEA	80 900 000	345 937 568	219 058	0.1	0.0
ICAO	32 500 000	119 997 726	1 137 225	0.9	0.0
ILO	474 000 000	1 991 875 000	27 593 000	1.4	0.0
IMO	No information	54 216 255	11 757 962	21.7	No information
ITC	No information	164 783 000	13 966 000	8.5	No information
ITU	185 100 000	609 649 162	14 525 140	2.4	0.0
United Nations Secretariat including UNCTAD and UNRWA[c]	1 484 900 000	5 414 808 000	138 048 000	2.5	2.0
UNAIDS	Not applicable	236 436 768	140 207 902	59.3	Not applicable
UNDP	263 200 000	1 168 732 000	1 007 850 000	86.2	51.0
UNEP	No information	232 250 000	72 932 000	31.4	No information
UNESCO	322 600 000	606 585 000	36 500 000	6.0	0.0
UNFPA	No information	362 836 000	336 179 000	92.7	0.0
UN-Habitat	No information	34 513 000	No information	No information	No information
UN-Women	Not applicable	103 042 000	106 600 000	103.5	Not applicable
UNHCR	136 100 000	1 200 464 000	468 300 000	39.0	0.0
UNICEF	182 500 000	1 648 546 000	724 133 000	43.9	22.0
UNIDO	59 100 000	243 424 973	0	0.0	0.0
UNODC	No information	101 562 000	53 541 000	52.7	No information
UNOPS	No information	87 600 000	112 200 000	128.1	No information
UNRWA[d]	No information	771 000	0	0.0	No information
UNWTO	No information	33 960 703	2 847 755	8.4	No information
UPU	No information	46 986 439	0	0.0	No information

[134] WHO was the first organization to recognize the need to make provisions for after-service health insurance and started funding accrued liability by special annual contributions in 1989.

Participating organization	*After-service health insurance liability in the 2007 JIU Report ($)*	*Disclosed after-service health insurance liability ($) as at end of 2021*	*Amount of funding reserved for after-service health insurance liabilities in 2021 ($)*	*Percentage of after-service health insurance liabilities funded in 2021 (%)*	*Percentage of after-service health insurance liabilities funded as reported in the 2007 JIU Review*
WFP	No information	892 000 000	892 000 000	100.0	No information
WHO	371 200 000	2 555 000 000	1 298 000 000	50.8	68.0
WIPO	43 200 000	633 538 547	221 363 437	39.0	0.0
WMO	12 100 000	83 235 754	0	0.0	11.0
Total		**20 335 062 895**	**6 306 795 490**	**31.0**	

Source: Consolidated by JIU based on the financial statements of the participating organizations.

[a] Based on the United Nations operational exchange rate as at 30 June 2023 and non-current liabilities are used, when available.

[b] Based on varying years of actuarial study (from 1999 to 2004).

[c] For international staff posts funded from the regular budget of the United Nations.

[d] For internationally recruited staff posts not funded under the regular budget of the United Nations.

214. **After-service health insurance liabilities have been on the agenda of governing bodies, CEB and external auditors as a system-wide issue since the 1990s.** The need to identify and implement a financing mechanism to fund such liabilities continues to be a subject of lengthy discussions both within and across the United Nations system organizations.[135] In this connection, the Advisory Committee on Administrative and Budgetary Questions, in its 1997 review of the proposed programme budget of the United Nations for the biennium 1998–1999,[136] raised the issue of the after-service health insurance liability and recommended that the Secretary-General addressed the long-term implications and impact of its growth on a system-wide basis.[137] The Board of Auditors,

[135] In 2017, UNHCR issued a conference room paper (available at https://www.unhcr.org/au/media/funding-after-service-health-insurance-and-repatriation-benefit-liabilities) on after-service health insurance, while the ILO Secretariat updated its governing body on the work of the Working Group set up by the Finance and Budget Network of the High-Level Committee on Management of CEB to study the matter from a system-wide perspective, and also the outcome of the work of the ILO Staff Health Insurance Fund Management Committee on cost containment (document GB.329/PFA/4). Both in 2017 and 2018, the WIPO Program and Budget Committee recommended to the Assemblies of WIPO to request the Secretariat to continue participating in the aforementioned Working Group on After-Service Health Insurance and to monitor any specific proposals to be made by the Secretary-General at the respective sessions of the United Nations General Assembly (documents WO/PBC/26/6 and WO/PBC/28/11). At the fortieth session (2019) of its General Conference, UNESCO reported on the funding for the after-service health insurance liability (report by the Director-General on the state of the Medical Benefits Fund and the governance structure, document 40 C/51). At its 2022 session, the UNESCO General Conference considered the status of financing the liability across the United Nations system, and funding principles and options (see long-term funding plan for the after-service health insurance, document 214 EX/6).

[136] A/52/7/Rev.1, part X, para. X.25.

[137] The system-wide nature of after-service health insurance liabilities was reiterated by the Advisory Committee on Administrative and Budgetary Questions in 2013. The Committee noted that "the funding of after-service health insurance benefits is an issue of system-wide concern and … that, in the long term, it would best be resolved by adopting a system-wide approach" (A/68/550), upon which the General Assembly, in its resolution 68/244, requested the Secretary-General "to examine the option of broadening the mandate of the United Nations Joint Staff Pension Fund … to include the … administration of after-service health insurance benefits" and also to "undertake a survey of current health-care plans for active and retired staff within the United Nations system". Notwithstanding, as General Assembly decisions are not binding on other system organizations, Advisory Committee on Administrative and Budgetary Questions recommendations endorsed by the General Assembly have to be proposed to the other competent governing bodies for formal evaluation and endorsement (A/71/698, para. 8). The system-wide dimension of after-service health insurance is also manifested through the way some organizations acted, as shown in annex II of the Secretary-

meanwhile, in its concise summary report of 27 June 2001,[138] "noted that liability for staff benefits and after-service health insurance was not provided for in most of the organizations"[139] and therefore "recommended that the United Nations and its various funds and programmes review the mechanism and targets for providing for end-of-service benefit liabilities".

215. **No agreement has yet been reached by the General Assembly to fund after-service health insurance liabilities as they accrue, despite numerous proposals and lengthy discussions.** In its resolution 58/249, the General Assembly requested the Secretary-General to propose measures that would ensure progress towards fully funding the liabilities. Consequently, on 27 October 2005, the Secretary-General issued the first of his eight reports on after-service health insurance,[140] in which he included a recommendation "to adopt a longer-term funding policy that provides predictable yet flexible annual contribution levels which support the process of ensuring that adequate funds are put aside on a regular basis to meet the costs of current plan participants and future benefit liabilities". However, the General Assembly did not take any decision on the proposed policy at that time,[141] nor has it endorsed any of the subsequent proposals by the Secretary-General to fund after-service health insurance to date.[142]

216. **Pay-as-you-go remains the funding model of half of the organizations.** Except in the case of extrabudgetarily funded staff posts, whose related liabilities are being covered through a payroll charge borne by donors in some organizations, and notwithstanding all previous discussions and the many years that have lapsed since the issue was first discussed, the fact is that for half of the 28 participating organizations, after-service health insurance is still funded on a pay-as-you-go basis, where funds are only provided to pay for current retirees' medical claims (for self-insured schemes) or the organizations' share of premiums (for commercially insured plans).

217. **The United Nations Secretariat, ILO and WHO account for 61 per cent of unfunded liabilities.** As shown in table 18, five organizations, namely UNDP, UNFPA, UNOPS, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and WFP, have their after-service health insurance liabilities fully or partially funded at a rate around or over 85 per cent; five (the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF, UNODC, WHO and FAO) have accumulated a reserve of between 40 per cent and 60 per cent of their liabilities; and four (IMO, the United Nations Environment Programme (UNEP), UNHCR and WIPO) have a reserve of between 20 and 40 per cent. The remaining 13 participating organizations have set aside no significant funding (less than 10 per cent, and in most cases no funds at all) to this end. Overall, and as mentioned before, the level of after-service health insurance funding as at 31 December 2021 had reached 31 per cent, whereas unfunded liabilities amounted to $14 billion, of which

General report A/64/366; 12 years after the Advisory Committee on Administrative and Budgetary Questions recommended that the General Assembly address the long-term implications and impact of its growth on a system-wide basis without success, IAEA, ILO, ITC ICAO, ITU, UNHCR, UNESCO, UNEP, UNIDO, UNOPS, UNPF, WMO and UNRWA had not set aside any funds for this purpose or had no plans to fund the accrued liabilities, pending decisions by the General Assembly that would inform their own discussions on the subject matter, while FAO, UNICEF, UNDP, WFP and WIPO had partially funded their liabilities.

138 A/57/201.

139 According to the Board of Auditors, in the biennium 2000–2001, UNDP made, for the first time, an accounting accrual of $54 million in respect of post-retirement health insurance, which nonetheless represented only 21 per cent of the estimated liability of $256 million, while the estimated liabilities as at 31 December 2001 for the United Nations ($1.44 billion), UNRWA ($143.6 million), UNHCR ($228 million), UNICEF ($196.4 million), UNFPA ($59.7 million) and UNOPS ($38.9 million) were not provided for at all.

140 A/60/450 and A/60/450/Corr.1.

141 General Assembly resolution 60/255.

142 See annex III for a brief summary of the Secretary-General's proposals, the Advisory Committee on Administrative and Budgetary Questions reports and the General Assembly resolutions on after-service health insurance liabilities.

37.6 per cent belongs to the United Nations Secretariat, 14 per cent to ILO and 9 per cent to WHO. All the other organizations hold 7 per cent or less of the entire liability.

218. **If no decision is taken, the risk of a financial crisis with the potential to compromise mandate delivery will continue to increase.** For the United Nations Secretariat and according to the latest report of the Secretary-General on managing after-service health insurance, the pay-as-you-go approach has resulted in increasingly large unfunded liabilities, currently projected to total an astonishing $20.2 billion by 2052.[143] It has also resulted in increasing annual after-service health insurance budget allocations, which are projected to reach, at present value, $499.7 million by 2051,[144] more than four times the amount currently required, albeit the number of after-service health insurance participants would multiply by 2.4, from 16,143 people to 38,101 people, by the same year. If nothing is done, the scale of the looming financial crisis is easy to predict when it is taken into account that $500 million (in present value, not 2051 value) is equivalent to almost 15 per cent of the United Nations regular budget for 2023.The review found that, for most entities, not even long-term estimates of liabilities are made on a regular basis, and much less on the long-term impact of the pay-as-you-go method of funding on future budgets, while several organizations, such as UNDP, UNFPA, UNHCR, UNOP, UN-Women and WHO, have approved and implemented a strategy or plan towards that goal, and FAO, IAEA and UNESCO are currently discussing such a plan.[145]

Table 19
Current practices in funding after-service health insurance liabilities among JIU participating organizations

Participating organization	*Pay-as-you-go*	*Pay-as-you-accrue*	*Other sources of funding*
FAO	Yes, for regular-budget staff	Yes, for extrabudgetary staff	Occasional funding allocations to an after-service health insurance reserve
IAEA	Yes, for regular-budget staff	Yes, for extrabudgetary staff	
ICAO	Yes	No	One-time funding allocation to an after-service health insurance reserve
ILO	Yes, for regular-budget staff	Yes, for extrabudgetary staff	Occasional funding allocations to an after-service health insurance reserve
IMO	Yes, for regular-budget staff	Yes, for extrabudgetary staff	Occasional funding allocations to an after-service health insurance reserve
ITC	Yes, for regular-budget staff	Yes, for extrabudgetary staff	
ITU	Yes	No	Occasional allocations to an after-service health insurance reserve

[143] A/76/373, table 3.
[144] Ibid., para. 20.
[145] See, for instance, the Executive Board of UNESCO document 217 EX/28, in which a proposal is made to the General Conference to finance the unfunded after-service health insurance liability of UNESCO by aligning the current after-service health insurance financing mechanism for the regular budget with that of voluntary contributions.

Participating organization	*Pay-as-you-go*	*Pay-as-you-accrue*	*Other sources of funding*
United Nations Secretariat including UNCTAD and UNRWA[a]	Yes, for regular-budget staff	Yes, for extrabudgetary staff	
UNAIDS	Yes	No	Occasional allocations to an after-service health insurance reserve Investment portfolio
UNDP	No	Yes	One-time allocation to an after-service health insurance reserve Investment portfolio
UNEP	No	Yes	
UNESCO	Yes, for regular-budget staff	Yes, for extrabudgetary staff	One-time allocation to an after-service health insurance reserve Investment portfolio
UNFPA	No	Yes	One-time allocation to an after-service health insurance reserve Investment portfolio
UN-Habitat	No	Yes	
UN-Women	No	Yes	Investment portfolio
UNHCR	No	Yes	Investment portfolio
UNICEF	No	Yes, 5 per cent for internationally recruited and 4 per cent for locally recruited staff	One-time funding allocation to an after-service health insurance reserve Investment portfolio
UNIDO	Yes	No	
UNODC	Yes, for regular-budget staff	Yes, for extrabudgetary staff	
UNOPS	No	Yes	Investment portfolio
UNRWA[b]	Yes	No	
UNWTO	Yes	No	Occasional funding allocations to an after-service health insurance reserve
UPU	Yes	No	
WFP	No	Yes	
WHO	Yes	No	Surplus from contributions Investment portfolio
WIPO	No	Yes	
WMO	No	Yes	

Source: Prepared by JIU.

[a] For internationally recruited staff posts funded from the regular budget of the United Nations.

[b] For internationally recruited staff posts not funded under the regular budget of the United Nations.

2. Sources, strategies and reasons for funding after-service health insurance liabilities

219. **After-service health insurance liabilities should be funded on an accrual basis, but the source and pace of funding depend on the specific circumstances of each organization.** As with any other liability, after-service health insurance must normally be funded from outside the organization, either through assessed contributions, donations or voluntary contributions, fees or property income, but it may also be funded internally, from accumulated reserves, or even from unspent funds from current or past appropriations, if permitted by the applicable rules and regulations or so decided by the competent governing body or legislative organ on an ad hoc basis.[146] This diversity of options, together with the specific demographic profiles of the different plans, explains that, as noted by the Working Group on After-Service Health Insurance, "while recognizing that the funding of after-service health insurance liabilities is a system-wide issue, the Working Group is of the view that a single system-wide approach to addressing that issue may not be necessary or achievable."[147]

220. **Use of reserves created from (excessive) health insurance contributions from beneficiaries**. Since funding after-service health insurance liability means providing funds for the entities' share of after-service health insurance premiums or cost, reserves created from (excessive) contributions from beneficiaries should not be used for this purpose, as this would mean that insured people, who are supposed to be the beneficiaries of the employers' after-service health insurance subsidies, would be in turn subsidizing the employing organization and, therefore, paying for their own subsidy. For the same reason, rebates or premium holidays occasionally given by schemes should exclude any amount contributed by the employing organization or scheme. In summary, only the part of the reserves that was contributed by the organizations should be used to fund after-service health insurance liabilities, precisely because they are liabilities of the entities and not of the beneficiaries.

221. **Use of accumulated reserves to fund after-service health insurance on an ad hoc basis to shun or smooth out the increase in contributions.** For organizations with a strong base of net assets and accumulated surplus, failing to provide for a specific cash flow from outside to fully cover after-service health insurance liabilities on an ongoing basis as they accrue, is not or need not necessarily be a concern in terms of their solvency and even their liquidity, provided assets are appropriate in nature and managed in a way consistent with the maturity of their liabilities. This type of organization can afford the allocation of reserves to the long-term needs of after-service health insurance (without requiring additional contributions from Member States, jeopardizing mandate delivery or compromising the entity's financial and budgetary stability) by means of one-off or periodic infusions of cash to the relevant fund. That is the case of UNDP, which already has an 89 per cent rate of funding for after-service health insurance after deciding to infuse a one-off transfer of $49.7 million to its after-service health insurance liabilities from its accumulated surplus in 2022. Similarly, FAO, ITU, UNFPA and UNWTO have also made such reallocations of accumulated resources from time to time so that they can provide for their financial needs without requesting additional funds from their Member States (see Table 19). Other organizations, such as UN-Women, UNDP, UNFPA, UNICEF and UNOPS, also fund their after-service health insurance liabilities from their investment portfolios, thus releasing Member States from having to increase their contributions while ensuring organizational solvency and protecting programme delivery.

222. **Unencumbered budget balances could be employed for the same purpose.** The same reasoning, *mutatis mutandis*, can be applied to the use of unencumbered budget balances to (partially) fund after-service health insurance liabilities, as first suggested by the Secretary-General in 2005[148] as an alternative to requiring a special assessment on Member States. In the Inspector's view, regardless of whether the financial regulations and rules authorize the executive heads to use unencumbered funds for purposes other than to reduce forthcoming assessments of Member States, e.g. to fund the long-term liability of

[146] All these sources of funding were contemplated in the first proposal to fund after-service health insurance long-term liabilities by the Secretary-General (A/60/450 and A/60/450/Corr.1, para. 16).

[147] A/71/698, para. 59.

[148] A/61/730, para. 30, and A/64/366, paras. 12, 65, 66, 71 and 86 (a) (i).

after-service health insurance, or whether the governing bodies or legislative organs decide on an ad hoc basis[149] to allow the suspension of financial regulations and the specific allocation of such savings to this end,[150] it cannot be denied that the funds saved come from the same source (previously assessed contributions) to which they would return and that their utilization to fund after-service health insurance has the effect of preventing future increases in assessments. Such use of unspent funds is a Pareto-optimal outcome in the sense that it does not make any harm to contributors, helps to fulfil their long-term financial obligations and stabilizes or improves the financial situation of the concerned organizations. Nevertheless, as pointed out in a report of the Advisory Committee on Administrative and Budgetary Questions,[151] the systematic use of savings as part of a funding mechanism for after-service health insurance should not be allowed as it may encourage deliberate overbudgeting. In that sense, **to avoid planning in advance the use of savings as part of the after-service health insurance funding mechanism, the Inspector recommends that all possible allocations of unspent funds for after-service health insurance purposes be approved by the relevant legislative organ on an ad hoc basis.**

223. **Voluntary contributions should include after-service health insurance costs without exceptions.** For organizations that are exclusively or almost entirely funded from voluntary contributions,[152] donors' contributions, whether earmarked or not, should include, as another component of staffing costs, the related after-service health insurance liabilities corresponding to the time served when implementing the project or the programme funded by them. This is the case for all entities under the United Nations financial regulation 3.12,[153] as well as for other organizations such as FAO, IAEA, ILO, IMO and the International Trade Centre (ITC).[154] Nonetheless, the review found that some participating organizations[155] do not factor in such costs when accepting donations or voluntary contributions (see Table 19). In this regard, the Inspector believes that accepting donations without charging the after-service health insurance cost of the staff involved to the cost of the programmes or

[149] As decided by the General Assembly, for instance, in its resolution 76/272 ("[The General Assembly] notes the exceptional amount of unspent funds from the 2021 regular budget to be credited to Member States, and decides to use 100 million United States dollars of these unspent funds to increase, on an exceptional basis and without setting a precedent, the Working Capital Fund").

[150] The Advisory Committee on Administrative and Budgetary Questions advised against this option ("The Committee considers the transfer of unencumbered balances to entirely alternate uses an inappropriate financial management practice. It therefore recommends against making an exception to financial regulation 5.3" (A/61/791)).

[151] A/60/7/Add.11, para. 17.

[152] According to *Financing the United Nations Development System Annual Report: Choices in Uncertain Times* (e Dag Hammarskjöld Foundation, 2023), the distribution in 2021 of the total United Nations system funding by financing instrument is as follows: (a) assessed contributions, 20.7 per cent ($13.6 billion); (b) voluntary core contributions, 10.4 per cent ($6.8 billion); (c) voluntary earmarked contributions, 60.7 per cent ($40 billion); and (d) other revenues, 8.2 per cent ($5.3 billion). Voluntary contributions therefore amount to $46.8 billion, equivalent to 71.1 per cent of all funds.

[153] United Nations Financial Regulation 3.12 controls the acceptance of voluntary contributions that involve additional financial liability for the organization. The Secretary-General's intention to start funding after-service health insurance accrued liability through the establishment of "a charge […] to be applied against the net base salary costs of staff financed under extrabudgetary funds and special accounts, as part of common staff costs" was announced to the General Assembly in his report A/64/366, and started to be applied as of 1 January 2017 (A/72/5 (Vol. I), chap. IV, para. 36). See also the memorandum of the United Nations Controller dated 29 November 2016 and entitled "After-service health insurance (ASHI) for staff funded from voluntary contributions and other non-assessed resources".

[154] This cost component is usually calculated by a payroll charge to be borne by the donors themselves. From the standpoint of its sufficiency, the charge should cover the full liability stemming from the funding provided, although it does not have to be the same for all entities or plans, as their after-service health insurance needs vary depending on the profile of the insured population. From this it inescapably follows that the payroll charge arising from after-service health insurance may act, in practice, as a competitive factor in the market of donor-funded programmes or projects, giving an additional advantage to entities with younger and healthier populations or with shorter careers.

[155] ICAO, ITU, UNAIDS, UNESCO, UNIDO, UNRWA, UPU and WHO.

projects for which the funds are intended constitutes a form of undue competition between organizations that should be avoided.

224. The following recommendation is intended to strengthen the coordination of after-service health insurance liability funding policies and practices with respect to programmes and projects funded by voluntary contributions.

Recommendation 6

From 2026, the executive heads of United Nations system organizations who have not yet done so should ensure that voluntary contributions cover future after-service health insurance liabilities corresponding to staff working on programmes or projects funded from such contributions as they accrue.

225. **Assessed contributions must defray the full cost of operations when other sources of income do not suffice.** For organizations or programmes with no significant revenue or source of funding for after-service health insurance other than assessed contributions, it is inevitable that Member States bear the burden, as is the case for any other expense related to the activities of the organizations concerned. The question then becomes when the necessary additional contributions will or must be made, which can only be answered by the Member States as it is their exclusive prerogative to set the priorities of the organizations[156] and thus to decide on the time for such contributions to be made, bearing in mind that while IPSAS does not require provisions to be made to fund the long-term after-service health insurance liabilities before payments fall due, the participating organizations have the responsibility to protect their financial health and sustainability and honour their obligations to their retirees. Consequently, the discussion on the timing shall be framed within the boundaries of what is financially sound and doable, considering all legitimate interests at play: on the one hand, the need to mitigate the financial risks associated with the growing balance of unfunded liabilities and, on the other hand, the opportunity cost of setting aside money to fund after-service health insurance needs well before they fall due at the cost of postponing other priorities.[157] This reflection is implicit in the belief of the Advisory Committee on Administrative and Budgetary Questions that "the objective of ensuring the availability of adequate resources to settle the recognized employee benefit liabilities can be achieved without … immediately creating a reserve"[158] and is central to the discussions conducted so far in the framework of the Secretary-General's reports on after-service health insurance.

226. **After-service health insurance liabilities not factored into calculations of assessed contributions negatively impact the organization's net assets, gradually eroding its financial position.** Regarding the financial stability of participating organizations, a lack of funds is not inconsequential in financial terms: to the extent that these liabilities, like any others, are indistinctly secured by the entirety of the organizations' assets, each new annuity (the "service cost" and its related "interest cost")[159] of after-service health insurance liability not factored into calculations of assessed contributions will negatively impact the organization's net assets, gradually eroding its financial position, stability and sustainability.

[156] General Assembly resolution 60/283, sect. III, para. 2.

[157] It can be argued that long-term and, therefore, unmatured liabilities do not require liquidity to support them until they fall due, whereas current or short-term programmatic activities of international organizations and even domestic public expenditure needs deserve priority. As the necessities are generally greater than the funds available and given that Member States' contributions to international organizations come from the same sources of financing (namely, taxes and fees, borrowing from financial markets or international financial institutions, external aid, transfers from public companies, etc.), the discussion ultimately boils down to which policy, programme or commitment deserves priority.

[158] A/76/579, sect. V, para. 51.

[159] The obligations of organizations for after-service health insurance increase each year, along with the liabilities associated with the accrual of entitlements for active staff ("service cost") and of the corresponding financial impact of liabilities becoming realized over time ("interest cost"). The service and interest costs of a given year are therefore the cost of the rights acquired by the staff for their services during that year.

In theory, in extreme cases, accounting for these liabilities could result in a negative equity scenario where debts outweigh assets, and the organization lacks the resources needed to meet its financial commitments even in the short term.

227. **As unfunded liabilities accumulate, the likelihood of a huge negative impact on future budgets also increases.** For public organizations as a whole, this is highly unlikely to be the case, as Governments and legislative bodies can and shall always provide additional resources or make decisions to meet any shortfall in order to ensure the payment of obligations, at least when they fall due, whether through an increase in assessed contributions, changes in budget priorities or other means. The problem is that, depending on the magnitude of such changes, the impact on both sides (Member States as contributors, and the participating organization concerned if changes in policy or programme priorities have to be introduced for lack of funds) may be hard to accommodate. In other words, as liabilities accumulate, the likelihood of a (huge) negative impact on future budgets and thus on Member States' contributions, or on participating organizations' programmatic activities, including the extent of the entitlement to after-service health insurance, also increases.[160] In the absence of a regular flow of funds to (at least partially) cover the long-term after-service health insurance liability and not only the short-term payments, it can be expected that a significant infusion of resources or, alternatively, a shift in budget priorities will be required in the future, crowding out relatively less urgent programmes or needs and postponing them to later dates to make room for the payment of (the now much higher) short-term after-service health insurance commitments.

228. **Budget-wise, after-service health insurance liabilities should be treated in the same way that pension contributions are.** It is also worth noting that the pay-as-you-accrue method is based on the legal and accounting logic that the right to after-service health insurance is earned by staff members, as in the case of pensions, progressively and throughout their career as opposed to at the end of it. It follows that the right to after-service health insurance should be treated as deferred compensation and included as a common staff cost in the years during which staff members render service. The correlative liabilities should therefore be treated the same as pension contributions, namely, as an additional component of staffing costs ordinarily charged to the staff budget line (and in the case of posts funded by assessed contributions, charged to such contributions, absent any other available revenues).

3. After-service health insurance and the transparency of budget processes and discussions

229. **Budgetary transparency is as important as transparency in financial statements.** When after-service health insurance is explicitly considered part of common staff costs, and consequently part of the direct cost of services, projects or programmes and therefore of the contributions to be made to meet expenses, it can be said that the related organizations or plans are fully transparent, not only in their accounting but in their budgeting processes. For entities or programmes funded from assessed contributions, regularly funding after-service health insurance liabilities through such contributions is undoubtedly the most transparent and appropriate course of action. **It is recommended that the full and true cost of the workforce be disclosed and taken into account in each budgetary cycle when deciding on budgetary priorities**.[161]

[160] Admittedly, the level of benefits and the contributions to be made by insured people (and consequently by the organization) are matters of political choice and are therefore subject to the sovereign decisions of Member States and governing bodies, provided that the acquired rights are respected, and the protection afforded is consistent with the desired attractiveness of the participating organizations as employers and the overarching principle that, in determining the conditions of service for its staff, the United Nations organizations be guided by "the necessity of securing the highest standards of efficiency, competence and integrity" (Charter of the United Nations, Art. 101, para. 3), as was recalled in the previous JIU review of the United Nations system staff medical coverage (JIU/REP/2007/2).

[161] As stated by the Secretary-General, "any shortfall in funding the liability should be included in the biennial performance report and considered as part of the budget formulations for future bienniums" (A/60/450 and A/60/450/Corr.1, para. 18).

230. **The failure to provide for after-service health insurance on an accrual basis distorts budgetary discussions.** The choice of the pay-as-you-accrue method is not only a matter of sound financial management or long-term financial sustainability, but also of transparency and efficiency in legislative budget discussions. There are two reasons for this: first, because not budgeting for the new portion of the long-term costs of after-service health insurance that will arise each year is tantamount to taking a cost that is real and inevitable out of the budget proposal and discussions; and second, because this lack of transparency and misalignment of costs and programme activities creates a fiscal illusion of resources being freed up for other budget programmes, shifts budgetary priorities or needs from the present to the future or vice versa, or simply leaves contributions below the level that would correspond to real costs (in the absence of a shift in priorities). In other words, and always subject to conditions *ceteris paribus*, if the annual share of long-term after-service health insurance liabilities that will be charged to the balance sheet of the following year is not taken into account in the budgetary proposals and discussions, not only will the financial position of that year deteriorate further, but discussions will result in a suboptimal outcome as they will not be based on full information, which will lead to an excessive allocation of resources to programmes or activities or an unrealistically low level of assessed contributions, or a combination of both outcomes.

4. Pay-as-you-accrue method of funding after-service health insurance liabilities compared with the pay-as-you-go method

231. **The pros and cons of funding after-service health insurance liabilities on a cash basis compared with an accrual basis.** To summarize the above discussion and for the purpose of illustrating decision-making on this recurring and long-standing topic, a synthesis of the advantages and drawbacks of each method of funding the long-term liabilities of after-service health insurance is presented in the following table.

Table 20
Comparison of funding methods for after-service health insurance liabilities

Method	*Advantages*	*Disadvantages*
Pay-as-you-go	Less costly in the short term as appropriations for after-service health insurance do not have to include service cost accrued by active staff members in each budget period, but only the organization's share of retirees' premiums or medical claims	Hinders the transparency and efficiency of budgeting processes as the future after-service health insurance costs associated with serving staff are not taken into account when deciding on budgetary allocations
	As a consequence, it allows for greater flexibility in the allocation of resources to other purposes	The lack of transparency creates monetary illusion and intergenerational inequity
	Reduces the administrative costs and complexity of managing after-service health insurance liabilities and assets	Exposes an entity to financial risks and uncertainties owing to the accumulation of unfunded debt without any existing funds to cushion against such risks
		Depending on the demographics of the insured population, the unfunded liabilities may take up an increasingly large share of the budget and, over time, crowd out resources for the fulfilment of the mandate
		May jeopardize the sustainability of after-service health insurance benefits in the long run

Method	*Advantages*	*Disadvantages*
Pay-as-you-accrue	Fosters transparency of budgeting processes, and avoids monetary illusions and intergenerational inequity, as each year's newly accrued after-service health insurance liabilities are provided for in that year's budgetary allocations and resources, and not charged against past or future savings, reserves or contributions, thus helping to disclose in real-time the full staffing cost of programmes and rationalize budget decisions	In the absence of additional contributions to the budget to meet the accrued annual share of after-service health insurance liabilities, pay-as-you-accrue restricts the availability of resources for other budget lines or programmes
		Requires an increase in contributions to maintain the breadth and scope of the organizational mandate and programmes
	Reduces the financial risks and uncertainties owing to the accumulation of after-service health insurance debt	Donors may find it less appealing to support an organization that has a payroll charge to cover after-service health insurance liabilities for staff associated with the programmes they fund, as this can make the organization less competitive compared with those that use the pay-as-you-go method
	Enhances the sustainability of after-service health insurance entitlements and liabilities in the long run	
	Funding of the liabilities is more economical in the longer term, as investment earnings serve to reduce future budgetary requirements	Increases the administrative costs and complexity of managing after-service health insurance funds or assets

Source: Prepared by JIU.

232. **Three main reasons to adopt the pay-as-you-accrue method to fund after-service health insurance liabilities.** According to the discussions in this chapter, the negative impact on the financial position of the organizations of a persistent lack of funds while liabilities are accumulated in the financial statements, the untimeliness and possible unaffordability of large increases in assessments when payments are due, and the desirability of improving budgetary transparency are, in summary, the reasons why, of the two most commonly known methods of funding after-service health insurance liabilities (pay-as-you-go and pay-as-you-accrue), the latter is preferable. This has been consistently recommended by JIU, the Working Group on After-Service Health Insurance, external auditors and financial experts and was confirmed through responses to the JIU corporate questionnaire and interviews for this review where participating organizations expressed their preference for this approach.[162]

233. **The application of the pay-as-you-accrue method is independent of any health insurance adjustments.** The conclusion reached still stands, irrespective of the level of protection afforded to beneficiaries, the proportion of insurance costs apportioned to the employing organizations and the impact of improvements in policy design and efficiency gained through any additional cost-containment measures, which must respect the acquired rights of beneficiaries. **The Inspector is of the view that providing for after-service health insurance liabilities as benefits accrue should not be conditional on the design and enactment of any health insurance policy changes.** The Inspector cannot overemphasize the importance of addressing this issue realistically, as failing to fund accrued and future liabilities could be tantamount to inflating a debt bubble that, over time, could become a severe risk to the financial stability of the organizations and their ability to continue to fulfil their mandates.

234. In its previous review of staff medical coverage in the United Nations system,[163] JIU recommended adequate financing to meet the liabilities, as was and is repeatedly advised by

[162] The Independent Audit Advisory Committee also reiterated its prior observation that maintaining the pay-as-you-go approach posed a significant risk that should be properly managed, recommending that "the General Assembly consider alternative … funding strategies to mitigate this risk" (A/76/270).

[163] JIU/REP/2007/2.

the Board of Auditors, the external auditors of the specialized agencies and IAEA, and the Independent Audit Advisory Committee. The following recommendation is expected to improve budgetary transparency and, with it, efficiency and accountability within the participating organizations besides their financial position and sustainability.

Recommendation 7

The legislative organs and/or governing bodies of United Nations system organizations that have not yet approved a plan to fund after-service health insurance liabilities as they accrue for posts funded from assessed contributions should establish a long-term strategy to that end, at least to cover future after-service health insurance liabilities for all newly recruited staff.

Annex I

Eligibility for enrolment in health insurance schemes

The eligibility of staff, retirees and their dependants to enrol in a particular health insurance plan or plans, based on their duty station and staff category, is outlined in this table.

		Type and location of active and retired staff			
		Internationally recruited		*Locally recruited*	
Policyholder and scheme	*Participating organizations*	*At headquarters location(s)*	*Outside headquarters*	*At headquarters*	*Outside headquarters*
FAO Basic Medical Insurance Plan/After-Service Medical Coverage	FAO	Yes	Yes	Yes	Yes[a]
FAO Medical Insurance Coverage Scheme/After-Service Medical Insurance	FAO	No	No	No	Yes[b]
IAEA Full Medical Insurance Plan/After-Service Medical Insurance Plan	IAEA	Yes	Yes	Yes	Yes
ICAO Medical Benefits Plan	ICAO	Yes	Yes	Yes	Yes
ILO Staff Health Insurance Fund	ILO	Yes	Yes	Yes	Yes
IMO Group Medical Plan	IMO	Yes	Yes	Yes	Yes
United Nations Office at Geneva United Nations Staff Mutual Insurance Society	United Nations Secretariat, ITC, ITU, WMO, UNDP, UNICEF, WMO, UNEP, UNOPS, UNIDO, UNCTAD	Yes (Geneva)	Yes (UNHCR, ITU, WMO only)	Yes (Geneva)	No
United Nations Office at Vienna/UNODC Group Headquarters Medical Insurance – Full Medical Insurance Plan	United Nations Secretariat, UNODC	Yes (Vienna, Turin)	No	Yes (Vienna, Turin)	No
United Nations Secretariat Aetna	United Nations Secretariat, UNDP, UN-Women, UNFPA, UNICEF, UNOPS	Yes (New York)	No	Yes (New York)	No

		Type and location of active and retired staff			
		Internationally recruited		*Locally recruited*	
Policyholder and scheme	*Participating organizations*	*At headquarters location(s)*	*Outside headquarters*	*At headquarters*	*Outside headquarters*
United Nations Secretariat Cigna Dental	United Nations Secretariat, UNDP, UN-Women, UNFPA, UNICEF, UNOPS	Yes (New York)	No	Yes (New York)	No
United Nations Secretariat Empire Blue Cross	United Nations Secretariat, UNDP, UN-Women, UNFPA, UNICEF, UNOPS	Yes (New York)	No	Yes (New York)	No
United Nations Secretariat Medical Insurance Plan	United Nations Secretariat	No	No	No	Yes
United Nations Secretariat United Nations Worldwide Plan	United Nations Secretariat, UNICEF, UNDP, UN-Women, UNFPA, UNOPS, UNIDO, UNRWA, UNWTO	No	Yes	No	No
UNDP Medical Insurance Plan	UNDP, UN-Women, UNFPA	No	No	No	Yes
UNESCO Medical Benefits Fund	UNESCO, ICAO (ICAO staff in Paris only)	Yes (Paris)	Yes	Yes (Paris)	Yes
UNHCR Medical Insurance Plan	UNHCR	No	No	No	Yes
UNICEF Medical Insurance Plan	UNICEF	No	No	No	Yes
UNIDO Field General Service Plan	UNIDO	No	No	No	Yes
UNIDO Group Headquarters Medical Insurance – Full Medical Insurance Plan	UNIDO	Yes (Vienna)	Yes	Yes (Vienna)	No
UNOPS Medical Insurance Plan	UNOPS	No	No	No	Yes
UNWTO Health and Accident Insurance Plan	UNWTO	Yes (Madrid)	Yes	Yes (Madrid)	Yes

		Type and location of active and retired staff			
		Internationally recruited		*Locally recruited*	
Policyholder and scheme	*Participating organizations*	*At headquarters location(s)*	*Outside headquarters*	*At headquarters*	*Outside headquarters*
UPU Health Insurance Fund	UPU	Yes (Bern)	Not applicable	Yes (Bern)	Not applicable
WFP Basic Medical Insurance Plan	WFP	Yes (Rome)	Yes	Yes (Rome)	Yes (Global Offices)
WFP Medical Insurance Coverage Scheme	WFP	No	No	No	Yes (except for Global Offices)
WHO Staff Health Insurance	WHO, UNAIDS	Yes (Geneva)	Yes	Yes (Geneva)	Yes
WIPO Group Medical Insurance Plan	WIPO	Yes (Geneva)	Yes	Yes (Geneva)	Yes

[a] For staff whose entry on duty date with FAO is before 1 October 2016.
[b] For staff whose entry on duty date with FAO is on or after 1 October 2016.

Annex II

Consolidated key performance indicators from service-level agreements with third-party administrators

A consolidated list of key performance indicators extracted from available service-level agreements signed between third-party administrators and commercial health insurers and JIU participating organizations is provided in this table. The key performance indicators are presented as is and may not represent good practices.

Key performance indicator	*Target (different target used)*	*Penalty[a] (different penalty rates used)*
Overall		
Turnover team: The rate of turnover of the teams involved in servicing the policyholder	No more than 15 per cent	0.50 per cent
Administration support	Monday to Friday from 9 a.m. to 6 p.m., excluding bank holidays	Fixed penalty for failure to meet service level
Account management		
Dedicated manager assigned	One assigned	0.50 per cent
Development of implementation timeline and decisions and issues document	Complete	0.50 per cent
Financial standard		
Financial accuracy: The average rate of all claims that are financially accurate.	At least 98 per cent	Different rates used from 0.50 to 10 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Payment accuracy: The number of correct payments divided by the total number of payments made in the audit sample.	At least 96 per cent	Different rates used from 1 to 10 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Processing accuracy: The number of correct claims processed divided by the total number of claims in the audit sample.	At least 96 per cent	Different rates used from 1 to 4 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Telephone standard		
Telephone response time: The percentage of calls answered within 10 to 30 seconds depending on the plan	At least 80 per cent	Different rates used from 0.50 to 4 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Telephone abandonment rate: The number of telephone calls abandoned as a percentage of total calls received into the telephone system	Maximum of 5 per cent	Different rates used from 0.50 to 4 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Helpline support	24 hours a day, 7 days a week, and in at least 5 languages	Fixed penalty for failure to meet service level

Key performance indicator	*Target (different target used)*	*Penalty[a] (different penalty rates used)*
Turnaround time standard		
Claims settlement: The average of the maximum number of days it takes to settle a claim	2 to 10 working days	Different rates used from 0.50 to 4 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Issuance of letter of guarantee for emergency hospitalizations: The average turnaround time it takes to issue a letter of guarantee upon receipt of completely documented request from the provider	2 to 24 hours	Different rates used from 0.50 to 4 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Issuance of letter of guarantee for non-urgent hospitalizations: The average turnaround time it takes to issue a letter of guarantee upon receipt of completely documented request from the member or provider	48 hours to 7 working days	Different rates used from 0.50 to 4 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Email response rate: The average turnaround time it takes to respond to an email request from member or provider.	1 to 3 working days	Different rates used from 0.75 to 4 per cent (some service-level agreements impose different penalty rates based on the level of service achieved)
Prior approval for medical treatment: The average turnaround time for prior approvals for medical treatment subject to medical review.	2 to 5 working days	Different rates used from 0.50 to 1 per cent
Uploading membership data and issuing of welcome email: The average turnaround time for the upload of membership data and receipt of the insured person's welcome email.	Within 5 working days	Different rates used from 0.50 to 0.75 per cent
Issuance of cards: The average turnaround time that the insurance card is received by the insured person.	5 to 10 working days	Different rates used from 0.25 per cent to 0.50 per cent
Courier service for claims The average frequency for insured persons to be informed that a courier service for claims will be available from the policyholder to the insurer.	Twice a week	Fixed penalty for failure to meet service level
Network		
Number of agreed providers: Number of providers per duty station Direct billing arrangements: In case of a specific request from the policyholder to set up a direct billing agreement, the contractor will first assess the requirement against its current network and provide similar alternatives if available. For the purpose of this turnaround time, only requests received from the policyholder's medical insurance unit shall be considered. If no alternative is available, the contractor will prioritize the request based on the total number of insured members impacted.	At least one The Contractor shall perform its best efforts, including three attempts to recruit the requested provider: a. within a maximum of 15 working days for duty stations following a field mission; b. within a maximum of 20 working days for duty stations classified as L3 Emergency;	0.50 per cent 0.50 per cent
Updates on the networks, the available discounts, and prices agreed with the providers: The frequency that updates on networks are provided.	Quarterly	Fixed penalty for failure to meet service level

Key performance indicator	*Target (different target used)*	*Penalty[a] (different penalty rates used)*
Satisfaction		
The level of satisfaction of insured persons	At least 75 per cent and up to 85 per cent	Different rates used from 0.50 to 1 per cent
Reporting		
The average turnaround time to deliver the reports:	From every ninth day of the month to before the end of the month following the reporting period	0.50 per cent
The insurer will provide statistical information to the policyholder demonstrating performance levels achieved compared with the agreed service levels.	Quarterly	Fixed penalty for failure to meet service level
Invoicing		
Monthly invoice: The average turnaround time to issue the monthly invoice.	Maximum of 15 working days	0.50 per cent
Meetings		
Quarterly meetings between the policyholder and insurer	At least one	0.50 per cent
Quarterly meetings between the policyholder managers and insurer	At least one	0.50 per cent
Others		
Evacuation/Transportation	The insurer will coordinate and pay the evacuation/transportation of insured persons to the nearest acceptable place of treatment	Fixed penalty for failure to meet service level
Third-party arrangements	• The insurer may engage third-party partners to assist in the provision of services, in which case the Insurer will have service-level agreements in place with third-party partners. • The insurer will monitor third-party service levels and have regular performance reviews to ensure adherence to agreed service levels.	Fixed penalty for failure to meet service level
Plan audits	• The insurer shall maintain complete, full and accurate books, accounts, records and supporting documents. • The insurer shall provide the policyholder and/or their representatives with assistance and access to and copies of all information, documentation and records held by the insurer.	Fixed penalty for failure to meet service level

[a] Penalties, represented as a percentage of the corresponding violation, are calculated against the annual administrative fees. Such an amount will then be withheld from the administrative fees payable to the insurer. However, there is another plan that imposes a fixed penalty of €5,000 per quarter if the insurer fails to meet any agreed service level.

Annex III

Overview of the Secretary-General's proposals on after-service health insurance

1. **By means of its resolution 58/249 adopted on 23 December 2003, the General Assembly, first requested the Secretary-General to propose measures that would ensure progress towards fully funding after-service health insurance liabilities.** Consequently, on 27 October 2005, the Secretary-General issued his first report on after-service health insurance[1] in which he included a recommendation "to adopt a longer-term funding policy that provides predictable yet flexible annual contribution levels which support the process of ensuring that adequate funds are put aside on a regular basis to meet the costs of current plan participants and future benefit liabilities". However, the General Assembly did not take any decision on the proposed policy at that time.[2]

2. **In his second report on after-service health insurance, dated 7 February 2007,[3] the Secretary-General presented to the General Assembly a revised version of his prior proposal together with four, in his opinion less viable,[4] alternatives.** The General Assembly, after receiving the advice of the Advisory Committee on Administrative and Budgetary Questions,[5] decided on 4 April 2007 to request, among other aspects, more comprehensive information and analysis on financing options and "the advantages and disadvantages for Member States of the 'pay-as-you-go' option of after-service health insurance liabilities versus the option of funding those liabilities".[6]

3. **The subsequent and third report of the Secretary-General on the subject matter,[7] dated 18 October 2009, followed by the report by the Advisory Committee on Administrative and Budgetary Questions,[8] led to General Assembly resolution 64/241**, in which the legislative organ decided to request the Secretary-General to submit a report on managing after-service health insurance liabilities "bearing in mind that the 'pay-as-you-go' principle is also one of the viable options", and to include in that report, inter alia: information on and an analysis of the scope and coverage of existing after-service health insurance plans; administration costs related to alternative financial options; options for contribution levels to after-service health insurance plans by its participants and by the United Nations; comprehensive long-term strategies for financing after-service health insurance liabilities; further measures to reduce United Nations costs related to health-care plans; after-service health insurance plans for retired public sector employees offered by their respective Governments; and the financial and legal implications of changing the scope and coverage of the after-service health insurance plans and the contribution levels for current retirees and active staff members.

4. **After considering the subsequent Secretary-General's report,[9] dated 27 August 2013, the Advisory Committee on Administrative and Budgetary Questions[10] noted that "the funding of after-service health insurance benefits is an issue of system-wide**

[1] A/60/450 and A/60/450/Corr.1.
[2] General Assembly resolution 60/255.
[3] A/61/730.
[4] Ibid., para. 38.
[5] A/61/791.
[6] See General Assembly resolution 61/264. The "pay-as-you-go" approach involves paying after-service health insurance premiums or reimbursing health insurance claims as they arise, without setting aside any assets beforehand for that purpose, while "pay-as-you-accrue" entails steadily accumulating funds designated for this specific end, no matter what the source of the funds may be. IPSAS 39 does not prescribe any method of funding for after-service health insurance liabilities and recognizes that the "defined benefit obligations" may be unfunded or wholly or partially funded.
[7] A/64/366.
[8] A/64/7/Add.4.
[9] A/68/353.
[10] A/68/550.

concern and … that, in the long term, it would best be resolved by adopting a system-wide approach similar to that currently employed by the United Nations Joint Staff Pension Fund for retirement and disability benefits".[11] Following that, on 27 December 2013, the General Assembly[12] decided to "[request] the Secretary-General to examine the option of broadening the mandate of the United Nations Joint Staff Pension Fund … to include the … administration of after-service health insurance benefits" and also to "[request] the Secretary-General to undertake a survey of current health-care plans for active and retired staff within the United Nations system, to explore all options to increase efficiency and contain costs and to report thereon at its seventieth session."

5. **The survey,[13] prepared by the inter-agency Working Group on After-Service Health Insurance established by the Secretary-General** under the auspices of the Finance and Budget Network of the CEB High-Level Committee on Management, and pursuant to General Assembly resolution 68/244, provided a comprehensive overview of the situation of 23 health insurance plans and after-service health insurance liabilities and funds of 25 United Nations system organizations as at 2015.[14] While the option of broadening the mandate of the United Nations Joint Staff Pension Fund was not found to be feasible, the fifth report of the Secretary-General contained eight recommendations on how to improve the efficiency and effectiveness of health insurance programmes within the United Nations system organizations, including shifting from the pay-as-you-go method to the pay-as-you-accrue approach to fund after-service health insurance liabilities for newly recruited staff.[15] As in its previous resolution 68/244, the General Assembly[16] accepted the Advisory Committee on Administrative and Budgetary Questions advice not to endorse such a recommendation, now because "the rationale for setting aside budgetary resources meant for current activities to provide for expected future liabilities has not been sufficiently justified by the Secretary-General".[17]

6. **By means of his follow-up report,[18] the Secretary-General provided updated and additional information on several aspects of United Nations health insurance schemes and related liabilities,** covering the status of implementation of the Working Group on After-Service Health Insurance recommendations endorsed by the General Assembly as at the end of 2016 on matters such as: collective negotiations with third-party administrators and health-care providers; using national health insurance schemes; expanding the mandate of the United Nations Joint Staff Pension Fund to operate a common health insurance arrangement; standardizing after-service health insurance liability valuations; adequate funding of after-service health insurance; and conducting underwriting reviews through financial performance indicators and further negotiations with carriers. The report also

[11] As General Assembly decisions are not binding on other system organizations, Advisory Committee on Administrative and Budgetary Questions recommendations endorsed by the General Assembly have to be proposed to the other competent governing bodies for formal evaluation and endorsement (A/71/698, para. 8).

[12] General Assembly resolution 68/244.

[13] The Working Group on After-Service Health Insurance conclusions and recommendations from the first and successive phases of the survey were reflected in the Secretary-General's reports on managing after-service health insurance from December 2015 (A/70/590), 2016 (A/71/698), and 2018 (A/73/662). This study was last updated in 2020 by the CEB secretariat. In addition to that, in its thirty-seventh Meeting (2022) the Financial and Budget Network launched a new survey to gather United Nations system organizations' after-service health insurance policies and practices. However, its results were not available at the time this report was drafted.

[14] The Working Group comprised representatives of 16 United Nations system organizations that are members of the Finance and Budget Network, the Federation of Associations of Former International Civil Servants, the Federation of International Civil Servants' Associations, the Human Resources Network of the High-Level Committee on Management, the Common Treasury Services Working Group of the Finance and Budget Network, the United Nations Joint Staff Pension Fund and CEB (see A/70/590).

[15] A/70/590, paras. 68, 69 and 70.

[16] General Assembly resolution 70/248 B.

[17] A/70/7/Add.42, para. 28.

[18] A/71/698.

included new recommendations or comments on the investment of reserves and other policy aspects.[19]

7. **The General Assembly**[20] **endorsed the subsequent Advisory Committee on Administrative and Budgetary Questions recommendations**[21] **on cost containment** and control in the administration of plans, cooperation among organizations in developing their access to health-care provider networks in all regions, pricing, risk-pooling, harmonization of the principles guiding liability valuation and the investment of reserves. However, the Secretary-General's proposal to switch to the pay-as-you-accrue method for funding after-service health insurance liabilities was once again not approved as the Advisory Committee on Administrative and Budgetary Questions noted that "the … funding proposal for after-service health insurance liability is not presented in a comprehensive manner and fails to consider different scenarios and variables that could have a potential impact on the liability".

8. **On 19 December 2018, the Secretary-General published his seventh report on after-service health insurance,**[22] **in which, among other aspects,**[23] **he addressed the issues of standardizing the valuation methodology and actuarial assumptions**, after-service health insurance premium apportionment and the funding of liabilities. The Secretary-General once again recommended that the General Assembly approve, through the implementation of a payroll charge, the funding of the after-service health insurance obligations in respect of future recruits,[24] with the simultaneous application of an entitlement accrual mechanism consisting of associating the part of the after-service health insurance premium paid by the agency and the staff member's period of service within the system.[25] On the advice of the Advisory Committee on Administrative and Budgetary Questions[26] and noting that the proposed payroll charge would entail an assessment on Member States, the General Assembly[27] decided to retain the pay-as-you-go funding model and requested the Secretary-General to present further details about the pay-as-you-accrue funding model and the entitlement accrual mechanism for future staff.

[19] Such as reporting and confidentiality clauses, underwriting results, risk-pooling, promoting consistency in health insurance plan design and plan consolidation along geographical and organizational lines, including merging schemes to attain critical scale; intergenerational solidarity; pricing (value-based premiums are considered more suitable for unpredictable risks such as the ones affecting property, while the cost-plus basis is better the United Nations typical health insurance risk profile).

[20] General Assembly resolution 71/272 B.

[21] A/71/815.

[22] A/73/662.

[23] Such as the feasibility or reasonability of engaging national health insurance schemes to provide: primary coverage for retirees; negotiations with third-party administrators on a system-wide or collective basis; cost-containment measures; and portability of health insurance benefits and entitlements across the system. In the same report, the Secretary-General acknowledged that "[he did] not have further information to impart in relation to … underwriting of reviews and negotiations with insurers; broadening of the mandate of the Pension Fund; and investment of reserves" and that the Working Group had "run its course".

[24] The Secretary-General's proposal only includes the entities that fall directly within the scope of the decisions of the General Assembly, among them, and in addition to the United Nations, the JIU participating organizations (ITC, UNEP, UN-Habitat and UNODC).

[25] The General Assembly, in its resolutions 38/235 and 69/251, decided that a maximum ratio of 2 to 1 between the share of the organization and that of the staff member would be used, and since that time that ratio has been applied in New York and it is used by many other international organizations. By way of the proposed accrual mechanism, after 10 years of service, the part of the premium paid by the employing organization would correspond to one-third of the total premium, and the maximum entitlement (to a maximum of two thirds of the premium) would be accrued after 20 or 25 years of service.

[26] A/73/792.

[27] General Assembly resolution 73/279 B.

9. **Although in its report [28] the Advisory Committee on Administrative and Budgetary Questions expressed its belief that "the objective of ensuring the availability of adequate resources to settle the recognized employee benefit liabilities can be achieved without necessarily and/or immediately creating a reserve"**, it did not provide information on how this could be done, whether by reducing the share of the premiums apportioned to the organizations, as suggested in its prior report,[29] adjusting coverage or eligibility criteria, creating a reserve at a later stage, or simply by facing the growing pressure on the assessed contributions as the projected expenses fall due. In this connection, it is worth recalling that the General Assembly "[acknowledged] with concern the importance of after-service health insurance liabilities … while highlighting the potential important impact of the proposals on future budgets and the future entitlements of concerned staff."

10. Albeit with variations, the eighth and Secretary-General's most recent report on the topic,[30] dated 30 September 2021, reiterated his recommendation that the funding of the after-service health insurance liability for new staff be achieved through the implementation of a payroll charge and, therefore, through an additional assessment on Member States.[31] At the time this review was conducted, this proposal has not been addressed in any General Assembly resolution and was, in any event, dismissed by the Advisory Committee on Administrative and Budgetary Questions[32] as the Committee was "not convinced" by the proposals and continued "to believe that the objective of ensuring the availability of adequate resources to settle the recognized employee benefit liabilities can be achieved without necessarily and/or immediately creating a reserve".

[28] A/73/792.

[29] A/71/815, para. 33.

[30] A/76/373.

[31] In the same report (section C), the Secretary-General stated that, owing to the lack of consensus within the Working Group on After-Service Health Insurance on the proposed entitlement accrual mechanism to more directly link a staff member's seniority within the United Nations system and the share of premiums to be borne by the Administration, the proposal was abandoned and replaced, effective 1 January 2023, with the application of a new and higher basis for calculating the contributions of retirees with less than 25 years of pensionable service, namely, the pension they would receive had they contributed for 25 years (the "theoretical pension" approved by the General Assembly by means of the resolution 61/264).

[32] A/76/579, sect. V.

Annex IV

Overview of actions to be taken by participating organizations on the recommendations of the Joint Inspection Unit

		Intended impact	Participating organizations of the Joint Inspection Unit																											
			United Nations*	UNAIDS	UNCTAD	ITC	UNDP	UNEP	UNFPA	UN-Habitat	UNHCR	UNICEF	UNODC	UNOPS	UNRWA	UN-Women	WFP	FAO	IAEA	ICAO	ILO	IMO	ITU	UNESCO	UNIDO	UNWTO	UPU	WHO	WIPO	WMO
Report	For action		☒	☐	☐	☐	☒	☐	☒	☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐
	For information		☐	☒	☒	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒
Recommendation 1		f	E										E	E			E	E		E		E		E	E	E	E			
Recommendation 2		g	E				E				E	E	E	E			E	E	E	E	E				E	E		E	E	
Recommendation 3		g					E		E		E			E		E			E	E	E	E			E	E	E			
Recommendation 4		d	L																											
Recommendation 5		e	E				E				E	E	E	E		E	E	E	E	E	E	E		E	E	E	E	E	E	
Recommendation 6		d													E					E			E		E	E	E	E		
Recommendation 7		a	L															L	L	L	L	L	L	L	L	L	L			

Legend:

L: Recommendation for decision by legislative organ

E: Recommendation for action by executive head

☐**:** Recommendation does not require action by this organization

Intended impact:

a: enhanced transparency and accountability; **b:** dissemination of good/best practices; **c:** enhanced coordination and cooperation; **d:** strengthened coherence and harmonization; **e:** enhanced control and compliance; **f:** enhanced effectiveness; **g:** significant financial savings; **h:** enhanced efficiency **i:** other.

* As described in ST/SGB/2015/3.