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Regional Overview of Social Health Insurance in South-East Asia

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CONTENTS

Page

Annexes

Foreword

Governments throughout the world are increasingly realizing the value of developing health systems that provide health care while financially protecting the people in the fairest way possible. In fact, health care financing reform is the path towards improved health system performance.

In order to ensure fair financing while providing appropriate incentives to health care providers, countries need to reform and harmonize the three interrelated sub-functions of financing, namely: (1) collection of revenue, (2) pooling of financial resources and (3) purchasing of interventions. Of these sub functions, pooling is of particular significance for fair financing.

The two most common mechanisms of financing that incorporate pooling are social health insurance and government tax funding. While these two mechanisms share some common characteristics, they also have some important contrasts. In tax-based systems, people contribute to the health funds only indirectly via taxes, whereas in social health insurance schemes, people, as members, contribute directly and are aware of the amount they contribute specifically for health care. Thus, it is an explicit contribution. Despite these contrasts, it is generally agreed today that these two systems complement each other in achieving the goal of Universal Coverage.

Successful introduction and expansion of SHI depend to a large extent on the income level of a country. According to the World Health Report 2000, while more than 50% of industrialized countries had social health insurance schemes as their health financing systems in 1998, not a single developing country with a gross national product per capita US$ 760 or below had a full-fledged social health insurance scheme. Among the lower middle-income countries with GNP per capita between US$ 761 and US$ 3030, the only country with a fully-fledged social health insurance scheme was Costa Rica.

Most countries in the South-East Asia Region employ mixed health care financing mechanisms. Some have implemented various mixes of social health insurance schemes covering certain segments of the population, such as employees of public departments and enterprises, workers from formal and informal production sectors and their families, where premiums or contributions could be collected easily. A few countries have tried to expand the social health insurance schemes to achieve universal or near-universal

coverage, through combining social health insurance and other risk pooling alternatives, such as community-based financing and a subsidy for the poor.

A major policy challenge today is to find a way to accelerate and expand the development of social health insurance. Even countries which already have coverage for specific groups are finding it increasingly difficult to extend the insurance coverage. Their efforts are frequently hampered by lack of administrative capacity and poor regulation. Countries that are yet to introduce SHI need to be aware of the potential risks involved. There is a danger that rapid expansion of health insurance coverage without appropriate safeguards could result in health systems moving away from their basic goals.

In view of the above situation, The SEA Regional Committee in September 2002 decided to hold technical discussions on SHI at its next Session in 2003. To facilitate the discussions, SEARO convened a regional expert group meeting in March 2003 and a Regional consultation in June 2003 for a thorough situation analysis. These meetings reviewed the development of various social health insurance schemes in the Region, particularly those in India, Indonesia and Thailand, and identified issues related to the promotion and expansion of social health insurance schemes in the Region. Finally, the 40th CCPDM in September 2003 discussed the issue at length and presented its findings to the 56th Regional Committee, which adopted a resolution on the topic. This document is a synthesis of the reports of the above meetings and the background documentation.

It is hoped that policy makers in the countries of the Region will find the document useful in selecting appropriate policy options for the introduction and expansion of social health insurance in their countries, as an important mile stone in their quest towards Universal Coverage.

1. INTRODUCTION

Currently, the world is witnessing higher achievements in health outcomes than at any other time in history. Improvements in socioeconomic, technology and health interventions with accompanying social policies, especially in health and education, have resulted in significant gains in human development. Enhancements in health systems performance have made a tremendous impact on the overall development.

One of the major functions of the health systems, i.e. financing health care, has three interrelated areas: (a) ***collection*** of revenue, (b) ***pooling*** of financial resources, and (c) ***use of*** financial resources either by ***allocating*** them or ***purchasing*** interventions. The challenge of reforming the three sub-functions of health care financing is to harmonize them, in such a way that, *health systems protect* people *financially* in the *fairest* way possible and that *appropriate incentives* are given to health care providers to motivate them to improve the health of the people by improving the responsiveness of the system.[1]

Harmonization depends on the technical, organizational and institutional arrangements of health systems. Health care financing denotes not only the use of disposable income of each household on health, but also the methods of financing, such as general taxation, insurance, or out-of-pocket payments as well as how they are used.

A ***health system*** is considered to be *fairly financed* if the ratio of contribution of each household to its ability to pay is identical for all households, independent of the household's state of health or use of health systems. *Fair financing* deals with whether funds are raised through progressive collection mechanisms and protection of catastrophic health expenditure directly linked to the household's capacity to pay. WHO defines health expenditure as "catastrophic" whenever it is greater than or equal to 40% of the capacity to pay (total household non-subsistence effective income).[2]

[1] Health care financing, financing health or financing health systems are used interchangeably throughout this document.

[2] Kawabata K. et al. Preventing impoverishment through protection against catastrophic health expenditure, WHO Bulletin, (80) 8 p612

The Forty-eighth session of WHO's Regional Committee for South-East Asia, held at Colombo, Sri Lanka in September 1995, debated the topic of "alternative financing of health care" as a subject of technical discussions. The Committee urged Member States to undertake various alternative financing reforms, within the framework of solidarity, equity and expanding essential coverage.[3] A follow-on regional consultative meeting held at Bangkok in October 1995 reviewed the regional experience of health care financing reforms, including development of social health insurance, and noted the importance of careful studies on various policy options and adoption of appropriate policy decisions.[4]

In May 1999, the Health Ministers of Member Countries of the Region participated in the "Ministerial Round Tables: Lessons learnt on world health" held during the 52nd World Health Assembly in Geneva. The Health Ministers agreed on the need to assess the consequences of health care financing reforms through an update of national health accounts and related studies.[5] At their 6th meeting held at Yangon, Myanmar, in February 2001, the Health Secretaries of Member Countries of the Region debated the experiences on health care financing reforms. They noted that while each country of the Region may have adopted different health care financing reforms based on its specific socioeconomic, political and health systems, there were a lot of lessons that could be learnt from each other. They requested WHO to share such evidence-based policy options.[6]

Several countries of the Region initiated reforms of health systems including those for health care financing, especially in attempting to expand the coverage of social health insurance or similar social protection for the poor. Subsequently, the 55th session of the WHO Regional Committee for South-East Asia held at Jakarta, Indonesia, in September 2002, having expressed its concern on the high level of out-of-pocket health expenditure and the low level of public spending on health in almost all countries, decided to hold technical discussions on social health insurance (SHI) at the fortieth meeting of the Consultative Committee on Programme Development and

[3] WHO, Report of the Technical Discussions on "Alternative financing of health care", 48th session of WHO Regional Committee for South-East Asia, September 1995 (SEA/HSD/195)

[4] WHO, Health care financing reforms: Report of Intercountry Consultation, 2-6 October 1995, Bangkok, Thailand (SEA/Econ./13)

[5] WHO, Ministerial Round tables: Lessons learnt on world health (WHA52/1999/REC/2 {p217-271}& WHA52/1999/REC/3 {p128-133})

[6] WHO, Report of Sixth meeting of Health Secretaries, February 2001, Yangon, Myanmar

Management (CCPDM), to be held prior to the 56th session of the Regional Committee in September 2003.[7]

Subsequently, the technical discussions on SHI were held at the 40th meeting of the CCPDM and the discussions and recommendations arising out of the technical discussions were submitted to the 56th session of the Regional Committee for its consideration. The Regional Committee, after thorough review and debate, passed the resolution SEA/RC56/R5. The background paper to this resolution highlights the regional overview of social health insurance in the Region within the broad framework of health care financing, explains the major issues in implementing various SHI schemes, and examines similar experiences elsewhere, with possible policy options for promoting and expanding SHI within the Region.

2. OVERVIEW OF HEALTH CARE FINANCING

2.1 Revenue Collection

There are five broad ways of revenue collection for health care financing, namely, general revenue (taxation); social health insurance, voluntary or private health insurance; out-of-pocket payments, and internal donations. Each country in the Region was adopted different ways of *collecting revenue*. Globally, in 1998, the estimated health expenditure (after adjusting purchasing power) was around US$ 3.1 trillion or 7.9% of the global income, with an average expenditure of US$ 503 per capita. The per capita health expenditure ranged from US$ 82 in Africa to over US$ 2 000 in OECD countries. While nearly 30% of this global expenditure came from taxation, around 20-25% was from out-of-pocket payments (OOP) and the same from social health insurance (SHI) contributions, with another 15% by private insurance. There is a wide variation in the distribution between different sources of financing. The Asian and African countries have spent more from out-of-pocket than from government general revenue or social health insurance.

According to the World Health Report 2000[8], "… in poor countries, roughly one-third of the disease burden in 1990 might have been averted at a

[7] WHO, Decisions and List of resolutions, 55th session of the Regional Committee, Document SEA/RC55/19, [Decision SEA/RC55/(1)]

[8] WHO, The World Health Report 2000, Health Systems: Improving Performance, 2000

total cost per person of only US$ 12." In addition, countries spending below US$ 10 per person per year seldom appear to achieve more than 75% of the life expectancy that should be possible. The Report of the WHO Commission on Macroeconomics and Health (WHO-CMH) recommended that countries should adopt an essential set of interventions with an average cost of US$ 30-40 per person.[9] There is evidence to show that health systems which spend less than approximately US$ 60 per capita find it difficult to deliver a reasonable, minimum range of services.

Resources for health care financing of countries, whether developed or developing, come mainly from the public general revenue, accumulated through various forms of ***taxation,*** social health insurance contribution, and other collections. Even though health policy-makers realize that the increase in the level of funding to the health sector depends largely on the rate of economic growth and the efficiency of taxation, which are outside their immediate control, they often ask what would be the optimal level of investment in health both by public and private sources, with a view to solicit public debate. Health policy-makers tend to raise issues such as: "What is the right amount for a country to spend?" or "How much of a nation's gross national product (GNP) or gross domestic product (GDP) should be devoted to health care?"

In 1981, an indicator, "the number of countries with at least 5% of GNP spent on health", was proposed for the purpose of monitoring and evaluation of the global strategy for health for all by the year 2000 (HFA2000).[10] While WHO and its Member Countries have not been able to formally adopt this indicator, the numerical level, i.e. "5% of GNP spent on health", has been used frequently in many policy debates, and even been mentioned in some cases as the "WHO- recommended target".

According to the World Health Report 2001 (WHR2001), the countries of the Region on an average had a total health expenditure (THE) of around 2-8% of GDP. In reality, except four countries, Bhutan, India, Maldives and Thailand, others could not spend more than 5% of their GDP on health. Similarly, many countries around the world never achieved this "fictitious target". A recent International Monetary Fund study suggested that effective

[9] WHO, Report of Commission on Macroeconomics and Health on investing in health for economic development, 2001

[10] WHO, Health for all 2000 (HFA2000) Series No. 4, Development of indicators for monitoring and evaluation of HFA2000, and Health for all 2000 Series No.3, Global strategy for Health for All by the Year 2000

health coverage would require around 12% of GNP in low-income countries in order to meet the international development goals.[11]

An appropriate percentage benchmark or target for health spending, like the fictitious target above, is extremely difficult to set. Research is under way to better define the ***minimum amounts*** of finance that countries should invest in order to optimally develop their health systems. In its 2001 Report, the WHO-CMH recommended that the low-income countries should increase their domestic spending on health by an additional 1% of GNP by 2007, and by an additional 2% by 2015, keeping in view the existing and future trends of economic growth.[12] Good governance, strong political leadership and political will of all stakeholders are required for increasing the investment in health.

While many countries rely on general revenue for financing health care, many others bank on the creation or expansion of ***compulsory health insurance contributions,*** generally referred to as "social health insurance", usually based on pay-roll deductions, with additional support from the government in the form of general tax revenue.

The proportion of government (public) contribution as a percentage of total health expenditure in countries of the Region ranges from 20-60%, depending on the general economy of the countries, the growth of health insurance schemes as well as the increasing role of private health care. This situation, however, has not changed much during the past few decades. Since national and local SHI schemes do not cover the whole population, the budgetary allocation to the health sector from public revenue has to accommodate a major proportion, and almost the entire amount in many countries.

The World Bank in 1997 estimated that when a country's taxation is low (10% of GDP or lower), it would take 30% of government revenues to meet 3% of the GDP health expenditure target, through formal collective health financing channels.[13] Usually, poorer countries have widespread tax evasion among the rich and the middle class in informal sectors, thereby leading to low tax collections. They also rely heavily on taxation on international trade

[11] IMF study "Public spending on health care and the Poor", 2001

[12] WHO, Report of the Commission on Macroeconomics and Health, Macroeconomics and Health: Investing in Health for Economic Development (WHO-CMH), 2001, p18-19 and p108-111

[13] World Bank, Sector Strategy Health, Nutrition & Population, 1997

(exports and imports) and have the added limitation of broad-based taxes such as income tax or value-added tax.

A few countries have tried to add extra resources for health through earmarking ***a certain proportion of revenue*** collected from indirect taxation for health promotion and disease prevention. Some countries run state lottery services or other special revenue collection schemes, and earmark a certain proportion of collected funds, for social services including health and education. Thailand recently enacted a legislation for a "Health Fund", which has specified a certain percentage of general revenue generated from taxes received from sale proceeds of tobacco and alcohol, being set aside for health promotion activities. With the adoption of the WHO Framework Convention on Tobacco Control (FCTC), an increasing number of countries are expected to use part of the revenue collected through a similar "sin-tax".

For intercountry comparisons, the level of health spending (like total health expenditure or per capita heath expenditure as a percentage of GDP) may be useful. However, experience in some high- and middle-income countries has shown that more is not always better or always possible. Some developing countries with low investment in health could show outcomes comparable with those with high investment. What needs to be seen is how efficiently and effectively countries spend their health resources according to their health needs. The output of effective spending according to health needs is reflected in the level of inequities in health outcom.

While countries are attempting to update their National Health Accounts (NHA) as comprehensively as possible, it is difficult to estimate the ***proportion of public health sector expenditure*** accounted for by ***external*** donations, grants, and borrowings, both from bilateral and multilateral agencies and financial institutions, and from ***internal*** resource collection through private grants and donations. Many governments do not show clearly these grants and loans in their public budget estimates or expenditure statements. While a few may show the value of expected external loans and grants, some report only the actual amount received in previous years.

A worldwide study in the early 1990s on external assistance to the health sector between 1972 to 1990 revealed that the least developed countries received more funds from external assistance, either in loans and grants, and the total funds accounted for around 20-30% of the total health

expenditure.[14] The WHO-CMH Report indicated that least-developed countries received an annual average of US$ 2.30 per person, from 1997-1999, as donor assistance for health, while the total outlay of donor assistance for health for these countries was around US$1.4 billion.[15]

While India received the largest amount of foreign loans and grants for the health sector, its proportion to that of public health expenditure is small, whereas Bhutan, Bangladesh, Indonesia and Nepal received a larger proportion of external resources compared to their public health outlays. While the least-developed nations might need additional resources through external donors' inputs in health sector either by grants or softloans, experience shows that many external financing programmes have imposed certain conditionalities, such as use of technical assistance, expertise and buying equipment from donor countries, and sometimes focusing only on physical infrastructure development. In some cases, the grant funds cannot be used for local expenses which the receiving countries require the most. Providing benefits to the health sector require strong capacity of national teams to counteract the above weaknesses, and to focus on local capacity strengthening and good governance.

International civil societies, including foundations and associations play an important role in financing health, especially in the areas of prevention and promotion. The Rockefeller Foundation, the Nippon Foundation, Rotary International, Médecins Sans Frontières (MSF), Help International, and many others are assisting the countries in prevention and control of diseases such as poliomyelitis, leprosy, TB, HIV/AIDS, malaria and other tropical diseases. In addition, multinational pharmaceutical corporations such as Novartis, SmithKline and Merck, etc. are donating their products and finances to help the global elimination of major communicable diseases such as leprosy, river blindness, filariasis, soil-transmitted helminthic infections and other diseases.

The recent entry of Rotary Club members and other national and international entrepreneurs as private philanthropists, in health and other social sectors such as the Sasakawa Health Trust, the HP Foundation, the Ted Turner UN Foundation, the Bill and Melinda Gates Foundation, Rotary Club, with multi-billion dollar contributions to specified funds and programmes for global health development, are making health an important investment for

[14] C. Michaud & C.J.L. Murray, Bulletin of World Health Organization, 1994

[15] WHO-CMH Report op cit

development. Presently, their inputs are usually aimed at special health development *funds or programmes* and/or assigned for certain *geographical areas*.

Similarly, national and sub-national nongovernmental organizations and other civil societies have played a major role in mobilizing human and financial resources for health. In most countries, community trust funds and foundations have been established at both national and local levels, in order to protect the financial risk for health care, especially for poor patients (Help Aid for Blind, National TB Union, etc.).

A few funding pools formed through public voluntary donations, have been earmarked to provide support for the prevention and control of specific diseases, especially non-communicable ones, such as cancer, diabetes and renal diseases like the National Cancer Foundation, National Diabetes Association, National Kidney Foundation and the National HIV/AIDS Association/Foundation etc. The extent of contributions by these national funding sources, which would be able to cover essential health care for these specific needy groups has not yet been properly accounted for, although efforts to do this within the NHA framework are under way. There is also a possibility of double counting since governments are also financing many international and national NGOs, including foundations. A few countries have created drug revolving funds or community trust funds for purchase of drugs and other essential supplies for the poor, mainly at the local level.

The Royal Government of Bhutan established the *Bhutan Health Trust Fund* in 1998 with the aim of safeguarding its primary health care services through a continuous supply of essential drugs and vaccines for its population. By June 2003, the Trust Fund received donations, sponsorships and partnership totalling nearly US$ 18 million. The famous "Health Walk" by the Minister of Health and Education and his team, done as part of the World Health Day 2002 "Move for Health" campaign in late September 2002, resulted in an additional fund of around US$ 1.7 million. A total of Bhutanese Ngultrum 1.4 million (US$ 30 000.-) was used in mid-2003 for purchase of Hepatitis B vaccines. It is understood that once the level of the Fund reaches US$ 24 million, the interest earned would cover a major portion of the annual health expenditure for essential drugs and vaccines.[16]

[16] Web access: Bhutan Health Trust Fund: http://www.bhtf.gov.bt

In many countries, the *out-of-pocket payments* (OOP) form a major part of the total health expenditure (THE). The analysis of NHA tables in WHR2002[17] indicated that in 60% of countries with incomes below US$ 1 000 per capita, OOP constituted 40% or more of THE, whereas only 30% of middle-and high-income countries depended as heavily on this kind of financing. Most countries in the Region have more than 50% of THE coming from OOP.

While people have the freedom of choice for paying out of pocket for health expenditure, and it might provide especially the rich, high satisfaction, there is no guarantee that the majority of the population would be able to afford health care costs through OOP. The real issue in many developing and even in developed countries is that of the high proportion of catastrophic expenses of households in all income deciles, especially among lowest and highest deciles.

People become impoverished due to the higher and/or rising costs of medical bills, because of the uncertainty of the amount of expenditure needed to meet the health care needs on an individual basis. In some cases, people have to incur 'under-the-table' expenditure for getting access to public health facilities. And, in other cases, the unskilled and unqualified private providers might charge higher rates for their service in exploitation of quick and easy access and convenient service hours. Strong stewardship of the government is required to rationalize the provider-consumer relationship. In fact, a strong purchasing power could play a better role in controlling health care costs, to a certain extent.

2.2 Resources Pooling

"Pooling of resources" refers to "the accumulation of health assets on behalf of a population." By pooling of resources, the financial and health risks are spread and transferred among the population. Good pooling can improve health conditions by sharing health resources effectively between individuals, so that people can get access to services when needed. By pooling, the financial resources are no longer tied to a particular contributor.

The essence of "health insurance" is the pooling of funds and spreading the risk for illness and financing. Health insurance may be classified into "Social" and "commercial" health insurance. The social health insurance has

[17] WHO, The World Health Report 2002, Reducing Risks, Promoting Healthy Life, Annex Table 5, 2002

in general three main characteristics: mandatory membership, contribution based on community-risk rating, and the objective is to meet the health needs rather than meeting the individual demand for health care. Commercial health insurance on the other hand is private, voluntary, involves individual risk-rating in most cases, and the objective is to meet the individual's need. A few countries have tried to expand different types of social health insurance (SHI) schemes to achieve ***universal coverage***[18] or near-universal coverage. Evidence shows that people with health insurance coverage, both social and commercial, tend to utilize more health care services than those with less or no insurance at all.

Recently, various mechanisms and schemes for voluntary, private, and multiple risk-pooling have emerged in many developing countries. These *risk-sharing schemes* were started covering informal sectors especially in rural areas, and their existence highlights the importance being given by national or sub-national governments in ensuring the financial risk-sharing is extended to the vast rural population. Section 3 provides an overview of the regional experience on resources especially with regard to social health insurance.

2.3 Purchasing

In order to have an effective and efficient health insurance, the essential health care packages should be available to the consumers literally free-of-cost, rather than under a fee-for-services arrangement for reimbursement. In addition, there should be a orivusuib if large amount of co-payment. The insurance agency or agency managing insurance fund must make various arrangements for purchasing services from health care providers, on behalf of consumers (insured). Health care providers from national public or private health care systems should ensure that the health care packages which they provide have to be responsive and financial fair. This can be achieved through strategic *purchasing.*[19]

[18] The term "Universal Coverage" means "effective protection of health and financial risk for all citizens". It is the provision of essential and affordable health care packages to everybody according to the needs and preferences, regardless of income, social status or residency (coverage by essential health care for all and not all possible care for whole population). (See WHR 2000, op cit p15) Joe Kutzin further defined it as "effective health risk protection at the least cost possible and the coverage may be in depth – the range of affordable health care packages, and in breadth – the proportion of people that would effectively protect from health risks. (Sanguan N. and A. Mills Achieving Universal Coverage of Health Care, 1998)

[19] "Purchasing" refers to the transfer of pooled resources to service providers on behalf of the population for which the funds are pooled. It means not only to include explicit purchases from public and private entities, but also to include management processes that allocate funds to providers within public agencies.

The successes in strategic purchasing depends not only on *what types or mixes* of health care interventions to buy, but also from *whom* to buy and *how* to buy them. Good purchasing contributes to achieving health sector policy goals by ensuring that funds are allocated and used effectively.

Strategic purchasing of an appropriate set of interventions requires a continuous search for the best interventions to purchase, the best providers to purchase from and also the establishment of the best payment mechanisms and contracting arrangements. The promotion of competition, either between providers or, more rarely, between financiers of health care, has been used as a strategy to finance reform programmes in industrialized countries.

The strategy to use public funds to buy clinical and non-clinical services as well as preventive and promotive health care from private providers is intended to improve the productivity of public resources by purchasing the gains in efficiency perceived to exist in the private sector. Service contracting (capitation, global budget, diagnostic related group, etc.) is primarily to improve the efficiency and/or increase the quantity of services that can be made available for a given amount of expenditure. An appropriate payment system also stimulates a better quality of health care. This kind of a competitive approach has also been introduced in a few countries of the Region.

Considerable evidence in developing countries including those in the Region has been documented on the consequences of introducing ***user-charges*** for health care, in the context of equity, efficiency and consumer satisfaction. This evidence clearly shows that the price paid for health provision alone is insufficient to explain the effects of fee systems being clearly equitable. The burden to pay user-charges is much higher for the low-income householders, compared to the higher-income groups. There is also high correlation between the user charges system and low health status. Issues of cost-effectiveness and quality of care need to be studied to better understand these effects.

In addition, managerial and organizational factors are central determinants of the impact of this policy reform. Imposing *user-charges at the time of service provision* sometimes encourages and, in some cases, hinders utilization of health services. The net impact depends upon whether the direct effects that tend to reduce demand are offset by positive effects on the supply and quality of services through, for example, health care provider incentives, subsidies, or availability of drugs or other health care interventions.

There is also evidence of the danger that the direct contribution from collection of user-charges for purchases of drugs, staff incentives and facility renovation, etc., could lead to a reduction in the allocation of government health budget. Due to the increasing use of high cost-low volume health technology, there is a tendency for higher and higher user-charges. As fee-for-services payment mechanism, become increasingly expensive and inequitable, the needs for pooling the risk of high financial costs associated with an illness (especially catastrophic ones) also get amplified.

Many countries *have promoted* or are in the process of *promoting privatization efforts* in the health sector, with or without the active participation of health ministries. Some countries have attempted to reduce public involvement in the management and delivery of health services like hospital or health centre autonomy as part of their privatization efforts. The rapid privatization without effective legislative action leads to higher and higher user-charges and increasing burden to the consumers spending more from out-of-pocket to meet their health needs. Without a balancing privatization effort with expansion of social health insurance coverage, privatization would increase inequity in health status, and result in unfair financing; and in the long run, it might lead to lowering the health status significantly.

3. CURRENT STATUS OF SHI SCHEMES

3.1 Basic Concept

Social health insurance (SHI) is a *mechanism for financing and managing health care* through pooling of health risks of its members on the one hand, and the financial contributions of enterprises, households, and the government, on the other.[20] It is generally perceived as a financial protection mechanism for health care, through *health risk-sharing* and *fund pooling* for a larger section of the population.[21] It usually forms part of a broader national ***social security*** framework, covering all contingencies which need financial protection and risk- sharing. It is not merely a new method to collect money

[20] Carrin G. et al, Social Health Insurance Development in low-income developing countries Building Social Security: the challenge of privatisation, X. Scheil-Adlung (ed.). Transactions Publication, London 2001

[21] This model of health care financing is popularly known as "**Bismarck Model**" that is applied in most EU countries like Germany, Belgium, Austria and Netherlands (based on a system of entitlement to health insurance on employment status and payment of contributions).

to co-finance services. It is a method that is able to achieve stable financing for a package of health services (health insurance benefits), while at the same time achieving greater access to health care among the population.

To be characterized as "social" and "insurance", the SHI must have certain characteristics. Countries that implement SHI schemes on a national scale usually adopt broad social security policies and legislation within the social policy stipulated under the National Constitution. In some cases, it is determined by the society's consensus. Major characteristics are:

(1) Compulsory or mandatory membership of individual or groups of individuals, and/or their immediate households and other dependents, initially targeted to cover civil servants and other formally employed people, from the public and private, commercial, semi-commercial, industrial and agricultural establishments and, usually expanding coverage to informally employed people, non-working people, retirees and even schoolchildren (*inclusion of target population does not necessarily depend on the structure of the economy*);

(2) Responsibility at the members for payment of the regular income-related contributions or flat-rate contributions, with added contribution from employers and the Government (*deduction as insurance contribution or as a pre-payment* [22] *from regular payroll or pre-set amount collected from individual or groups*);

(3) Contribution according to the ability to pay (based on economic means) and not related to health risks of individuals, households or employment groups;

(4) Establishment of appropriate collection mechanisms for collecting regular contributions;

(5) Choice of health care according to the health needs (basic benefit packages are usually pre-set and the schemes allow the members to make co-payment and also to purchase supplementary health care services);

[22] There is some fundamental difference of "prepaid" or "prepayment" for insurance with other "prepaid" services like "prepaid telephone card" or "prepaid goods'. The money spent for the goods or services by the consumers in such cases is limited to the amount prepaid. Whereas, in health insurance, the goods/services received by the consumer might get will be costing many times of the actual value prepaid. The term "insurance contribution" may be better used than "prepaid". (Personal communication with Professor T. Hasbullah)

(6) Solidarity across the population; risk equalization and cross subsidization;

(7) Arrangement for social assistance to cover vulnerable populations (young and old, disabled, pregnant women) (C*ontributions by these groups may be partially or totally subsidized by the Government through general revenue*);

(8) Covering a significantly large proportion of population, and

(9) Funds collected from contributions to be pooled as a single or multiple fund arrangement, administered by a quasi-independent public body.

According to the International Labour Organization (ILO) Convention No.130, its Member Countries are free to choose different "Social Security Schemes" (SSS), inclusive or with a separate SHI scheme. A country will fall into the category of "those with SHI" only if the major proportion of the population of that particular country is legally covered under an SHI scheme with a designated (statutory) purchaser through non-risk-related insurance contributions separated from general taxes or other legally mandated payments.

SHI schemes ensure that all people who make contributions, receive a pre-defined entitlement to health care, irrespective of their income or social status. The schemes usually cover the minimum health and financial risks (basic packages for health care and its expenditure) that, in the absence of insurance, would entail a financial burden on the households as a result of the cost of health care.

SHI and the general revenue-based health care financing system share similar characteristics of pooling risks and contributions. In SHI, people as members of insurance schemes are directly aware of their insurance contributions (*explicit*).[23] Usually people contribute from their daily, weekly, or monthly payroll. These contributions are the pre-set, proportionate and prepaid collections from members (employees), employers, and governments.

In the ***general revenue-based or tax-funded systems***[24], the resources for health care come directly from general revenue and, in some cases, from special or earmarked taxes or revenue. In this method of financing, people or

[23] WHO, The World Health Report 2000, Health systems: Improving performance, WHO-Geneva, 2000

[24] The general revenue-based or tax-funded health care financing model is popularly known as "**Beveridge Model**", applied by western European countries like Denmark, UK, Ireland, Italy, Portugal, Spain, and Sweden.

enterprises contribute for health care in an *indirect* way via general taxation. Thus, people are not aware of the amount they contribute solely for health care (*implicit*).

SHI is generally associated with compulsory or mandatory membership involving all people. This would ensure compulsory inclusion of certain underserved groups such as the poorest and the vulnerable people who are usually left out from the voluntary private health insurance schemes. The compulsory scheme would guarantee an appropriate mix of good and bad health risks.

SHI schemes aim at reaching ***universal coverage.*** Once the target is achieved or is near achievement, there is a strong potential to foster efficiency and effectiveness of health systems performance, by pushing forward the ***monopsony***[25] of purchasing power, in ensuring the quality of care and efficient resource consumption. Many countries with SHI schemes that either relied on fee-for-services payment mechanisms are now modifying them into more closely regulated payment mechanisms, such as capitation, global budget and DRG. It is more of a self-sustaining health care financing mechanism, provided it is properly managed.

3.2 Regional Experiences

The introduction of SHI schemes as a method of financing health care in the Region dates back to more than fifty years. Since the socioeconomic and political development of the countries varied widely, it actually affected the development of SHI schemes. *Carrin et al* [26] analysed that by 2000, about 80 countries around the world have advanced risk-sharing health systems. A majority have either general tax-based health care financing system (50 countries) or a social health insurance scheme (30 countries). A total of 61 countries are in the medium risk-sharing category with three variants. In the first group of nine countries, all employees including the self-employed are covered under health insurance. In the second group of 20 countries, the SHI schemes cover only employees, while in the third group of 32 countries, the SHI schemes cover specific population groups. Besides, a total of 50 countries are in the low risk-sharing group and are generally under-financed.

[25] "Monopsony" means a single-customer market situation in which a particular type of product or services is only being bought or used by one customer.

[26] Carrin G. et al, The Impact of the Degree of Risk-sharing in Health Financing on Health System Attainment, HNP Discussion Paper, The World Bank, 2001

According to the WHR 2000, more than 50% of industrialized countries selected SHI as their health financing mechanism. Not a single developing country with a GNP per capita US$ 760 or below had a full-fledged SHI scheme. Among the lower middle-income countries (with a GNP per capita between US$ 761 and US$ 3 030), the only country with a fully-fledged SHI was Costa Rica.[27] India, Indonesia, Myanmar and Thailand have mixed health care financing systems with certain percentages of coverage under the SHI schemes.

The historical development of SHI schemes over the decades, from a single to a multiple-fund arrangement, is worth noting. Even in some East Asian countries with substantial and sustained economic growth, the expansion of SHI to achieve universal coverage was slow and steady for over 30-50 years. Each country has therefore to consider introducing and expanding the SHI slowly and steadily over several decades to achieve universal coverage, or to make a ***big-bang*** transformation by jumping certain steps.

India[28]

India, with a GDP of around US$ 1 800 per capita, spends about 5% of its GDP on health, of which less than 17% accounts for public sector health facilities and human resources (hospitals, clinics and preventive establishments). SHI mainly covers civil servants and a certain proportion of employees in the formal sector. Private health insurance is still negligible, but growing rapidly. Out-of-pocket payments to the private clinics, hospitals and pharmacists including traditional medicine practitioners account for 83% of health expenditure.

The financial burden on the national health system has increased in recent decades with spiralling health costs aggravated by an increasing burden of new and emerging diseases and also by the increasing demand for health care. Hospitalization for major illnesses like cardiovascular diseases, diabetes and renal diseases is a cause of indebtedness for low- and middle-income groups. A large section of the population, especially from the low-income

[27] See WHR 2000, op cit

[28] India Country Paper on SHI, presented at the Technical Discussions session of 40th CCPDM, 5 September 2003; Sujatha Rao. Social Health Insurance in India, Presentation made at the regional meeting on SHI, 13-15 March 2003; and Indrani Gupta, et al, Health Insurance in India: Prognosis and Prospectus, Economic and Political Weekly, January 2000 207-217

groups does not have easy access to good quality health care. Because of the resources crunch faced in recent years, the federal government is not in a position to increase health budgets. State governments too are facing a fiscal crisis and are unable to meet the recurring health expenditure. In this scenario, health insurance is seen as an alternative mechanism for financing health care.

The Government established a health insurance scheme called the "Employees State Insurance Scheme (ESIS)" under a health insurance act in 1948 to provide cash and medical benefits as part of a compulsory social security benefit scheme for formally employed workers from industrial sectors. The ESIS provides financial and other social protection measures to employees with regard to sickness, maternity, disability and death caused by employment injuries. The ESIS scheme has its own health care facilities providing care to employees and their family members free for cost. Originally, ESIS scheme covered all power-using non-seasonal factories/industries employing 10 or more people. Later, it was extended to cover employees in all non-power using factories with 20 or more persons. While persons working in mines and plantations or an organization offering health benefits as good or better than ESIS, are specifically excluded, some service establishments like shops, hotels, restaurants, cinema houses, road transport and newspapers printing are covered. The monthly wage limit for enrolment in ESIS is Rs 6 500, with a prepayment contribution in the form of a payroll tax of 1.75% by employees, 4.75% of employees' wages to be paid by the employers, and 12.5% of the total expenses borne by the state governments. The number of beneficiaries covered are more than 33 million, spread over 620 ESI centres across the states. Under the ESIS, there are 125 hospitals, 42 annexes and 1 450 dispensaries with over 23 000 beds. The scheme is financed by the Employees State Insurance Corporation (a public undertaking) through state governments, with a total expenditure of Rs 3 300 million or Rs 400 per capita insured person.

India is implementing the Central Government Health Scheme (CGHS) since 1954. The scheme is aimed at providing comprehensive medical care to employees (present and retired) of the Central Government; staff of autonomous and semi-government institutions; Member of Parliaments; judges; freedom fighters and journalists. The benefits include all OP facilities, preventive and promotive care at public dispensaries, inpatient care at both public and approved private hospitals. The premium is progressive with salary

scales (ranging from Rs 15 to Rs 150 per month). Beneficiaries under the CGHS are about 4.5 million. The CGHS scheme has been criticized for quality of care and accessibility. Beneficiaries also complain about the delays in reimbursement and about the high proportion of out-of-pocket payment (co-payment).

The General Insurance Corporation (GIC) and its four subsidiary companies, public-sector undertakings, have been offering voluntary health insurance (*Mediclaim Plan*) since 1986. These schemes mainly cover hospital care and domiciliary hospitalization benefits (specified outpatient care provided in lieu of inpatient treatment). In addition, certain private insurance companies also offer health insurance. The GIC recently introduced a new health insurance to extend the coverage of health care needs to middle-and low-income groups. It has also introduced the *Jan Arogya Bima,* an insurance policy specifically targeting poor population groups. It covers the reimbursement of hospitalization costs up to Rs 5 000/- annually for an individual premium of Rs 100 per year. In 2002, the schemes of GIC covered around 7.2 million people.

Both public and private sector companies offer some forms of risk-sharing by providing free health care at employer-owned facilities (Tata and Reliance), or by way of lumpsum monthly or annual payments and bonuses, partial or full reimbursement of health expenditure incurred by employees, and arrangement of health care coverage under group health insurance policies (such as Bajaj Allianz, ICICI Lombard, Royal Sundaram, or Cholamandalam group insurance policies). The population coverage under these schemes is low and is estimated to cover around 30-40 million people.

The National Health Policy (NHP) 2002 of India acknowledged that access to the public health care systems was inequitable between those better endowed, and the more vulnerable sections of society. The new policy thus aims to evolve a system which would reduce inequities and enable the disadvantaged sections of the population to have a fairer access to essential health care. The NHP aims to increase the aggregate health investment from public sources through increased contribution from the Central (Federal) and state governments. It encourages the setting up of private insurance for increasing the scope of coverage of the secondary and tertiary sectors.

The national federal budget of India for 2002-03 introduced an insurance scheme called "***Janraksha***", designed to provide financial protection to the needy population. With a premium of just Re 1 per day, it

promises a benefit package that would include: (a) inpatient treatment up to Rs 30 000.- per year at selected and designated hospitals, and (b) outpatient treatment up to Rs 2 000 per year at designated clinics and hospitals, including civil facilities, medical colleges, private trust hospitals and other NGO-run institutions.

During the budget year 2003-04, another initiative called "***Community based universal health insurance scheme***" is to be introduced. This scheme aims to provide easy access to quality health care for underprivileged citizens. With a premium equivalent to Re 1 per day for an individual, Rs 1.50 per day for a family of five, and Rs 2 per day for a family of seven, the insured persons would benefit from (a) reimbursement of medical expenses up to Rs 30 000 towards hospitalization, (b) a cover for death due to accident for Rs 25 000 and (c) compensation due to loss of earning at the rate of Rs 50 per day up to a maximum of 15 days. To ensure the affordability of the scheme to below-poverty-line (BPL) families, the Government would contribute Rs 100.- per year towards their annual premium costs.

The following are a few issues involved in implementing or expanding the SHI scheme.

- India is a lower middle-income country, with 26% of the population living below the poverty line and 35% of the population being illiterates with skewed health risks.
- Social health insurance coverage is inadequate, limited to only a small proportion of people working in the organized formal sector, covering less than 10% of the total population.
- Even though there is a rapid improvement in banking and other financial infrastructure, the introduction and expansion of social health insurance is slow and weak. While some voluntary nongovernmental organizations have introduced various collection mechanisms for financial contribution, these are not yet applied widely on the national scale.
- Most of the SHI schemes adopt exclusion and adverse selection, having moral hazards and cream skimming. Much of the focus of the existing schemes is on expenses for hospital care.
- The schemes have not been addressed the quality of care effectively.

There is inadequate information about various social health insurance schemes. Different financing options would need to be developed for different target groups. India as a heterogeneous country needs to undertake several pilot projects to provide a wide range of evidence-based experience on various health insurance schemes including other alternative risk-sharing mechanisms, and to develop options for different population groups. Health policy and health systems research institutions, in collaboration with economics policy study institutes, need to gather information about the prevailing disease burden at various geographical areas; develop standard treatment guidelines; undertake costing of health services to enable one to develop benefit packages to determine the premiums to be levied and subsidies to be given and map health care facilities available and the institutional mechanisms which need to be in place, for implementing health insurance schemes.

Indonesia[29]

The health status of people in Indonesia has improved over the last few decades, with some slow progress in recent years. The Asian economic crisis of the late 1990s has had the additional impact on the health status, making people less accessible to health care. Data from national surveys for the last decade showed that the access to hospital care has been very poor for the bottom 60% of the population. In most cases, each household has to spend more than its income whether public or private. One of the principle reasons for the slow improvement in the health status is the presence of some deficiencies in managing health care financing reforms. While some form of social health insurance had been implemented even before independence, as lots of work needs to be done in order to reach universal coverage.

The Dutch colonial government implemented a reimbursement scheme for civil servants, originally including only European employees, and later national civil servants. After independence in 1948, the government continued this scheme with reimbursement for health care. It had several drawbacks such as high moral hazards and discrimination between high- and low-ranked civil servants. In 1960, the Government initiated a pilot social health insurance project to cover the cost of inpatient care but not medical

[29] Hasbullah Thabrany & Ascobat Gani, et al. Social Health Insurance in Indonesia: Current Status and the Proposed National Health Insurance, Updated working paper submitted originally at the regional meeting on SHI, 13-15 March 2003 and later presented as country paper at the technical discussions on SHI at 40th CCPDM meeting, September 2003

fees. The scheme suffered a huge budget deficit and was later abandoned. Since then, several landmark initiatives have been undertaken. In 1965, the Honourable Minister of Health initiated an extensive expansion of basic health care facilities under a "New Order" of the Government. The Ministry of Health, after a year, established a contributory sickness fund for civil servants, which failed after a few years. In 1968, the Ministry of Labour established a civil servant welfare team, a forerunner management team for the present-day civil servant health insurance scheme. Reimbursement was based on fee-for-service (FFS) system and the premium was 5% of salary. In 1984, the *Perum Husada Bhakti* (PHB), a public corporation, was formed to be responsible for the insurance of state employees with 2% of basic salary as contributions. After four years, a pilot project was implemented for private employee's health insurance. By 1992, the national PHB was transformed into a for-profit state-owned company - ***PT Askes*** (*Asuransi Kesehatan Indonesia*) (a Civil Servant Social Health Insurance Company), within the legislative framework of the national regulation on insurance.[30]

The ***PT Askes*** scheme provides mandatory health insurance coverage to all civil servants, pensioners and military personnel of all public and semi-public establishments. All have to contribute 2% of the basic monthly salary as prepayment premium, regardless of their marital or family status. There is no ceiling. Since early 2003, the Central Government started contributing 0.5% of the basic monthly salary. The scheme is supposed to provide a comprehensive health benefit package with no specific exclusion. The coverage of beneficiaries includes the spouse and two children less than 21 years old, who are not working and are not married. The health care packages are provided through provider networks, consisting of over 7 000 government health centres, nearly 400 public hospitals and 150 private hospitals. Special fee schedules have been established by the Government, which are 40-70% of the public fee schedules. The ***PT Askes*** pays the providers using prospective payments mostly on a "per case" and per diem basis. Drugs are covered if prescribed on the national formulary. The ***PT Askes*** covers nearly 15 million civil servants. The contribution is about 4 000 Rupia (Rp) per capita. This figure has not been revised since 1993 and has depreciated due to inflation. Currently, it is equivalent to just about Rp 1 000.- as compared to the 1993 value. The scheme has expanded its products in the form of Health Management Organization (HMO) products on commercial basis to more

[30] MGS Aritonang, Social health insurance in Indonesia, presentation at Bangkok SHI meeting

than 2 500 companies covering about 1.5 million members. While the ***PT Askes*** have been awarded and rated the best agency for its efficient outputs amongst the government agencies, it still has the following problems and constraints:

- Delay in collection of premium, despite the fact that the major contributors are all civil servants;
- Too ambitious benefits compared to small contributions;
- Historically high-cost sharing due to the low price tag set by the Ministry of Health;
- Relatively low reimbursement level to providers (transforming public hospitals into corporate management led to increases user-charges, and made people to pay more from out of pocket);
- Relatively richer individuals (high-salaried people) covered by very low premiums, creating gaps in expectation and satisfaction;
- Adverse selection from retired military personnel;
- Request for decentralization of management of *PT Askes* funds by local authorities; and
- For-profit operation creates jealousy among providers.

Another social health insurance scheme introduced in Indonesia in 1993 was the SHI scheme for employees of formal private sectors- the ***PT Jamsostek*** scheme that was established under the Social Security Law of 1992. This scheme is also managed by a for-profit government company. From the start, the scheme provides exemption to cover those employed people who could access health benefits by any means including self-insured, or who could purchase more generous health insurance packages. Due to this, a majority of employers opted out in *PT Jamsostek* in other make arrangements for own insurance coverage either from other public or private insurance companies. The *PT Jamsostek* scheme is a mandatory insurance scheme for all private employers with 10 or more employees or with monthly payrolls exceeding Rp 1 million. The scheme is non-contributory as employees do not have to contribute anything. It is the employers who have to contribute 100% of the premium, 3% (single) and 6% (married) of employee's salary. There is a contribution ceiling of Rp 1 million per month. The benefit package is comprehensive, with excludes cancer treatment, cardiac surgery, haemodialysis, and congenital diseases. Drugs are covered if prescribed on the national formulary. The beneficiaries also include the

spouse and children under 21 years, up to the third child, who are not working and are not married. Health care services are provided through various health care providers either contracted directly or indirectly by *PT Jamsostek*. The scheme also use the main providers as the management contractor who could manage capitation and FFS for service providers. Except for a limited out-of-network emergency care which is reimbursable, health care in general is provided "in kind" by the registered network of providers. The *PT Jamsostek* scheme now covers nearly three million formal employees, with an average contribution of Rp 5 000 per capita. This scheme also has some setbacks:

- Adverse selection due to the provision to opt out (if the scheme's policy is strictly followed and no opt-out option is allowed, it would be possible to cover around 100 million employed people, which is nearly 50% of the country population);
- Low income employees enrolled, while the higher-income employees opted out;
- Big employers are less likely to enrol and retired employees are not covered;
- Expensive procedures are not covered;
- High administrative costs lead to less incentive to providers, and
- For profit operation creates a perception of mismanagement.

The Ministry of Health through the Health Act of 1992, introduced another scheme called the nationally managed health care scheme - ***Jaminan Pemeliharaan Kesehatan Masyuarakat (JPKM***), similar to the US Health Maintenance Organization (HMO). The scheme was originally meant for protecting financial risk for the poor. The scheme was promoted widely through local governments, private businesses, private insurance companies and communities at large. It became effective as a national programme in 1995. The promotion of *JPKM* led to the development of *bapels* (Indonesian version of HMO). By the end of 2002, there were 24 licensed *JPKM bapels*, which are basically non-insurance companies selling health insurance products as carriers. These *bapels* are mandated to provide comprehensive health benefits through a network of health care providers and to make payment to providers on capitation. The *bapels* are also supposed to conduct quality assurance, utilization review, grievance procedures and other cost and quality control measures. Most *bapels* are actually selling a combination of

managed care and traditional insurance products. The scheme covers less than half-a-million people. The conflicting interest of business and social causes, and the deficient managerial capacity of the Ministry of Health to regulate and supervise has led to slow progress in coverage by this scheme.

The ***Dana Sehat*** (Community Health Fund or micro-health financing scheme) was introduced in the mid-70s starting from a small scale in various parts of the country. The scheme was further expanded on a national scale by introducing local schemes mainly in areas where poor people constituted large proportions of the population. The scheme was based on contributions of the people by consensus among beneficiary households. Recent studies have indicated that the smaller proportion of the population, less than 2%, are either holding health cards or are members of a community health fund. The majority of these local schemes could not expand the geographical or population coverage for various reasons. Many local community-based schemes have stopped functioning after the wide introduction of the ***social safety net (SSN)*** programme in the health sector in the late 1990s.

The ***social safety net*** programme was introduced as part of national efforts to mitigate the economic crisis in the late 1990s and later as social packages for the poor in 2000s. The programme was implemented through different financial assistance mechanisms to ensure that the poor were able to get access to essential health care. The first scheme targeted high risk pregnant women by providing a block grant of Rp 10 000 per household, and the fund was directly given to a village midwife. The midwife, in turn, could use the fund, for referral of high-risk pregnant mothers (beneficiaries) to the nearest health centres or hospitals for further treatment, including payment for drugs, health care or transportation costs. This programme actually benefited pregnant mothers by facilitating their access to hospital care, especially for complicated obstetric cases. The second SSN scheme promoted the JPKM scheme of the Ministry of Health. Under this scheme, the funds were provided to pre-*bapels* such as private businesses, cooperatives and/or foundations seeking to be established as JPKM *bapels* (HMO), with Rp. 10 000 per poor family in each district. These pre-*bapels* retained 8% of the funds received for administrative costs. The remaining funds were marketed for HMO products to non-poor families. After a year, however, the programme was terminated due to non-viability. The third SSN scheme aimed at public health facilities. These health care facilities (health centres) were provided with a block grant of Rp 10 000 per poor family which could use the funds to buy essential drugs and other essential medical supplies, in order to

supplement the supplies already provided by the Ministry of Health. Under the fourth scheme, the public hospitals received some block grants for meeting operational costs to take care of the poor. Some reports indicate that people in the category of the marginally poor (not qualified for SSN assistance such as self-employed, part-time workers, seasonal workers and, landless farmers) and also those who were unable to pay for expensive medical care, face financial problems in meeting their medical needs.

A few policy and managerial actions are required to improve the current SHI schemes in Indonesia. These include:

- Increase the premium rate – for both employers and employees, supplemented by the government for those people who may not be able to afford;
- Improve the health care benefit packages, to make them more reasonable and acceptable;
- Increase the payment levels set by the government at public health establishments, in order to improve the quality and access of health services;
- Remove the "opt out" or exemption option by *PT Jamsostek*;
- Change the "carrier" status of *PT Jamsostek* and *PT Askes* from "for-profit" companies to "not-for-profit" establishments so as to be consistent with the national social policy;
- Improve transparency in management in all institutions;
- Expand the coverage to retired private employees, small employers, the poor, and self-employed, and
- Benefits must be the same for everybody regardless of contribution.

In 2002, the President of the Republic of Indonesia established a "Presidential Taskforce on Social Security" to look into the restructuring of the existing SHI schemes. Similarly the Ministry of Health has also reviewed its policy on health care financing and has proposed to reform it. The National Parliament is also making a review of social health insurance as part of national social security and drafting a bill. The aim of these initiatives is (a) to integrate public and private employee schemes into one scheme, creating a specialized SHI management under a National Social Security System, with uniform benefits for all; (b) to look into the possible merger of the *PT Askes* and *PT Jamsostek* into a single "Independent SHI Agency" at the national

level, like "National Health Insurance"; and (c) to make the "New Carrier" to be independent, not-for-profit, controlled by a tripartite body (representation from employees, employers and the government). Currently, there are three almost similar alternatives to be considered, with each of them having its own strengths and weaknesses. National debates and consensus-building are required and more evidence-based information is needed to evaluate each of the proposed models. The first is a ***model of National Health Insurance*** proposed by the Presidential Taskforce. Indonesia having high proportion of nonformal workforce, low family income and low government budget needs to adopt a comprehensive social health insurance that has the following characteristics: (i) works on contribution and the general revenue model; (ii) simplicity, uniformity, portability, efficiency; (iii) intersectoral commitment and supported by many parties; (iv) very ambitious and large programme, but develop in stages; (v) address unequal distribution and quality of providers, and (vi) possible opposition from the existing insurance companies, JPKM *bapels* and also from local governments. The second proposal which originated from the Ministry of Health, was the ***model of Oligo Insurers,*** a national mandatory health insurance with multiple HMO that*:* (i) accommodates interests of insurers, regions, and sectors; (ii) makes unequal distribution and quality of providers, and (iii) is less efficient and portabe. The third proposal is the draft bill prepared by parliamentarians, the contents of which are similar to the proposal of the Presidential Taskforce, except that it proposes to have a single agency to manage the total health insurance fund.

Though Indonesia has considerable experience in implementing SHI on a national scale, the growth has been very slow due to inconsistent implementation of the principles and policies. The current implementation needs improvement in expansion strategies as well as other areas, such as benefit packages, premiums, management, and payment to providers.

Thailand [31]

Thailand introduced the national social welfare scheme for the poor low-income households in 1975. The low-income medical welfare scheme (MWS) was originally introduced for providing free medical care for poor workers but was later extended to cover people over 60 years, children under 12 years,

[31] Viroj Tangcharoensathien, Overview of Health Insurance Systems, Chapter 2, Health Insurance System in Thailand, HSRI, Thailand, 2002; and presentations made the regional meetings on SHI in WHO-SEARO and Bangkok and Ponpisut Jongudomsuk, Achieving universal coverage of health care in Thailand through 30 Bhat scheme, paper presented at SEAMIC conference in January 2002.

secondary school students, the disabled, veterans and monks. The service package included free medical care at public facilities for ambulatory and inpatient care. By 2000, around 20 million people were covered under this scheme. The budget was allocated from general revenue on capitation basis but was inadequate. The scheme was poorly designed with no provision to ensure accountability or quality of care. It often excluded poor families as there were no effective mechanisms for means-testing.

In 1980, under a Royal Decree, Thailand introduced the Civil Servants Medical Benefit Scheme (CSMBS), in order to extend the SHI coverage to all government employees (including staff of state enterprises), pensioners and their dependents (parents, spouses and children). Currently, the scheme covers around seven million civil servants and their dependents. It is a fee-for-service reimbursement model and the source of funds is from the general revenue as a non-contributory fringe benefit scheme. The FFS model has resulted in a longer hospital stay and frivolous use of drugs and clinical investigations. The capacity of the scheme to monitor fraud and overcharging is poor. Following various studies and as an after-effect of the economic crisis of the late 1990s, the government reformed the CSMBS to include capitation for ambulatory care, global budget and diagnosis related groups (DRG) for inpatient care. An electronic disbursement system was introduced for inpatients using DRG.

Following the enactment of the Social Security Act 1990, the government introduced another national health insurance for mandatory coverage of employees for all private companies with more than 20 employees using a capitation, low-cost contract model. In 1994, the coverage extended to companies or commercial establishments with more than 10 employees, and by 2002, it included small enterprises with more than one employee. Compulsory health insurance for formal employees had certain strengths, as it was based on the contract models. Employees had the choice of any registered public and private contractors (outpatient and inpatient health facilities). The scheme covered, by now, around six million employees. The administrative costs were low, while maintaining decent quality of care. The financial contribution was progressive with a five-fold gap between the contribution of the highest and lowest wage earners. Still, there were some drawbacks since the scheme covered only employees as beneficiaries, and not family members. There was also some reluctance to expand the facility to the self-employed sector. Preventive and promotive health needs were not adequately addressed.

The Voluntary Health Card (VHC) project was started with the possibility of expansion of health insurance coverage in 1983, initially covering MCH care. It was expanded in 1994 to cover the village health volunteers and local leaders with 100% government subsidy. The VHC covered around 11 million people. It was a voluntary health insurance programme with an affordable premium for rural households not covered by the national social welfare scheme. Different health cards were introduced, based on the type of health care benefits, maternal care and immunization, curative medical care, or the totally free health care. Unused health cards were no longer renewable. By the mid-1990s, the VHC scheme was revised with a single card for an individual or an individual family, and it started offering a comprehensive health benefit package. Since 1994, the government is subsidizing in the ratio of B 500/- for every B 500/- paid by each family for a family card. This has had several important implications, as it creates adverse selection and limited risk-sharing. The sick usually joined while the healthy opted out. The financial viability was a major issue and there also was inequitable access between the urban and rural members. The referral system was inefficient, with frequent bypassing of primary care. A smaller number of people who could afford the contributions were covered under private voluntary health insurance schemes.

The timeline for expansion of SHI schemes in Thailand is:

1975: Free Medical Care for the poor (Medical Welfare Scheme), drawing lessons, gradual expansion and amendments in the health systems;

1980: Royal Decree for CSMBS;

1983: Voluntary health insurance (Voluntary Health Card) scheme: transitional measures, building up the social capital and institutional capacity to manage insurance fund;

1990: Social Security Act: Introduction of SHI for employed sector, capitation, and predecessor of the current universal coverage (UC) design;

1992: Reform of CSMBS - not very successful;

1996: Reform of health systems including financing (drafting national health insurance act), and

2001: Political will to adopt universal coverage of health care – financed from general revenue.

The Universal Coverage (UC) Scheme, notably the "30 Bahts-Scheme", was introduced in October 2001 on a national scale covering all provinces, with the idea of replacing the existing "Social Welfare Scheme" and the "Voluntary Health Card Scheme". It aimed at incorporating the 30% uninsured population into a "Single SHI Scheme". The UC plans to provide comprehensive health care coverage with virtually no co-payment by users, apart from a nominal fee of just "30 Bahts" per each health visit or hospital admission. The scheme is subsidized by general revenue. The coverage of "30 Bahts Scheme," by the end of 2002, was around 76% of the total country population. The remaining population is still covered by the CSMBS (11%) and social health insurance under social security for employees (13%). Some people are still not accepting the "30 Bahts Scheme" as strictly being social health insurance, as the payment is not on prepaid contribution, but is based on payment at time of illness.

Reforms related to the "UC scheme" are expected to provide several benefits, such as favourable cost-containment (around B1 400 per capita); use of close-end provider payment method; ensuring an overall systems efficiency by introducing quality assurance measures and merging the existing health insurance funds; decentralizing the management of funds, and having almost no financial impact on families due to catastrophic illnesses. The prepayment component of the total health expenditure would probably increase to 90%, leaving less than 10% for out-of-pocket. There would be a convergence of the benefit packages and expenditure across the three public schemes. The Royal Government has laid down the legal framework for universal coverage by promulgating the National Health Insurance Act in November 2002. The National Health Security Organization (NHSO) is now fully operational to undertake full universal coverage in the near future. The NHSO has many important tasks ahead such as the need for standardizing the benefit package(s), the payment methods, and the level of budget subsidy across the three public schemes, amending the benefit package and seeking sources other than general revenue, and finally how best to work with two other continuing SHI schemes (CSMBS and Social Security), and other private health insurance establishments, as well as the Ministry of Public Health which has the major control over public health care providers and facilities.

Myanmar[32]

Myanmar introduced a nationwide SHI scheme in 1956, within the stipulation of the National Social Security Act of 1954. The social security scheme is managed by the Social Security Board (SSB) under the Ministry of Labour. The scheme provides mandatory insurance of all formal employees from both public and private sector enterprises, which employ more than five people. Dependants are not yet included under the scheme. Exemptions are also provided for for some state enterprises that are already covered by some legal and administrative arrangements for health care and social security, such as the railways, mining and petroleum industries, and ports and dockyards. The benefits of SHI scheme under Social Security include free medical care and cash benefits for general insurance for sickness, maternity and deaths, and partial or full salary for some period based on employment-related illness and injuries. The scheme covers around 765 000 workers from around 25 000 establishments. The SSB has also established its own health care facilities (three hospitals and 89 dispensaries) in addition to utilizing all available public facilities. The premium contribution is derived from proportionate deduction of monthly payrolls, from employees (2.5%) and employers (1.5%). The government provides additional budget for current and capital items depending upon the annual expenditure of the SSB. A revised policy framework for expansion of SHI in Myanmar is under consideration. The Myanmar Insurance Enterprise, another public agency, also provided special health benefit packages as 'health riders'[33] for their life insurance policy holders. The benefits include lumpsum reimbursement for hospitalization, major surgery, disability, delivery and death. Since the early 1990s, Myanmar has introduced various community-based health finance options in order to reduce the financial burden on the poor.

Experiences from other countries within the Region

Except for a few private health insurance programmes and some subsidies for the poor, ***Sri Lanka*** does not have any formal social health insurance schemes, despite a large proportion of people working in the formal employed sectors. ***DPR Korea*** also has no explicit policy for social health insurance. ***Maldives,*** excepting some form of subsidy for medical expenses for

[32] Aung Kyaing and Aung Lin, presentation on SHI and SSS in Myanmar at Bangkok meeting on SHI, June 2003

[33] Health riders: explanation

civil servants, does not have any social welfare packages. National social welfare policy and schemes are under consideration. As part of tourism, some private insurance companies operating in Maldives are covering a few people as health riders on life insurance.

In ***Bangladesh***, social health insurance schemes are almost non-existent or, if present, cover only a few people in limited geographical areas. Most schemes rely on external funding and are based on some contributions. There are a small number of private health insurance and community-based insurance schemes with limited coverage.

Nepal[34] has implemented various alternative health financing approaches, such as user-charges at public health care facilities, drug revolving funds and other community-based drug financing mechanisms, and community-based health insurance schemes. Most of these rely heavily on the out-of-pocket payment by users at the time of illness. The government recently promoted social health insurance by implementing a few pilot schemes. Only a small number of private agencies provide medical benefit packages, including membership of private insurance schemes to their employees. The following models on health insurance of limited coverage are under operation:

(1) **The Hospital-based micro-social health insurance scheme** was initiated in 2000 at the BPK Institute of Health Sciences which offers health care services to rural and urban household members through linkage with Village Development Committees (VDC), local cooperatives, business associations, and educational institutions etc. The premium for urban areas is four times higher than for rural areas and the scheme covers 2 400 members from 565 households. The service package includes free consultations and investigations, hospital beds, medicines and operation charges beyond a certain limit. The entire premium, and contributions from VDC etc. go to hospitals. The income shows surplus, but does not include expenditure, borne for manpower, and equipment cost etc.

(2) **The Community Health Post-based Insurance** was initiated in 1976, as Lalitpur Medical Insurance Scheme, with a coverage of 19 to 52% of the rural population in six health posts, near Kathmandu. The premium varied and the scheme was managed by the local committee. The government also

[34] Pande, Maskey & Chataut, presentation on SHI and SSS in Myanmar at Bangkok meeting on SHI, June 2003

subsidized the drugs. Registration-fee based free clinical service was provided at the clinics and the user-changes for cases referred to Patan Hospital. There was no surplus revenue over the expenditure. Sustainability may be a problem with the existing premium.

(3) **The Health Cooperative Model** was initiated by an NGO, PHECT (Public Health Concern Trust) of Nepal, which offered health service through a Cooperative Society with the members maintaining a daily saving of a nominal amount to contribute for health, both in rural and urban areas in and around the Kathmandu City. The community clinics provided primary care services as also the referrals to Kathmandu Model Hospital (KMH). A half of the total collections went to the funding of KMH. Subsidies or exemptions were provided to the poor on referral cases. The scheme covered 2 038 persons from 438 households.

(4) **The General Federation of Nepal Trade Unions (GEFONT)** supported another cooperative health scheme for transport and industrial workers. A monthly premium was collected from workers to establish a "Health Cooperative Fund" which ran a clinic for primary service and supported the referred cases to go to KMH. For the poor, PHECT Nepal provided financial support as part of solidarity. The fund covered around 500 families (two members from each family) out of 300 000 GEFONT members.

The National programme in Nepal, under the ILO's Strategies and Tools against Social Exclusion and Poverty (STEP) Global Programme, provided technical assistance to civil society groups to carry out feasibility studies to set up and manage the micro-insurance systems based on solidarity at the grass-root-level. The aim is to extend social protection measures through health micro-insurance schemes, which are gender-sensitive, accessible and affordable for the poor, vulnerable and excluded workers in the informal economy of Nepal. Support through this initiative was provided to the Credit and Savings Cooperatives, (GEFONT) and Social protection provided for porters and their families in Solokhumbu district, etc. Nepal has an opportunity of expanding and integrating the existing community-based health financing schemes into the community-based health insurance schemes so as to have a higher proportion of coverage, provided there is a strong political will and strategic actions are developed through political and technical consensus.

3.3 Experiences from Selected Asian Countries outside the Region

China

China spent around 476.4 billion (RMB) on health in 2000 with average health expenditure per capita of 376 RMB (US$ 47). The percentage of total health expenditure to GDP is around 5.3%. The government budget on health in the last decade decreased from 60% to 40%. According to the Chinese NHA in the year 2000, OOP expenditure was around 60%, of which only 6% was on private insurance, the rest being direct payments for user fees. Within the public expenditure, at least 47% was accounted for by social health insurance. In 1952, China introduced the Government employees' health insurance (GHI) scheme financed from general revenue. This scheme covered all government employees, college teachers and students. The beneficiaries received free medical care at both public outpatient and inpatient facilities.

About 30 million people (3% of the total population) were covered. Labour Health Insurance (LHI) for workers was introduced in 1951. State enterprises with more than 100 employees were mandated to have insurance coverage. Other smaller enterprises and collective industries joined on a voluntary basis. LHI covers dependent family members who are also entitled to be reimbursed for 50% of their health care expenses. By 1990, the total number of LHI members was about 127 million (11% of the total population). The medical benefits are the same as GHI. The LHI was managed and financed by individual enterprises. Large enterprises with more than 1 000 employees organized their own health care facilities while medium ones (with 200-1 000 workers) had their own outpatient clinics. Private and public hospitals have been contracted to provide inpatient care.

Following trade liberalization with an open-market economy in the 1980s, the cost of health care in China has escalated tremendously. The national policy on SHI schemes in China was further updated and efforts made to have universal coverage. At the initial stage in 1993, less than 10 million people (not covered by GHI or LHI) in metropolitan urban areas were covered with the urban and medical insurance scheme. By 2002, it increased to 80 million. This insurance scheme covers formal employees and retirees. From 2003 onwards, the coverage is expected to be extended for employees in the informal sector and their dependents. The government is also planning to revive or to establish new types of rural cooperative medical and medical aid systems through a government subsidy for the benefit of the poor in rural areas, and to achieve universal coverage by 2010.

Vietnam

Vietnam sfipends less than one per cent of its GDP on government health expenditure. The total health expenditure is around 5% of GDP, with an annual average health expenditure of US$ 20. Private out-of-pocket payments also form about 80% of the total health expenditure. With its economy in transition, fixing higher user-charges at public and private health facilities was increasing the burden on the population, especially on the poor and the lower-income groups. The government initiated SHI schemes in 1992 and rapidly expanded the coverage to the present level of around 14 million (11% of total population). The scheme presently covers employees and retirees from the formal sector and their family members. Schoolchildren are also included. The SHI programme is to expand coverage to include people working in the informal sector, especially in rural areas.

Philippines

The total health spending of the Philippines is around US$ 2.2 billion (about 3% of GDP) with per capita health expenditure of approximately US$30, and has remained unchanged for the last few decades. Around half of this is out-of-pocket private expenditure. Under the Medicare Act of 1969, the Philippine Medical Care Commission was established and the social security systems (SSS) for private sector employees and the Government Social Insurance System (GSIS) for government (public) employees were set up. The medical benefits under the national SSS included reimbursement of inpatient and outpatient care provided by both public and private health facilities. The premium was a mandatory payroll deduction of 2.5% of monthly wages up to a ceiling of Peso 3 000/- with employers and employees contributing equally. The GSIS provided medical benefits for civil servants. Both schemes are operated by the Philippines Medicare Commission (PMC). It is almost self-financed with limited public subsidies. By early 1990s, the PMC covered around 40% of the population.

With the enactment of the National Health Insurance Act in 1995, the Philippines Health Insurance Corporation (***PhilHealth***) was established as a para-statal corporation attached to the Department of Health with quasi-judicial functions, and administered the national SHI scheme. It has expanded the coverage to around 75% of the total population, consisting of employees from formal and informal sectors, and has sponsored indigent members and non-paying members (retirees and pensioners who enjoyed life-time

coverage, after paying at least 120 monthly contributions). The voluntary individual membership to ***PhilHealth*** has grown from around 165 000 in 1999 to seven million in 2002. Efforts are being made to reach universal coverage as soon as possible. The benefit packages include: subsidy for room and board, drugs, diagnostic examinations (X-ray and laboratories), professional fees, operation room charges and consultation costs for inpatient care and reimbursement for outpatient care charges, including chemotherapy and radiotherapy and minor operations. The government provides finance for SHI through regular payroll deduction (1.25% of the salary by employers and employees, with a salary cap of US$ 189 per month), and general tax revenue. Another feature is the strong involvement of local governments and their commitment to the subsidized indigent programme. The number of indigent members has increased from about 15 000 in 1997 to seven million in 2003 due to increasing sponsorship by local government units, legislators, private wealthy citizens, NGOs and other government agencies.[35]

One of the important lessons from ***PhilHealth*** is the method of payment to providers for outpatient and inpatient care based on the conventional fee-for-service and case payment reimbursement model, resulting in cost escalation, overcharging, excessive admissions, and irrational use of drugs and investigations. The package for inpatient care is limited. Co-payment isvery high especially with private providers, with average support ranging from 30-70% of billing. The awareness and utilization rates are low, resulting in a funds surplus. There is an enormous workload on claim reviews, resulting in high administration costs (12% of total spending) and ineffective filtering of frauds.

Republic of Korea

The Republic of Korea started the SHI scheme with the enactment of health insurance legislation in 1963. The national mandatory health insurance initially covered employees of formal sector establishments (with more than 500 workers). In the 1980s, the programme expanded to cover government employees and teachers and firms with less than 300 employees. This was further extended to small firms of less than 16 employees and then to the self-employed in all urban and rural areas. Since 1989, almost 96% of the 47 million population of South Korea are covered under the mandatory social

[35] Fransco T Duque III & Ruben John Basa, PhilHealth, Moving towards universal SHI coverage in the Philippines, a presentation at Bangkok meeting on SHI, June 2003 (unpublished) and School of Economics, University of Philippines, Proceedings of a Regional Conference on Health Sector Reform in Asia, 22-25 May 1995

health insurance scheme. The remaining 4% of the population are covered by a medical aid programme for the poor, fully subsidized from the general revenue of the government. The proportion of public to private health facilities decreased from 40% in the 1970s to less than 10% by the 1990s.

The profit-oriented private sector has dominated the market and the cost of health care, both from insurance funds and out-of-pocket payment (co-payment) by the consumers has risen over the years. By 2000, over 350 health insurance societies that managed different funding arrangements and benefit schemes were merged into a "single fund". In order to improve the quality of health care and also to contain the increasingly higher costs of health care, the government attempted to separate the prescription and dispensing of drugs in 2002.

4. OTHER FORMS OF HEALTH INSURANCE AND PREPAYMENT

4.1 Role of Savings in Covering Medical Expenses

The savings approach for health care financing was introduced recently, keeping in view the basic concept that the savings of individuals or households could cover a part or all of health care expenditure when required. Although the need for health care usually occurs unexpectedly, it is not purely a matter of chance. A healthy young person can anticipate the time, place and type of health care that may be needed in future, e.g. he or she could suffer problems related to reproductive health or occupational health, and/or other chronic noncommunicable diseases, more likely when he or she grows older. The changing needs for health care, over the course of a life, imply that health care expenses could be funded at least in part by savings.

The Asian culture has the belief of people contributing among families and friends and paying for health care with their own savings. Normally, personal savings alone are not sufficient to fund health care for most people, since only a few people are able to save enough, especially in times of rising costs of treatment for the most expensive illnesses (catastrophic illnesses). Furthermore, low-income people often have little savings for any purpose during their working years, including savings for health care. There is a need for government intervention to promote personal savings, which require a lot

of financial and administrative management. This makes the pure savings approach less attractive to policy- makers as a choice of health care financing in most cases.

One possible approach of using savings to cover medical expenses is to develop an additional component of the national SHI schemes, as pioneered by the famous "3M" health financing schemes, i.e. Medisave, Medishield and Medifund of ***Singapore***.[36] The ***Medisave*** scheme is an individual saving scheme for which the accumulated savings could be used for medical care expenses. It generally excludes the expenses for outpatient services, in order to take care of paying for infrequent but highly costly inpatient care. As the scheme depends on inter-temporal pooling over the individual's lifecycle, it is not actuarially feasible for ***Medisave*** balances to insure against truly catastrophic contingencies. To solve this problem, Singapore introduced ***Medishield***, a back-up health insurance programme based on cross-sectional risk-pooling, designed to finance the extreme catastrophic tail of risk distribution. In addition, the Government of Singapore also introduced ***Medifund,*** which is an endowment fund for those whose health care costs are beyond their means, even with Medisave and Medishield.

The "3M" health financing schemes rely heavily on individual responsibility for health care costs. The system combines the non trivial co-insurance rates with explicit targeting of costly risks. Even though on average, about 60% of hospitalization costs in public hospitals are subsidized by the government, the residual 40% are charged to patients through their ***Medisave*** and the OOP payments. Thus, consumers (patients) have a double burden of individual responsibility, not only in the form of 20% co-insurance paid out of their ***Medisave*** account, but also another 20% paid directly as OOP payment. Claims for back-up ***Medishield*** coverage of catastrophic expenses are also subject to 20% co-insurance on top of high annual payment.

Countries with higher level of life expectancies for both sexes usually recognize the need for social security measures for the elderly. Rapid urbanization and the increased mobility of young working people are also eroding extended family networks and traditional means of support for older people. Newly industrialized countries that are developing "old-age social security systems" could fall into the trap of repeating the costly mistakes of the earlier groups of industrialized economies. Social security schemes for the

[36] Phua Kai Hong, Social Health Insurance and Medical Savings, Presentation at 3rd Forum of Asia Pacific Health Economic Network, Manila, February 2003

elderly should have basic functions of social security systems: redistribution, savings and insurance. The first is a mandatory publicly-managed and general revenue-based health care financing system, in which the financial burden is redistributed. The second is a mandatory privately-managed personal savings system, where each individual has the obligation to set aside a portion of his/her income as savings for future use in covering medical expenses in part or whole. These two could be supplemented by a third, which is a voluntary system of occupational or personal saving plans. These three pillars together would co-insure against risks of old age while, at the same time, not impeding growth in ageing societies. Countries like Sri Lanka, Indonesia and Thailand, which now have increasing proportions of elderly people could consider this alternative financing mechanism as options.

The health care financing systems of Singapore have shifted from a tax-based "national health service" model to a "mixed system" where public financing plays a dominant role in providing universal coverage through a combination of taxation and savings, with social health insurance only for catastrophic illness and long-term care. It is purposely designed to move away from the comprehensive and overly generous insurance models that may be unsustainable. The role of the state is as a large resort to support the truly needy, while average individuals and families are expected to contribute towards greater cost-sharing of increasingly expensive health care, to achieve greater sustainability. These considerations have formed the basis for the existing integrated systems of old-age social security and social health insurance in countries such as Singapore, which are fully-funded saving schemes that would avoid the inter-generational transfer problems of pay-as-you-go systems financed from taxation.

The attractiveness of the "mixed financing" system with ***medical savings*** comes with several issues in its implementation.[37] Firstly, the management of medical savings requires strong political will and onerous administration and management capability and competency at various levels to regularly collect money, process claims, manage accounts, and invest the fund. This would be a difficult position for countries with predominantly rural population or countries with large proportion of informally employed sectors. Secondly, population in poverty or population with chronic diseases or disability would not have adequate savings from the beginning. Introducing medical savings

[37] Piya Hanvoravongchai, Medical Savings Accounts: Lessons Learned from International Experience, EIP Discussion Paper No. 52, WHO, Geneva (http://www.who.int/whosis/discussion_papers/

and high cost-sharing without adequate social safety nets would result in financial inaccessibility, or could also lead to increasing number of households with catastrophic spending and increasing income inequality. Lastly, stewardship role of the government is crucial in the "mixed system" despite the concept of increasing individual responsibility. Singapore itself demonstrates many of its stewardship roles such as control on the provider, wide and extensive public education, and the provision of social safety net.

4.2 Role of Private Health Insurance

The role of the private sector in providing health care is expanding rapidly in the Region as a result of many national health systems not being able to cope with rising costs, especially for co-payment, and increasing demand for services. The WHR 2 000 has indicated that "low-income countries could encourage different forms of prepayment-job-based, community-based and provider based- as part of a preparatory process of consolidating small pools into larger ones." Development and expansion of national SHI and private health insurance schemes should be seen in the context of globalization and rapid liberalization of international trade, including opening of markets for the private sector.

Private health insurance could also be classified into three main categories: (1) private for-profit or commercial health insurance; (2) private not-for-profit health insurance (voluntary health insurance), and (3) community health insurance. Experience shows that there is a continuum of arrangements between private insurance and social health insurance. Private health insurance can serve as one of the sources of coverage or act as augmentation for co-payment to public/social health insurance.

Private health insurance in one way might reduce the OOP expenditure and evolve in the long run towards a broader social health insurance system. Unless majority of population is covered by the social health insurance or tax-based financed health systems, there is a need to have appropriate regulation of private health insurance schemes to ensure the basic principles of solidarity, solvency requirements, cross-subsidization and control of exclusion.[38]

Private health insurance can serve as an alternative source of health financing, if the principal coverage is aimed at the larger segment of

[38] Neelam Sekri, Using private health insurance to serve the public interest, presentation at Bangkok SHI meeting, June 2003

population with comprehensive health packages. Countries that have instituted or are soon going to introduce private or commercial health insurance markets should be aware of their side-effects and should ensure a proper regulatory framework. Many private financial and insurance companies have introduced health insurance schemes for the young, productive and high-income groups setting high premiums, with lucrative and limited benefit packages (one or two major health crises). In addition to adverse selection and risk selection (cream skimming), there are issues such as risk-related premium, different benefit packages designed by insurers, moral hazard, opt-out option, cost escalation and high administrative cost. The scheme is usually of limited population coverage, but the demand for its expansion is growing due to increasing advertisement and advocacy by financial and insurance enterprises, as well as due to pressure from the growing number of high-income groups.

While the total market outlay of private health insurance in ***India*** is unknown, it is expected to be less than 1% of the total health expenditure (THE). Since 1999, after India adopted the Insurance Regulatory and Development Authority (IRDA) Bill, which seeks opening up the insurance sector to foreign and private insurance investors, a series of policy debates and feasibility studies have been conducted to review various possibilities. The IRDA Bill aims to facilitate the establishment of the Authority to protect the interests of insurance policy holders by regulating, promoting, and ensuring orderly growth of the insurance industry. International investors can hold up to 26% equity.[39] The IDRA Bill will also apply to health insurance market. Many NGOs which have established various community-based health insurance schemes have expressed concerns on the IRDA Bill, mainly on its regulation of capital outlay requirement. A few life insurance and non-life insurance companies have started promoting different schemes of individual and group health insurance as "health riders".

Thailand''s private health insurance covered less than 2% of THE in 1999. Most of the health insurance policy holders are "health riders", extending their existing individual or group life insurance package by covering hospitalization and major surgery or part of the group life insurance combined with accident and health insurance as a comprehensive package, usually offered by a life insurance company.

[39] Gupta I., Private health insurance and health costs, Economic and Political Weekly, Vol.37, No. 27 July 2002

In other countries, there may be a non-life insurance company (usually mutual funds or medical-aid or health insurance) which provide individual or group life insurance policies. The premium is linked to the benefits offered. The insurance business is usually tightly regulated by the government because of the public financial liability and national security. Thailand adopted a series of legislative frameworks for private insurance including health insurance, with the most recent amendment in 2000 for allowing foreign investment (up to 25% equity). Even though the number of insurers in foreign insurance companies is around 6% of the total insured in private insurance, the premium volume is one-third of the total estimated funds of 115 million bahts.[40]

Health ministries have to monitor the impact of rapid growth of private health care providers and, at the same time, the growing number of private health insurance schemes in a liberalized environment. Is the country ready for the introduction or expansion of private (commercial) health insurance? What is the consumers' reaction? Are they willing to pay and participate in private health insurance schemes? What impact will these schemes have on the existing SHI schemes as well as on health care delivery systems in ensuring equity and efficiency? These are a few policy questions that need to be addressed with solid evidence in the context of each country.

According to a recent trend analysis, accidents and injuries would become an increasing cause of global and regional burden and may emerge as one of the five major killers and cripplers in the next few decades. While efforts have to be made in road construction and traffic control, there is need to restructure the traffic accident insurance. While all countries have traffic insurance as part of a Third Party Insurance to reduce the financial and health risks from the individual to a pooled one, there is a mismatch between funds and services.

For example, in Thailand, a majority of accidents and injury cases are taken care of by public sector facilities (with the excuse of being police cases), thereby placing a burden on public funds. As the "Third-Party Health Insurance" funds, handled by private insurance companies do not go to public sector facilities, the private companies make huge profits with fewer claims.

[40] Tangcharoensathien. V. & Pitayarangsarit S., Private Health Insurance, Chapter 7, Health Insurance System in Thailand, HSRI, Thailand , 2002

4.3 Community-based Health Insurance

During the last few decades, voluntary pooling of resources for health at the community level emerged as another health financing mechanism in low-income and lower-middle income countries. These community-based health insurance (CHI) schemes, based on voluntary risk-sharing (both in the formal and informal sectors) highlight the importance of national or sub-national governments ensuring that financial risk sharing covers vast populations. Presently these risk-sharing schemes have limited coverage, both in terms of population and health care provision range.

For example, in India, various states had established a multitude of community-based health insurance schemes including variations of community-based health financing with some form of risk-pooling. These schemes mainly serve the people living in same localities or communities, with an estimated coverage of 30-50 million, and the main benefits are in preventive care. In some cases, ambulatory and inpatient care are also covered. The premiums are financed through fee-for-service arrangement at time of providing care, and through government subsidies and community donations. Some schemes have introduced premiums based on the regular income level, while others charge a flat rate. Provider payments are mainly fee-for-service.[41] Some examples of community-based health insurance or risk-sharing schemes include:

(1) Gujarat: *Self-Employed Women's Association (SEWA)*: provides health, life and assets insurance to women working in the informal sector and their families; enrolment in 2002 was around 93 000. This scheme was established in 1992, and operates in collaboration with the National Insurance Company (NIC). A premium of Rs 85 per woman is paid for life, health and assets insurance. At an additional payment of Rs 55, her spouse too can be covered. Rupees Twenty per member is then paid to the NIC who provides coverage, upto a maximum of Rs 2 000 per person per year for hospitalization. After being hospitalized at a hospital of one's choice (public or private), the insurance claim is submitted to

[41] See details in (a) Ranson Kent & Acharya Akash, Community based health insurance: the Answer to India's risk sharing, Health Action, March 2003; and Ranson Kent & Jowett Matthew, Developing health insurance in India: Background paper presented at National Health Insurance Workshop, 3-4 January 2003, New Delhi, India and presentations made at Bangkok meeting on SHI, June 2003

SEWA. The responsibility for enrolment of members, and for processing and approving of claims rests with SEWA. NIC in turn receives premiums from SEWA annually and pays them a lump sum on a monthly basis for all claims reimbursed.

(2) Gujarat: *Tribhuvandas Foundation (TF)*, Anand: It was established in 2001, with an enrolment of over 100 000 households, and the membership is restricted to members of the Amul Dairy Cooperatives. It is acting as a third party insurer.

(3) Karnataka: *Mallur Milk Cooperative*: It was established in 1973, covering 7 000 people in three villages. The outpatient and inpatient health care are directly provided by the cooperative health facilities.

(4) Maharashtra: *Sewagram, Wardha*: An NGO, established in 1972, it started the scheme covering about 14 390 people in 12 villages; and provides outpatient and inpatient care to members directly through its own facilities.

(5) Tamil Nadu: *Action for Community Organization, Rehabilitation and Development (ACCORD)*, Nilgiris; established in 1991, covering around 13 000 under a group policy purchased from New India Assurance;

(6) Tamil Nadu: *Kadamalai Kalanjia Vattara Sangam (KKVS)*, Madurai: A voluntary health insurance scheme was established in 2000 with enrolment in 2002 of around 5,710 families, covering members of women's self help groups and their families, and acting as third party insurer;

(7) Tamil Nadu: *Voluntary Health Services (VHS)*, Chennai: the scheme was established in 1963, and by 1995, its membership was 124 715. The scheme offers sliding premium with free care to the poorest; the benefits include discounted rates for both outpatient and inpatient care. The VHS is both an insurer and health care provider, and suffers from low levels of cost recovery due to problems of adverse selection.

(8) Chhatisgarh: Raigarh *Ambikapur Health Association (RAHA)*: was established in 1972 with an enrolment of around 100 000 and is acting as a third party administrator.

Bangladesh also has a few community-based health financing schemes, a few of which are based on social health insurance principles. A few selected community-based health insurance or risk-sharing schemes[42] include:

(1) ***BRAC***: *BRAC health programme:* covered around 12,000 families with a prepaid contribution ranging from Tk 100-350 according to economic means, with the benefit packages of free consultation, limited curative care, delivery, co-payment for referral, medicine and diagnostics. BRAC's networks of health care facilities provide free health care.

(2) ***Gonosasthya Kendra (GSK), Savar***: *The GSK health care system* covers over 10 000 households (30% of families living in GK area, with sliding scale of premium. The benefit package includes free preventive and curative care with a fixed-term for co-payment.

(3) ***Integrated Development Foundation***: covers around 30 000 members with TK 150 per month as premium and provides care through its own health care facilities. Co-payment is also fixed for medicine, specialist consultations and diagnostics.

(4) ***Society for social services***: covers around 54 000 members registered through the health card system and free health care is provided through SSS hospitals with a provision for co-payment.

(5) ***Dhaka Community Hospital***: also established a hospital-based health insurance, covering around 200 000 people, as registered on health card with some payments. The benefits range from free medical care to co-payment.

(6) ***Grameen Bank Health Programme***: covers around 143 000 members. The premium ranges from Tk 120 for Grameen Bank members, Tk 150 for non-Bank members and Tk 10 for schoolchildren. The Grameen Bank health care facilities provided free health care for outpatients and re-imbursement of around 10% of inpatient care.

Similarly, a few other countries have developed various forms of *CHI schemes* to cover certain targeted groups such as poor women, low-wage workers and the semi-employed both in rural and urban settings. The major

[42]Ministry of health and Family Welfare, Bangladesh, Social health insurance in Bangladesh, paper and presentation made at Bangkok SHI meeting, June 2003

policy challenge is how to accelerate the development of community health-risk-sharing initiatives and facilitating a broader coverage of people. Continuous and sustained support and incentives from national and local governments are required to improve the managerial skills and to provide opportunities for pooling of funds to generate greater financial viability and sustainability.

Large financial pools are better than small ones as they can provide for a better sharing of health risks, and, at the same time, raise more revenue. A larger pool can also take advantage of economies of scale in administration and reduce the level of contributions required to protect uncertain needs, while ensuring that sufficient funds are available to pay for services. Experience has shown that pooling risks to cover both health problems and financial burden have increased the efficiency of health systems, creating better health outcomes. WHO-CMH recommended that out-of-pocket expenditures in poor communities should increasingly be channelled into 'community financing' schemes…. [through] an incentive scheme, in which each $1 that the community raises for pre-paid health coverage would be augmented, at some rate of co-financing, by the national government (backed by donor assistance). This method would offer a degree of risk-spreading, so that households would not face financial catastrophe in the event of an adverse health shock to household income"[43]. The World Bank in its World Development Report 2002 has emphasized the relevance of community-based health financing schemes.[44]

Community-based health insurance (CHI) schemes are voluntary private membership using the principle of pooling health risks and resources, usually known as rural health insurance, mutual health organizations or associations, medical aid societies, medical aid schemes. There are different from other forms of community-based health financing, like community cost-sharing, drug-funds, in which risk-sharing can even be absent. These non-formal, community-based health insurance initiatives are usually launched on non-profit basis, to cover certain targeted groups. A few studies have shown that smaller number of such schemes cover large proportion of groups, while larger number have lower coverage of the eligible population. Most people join these schemes only at the time of illness. The WHO and ILO studies

[43] WHO-CMH Report *op cit* p60-61

[44] World Bank, World Development Report 2002, p179

indicated that enrolment was very low, and more than 90% of the schemes did not bear the bulk of the financial risk.[45,46,47,48]

Existing CHI schemes in most countries cover limited medical care benefit packages and sometimes include preventive health care with minimum medical and diagnostic services. There is a possibility that if a comprehensive package is introduced, these schemes would collapse.

The CHI schemes with a small pool of participants are not viable financially in the long run. Experience shows that CHI schemes with less than 100 000 participants are not viable. Many schemes are usually provider-driven, initiated by wealthy people as a trust, linked with or are part and parcel of national or sub-national poverty-reduction programmes, including micro-financing schemes. The CHI schemes are often carried out as sideline benefit packages. This hampers sustainability. Many community-based schemes have limited scope, as they are often expensive, considering the high hidden costs which are covered by donors and governments. Once donor funding ceases, only 10% of such schemes survive. In order to overcome this, CHI should be implemented as a 'core business' addressing the poor, as shown historically in Germany and the Netherlands, where such schemes were initially established as sickness funds.

Social capital is a prerequisite to implement CHI schemes. Since social capital varies among states and even among localities, the design of the scheme including management of programmes should be local-specific. This has led to difficulties in replicating the schemes in other areas. There should be a strong stewardship from the government in enhancing CHI and, if possible, providing additional funding. For various reasons, the NGOs' involvement in community-based social health insurance development on a wider scale is relatively marginal compared to other development areas. This issue needs to be addressed. The experience already gained by implementing various models of CHI schemes, especially in ensuring consensus on solidarity and contribution, and on community management of collecting and allocating funds, could play a useful role in expanding the national SHI schemes.

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[45] Bennett S, Creese A, and Monasch R (1998). Health Insurance Schemes for People Outside Formal Sector Employment, WHO Geneva (Document WHO/ARA/CC/98.1)

[46] Carrin G, et al (Ed.) The Economics of Health Insurance in Low and Middle-income countries, Social Science and Medicine (Special Issue), vol.48, 1999

[47] ILO and PAHO, Synthesis of case studies of micro-insurance and other forms of extending social protection in health in Latin America and the Caribbean (http://oitopsmexico99.org.pe)

[48] Baeza C. et al, Extending Social Protection in Health through Community based Health organizations: Evidence and Challenges, ILO, Geneva 2002

5. KEY ISSUES FOR FURTHER EXPANSION

There is a danger that rapid expansion of health insurance coverage without appropriate safeguards could result in health systems moving away from the primary goals of efficiency, effectiveness and protection of the poor and the vulnerable. The success of health insurance in achieving health reform goals is closely related to its particular institutional characteristics and managerial capacity. Usually, middle- and high-income countries, whose economies can sustain a larger proportion of employed labour workforce, are capable to expand the coverage of social health insurance as quickly as possible. They initially start with multiple agencies handling social health insurance or social mutual funds through prepaid schemes and are later consolidated into small funding groups. They act as fund managers and purchase services from both public and private health care providers.

Several countries around the world which have relied heavily on tax-based health financing are moving towards expanding social health insurance. Many households are spending large proportion of their HH expenses (out-of-pocket expenditure) on public-funded health care facilities (which are supposed to provide health care literally free of cost). There are many reasons of inefficiency of public health care providers in the form of low quality, inadequate coverage, by-passing of care, under-the-table and over-counter (unofficial) payment, rising cost of travel expenses, overcharging by private providers, etc. Most countries have a mix of specific arrangements for insurance, such as social health insurance (independent or within social security), commercial health insurance, and community prepayment schemes which varies across countries. Ultimately, it is the government that must provide subsidies for the poor and disadvantaged groups, by ensuring the financial and health risk protection for those who cannot afford to fully finance their own health expenses. Some countries have made detailed studies on this aspect, in collaboration with external agencies including ILO, GTZ, UNDP, UNICEF, the World Bank and ADB, etc. More information is required to study these issues comprehensively in the Region.

5.1 Prerequisites for Introducing or Expanding the Coverage SHI

Social health insurance is just a mechanism to ensure equity and efficiency by pooling the health and financial risks. Once the SHI scheme reaches a certain high level of population coverage, there is a strong potential to foster health

systems equity and efficiency through monopsonistic purchasing power of the Insurance Fund. While SHI is a promising alternative source of financing in order to promote equity and efficiency, it cannot be the only solution to bridge the financial gaps for resources required for additional health funding. The SHI scheme, alone, is not a panacea or remedy to replace other mechanisms or forms of health care financing, particularly financing based on general tax revenue. The government should not shirk its responsibility to ensure and regulate provision of health care, including essential public health functions, whether directly by public or private health care providers.

The main reasons for adopting the SHI scheme,[49] in general, are:

- It can provide a stable source of revenue for health care;
- It would ensure self-reliant financing of health care compared to loans, grants and other dxternal sources;
- The flow of funds into the health sector is visible;
- It can assist to establish patients' rights as customers.
- It combines risk pooling with mutual support, by allocating services according to need, and distributing financial burden according to the ability to pay;
- It can operate within government health policy goals, yet maintain a degree of independence;
- It can be associated with efficient provision of health services, and
- It solves equity and affordability of health care financing contribution in which the private health insurance fails to facilitate.

Health systems and health care are necessarily shaped by the politics of their countries, with the emphasis given to different health system goals, the relative importance assigned to health, and the assignment of responsibilities for health care among individuals, families, and society. People who use health care services, medical professionals, insurance institutions, employers, and unions are among the prominent groups that take a particular interest in public policy towards health financing. In most countries, large sums of money are at stake and different groups will benefit depending upon how these funds are allocated and regulated.

[49] Modified from Normand C. & Weber A, Social Health Insurance: A Guide for Planning, WHO/ILO 1994 (WHO/SHS/NHP/94.3) p15

All of this is a normal consequence of combining the political processes of governance and collective decision-making with the widespread recognition that public policy must play a significant role in guiding the health system. Therefore, the design of health financing in any particular context should not only recognize political influences, but explicitly address and take advantage of the opportunities presented by political debate and governance. What kind of alternative financing options should be considered depends upon the intensity and source of pressure. It is the alternatives but the balanced mixture of many alternative health financing options that the countries need to consider. The former central-market-economy-oriented countries like those of the Eastern European Region and similar Asian countries like Myanmar, India and Sri Lanka, with low levels of public health spending, low salaries for health care professionals, and inadequate quantity of health care interventions and facilities do require a higher level of health funding by governments. The main pressure usually comes from health professionals (both public and private) to improve their incomes.

Considering various options through intercountry comparison, policy makers/analysts usually concluded that the Asian developing countries tend to spend in health from public sources less than expected (given their income levels compared to Latin American countries or even among themselves). They advocated for an increase in the level of public health spending, exclusively focusing on the inputs to the health systems like expanding or upgrading hospitals, opening more and more medical universities, etc. It is worthwhile to look more carefully not on how much of this additional fund, but on how this additional spending could better benefit the poor and how it could assist in reducing inequity and improving health systems efficiency.

Expanding the social health insurance coverage is one possibility. This expansion is traditionally linked with national social security policy and programmes. Only four out of the 11 Member Countries of the Region introduced SHI schemes, without a wide coverage for some decades, except Thailand. Other countries have not yet implemented SHI schemes on national scale. Since the labour markets are growing rapidly in countries where governments provide free health care utilizing funds from general tax revenue, these countries may need to consider the SHI scheme as an alternative health financing. Health ministries usually have limited budgets and are competing with other sectors. In situations where basic services are already free, SHI could be an added advantage in ensuring access to health services, especially

from private providers. Before looking at the policy dimensions, it is important to look at the technical feasibility of SHI, since insurance arrangements are more complex than tax-based funding. The major issues that need to be examined carefully are:

- ***The labour and financial market structure***: If the country has more formal labour establishments (usually a country with fair or good economic growth, liberal trade, education and employment opportunities), there is the possibility of expanding the coverage of SHI. The regular collection of contribution from salaried income of employees from formal sector would be easily managed, while contribution from informal sectors, usually of unstable labour market, would be difficult. There are some instances where group health insurance are organized for covering bus, truck or taxi drivers and conductors, fishermen, village agricultural cooperatives. Appropriate managerial set-up on how premium from informal sector employees can easily be collected without much burden, such as payment on kind or contribution on quarterly or yearly fees, has to be considered. In addition to the need for an understanding of the importance of mandatory contributions (national solidarity), there is a need for nation-wide financial institutions to manage the collection and disbursement of funds.
- ***Existence of other forms of insurance schemes***: Some countries have introduced many forms of insurance part of financial market arrangement or under the social security framework. Almost all countries have private health insurance as "health riders' to life insurance, mutual funds, and other insurance packages offered by financial institutions. "Third-party insurance" for accident and injuries is another area health ministries kept out-of-touch.
- ***Regular contribution from the payroll***: The SHI contributions come from regular deductions from payroll and accumulated as a "Health Fund". Although the total contribution is calculated as a percentage of the monthly income, the amount is normally split between the employee and employer, and sometimes even additional subsidy by the Central or State Governments, depending upon the national policy and social consensus. One actuarial issue is what proportion of salary should be compulsorily deducted (along with other deductions like pension and provident fund, income tax, etc.).

- ***The health infrastructure***: The SHI schemes act as main purchasers and can help to ensure that those covered under them receive appropriate health care. The schemes have to work in an environment where the health care facilities are functioning in an adequate manner so that access to health care by the insured people is not denied for any reason. It does not mean that the schemes themselves should establish their own health care facilities. Traditionally, social security schemes in India and Myanmar established their own health care facilities in order to fill the gaps made by public health care providers. Similarly big state or private enterprises like mines, railways, electricity, petrol-chemical industries and other heavy industry complexes have established their own health care facilities. Some even have secondary and tertiary health care facilities that inadvertently led to inequity. Those population groups who are not insured (due to differences in their employment status, especially people from informal sectors and mainly from agricultural, fishery and animal husbandry sectors) are often not able to get appropriate health care due to their inability to pay contribution regularly or in most cases because of lack of social health insurance coverage. Thus the main aim of SHI scheme is to add on the health financing resources for universal coverage, and not to treat them as a mere alternative.
- ***Management infrastructure***: The SHI schemes need a large ***social capital*** in all aspects: appropriate human resources with skill and knowledge in social science, commerce and economics, disease burden, clinical management, public health management, banking and financial management (i.e. health economists, insurance mathematicians, actuarial scientists, social economists, accountants, demographers, epidemiologists, medical record keepers and statisticians, information specialists, public health legislators). Many countries do not have much national capacity to fulfil the requirement of national social capital. Regional solidarity may be required to improve and strengthen the capacity of social capital. In addition to the need for setting up appropriate collection of funds, there must be a nationally approved mechanism for managing this fund. It is critical to ensure the independence of the "Health Fund" from the general management of public finance. There is also the need to ensure transparency in Fund management, particularly to

strengthen the people's trust in the public management of the Fund. Some countries are still keeping the social security agency or agency managing social health insurance, as an integral part of government public departments. They collect the contribution and put them into the general revenue. The Fund Agency has to compete with other public agencies for annual budget, thus limiting the scope and work of the agency. In many middle-income countries, the SHI fund is usually managed by an independent single agency or multiple agencies, as parastatal bodies or private enterprises (with their own budget, legal status and management). However, they all should be under the strict control of national legislation and its subsidiary body.

5.2 Issues in Expanding SHI Schemes[50,51]

There are some limitations of SHI that make it inappropriate to fund certain health functions. For example, people are generally not happy sharing the cost of public goods such as public health programmes and infrastructure (e.g. immunization, water supply and sanitation, food safety, disease surveillance, etc.). People are also unwilling to share the costs of highly personalized treatment such as cosmetic surgery. However, there are more and more countries which are accepting the inclusion of alternative care, using traditional health care practices.

In those countries where public health facilities provide health care free of cost at the point of use of care (although the expenditure may be through general revenue or any other financing mechanisms), the expansion of SHI will need a lot of awareness-building among the general population to accept the idea of prepayment and cost-sharing. There is the possibility of resistance to change a system where payments are more visible. Usually, higher-middle and high-income countries whose economies can sustain a larger proportion of employed labour are able to achieve complete or near universal coverage through social health insurance. They initially started with multiple finance managing agencies handling various social health insurance schemes, some as part of the overall social security measures. They tended to contract out health care provision to both public and private care providers.

[50] Detailed analysis can be reviewed in "Guy Carrin, Social health insurance in developing countries: a continuing challenge, International Social Security Review, p57-69, Vol.55, 2/2002".

[51] WHO-SEARO, Report of Regional Consultation on Social Health Insurance, 7-9 July 2003, Bangkok, Thailand

It is necessary to build a stronger evidence base for analysing and evaluating the health financing function. There are a lot of information gaps on evidence for policy in health care financing. Most countries have not yet established or updated their national health accounts. While many countries may have regular socioeconomic surveys, the results of these surveys are not properly analysed for policy trends. Countries need to initiate, in collaboration with WHO and other agencies, a variety of activities to address these needs. Such future studies should:

- Emphasise good primary data collection and secondary data analysis;
- Emphasise greater care to eliminate bias, misinterpretation and to do systematic literature reviews;
- Generate ways to measure the effectiveness of health insurance under different systems;
- Analyse different ways of expanding prepayment schemes: including top-down and bottom-up approaches;
- Learn more about how households view fees and prepayment schemes; and
- Understand better how providers respond to mixes of payment mechanisms.

The ultimate goal of health care financing is to achieve universal coverage. Health care financing based on general tax source is the fairest way. Some countries with a high proportion of salaried workers in formal and informal employment sectors might need to consider implementing or expanding the SHI schemes. Experience has shown that several SHI schemes are facing difficulties in controlling costs if fee-for-service billing is the major form of provider payments. There are different methods available for reimbursing service providers.[52] These include salaries, fee-for-service, capitation/block contract, fixed budget, daily allowance and case-based payment. The following table shows each of these methods associated with certain negative behaviours by service providers.

[52] Detailed framework on providers' payment is in "J. Kutzin, A descriptive framework for country-level analysis of health financing arrangements, Health Policy 56 (2001) 171-204

Table. *Payment method and provider behaviour*

Payment method	Provider behaviour	Remedy
Salaries or contract	Restrict number of patients, services	Performance-rated payment and variety of incentives
Fee-for-service, with or without fee schedule	Overproduction: expand the number of cases, service intensity, expensive services, diagnostics and drugs	Combined with budget and adjust fees when specified level exceeded
Capitation and block contract with or without fund holding	Underproduction: Attract more registered persons, minimize contacts per patient, service intensity	Integrated referral system
Fixed budget	Reduce the number of patients, services	Balanced budget on performance
Daily allowance	Expand the number of bed days, longer stay, more admissions	Control daily payment by adjustment on long stay
Case-based payment, DRG	Overproduction: expand the number of case, less serious, decrease service intensity, less expensive services	Need negotiation from the start

While a number of developing countries have started introducing SHI or to further extending the existing social security or social welfare schemes, a review of such schemes in many low-and middle-income developing countries has shown the following major difficulties.

- ***Deficient in understanding the basic conceptual framework on social health insurance and lack of nation-wide consensus*** between stakeholders is a major issue in the adoption of SHI for achieving universal coverage. Appropriate policy framework has to be adopted to ensure the basic concept and ground rule of SHI, i.e., to guarantee equitable health benefits to those with similar health needs, regardless of the level of contributions.

- ***The need for trust building by the potential members on the fund (its creation and management)*** is also another major hurdle. Consumers (beneficiaries) have to fully understand of the basic concept, the contributory obligation, agreement of benefit packages, and how it is easy for them to be in the system, etc.
- ***Inadequate or ineffective health care*** provided to the insured members may be another constraint impeding expansion. If the existing health care system is not able to provide an essential basic health care package, it makes little sense to start an SHI scheme.
- ***Insufficient or lack of human capital or social capital*** *leading towards* inefficient and ineffective managerial or administrative capability or capacity to organize nation-wide SHI schemes, could lead to inadequate collection, reimbursement, capitation payment, inefficient management of revenues and assets collected, or lack of monitoring the necessary health and financial information.
- ***Political instability***, usually linked with national internal politics, and social and economic insecurity are the main hurdles. In some cases, there is also lack of policy debates between high-level policy-makers and beneficiaries.

While a few countries in the Region might face similar impediments for expansion of SHI schemes, there are many examples where opportunities could be exploited to facilitate the acceleration of SHI implementation, or the transition from other financing options to social health insurance.

5.3 Ingredients of Successful Expansion of SHI

The main ingredients of successful expansion of SHI schemes are:

- ***Political stability:*** Stability in governance, with a strong political and social commitment towards adopting SHI policies by the stakeholders as a solidarity measure, within the national framework of social security and welfare policy, will be the *raison-d'etre* for the success of the SHI programme.
- ***Economic growth***: There is no doubt that economic growth has an impact on the speed of expansion of insurance coverage. If the growth spreads more equitably within the country, the willingness and ability to pay SHI contributions could be enhanced.

- ***Level of income***: Once the general population has access to better income, they tend to participate in health insurance schemes and to make higher contributions. If people are willing to pay and can afford to pay even a small amount, it would be a prime time to start with.
- ***Expanding risk pools (Universal coverage)***: The challenge for countries which do not have a higher coverage of risk-pooling is the enormous task of expansion that would require significant political will and an enhanced managerial and technical capacity. There is a need to increase the risk pool by expanding the beneficiaries or adding essential packages. Partnerships of employers, employees, families and enterprises will ensure that the direct burden of financing is spread more widely among them.
- ***Solidarity***: There is no general rule about the proportion of the population to be covered with an SHI scheme. No single country starts with a clean slate. There are historical, political and technical reasons for not covering the whole population. It is a measure of social solidarity to protect every citizen against financial and health risks. If people accept this, it facilitates in arriving at a general consensus faster, on the type of SHI, premium and the benefit package to be made available.
- ***Relative size of informal and formal sectors***: The larger the size of the informal employment sectors, the more difficult it is to determine and collect contributions and to provide appropriate benefit health care packages to reach them effectively and efficiently. For the SHI schemes covering only employees from the formal sectors, it could easily be expanded to dependents, pensioners and temporarily unemployed workers.
- ***Managerial capacity***: Adequate capacity of financial sectors such as banking and financial transactions including actuarial and managerial arrangement is essential for the success of SHI schemes.
- ***Transparent Policy Debates***: For the success of SHI, a thorough political process of debates is required before any policy is adopted, especially what type of social health insurance, the level of the premium, what proportion of contribution to be made by the government, employers and employees, what are the benefit packages, how to contain cost, who are the providers and how they are paid, and what are the total financial returns, etc.

- ***Globalization and liberalization of multilateral trade and commerce***: There are increasing concerns that liberalization of multi-lateral trade and commerce in services, especially promoting foreign competition in the financial and health sectors through multilateral trade agreements like TRIPS agreement and the General Agreement on Trade in Services (GATS) could pose risks to equity, access to health services, and the quality of health care. However, countries could easily handle these concerns through appropriate rules and regulations. Governments can regulate the private insurance market including financial institutions handling private/commercial health insurance, by enforcing on them that they should offer to supplement the basic minimum health care packages, prohibiting dumping of high-cost patients on the public health care systems, and encouraging them to ease exclusion criteria.
- ***Democratization and decentralization***: Even though SHI schemes do not have the widest coverage in least developed countries, experience shows that they could consolidate, expand, and catalyse various local-level community-based health insurance schemes and transform other community-based health financing schemes to expand risk-sharing. Within the context of democratization and decentralization, there could be fewer hurdles in administrative and managerial capacity and financial capability.
- ***Institutional arrangements***: Establishment of appropriate institutions to be responsible for governance, technical skill development and administrative and management capacity-building, as well as the monitoring and evaluation of SHI schemes is vital.
- ***Time implications***: Experience indicates that more than two to three decades are needed to reach the target of universal coverage. Appropriate strategic development plans are required, as most countries of the Region would take several decades to achieve universal coverage.

5.4 Role of Community-based Health Insurance

Most countries have adopted different forms of community-based health insurance (CHI), through non-formal insurance initiatives, covering certain targeted groups such as poor women, low-wage labourers and the semi-employed both in rural and urban settings. A lot of these initiatives have

exclusion criteria and problems of economic sustainability. Some of these initiatives could be merged into the national health insurance policy framework like in Thailand and now in Indonesia. Many other countries have still not made any major policy efforts to expand these schemes or to integrate them into the national SHI stream.

There is no doubt that community-based health insurance is well established in some Asian countries as part of their social and cultural norms for community risk-sharing. Households in the community tend to assist each other with finance and voluntary labour at various social events like births, marriage, religious ceremonies, health crisis, and deaths. They always share equally for the expenditure and in some cases, even capital costs like building schools, health centres or hospitals. Some of the funds generated as trust funds are also managed by them. As most countries where the government-financed health care system is inadequate to provide financing for all health care activities, the community comes with resources to share the burden. Various cost-sharing schemes have mushroomed in these countries with the aim of increasing the access to essential drugs and diagnostics. Drug-revolving funds have been established to reduce the financial burden for drug costs. People have to pay a fixed amount for each consultation or user-charges are levied upon the type of illness and medicines prescribed. The funds accumulated are used locally to purchase supplies, to maintain the health facilities and to provide incentives to carers.

Evaluation studies are needed to review these funding arrangements to determine whether they are viable in the long run. Preliminary results have showed a mixed response, indicating that some are viable and good providing increased access to essential drugs. Some studies have also shown that people are willing to pay more for better health care services. A few other studies have revealed the non-viability of the system if it is not properly developed and managed. In some countries, prepaid voluntary health insurance schemes have been initiated at the community level, mainly provider-initiated, by wealthy or dedicated persons, or by piggy-backing on other micro-insurance schemes like *Gonosasthya Kendra* (GK) and *Grameen Bank* in Bangladesh, or *SEWA* in India and other community-based schemes as indicated earlier. Some schemes are implemented as part of the national or sub-national poverty reduction programme.

While CHI plays a significant role in institutionalizing the idea of pooling risks and strengthening the capacity to manage at the community level, its role

in expanding the coverage is still limited. It is no doubt that it would reduce the burden of the OOP expenditure (despite minimal amount).[53] It also ensures health care provision reaching to the poor and the underserved population, making them familiar with financial and health risk-pooling, customizing health benefit packages and promoting self-reliance and solidarity spirit. The CHI could be used as transitional mechanism before the full implementation of nation-wide SHI schemes or tax-based health care systems. The CHI could easily be integrated into other community-based financing schemes, mainly initiated through poverty reduction programmes. Even though CHI schemes play some role in health financing, they cannot be a replacement to government's health financing.

The major reasons for such CHI schemes not being able to expand coverage are:

- ***Policy Commitment***: National poverty reduction strategies (PRSP) and related strategic programmes (like mircocredit schemes) usually address the issue of financial risk protection for poor families. However, the so-called social subsidy for poor, food-for-work or other social safety net (SSN) programmes or similar national programmes for subsidizing the poor families, especially below the poverty level (BPL) households, are not addressing much to promote community-based health insurance schemes. There is strong evidence that governments should regulate, promote and assist in designing new CHI schemes, provide financial incentives and even subsidize funds earmarked for poor families, and monitor implementation of these schemes.
- ***Technical issues***: The CHI schemes tend to use a lot of adverse selection or risk selection, if they enrol only specific population groups such as pregnant women, workers in stone quarries or other hazardous workplaces, and fishermen etc. As all of them are already in high-risk groups, this adverse selection could lead to higher health care costs and discontinuation of insurance, unless funds are pumped in from other sources, including government tax revenue and mostly from external donor funding. The contributions for each individual could become very high and the scheme may not be viable because it would lose potential members. The CHI should

[53] Ranson MK, Reduction of catastrophic health care expenditures by a community-based health insurance scheme in Gujarat, India: current experiences and challenges. Bulletin of the World health organization 80 (8) 613-621, 2002

have a larger pool of low and high risks and also cater to both ambulatory and inpatient care.

- ***Existence of socially cohesive groups:*** Some countries are promoting development cooperatives, mircocredit organizations or other social groups based on people's trust. It might be easier to initiate CHI in such communities. The health care system in China was successful in the 1970s with a wide coverage of the rural cooperative health care systems which were in place in almost 98% of villages. With the breakdown of collective economic units in the communes which resulted from market economy reforms, the collective health care financing schemes were reduced to less than 10% by 1993. After some years of gap, the Chinese Government re-introduced in 2002, the rural community-based health insurance schemes based on prepaid risk-sharing principles, in a phased manner. Similar approaches may need to be revived, introduced or expanded in some countries of the Region.

It is not a good strategy to promote sporadic CHI schemes but to integrate them as much and as fast as possible into the national health insurance framework. The government may provide support and augment the coverage with subsidy, as the CHI schemes usually operate in areas where government health care delivery system is not able to provide full coverage. The CHI schemes also flourish where institutional capacity is too weak to organize nation-wide SHI schemes.

6. CONCLUSIONS AND RECOMMENDATIONS

All countries in the Region are facing a formidable challenge in expanding social health insurance as an alternative mix, together with other mechanisms of health care financing. The situation is much more complex, especially in least-developed countries (LDC) of the Region, where most payments are made at the time when people seek allopathic or traditional health care, which is sometimes more than they can afford to pay. For the poor, who are unlikely to have any prepayment schemes and are frequently unable to benefit from tax-funded subsidized public health care, the out-of-pocket payment (OOP) is the only mechanism for them to ensure adequate health care. It is thus difficult to have a sustainable, effective and equitable health care system facing a heavy burden due to the heavy OOP expenditure in the long run.

The following are some of the possible health care financing policy options for national health policy-makers and planners to consider while formulating health policies and reforms.

6.1 Increasing Public Allocation

Almost all countries in the Region have low investment in health, with limited government revenue, especially due to the downturn in economic situation, increasing unemployment and high inflation Etc. While they have realized that health sector has to compete with all other sectors and the government budget is subject to political decision, the most obvious option of health financing for all governments still to be considered is to increase the level of resources in health financed through general revenue and also by increasing the level of public and quasi-public finance (social health insurance).

There are many valid reasons for countries to increase the public investment in health care. Policy-makers need to review the differential allocation among sectors and adopt their fiscal policy in order to adjust the financial allocations so that the health sector can have a higher level of resources. According to the WHO-CMH, each 1% rise in income leads to a slightly more than 1% rise in health spending. The national income in countries of the Region is rising steadily over the years. While the annual economic growth might have been slowing down a while due to the Asian economic crisis of the late 1990s, most countries are recovering quickly. The annual growth of the health budget for public spending should be at par with, or even more than the overall annual economic growth.

While a few countries are continuously facing internal civil strife and political unrest, many have experienced stable political situations. Even in countries experiencing conflict, peace initiatives are in progress. Once the socioeconomic burden of civil strife or political instability is under control, there could be increasing concentration on social development including health.

There is also the possibility of increasing the allocation to health sector through foreign assistance in grants and loans. National policy-makers need to be aware of the drawbacks of such external inputs, imposing a greater share of in non-priority areas, limitation to pay health workers' remuneration, poor governance, and heavy investment in material capital rather than human and social capital.

6.2 Expansion of the SHI Coverage

SHI schemes in most countries are of different types and have varying degrees of coverage, and their development too is in different stages. Governments should further develop, expand and consolidate them. Most countries especially LDCs, would need financial inputs from external sources for expanding appropriate risk-pooling systems, especially those schemes designed to expand the membership among the poor.

With improvement in employment conditions both in quantity and quality, SHI schemes have the highest potential to improve health care coverage. Social security and social health insurance schemes that are covering only regular income earners/employees could extend their coverage to their families/dependents, without additional investment. Those countries where community health insurance schemes are well established should also find ways and means to expand and consolidate them. There is potential for expansion in countries which are already experienced with community-based SHI schemes and other community-based financing programmes. Some form of subsidy, such as parliamentarians supporting prepayment for indigents, or some other forms of government subsidy for poor families and informal workers, could pave the way for enhancement of the expansion programmes. Those countries which have implemented the fee-for-services model should redirect their strategy to capitation, and global budget, etc.

6.3 Research into Policy and Practice

The policy stakeholders, including parliamentarians and the ministries of health, require vision, understanding and influence. Without a good understanding of what is happening in financing health care, it will not be possible for these stakeholders to develop appropriate policies and strategies to successfully implement the appropriate mix of health care financing options. Periodic summary reports showing geographical and temporal variations of the socioeconomic and health status have to be prepared. Information on the distribution and impact of public sector health inputs and of budgetary allocations could reveal crucial variations. For policy analysts and health planners, a detailed analysis of stakeholders, including political mapping is required to indicate as to whom the results of policy analysis should be addressed to.

Regular updating of National Health Accounts (NHA) will provide necessary guidance for policy options and useful insights into the finances of the health sector. It would also provide appropriate interpretation and analysis to decision-makers and planners to review how they can and should allocate public resources for health, what should be the level of public and private expenditure, and how private resources can be mobilized for public health expenditure, etc. Practical difficulties might arise in updating NHA in many countries, such as difficulty in getting the total expenditure of private sector health care institutions; estimating community financing (donations/trust funds); estimating external donor inputs in the health sector, especially when these donor agencies work directly with NGOs and communities and the need for capacity-building for national NHA teams.

Health care financing is one of the key functional areas for improving health system performance. Appropriate stewardship or governance of health systems is required to achieve better health financing reform. Each country needs to review how these organizational and institutional arrangements on health financing can be improved, in order to increase as well as reallocate financial resources for health care while, at the same time, not having to overburden the poor.

6.4 Development of Social Capital

Gathering, sharing, analysing and reporting information on health systems development could be done by agencies within and outside the ministries of health. In addition to the health planning and policy units, bureaus and departments usually established under the direct responsibility of the ministries of health, there are enough institutions and individual expertise, both in public and private institutions like national research institutes, institutes for policy studies, academic departments of universities, semi-government and nongovernmental organizations, local and international research and development institutions, which could be exploited for the national cause. Many of such institutions are parastatal, not-for-profit institutions and they could be effectively utilized to gather and share intelligence and expertise. These institutions could be set up at some distance, but they should not be too dissociated, too academic and irrelevant. The ministries of health could still play a role on appropriate contract-setting, and in facilitating and overseeing the work of these institutions.

6.5 Conclusion

In conclusion, it is critical to recognize that in recommending any policies for financing the health system, no country starts from a blank slate. The appropriateness of particular strategies in any particular country will depend on its specific history, institutions, culture, politics and economic resources. The development of various types of mix of health care financing mechanisms could be judged by how well they are likely to achieve the goals of equity, better health and responsiveness, and fair financing. There is a need to have a higher level of fairly distributed prepayment schemes with appropriate strategic purchasing.

The existing systems of taxation, social security institutions, and the organization of health care service providers and insurers have been developed out of historical processes and conditioned by experiences of nation-building, colonialism, labour movements, wars, communal and kinship patterns, and technological changes. Out of this, citizens have already developed their beliefs and expectations, with regard to payment mechanism. As with all social arrangements, there are ways and means to undertake reforms, but it requires inputs from social institutions and support from all stakeholders.

The out-of-pocket payment, which is the major mode of financing in most countries of the Region, tends to be quite regressive and often impedes access to health care. The challenge in revenue collection is how to expand pooling mechanisms through general tax revenue and/or social health insurance contributions. The experience on implementing nation-wide mandatory health insurance schemes in low- and middle-income countries could be shared and appropriate adaptations could be made in accordance with the respective socioeconomic conditions of countries.

The existing social health insurance schemes mainly covering the formal employed sector could be reviewed thoroughly and appropriate organizational and institutional reforms could be introduced in order to improve their efficiency and effectiveness. At the same time, their coverage could also be increased. Many other forms of risk-pooling schemes such as community-based or population-based trust funds and foundations could be introduced so that the financial and health risks of the poor are adequately protected.

Further, they emphasize the need to attend to the process of health financing reform and its related transitions because such a reform requires changes in institutions, management, accountability mechanisms and population behaviours that take time and resources. SHI is not merely a new method to collect money to co-finance services. It is a promising tool of alternative health care financing which ensures equitable access with sustainable source of finance. It is a method to achieve stable financing for a package of health services (health insurance benefits), while at the same time achieving greater access to health care. While SHI is a promising alternative financing mechanism, it cannot be the main solution to bridge the financial gaps for resources required for additional health funding. The SHI scheme is not a panacea or remedy to replace other mechanisms or forms of health care financing, particularly financing based on general tax revenue. The government should not shirk its responsibility to ensure and regulate the provision of health care, including essential public health functions, whether directly by public or private health care providers.

Further Reading

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Annex 1

REPORT OF THE TECHNICAL DISCUSSION ON SOCIAL HEALTH INSURANCE HELD DURING THE 40TH CCPDM

Introduction

Technical Discussions on Social Health Insurance agenda item 7 of the 40th session of the Consultative Committee for Programme Development and Management (CCPDM) were held on 5 September 2003 at WHO-SEARO, New Delhi. Dr Gado Tshering, Director of Health Services, Ministry of Health, Bhutan, and Mr Anil Jha, Director, International Health, Department of Health, Ministry of Health and Family Welfare, India, were elected as Chairman and Rapporteur respectively. All the CCPDM participants, special invitees and concerned WHO staff, participated in the discussions.

Opening Remarks by the Chairman

The Chairman in his opening remarks highlighted the importance of selecting the subject and said that the crux of the discussions should be based on policy perspectives rather than the detailed technical aspects of social health insurance (SHI). He also briefly provided the history of the collaborative work done by WHO with Member Countries in health care financing*, including social health insurance. Noting that SHI is an important alternative mechanism for financing and health care management, many low income countries had succeeded in providing adequate coverage with SHI. Unable to cope with increasing health expenditure, many countries in the Region still relied primarily on tax funded finance. Indonesia and India with middle income levels, had much lower coverage, compared to the stage of their socioeconomic development. WHO had organized a meeting of an expert group in March 2003, and a regional consultative meeting on SHI in July 2003, in order to review the regional experience and major issues. The outcome of this consultative meeting had been incorporated in the background paper prepared for the technical discussions. The discussions could concentrate on a review of SHI schemes within the broad framework of

* Throughout this document, "health care financing" and "health financing" have been interchangeably used.

health care financing, and identification of major issues and policy options in implementing various SHI schemes. He urged the delegates to formulate implementable recommendations to be considered by the 56th session of the Regional Committee.

Introductory Remarks

In his presentation, Dr U Than Sein, Director, (Evidence and information for Policy), WHO-SEARO, provided a brief overview of health financing functions within the framework of health systems development. Every health system aims at attaining the highest level of health for all (HFA), through universal coverage, i.e. effective protection of health and financial risk for all citizens. Health financing is one of the major functions of the health systems and has three main components: a) Collection of financial resources; b) Pooling of resources and health risks; and c) Strategic purchasing.

He further elaborated on "Risk pooling", which is sharing of the financial and health risks across individuals and households, who are willing to pool their income to deal with the financial burden of health care in times of need. There are several methods of pooling health and financial risks: (a) public financing through general tax revenue; (b) social health insurance, (c) private (voluntary) health insurance, (d) community health financing, and (e) other private and public funds including earmarked tax, foundations, trust funds, and saving accounts.

Social health insurance (SHI) is generally perceived as "a financial protection mechanism for health care, through health risk sharing and fund pooling for a larger group of population". It is popularly known as the "Bismarck Model". There were certain characteristics and pre-requisites for introduction of SHI, such as solidarity, compulsory membership and ensuring equitable and sustainable social financing, and fostering health systems efficiency and effectiveness.

Most countries also adopted different forms of community health financing (CHF) schemes, through non-formal insurance initiatives to cover certain targeted groups such as poor women, low-wage labourers and the semi-employed both in rural and urban settings. Some of these initiatives had been merged into the national health insurance policy framework, as in Thailand and now in Indonesia. Many others had not made any major policy efforts to expand these schemes or to integrate them within the national SHI stream.

A few policy directions could be developed based on the following options.

- ***Increase Public Revenue for Health***: Almost all countries of the Region have a low investment in health from public resources. There is a possibility to increase the public investment in health sector, by allocating more from general tax revenue in each budget year, by promoting earmarked indirect tax (sin-tax), and by mobilizing external resources both in grants and loans and also internal resources from foundations, trust funds, and saving accounts.
- ***Promote pooling of financial risks***: Almost all countries have a low or medium coverage of risk pooling. Various mechanisms for financial risk-pooling could be introduced or expanded by the increasing coverage of various health insurance schemes (mandatory and voluntary and public or private). Establishing or promoting other risk and resource pooling schemes including community-based risk-pooling schemes and public trust funds can be considered.
- ***Strategic Purchasing***: Countries should also adopt various financial and managerial incentives and instruments in order to implement strategic budgeting such as service-based purchasing; use of appropriate technology and cost-effective interventions; promoting essential public health functions; and establishing various competitive and contracting mechanisms. Countries should establish a national quality assurance and accreditation policy and procedure, in order to provide incentives for public and private health care providers.

Discussions

The following sections provide the highlights and conclusions of the discussions on various issues relevant to health care financing and social health insurance.

Definition and Scope of SHI

Countries were in different stages of health care reforms, and some laid more emphasis on development of social health insurance with the aim of achieving universal coverage. Four countries (Thailand, Indonesia, India and Myanmar) were implementing social health insurance on a national scale with varying degrees of coverage. Most of the other countries had some experience of

health insurance programmes either through private sector or community-based financing schemes. It was agreed that national SHI schemes should include the following characteristics:

- Compulsory or mandatory membership;
- Earmarked deduction as prepayment contribution from regular payroll, based on income and not risk related;
- Cross subsidization and coverage of a large proportion of the population;
- Benefit based on need; and,
- Collected fund administered by some type of quasi-independent public body.

If the above principles and scope of SHI are applied, the scheme would exclude a large proportion of people working in the informal sector in many countries of the Region, particularly those who cannot afford to make regular pre-payment contributions. Thus, expansion of SHI schemes based on traditional principles might not by itself be able to achieve the goal of universal coverage. One option that could be considered is the possibility of governments subsidizing the premiums for those unable to pay. National programmes on 'subsidizing the health care costs of the poor', implemented in India and some other countries need to be studied further.

Most SHI schemes in the countries of the Region cover mainly the protection of financial risk for hospital care and usually inpatients' care only. According to empirical evidence, the cost of health care for hospitalization is only a proportion of other costs (such as transportation, cost of medicines and consultation, under-the-table payments, etc.). There is a need to consider covering such risks as well. Experiences from countries with high coverage of SHI schemes showed that there were gradual developments over decades from single-funded SHI to multiple-funded SHI, and national health insurance. Countries considering expansion of SHI schemes need to study how they would embark from the SHI stage to NHI within a specified, though a long time frame.

Role of SHI as an Alternative for Health Financing

The ultimate goal of health care financing is to achieve universal coverage. Health care financing based on general tax source is still falling in the biggest proportion for health financing and also it is the fairest way.

Some countries with a high proportion of salaried workers in the formal and informal employment sectors may consider implementing or expanding SHI schemes. Even in countries where governments are providing free health care utilizing general tax revenue, they may consider SHI as an alternative means for health financing because health ministries have limited budgets, competing as they are with other sectors. In situations where basic services are already free, SHI has an added advantage to ensure access to health services, especially from private providers.

Social health insurance is not a panacea or remedy that can replace other mechanisms of health care financing, particularly finances based on general tax revenue. Governments should not shirk responsibility to provide essential health care and public health functions.

There are several limitations of SHI making it inappropriate to fund certain health functions. For example, people are generally not happy sharing the cost of public goods such as public health programmes and infrastructure. People are also unwilling to share costs of highly personalized treatment such as cosmetic surgery. There are a lot of information gaps on evidence for policy. Most countries have not yet established or updated their national health accounts. While many countries may have regular socio-economic surveys, the results are not properly analyzed for policy trends. SHI schemes should also cover the preventive and promotive aspects of health care.

The Governments have to ensure health care for the poor by protecting their health and financial risks through various means of financing. WHO should provide appropriate policy guidance and advocacy materials to Member Countries. National consensus and political commitment are considered necessary for initiating and sustaining the social health insurance programme. Poor understanding of the basic conceptual framework and lack of nationwide consensus between stakeholders are the major issues in adoption of SHI as a means for achieving universal coverage. An appropriate policy framework leading towards the enactment of social health insurance is essential to ensure the wide acceptance of the basic concept and ground rule of SHI, i.e. to guarantee equitable health benefits to those with similar health needs, regardless of the level of contributions (income).

While the expansion and improvement of public health care facilities still need to be undertaken, governments have to ensure proper control of private health care providers. If the existing health care system is not able to provide full access to essential health care, it makes little sense to start a SHI scheme. However, experience indicates that SHI provides a good financial opportunity to control the service providers.

Role of the Private Sector in Development of SHI

Development and expansion of SHI should be seen in the context of globalization and rapid liberalization of international trade including opening markets for the private sector. Private health insurance schemes need to be regulated to ensure the basic principles of solidarity, cross-subsidization and control of exclusion. In some cases, there is a mismatch between funds and services. It is the role of health ministries to monitor the impact of the rapid growth of private health care providers and, at the same time, the growing number of private health insurance schemes in a liberalized environment.

Community-based Health Insurance (CHI)

Social capital, which is a pre-requisite to implement CHI, varies among states and even among localities, and thus, the design and action programmes are very local and specific. This makes it difficult to replicate the schemes in other areas. There should be a strong stewardship from the government in enhancing CHI and, if possible, its funding. Many CHI schemes have limited scope as they are often expensive, considering the high hidden costs, which are usually subsidized by donors and governments. Once donor funding dwindles, only 10% of such schemes survive.

Existing CHI schemes in most countries cover limited packages of benefit that generally include preventive health care including very basic medical and diagnostic services. When a comprehensive package is introduced these schemes usually collapse. The CHI schemes with a small pool of participants are not viable financially in most cases. Experience abroad has shown that HMOs (health management organizations) with less than 100,000 participants are not viable.

Many CHI schemes are related to, or a part and parcel of, national or sub-national poverty reduction programmes including those related to micro-financing or social subsidy or social safety net. As CHI schemes are carried out as sideline benefit packages, it has hampered the sustainability. The experience gained in implementing various models of CHI schemes, especially in ensuring consensus on solidarity and contribution, community management of collecting and allocating funds, could play a useful role in expanding the national SHI schemes.

Conclusions and Recommendations

After reviewing the SEAR country experiences where some form (with varying degrees of coverage) of social health insurance was already in place, it was unanimously felt that all countries needed technical support of WHO in reviewing the country situations, providing evidence-based research findings, developing policy options, providing models for consideration, and facilitating policy debates among the stakeholders including donor coordination.

The group made the following recommendations:

Member Countries

- An in-depth study on the possible options for alternative health care financing, within the context of national socioeconomic and development policies, should be undertaken.
- Countries that already have a wider coverage of social health insurance should document their experience on various social health insurance schemes by comparing the target population and coverage, contribution mechanism, management of funds, packages of services and their accessibility and quality.
- Countries considering adopting social health insurance need to review the basic pre-requisites for introducing SHI, such as the labour and financial market structure, existence of other forms of insurance schemes, the possibility of collecting contributions and the capability of managing funds, the existing of health infrastructure (both public and private), including their accessibility and quality.
- Based on the evidence collected from the indepth studies, a policy framework has to be developed for introducing or expanding social health insurance, by reaching consensus through different policy development mechanisms. In this regard, parliamentarians could play a crucial role in soliciting national consensus.
- Steps should be explored to increase the public health expenditure by increasing the allocation of national budget or through earmarked taxation.

WHO

- Technical support should be provided in reviewing the country situations and in providing evidence-based research findings for implementing SHI on a countrywide basis.

- The work on development of an Organization-wide policy on health care financing should be expedited.
- Member Countries should be supported in developing a national framework for expanding social health insurance or in adopting national legislation for introduction of SHI as an alternative to health care financing.
- With the involvement of WHO collaborating centres and national centres of excellence, and the national and regional expertise on health economics and health policy analysis, policy options and models should be developed for consideration by countries, and for facilitating policy debates among stakeholders including donor coordination.

Considering the background situation of social health insurance in the South-East Asia Region and having arrived at the above conclusions and recommendations, the CCPDM recommended to the 56th session of the Regional Committee to adopt a resolution on SHI.

RESOLUTION*

SEA/RC56/R5

The Regional Committee,

Recalling its own resolutions SEA/RC48/R6, SEA/RC50/R3 and SEA/RC53/R3 on alternative health care financing, health sector reform and equity in health and access to health care,

Acknowledging the need for increasing investments in health with a balanced mix of alternative health care financing options, and expressing its concerns on the high level of out-of-pocket expenditures, which would lead to impoverishment of a majority of families,

Being aware of the need to review and adopt appropriate strategies for expanding the various risk-pooling mechanisms, including social health insurance, and

Having considered the report and recommendations of the Technical Discussions on "Social Health Insurance" (SEA/RC56/17),

1. ENDORSES the recommendations contained in the report;
2. URGES Member States:
   (a) to facilitate the optimal use of available financial resources for health care by suitable financing mechanisms;
   (b) to strive for equity in access and efficiency of comprehensive health care while implementing national policies, strategies and plans for various health care financing options, and
   (c) to study and explore social health insurance as one of the alternatives for health care financing for countries which have not yet adopted it on a national scale, and
3. REQUESTS the Regional Director:
   (a) to share evidence-based information and country experiences on social health insurance and other risk-pooling mechanisms;

* SEA/RC55/R4

(b) to provide appropriate support to Member States in their efforts to introduce or expand alternative health care financing, including social health insurance schemes, in partnership with WHO collaborating centres, national centres of excellence and national expertise, and

(c) to assist Member States in capacity building in managing health care financing and policy analysis.

Sixth Meeting
12 September 2003

Annex 2

HEALTH INSURANCE IN INDIA: CURRENT SCENARIO

Introduction

The health care system in India is characterised by multiple systems of medicine, mixed ownership patterns and different kinds of delivery structures. Public sector ownership is divided between central and state governments, municipal and *Panchayat* local governments. Public health facilities include teaching hospitals, secondary level hospitals, first-level referral hospitals (CHCs or rural hospitals), dispensaries; primary health centres (PHCs), sub-centres, and health posts. Also included are public facilities for selected occupational groups like organized work force (ESI), defence, government employees (CGHS), railways, post and telegraph and mines among others. The private sector (for profit and not for profit) is the dominant sector with 50 per cent of people seeking indoor care and around 60 to 70 per cent of those seeking ambulatory care (or outpatient care) from private health facilities. While India has made significant gains in terms of health indicators - demographic, infrastructural and epidemiological (See Tables 1 and 2), it continues to grapple with newer challenges. Not only have communicable diseases persisted over time but some of them like malaria have also developed insecticide-resistant vectors while others like tuberculosis are becoming increasingly drug resistant. HIV / AIDS has of late assumed extremely virulent proportions. The 1990s have also seen an increase in mortality on account of non-communicable diseases arising as a result of lifestyle changes. The country is now in the midst of a dual disease burden of communicable and noncommunicable diseases. This is coupled with spiralling health costs, high financial burden on the poor and erosion in their incomes. Around 24% of all people hospitalized in India in a single year fall below the poverty line due to hospitalization *(World Bank, 2002).* An analysis of financing of hospitalization shows that large proportion of people; especially those in the bottom four-income quintiles borrow money or sell assets to pay for hospitalization *(World Bank, 2002)*

This situation exists in a scenario where health care is financed through general tax revenue, community financing, out of pocket payment and social and private health insurance schemes. India spends about 4.9% of GDP on

health *(WHR, 2002).* The per capita total expenditure on health in India is US$ 23, of which the per capita Government expenditure on health is US$ 4. Hence, it is seen that the total health expenditure is around 5% of GDP, with breakdown of public expenditure (0.9%); private expenditure (4.0%). The private expenditure can be further classified as out-of-pocket (OOP) expenditure (3.6%) and employees/community financing (0.4%). It is thus evident that public health investment has been comparatively low. In fact as a percentage of GDP it has declined from 1.3% in 1990 to 0.9% as at present. Furthermore, the central budgetary allocation for health (as a percentage of the total Central budget) has been stagnant at 1.3% while in the states it has declined from 7.0% to 5.5%.

Table 1. *Socioeconomic indicators*

Land area	2% of world area
Burden of disease (%)	21% of global disease burden
Population	16% of world population
Urban : Rural	28:72
Literacy rate (%)	65.38
Sanitation (%)	Rural – 9.0; Urban – 49.3
Safe drinking water supply (%)	Rural – 98; Urban – 90.2
Poverty (%)	Below poverty line – 26 Rural – 27.09; Urban – 23.62
Poverty line (Rs.)	Rural – 327.56; Urban – 454.11

Table 2. *Achievements: 1951-2000*

	1951	**1981**	**2000**
Demographic changes			
Life expectancy	36.7	54	64.6 (RGI)
Crude birth rate	40.8	33.9 (SRS)	26.1 (99 SRS)
Crude death rate	25	12.5 (SRS)	8.7 (99 SRS)
Infant mortality rate	146	110	70 (99 SRS)

	1951	1981	2000
Epidemiology			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small pox (no of cases)	>44,887	Eradicated	
Guinea worm (no. of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries & hospitals (all)	9209	23,555	43,322 (95–96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors (Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing personnel	18,054	1,43,887	7,37,000 (99-INC)

In light of the fiscal crisis facing the government at both central and state levels, in the form of shrinking public health budgets, escalating health care costs coupled with demand for health-care services, and lack of easy access of people from the low-income group to quality health care, health insurance is emerging as an alternative mechanism for financing of health care.

Health Insurance

Health insurance in a narrow sense would be 'an individual or group purchasing health care coverage in advance by paying a fee called *premium*.' In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals

and households. Given the appropriateness of this definition in the Indian context, this is the definition, we would adopt. The health insurance market in India is very limited covering about 10% of the total population. The existing schemes can be categorized as:

(1) Voluntary health insurance schemes or private-for-profit schemes;

(2) Employer-based schemes;

(3) Insurance offered by NGOs / community based health insurance, and

(4) Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS).

Voluntary health insurance schemes or private-for-profit schemes

In private insurance, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the premiums are set at a level, which provides a profit to third party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumer's income.

In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) and the Life Insurance Corporation (LIC) of India provide voluntary insurance schemes. The Life Insurance Corporation offers *Ashadeep Plan II and Jeevan Asha Plan II*. The General Insurance Corporation offers Personal Accident policy, *Jan Arogya policy*, *Raj Rajeshwari policy*, *Mediclaim policy*, *Overseas Mediclaim policy*, *Cancer Insurance policy*, *Bhavishya Arogya policy* and *Dreaded Disease policy (Srivastava 1999 as quoted in Bhat R & Malvankar D, 2000)*

Of the various schemes offered, Mediclaim is the main product of the GIC. The Medical Insurance Scheme or Mediclaim was introduced in November 1986 and it covers individuals and groups with persons aged 5 – 80 yrs. Children (3 months – 5 yrs) are covered with their parents. This scheme provides for reimbursement of medical expenses (now offers cashless scheme) by an individual towards hospitalization and domiciliary

hospitalization as per the sum insured. There are exclusions and pre-existing disease clauses. Premiums are calculated based on age and the sum insured, which in turn varies from Rs 15 000 to Rs 5 00 000. In 1995/96 about half a million Mediclaim policies were issued with about 1.8 million beneficiaries (Krause Patrick 2000). The coverage for the year 2000-01 was around 7.2 million.

Another scheme, namely the *Jan Arogya Bima* policy specifically targets the poor population groups. It also covers reimbursement of hospitalization costs up to Rs 5 000 annually for an individual premium of Rs 100 a year. The same exclusion mechanisms apply for this scheme as those under the Mediclaim policy. A family discount of 30% is granted, but there is no group discount or agent commission. However, like the Mediclaim, this policy too has had only limited success. The *Jan Arogya Bima* Scheme had only covered 400 000 individuals by 1997.

The year 1999 marked the beginning of a new era for health insurance in the Indian context. With the passing of the Insurance Regulatory Development Authority Bill (IRDA) the insurance sector was opened to private and foreign participation, thereby paving the way for the entry of private health insurance companies. The Bill also facilitated the establishment of an authority to protect the interests of the insurance holders by regulating, promoting and ensuring orderly growth of the insurance industry. The bill allows foreign promoters to hold paid up capital of up to 26 percent in an Indian company and requires them to have a capital of Rs 100 crore along with a business plan to begin its operations.Currently, a few companies such as Bajaj Alliance, ICICI, Royal Sundaram, and Cholamandalam among others are offering health insurance schemes. The nature of schemes offered by these companies is described briefly.

- **Bajaj Allianz**: Bajaj Alliance offers three health insurance schemes namely, Health Guard, Critical Illness Policy and Hospital Cash Daily Allowance Policy.
    - The Health Guard scheme is available to those aged 5 to 75 years (not allowing entry for those over 55 years of age), with the sum assured ranging from Rs 100 0000 to 500 000. It offers cashless benefit and medical reimbursement for hospitalization expenses (pre- and post-hospitalization) at various hospitals across India (subject to

exclusions and conditions). In case the member opts for hospitals besides the empanelled ones, the expenses incurred by him are reimbursed within 14 working days from submission of all the documents. While pre-existing diseases are excluded at the time of taking the policy, they are covered from the 5th year onwards if the policy is continuously renewed for four years and the same has been declared while taking the policy for the first time. Other discounts and benefits like tax exemption, health check-up at end of four claims free year, etc. can be availed of by the insured.

- The Critical Illness policy pays benefits in case the insured is diagnosed as suffering from any of the listed critical events and survives for minimum of 30 days from the date of diagnosis. The illnesses covered include: first heart attack; Coronary artery disease requiring surgery: stroke; cancer; kidney failure; major organ transplantation; multiple sclerosis; surgery on aorta; primary pulmonary arterial hypertension, and paralysis. While exclusion clauses apply, premium rates are competitive and high-sum insurance can be opted for by the insured.
- The Hospital Cash Daily Allowance Policy provides cash benefit for each and every completed day of hospitalization, due to sickness or accident. The amount payable per day is dependant on the selected scheme. Dependant spouse and children (aged 3 months – 21years) can also be covered under the Policy. The benefits payable to the dependants are linked to that of insured. The Policy pays for a maximum single hospitalization period of 30 days and an overall hospitalization period of 30/60 completed days per policy period per person regardless of the number of confinements to hospital/nursing home per policy period.

➢ **ICICI Lombard**: ICICI Lombard offers Group Health Insurance Policy. This policy is available to those aged 5 – 80 years, (with children being covered with their parents) and is given to corporate bodies, institutions, and associations. The sum insured is minimum Rs 15 000/- and a maximum of Rs 500 000/-. The premium chargeable depends upon the age of the person and the sum insured selected. A slab wise group discount is admissible if the group size exceeds 100. The policy covers reimbursement of hospitalization expenses incurred for diseases

contracted or injuries sustained in India. Medical expenses up to 30 days for Pre-hospitalization and up to 60 days for post-hospitalization are also admissible. Exclusion clauses apply. Moreover, favourable claims experience is recognized by discount and conversely, unfavourable claims experience attracts loading on renewal premium. On payment of additional premium, the policy can be extended to cover maternity benefits, pre-existing diseases, and reimbursement of cost of health check-up after four consecutive claims-free years.

- **Royal Sundaram Group**: The *Shakthi* Health Shield policy offered by the Royal Sundaram group can be availed by members of the women's group, their spouses and dependent children. No age limits apply. The premium for adults aged up to 45 years is Rs 125 per year, for those aged more than 45 years is Rs 175 per year. Children are covered at Rs 65 per year. Under this policy, hospital benefits up to Rs 7 000 per annum can be availed, with a limit per claim of Rs 5 000. Other benefits include maternity benefit of Rs 3 000 subject to waiting period of nine months after first enrolment and for first two children only. Exclusion clauses apply *(Ranson K & Jowett M, 2003)*
- **Cholamandalam General Insurance**: The benefits offered (in association with the Paramount Health Care, a re-insurer) in case of an illness or accident resulting in hospitalization, are cash-free hospitalization in more than 1 400 hospitals across India, reimbursement of the expenses during pre- hospitalization (60 days prior to hospitalization) and post- hospitalization (90 days after discharge) stages of treatment. Over 130 minor surgeries that require less than 24 hours hospitalization under day care procedure are also covered. Extra health covers like general health and eye examination, local ambulance service, hospital daily allowance, and 24 hours assistance can be availed of. Exclusion clauses apply. **Employer-based schemes**

Employers in both the public and private sector offers employer-based insurance schemes through their own employer-managed facilities by way of lump sum payments, reimbursement of employee's health expenditure for outpatient care and hospitalization, fixed medical allowance, monthly or annual irrespective of actual expenses, or covering them under the group health insurance policy. The railways, defence and security forces, plantations

sector and mining sector provide medical services and / or benefits to its own employees. The population coverage under these schemes is minimal, about 30-50 million people.

Insurance offered by NGOs / community-based health insurance

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premia are usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk members, since premiums are not based on assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits.

Community-based schemes are typically targeted at poorer populations living in communities, in which they are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package, and / or allocating the schemes, financial resources *(International Labour Office Universities Programme 2002 as quoted in Ranson K & Acharya A, 2003).* Such schemes are generally run by trust hospitals or nongovernmental organizations (NGOs). The benefits offered are mainly in terms of preventive care, though ambulatory and in-patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with the for-profit insurers for the purchase of custom designed group insurance policies. However, the coverage of such schemes is low, covering about 30-50 million (*Bhat, 1999*). A review by Bennett, Cresse et al. *(as quoted in Ranson K & Acharya A, 2003)* indicates that many community-based insurance schemes suffer from poor design and management, fail to include the poorest-of-the-poor, have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes.

Table 3 provides an overview of some non-profit social insurance schemes. Some of the schemes are described below *(Ranson K & Jowett M, 2003).*

Table 3. *Non-profit social insurance schemes in India*

Name	Location	Members	Type of insurance
1. ACCORD/ ASHWINI Health Insurance Scheme	Tamil Nadu (Gudalur)	7 356 (1997)	Health Insurance (with NIA)
2. Aga Khan Health Services3	Gujarat (Sidhpur)	40 000 (1997)	Health insurance
3. Apollo Hospital Association (AHA)	Tamil Nadu (Madras)	10 000 (1995)	Health Insurance (with GIC)
4. ASSEFA (Association of Sarva Sewa Farms)	Tamil Nadu (Madurai)	N.N.	Cattle Insurance Health Insurance
5. Cooperative Development Federation (CDF)	Andhra Pradesh (Hyderabad)	26 000	Death Relief Fund (Life Insurance)
6. Goalpara Cooperative Health Society	West Bengal (Shantiniketan)	1 247 (1997)	Health Insurance
7. Kottar Social Service Society (KSSS)	Tamil Nadu (Kanyakumari)	34 000	Health Insurance
8. Mallur Health Cooperative	Karnataka	7 000 Health	Insurance
9. Mathadi Hospital Trust	Maharashtra (Bombay/Mumbai)	150 000	Health Insurance
10. Medinova Health Card Scheme	West Bengal (Calcutta)	35 000	Health Insurance
11. Navsarajan Trust	Gujarat	10 000	Health Insurance (with NIA) Accidental Insurance (with LIC) Nutrition Legal Aid Drugs Fight Against Corruption
12. New Life	Tamil Nadu	N.N.	Health Insurance
13. Organization for Development of People (ODP)	Tamil Nadu (Mysore)	1 137	Health Insurance Accidental Insurance (with NIC)

Name	Location	Members	Type of insurance
14. Pragati Thrift and Credit Society	–	410	Death Relief Fund
15. Raigarh Ambikapur Health Association (RAHA) Medical Insurance Scheme	Madhya Pradesh (Raigarh District)	75 000	Health Insurance
16. Saheed Shibsankar Saba Samity (SSSS)	West Bengal (Burdwan)	6 800	Health Insurance
17. Seba Cooperative Health Society	West Bengal (Calcutta)	3 000 families	Health Insurance (with GIC)
18. Self Employed Women's Association (SEWA)	Gujarat (Ahmedabad)	40,000	Integrated Insurance Scheme Health Insurance Life Insurance (with LIC) Accident (with NIA) Asset Insurance Maternity Benefit
19. Kasturba Hospital Scheme, Sewagram	Maharashtra (Wardha District)	19 457 (1997)	Health Insurance
20. Social Work and Research Centre (SWRC) (defunct?)	Rajasthan (Ajmer)	20 000	Health Insurance
21. Society for Promotion of Area Resources Centre (SPARC)	Maharashtra (Bombay/Mumbai)	1 200 couples	Health Insurance Accident Housing (with OIC)
22. Students Health Home	West Bengal (Calcutta)	550 000	Health Insurance
23. Tribhuvandas Foundation	Gujarat (Anand)	800 000	Health Insurance
24. Trivandrum District Fishermen's Federation (TDFF)	Kerala (Thiruvananthapuram)		Craft & Gear Fund (loan basis) Contingency Fund (death, accidents, loss of work)

Name	Location	Members	Type of insurance
25. Urmal Rural Health and Research Development Trust (defunct?)	Rajasthan (Bikaner & Jodhpur)	N.N.	Health Insurance
26. Voluntary Health Services Medical Aid Plan	Tamil Nadu	160 000	Health Insurance

Source: Patrick Krause (2000), 'Non-profit Insurance Schemes for the Unorganized Sector in India', Social Policy Division 42, Working Papers No. 22 e, GTZ

Some examples of community-based health insurance schemes are discussed herein.

- **Self-Employed Women's Association (SEWA), Gujarat**: This scheme established in 1992, provides health, life and assets insurance to women working in the informal sector and their families. The enrolment in the year 2002 was 93 000. This scheme operates in collaboration with the National Insurance Company (NIC). Under SEWA's most popular policy, a premium of Rs 85 per individual is paid by the woman for life, health and assets insurance. At an additional payment of Rs 55, her husband too can be covered. Rs 20 per member is then paid to the National Insurance Company (NIC) which provides coverage to a maximum of Rs 2 000 per person per year for hospitalization. After being hospitalized at a hospital of one's choice (public or private), the insurance claim is submitted to SEWA. The responsibility for enrolment of members, for processing and approving of claims rests with SEWA. NIC in turn receives premiums from SEWA annually and pays them a lumpsum on a monthly basis for all claims reimbursed. (Ranson K & Acharya A, 2003).
- Another CBHI scheme located in Gujarat, is that run by the **Tribhuvandas Foundation (TF),** Anand. This was **e**stablished in 2001, with the membership being restricted to members of the AMUL Dairy Cooperatives. Since then, over 1 00 000 households have been enrolled under this scheme, with the TF functioning as a third party insurer.
- **The Mallur Milk Cooperative** in Karnataka established a CBHI scheme in 1973. It covers 7 000 people in three villages and outpatient and inpatient health care are directly provided.

- A similar scheme was established in 1972 at **Sewagram**, Wardha in Maharashtra. This scheme covers about 14 390 people in 12 villages and members are provided with outpatient and inpatient care directly by Sewagram.
- The **Action for Community Organization, Rehabilitation and Development (ACCORD),** Nilgiris, Tamil Nadu was established in 1991. Around 13 000 *Adivasis* (tribals) are covered under a group policy purchased from New India Assurance.
- Another scheme located in Tamil Nadu is **Kadamalai Kalanjia Vattara Sangam (KKVS),** Madurai. This was established in 2000 and covers members of women's self-help groups and their families. Its enrolment in 2002 was around 5 710, with the KKVS functioning as a third party insurer.
- **The Voluntary Health Services (VHS),** Chennai, Tamil Nadu was established in 1963. It offers sliding premium with free care to the poorest. The benefits include discounted rates on both outpatient and inpatient care, with the VHS functioning as both insurer and health care provider. In 1995, its membership was 124 715. However, this scheme suffers from low levels of cost recovery due to problems of adverse selection.
- **Raigarh Ambikapur Health Association (RAHA**), Chhatisgarh was established in 1972, and functions as a third party administrator. Its membership in the year 1993 was 72 000.

Social Insurance or mandatory health insurance schemes or government run schemes (namely the ESIS, CGHS)

Social insurance is an earmarked fund set up by government with explicit benefits in return for payment. It is usually compulsory for certain groups in the population and the premiums are determined by income (and hence ability to pay) rather than related to health risk. The benefit packages are standardized and contributions are earmarked for spending on health services

The government-run schemes include the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS). (See Table 4)

Table 4. *Public insurance schemes*

	ESIS (Employees State Insurance Scheme)	CGHS (Central Government Health Scheme)
Contribution	Employees: 4.75% of wages. Employers: 1.75% of wages. All contributions are deposited by the employer. State governments contribute a minimum of 12.5 %on ESIS expenditures in their respective States (Garg 1999b, p. 30). See also section 59A (Govt. of India, 1999g, pp. 51-52)	Pay/pension Contribution (Rs/month) (Rs/month) <3,000 15 3001–6000 40 60001–10000 70 10001–15000 100 >15000 150 The bulk of resources (85%) come from general revenues of the Central Government (Garg 1999b, p. 34)
Reimbursement	Does not allow reimbursement of medical treatment outside of allotted facilities. For example, the Employees State Insurance Act 1948 states that entitlement to medical benefits does not entitle the insured to 'claim reimbursement for medical treatment. except under regulations' (Govt. of India, 1999g, p. 50) and ESI (General) Regulations, (Govt. of India, 1999g, p. 156)	1. Reimbursement of consultation fee, for up to four consultations in a total spell of ten days (on referral) 2. Cost of medicines 3. Charges for a maximum of ten injections. Reimbursement for specified diseases or ailments
Entitlement	Depending on 'allotment' as per the ESI Act 1.Outpatient medical care at dispensaries or panel clinics, 2. Consultation with specialist and supply of special medicines and tests in addition to outpatient care; 3. Hospitalization, specialists, drugs and special diet. 4. Cash benefits: Periodical payments to any insured person in case of sickness, pregnancy, disablement or death resulting from an employment injury.	1. First-level consultation and preventive health care service through dispensaries and hospitals under the scheme 2. Consultation at a CGHS dispensary / polyclinic or CGHS wing at a recognized hospital. 3. Treatment from a specialist through referral, emergency treatment in private hospitals and outside India.
Eligibility	Employees (and dependants) working in establishments employing ten or more persons (with power) or twenty or more persons (without power) and earning less than Rs. 6 500 per month. (Garg 1999a, p.85)	Employees of the Central Government (excepting railways, Armed Forces pensioners and Delhi Administration), pensioners, widows of Central Government employees, Delhi Police employees, Defence employees and dependants residing in 24 specified locations (See Govt. of India, various publications)

Reproduced from Mahal A (2001), 'Assessing Private Health Insurance in India: Potential Impacts and Regulatory Issues', Discussion Paper Series, No. 16, National Council of Applied Economic Research, New Delhi. p. 35

Central Government Health Scheme (CGHS)

Since 1954, all employees of the Central Government (present and retired); some autonomous and semi-government organizations, MPs, judges, freedom fighters and journalists are covered under the Central Government Health Scheme (CGHS). This scheme was designed to replace the cumbersome and expensive system of reimbursements *(GOI, 1994).* It aims at providing comprehensive medical care to the Central Government employees and the benefits offered include all outpatient facilities, and preventive and promotive care in dispensaries. Inpatient facilities in government hospitals and approved private hospitals are also covered. This scheme is mainly funded through Central Government funds, with premiums ranging from Rs 15 to Rs 150 per month based on salary scales. The coverage of this scheme has grown substantially with provision for the non-allopathic systems of medicine as well as for allopathy. Beneficiaries at this moment are around 432 000, spread across 22 cities.

The CGHS has been criticized from the point of view of quality and accessibility. Subscribers have complained of high out-of-pocket expenses due to slow reimbursement and incomplete coverage for private health care (as only 80% of cost is reimbursed if referral is made to private facility when such facilities are not available with the CGHS).

Employee and State Insurance Scheme (ESIS)

The enactment of the Employees State Insurance Act in 1948 led to formulation of the Employees State Insurance Scheme. This scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It offers medical and cash benefits, preventive and promotive care and health education. Medical care is also provided to employees and their family members without fee for service. Originally, the ESIS scheme covered all power-using non-seasonal factories employing 10 or more people. Later, it was extended to cover employees working in all non-power using factories with 20 or more persons. While persons working in mines and plantations, or an organization offering health benefits as good as or better than ESIS, are specifically excluded. Service establishments like shops, hotels, restaurants, cinema houses, road transport and news papers printing are now covered. The monthly wage limit for enrolment in the ESIS is Rs. 6 500, with a prepayment contribution in the form of a payroll tax of 1.75% by employees,

4.75% of employees' wages to be paid by the employers, and 12.5% of the total expenses are borne by the state governments. The number of beneficiaries is over 33 million spread over 620 ESI centres across states. Under the ESIS, there were 125 hospitals, 42 annexes and 1 450 dispensaries with over 23 000 beds facilities. The scheme is managed and financed by the Employees State Insurance Corporation (a public undertaking) through the state governments, with total expenditure of Rs 3 300 million or Rs 400/- per capita insured person.

The ESIS programme has attracted considerable criticism. A report based on patient surveys conducted in Gujarat *(Shariff, 1994 as quoted in Ellis R et a, 2000)* found that over half of those covered did not seek care from ESIS facilities. Unsatisfactory nature of ESIS services, low quality drugs, long waiting periods, impudent behaviour of personnel, lack of interest or low interest on part of employees and low awareness of ESI procedures, were some of the reasons cited.

Other Government Initiatives

Apart from the government-run schemes, social security benefits for the disadvantaged groups can be availed of, under the provisions of the Maternity Benefit (Amendment) Act 1995, Workmen's Compensation (Amendment) Act 1984, Plantation Labour Act 1951, Mine Mines Labour Welfare Fund Act 1946, *Beedi* Workers Welfare Fund Act 1976 and Building and other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996.

The Government of India has also undertaken initiatives to address issues relating to access to public health systems especially for the vulnerable sections of the society. The National Health Policy 2002 acknowledges this and aims to evolve a policy structure, which reduces such inequities and allows the disadvantaged sections of the population a fairer access to public health services. Ensuring more equitable access to health services across the social and geographical expanse of the country is the main objective of the policy. It also seeks to increase the aggregate public health investment through increased contribution from the Central as well as state governments and encourages the setting up of private insurance instruments for increasing the scope of coverage of the secondary and tertiary sector under private health insurance packages. The government envisages an increase in health expenditure as a % of GDP from existing 0.9% to 2.0 % by 2010 and an

increase in the share of central grants from the existing 15% to constitute at least 25% of total public health spending by 2010. The State government spending for health in turn would increase from 5.5% to 7% of the budget by 2005, to be further increased to 8% by 2010.

The National Population Policy (NPP) 2000, envisages the establishment of a family welfare-linked health insurance plan. As per this plan, couples living below the poverty line who undergo sterilization with not more than two living children would be eligible for insurance. Under this scheme, the couple along with their children would be covered for hospitalization not exceeding Rs 5 000 and a personal accident insurance cover for the spouse undergoing sterilization. The Institute of Health Systems (IHS), Hyderabad has been entrusted the responsibility of operationalizing the mandate of the NPP 2000. The initial scheme proposed by the HIS was discussed at a workshop in June 2003. The consensus at the meeting was that the scheme, needed further improvement prior to its implementation even as a pilot project.

In keeping with the recommendations of the Tenth Five Year Plan and the National Health Policy (NHP) 2002, the Department of Family Welfare is also proposing to commission studies in eight states covering eight districts, to generate district-specific data, which is essential for conceptualization of a reasonable and financially viable insurance scheme.

The current plan – the Tenth Five Year Plan (2002-07) - also focuses on exploring alternative systems of health care financing including health insurance so that essential, need-based and affordable health care is available to all. The urgent need to evolve, implement and evaluate an appropriate scheme for health financing for different income groups is acknowledged. In the past, the government has tried to ensure that the poor get access to private health facilities through subsidy in the form of duty exemptions and other such benefits. Social health insurance for families living below the poverty line has been suggested as a mechanism for reducing the adverse economic consequences of hospitalization and treatment for chronic ailments requiring expensive and continuous care.

In the budget for the year 2002-2003, an insurance scheme called *Janraskha* was introduced, with the aim of providing protection to the needy population. With a premium of Re 1/- per day, it ensured indoor treatment up to Rs 3 000 per year at selected and designated hospitals and outpatient treatment up to Rs 2 000 per year at designated clinics, including civil hospitals, medical colleges, private trust hospitals and other NGO-run

institutions. A few states have started implementing this scheme under pilot phase.

In the budget for the period 2003-2004, another initiative of community-based health insurance has been announced. This scheme aims to enable easy access of less advantaged citizens to good health services, and to offer health protection to them. This policy covers people between the age of three months to 65 years. Under this scheme, a premium equivalent to Re 1 per day (or Rs 365 per year) for an individual, Rs 1.50 per day for a family of five (or Rs 548 per year), and Rs 2 per day for a family of seven (or Rs 730 per year), would entitle them to get reimbursement of medical expenses up to Rs 30 000 towards hospitalization, a cover for death due to accident for Rs 25 000 and compensation due to loss of earning at the rate of Rs 50 per day up to a maximum of 15 days. The government would contribute Rs 100 per year towards the annual premium, so as to ensure the affordability of the scheme to families living below the poverty line. The implementation of this scheme rests with the four public sector insurance companies.

The government also offers assistance by way of Illness Assistance Funds, which have been set up by the Ministry of Health and Family Welfare at the national level and in a few states. State Illness Assistance Funds exist in Andhra Pradesh, Bihar, Goa, Gujarat, Himachal Pradesh, Jammu and Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Mizoram, Rajasthan, Sikkim, Tamil Nadu, Tripura, West Bengal, NCT of Delhi and UT of Pondicherry. A National Illness Assistance Fund (NIAF) was set up in 1997, with the scheme being reviewed in January 1998. Through this, three Central Government hospitals and three national-level institutes have been sanctioned Rs 10 00 000 each at a time from the NIAF to provide immediate financial assistance to the extent of Rs 25 000 per case to poor patients living below the poverty line and who are undergoing treatment in these hospitals / institutions. Thereafter the scheme has been extended to few other institutes across the country and provides Rs 25 000 – Rs 50 000 per case.

Health insurance initiatives by State Governments

In the recent past, various state governments have begun health insurance initiatives. For instance, the Andhra Pradesh government is implementing the *Aarogya Raksha* Scheme since 2000, with a view to increase the utilization of permanent methods of family planning by covering the health risks of the

acceptors. All people living below the poverty line and those who accept permanent methods of family planning are eligible to be covered under this scheme. The Government of Andhra Pradesh pays a premium of Rs 75 per acceptor. The benefits to be availed of, include hospitalization costs up to Rs. 4000 per year for the acceptor and for his / her two children for a total period of five years from date of the family planning operation. The coverage is for common illnesses and accident insurance benefits are also offered. The hospital bill is directly reimbursed by the Insurance Company, namely the New India Assurance Company.

The Government of Goa along with the New India Assurance Company in 1988 developed a medical reimbursement mechanism. This scheme can be availed by all permanent residents of Goa with an income below Rs 50 000 per annum for hospitalization care, which is not available within the government system. The non-availability of services requires certification from the hospital Dean or Director Health Services. The overall limit is Rs 30 000 for the insured person for a period of one year.

A pilot project on health insurance was launched by the Government of Karnataka and the UNDP in two blocks since October 2002. The aim of the project was to develop and test a model of community health financing suited for rural community, thereby increasing the access to medical care of the poor. The beneficiaries include the entire population of these blocks. The premium is Rs 30 per person per year, with the Government of Karnataka subsidizing the premium of those below poverty line and those belonging to Scheduled Castes/ Scheduled Tribes. This premium entitles them to hospitalization coverage in the government hospitals up to a maximum of Rs 2 500 per year, including hospitalization for common illnesses, ambulance charges, loss of wages at Rs. 50 per day as well as drug expenses at Rs 50 per day. Reimbursements are made to an insurance fund which has been set up by the NGO / PRI with the support of UNDP.

The Government of Kerala is planning to launch a pilot project of health insurance for the 30% families living below the poverty line. The scheme would be associated with a government insurance company. Currently, negotiations are under way with the IRA to seek service tax exemption. The proposed premium is Rs 250 plus 5% tax. The maximum benefit per family would be Rs 20 000. The amount for the premium would be recovered from the drug budget (Rs 100), the PRI (Rs 100) and from the beneficiary (Rs 62.50)

while the benefits available would include cover for hospitalization, deliveries involving surgical procedures (either to the mother or the newborn). Instead of payment by the beneficiary, Smart Card facility would be offered. This scheme would be applicable in 216 government hospitals.

Concerns, Challenges and the Way Ahead

The preceding sections of this paper present the health insurance scenario in India. Given the situation, there are few issues of concern or barriers towards implementing a social health insurance scheme in India. These are enumerated below along with the possible way ahead.

India is a low-income country with 26% population living below the poverty line, and 35% illiterate population with skewed health risks. Insurance is limited to only a small proportion of people in the organized sector covering less than 10% of the total population. Currently, there no mechanism or infrastructure for collecting mandatory premium among the large informal sector. Even in terms of the existing schemes, there is insufficient and inadequate information about the various schemes. Data gaps also prevail. Much of the focus of the existing schemes is on hospital expenses. There continues to be lack of awareness among people about health insurance. In spite of existing regulation in some States, the private sector continues to operate in an almost unhindered manner. The growth of health insurance increases the need for licensing and regulating private health providers and developing specific criteria to decide upon appropriate services and fees. Health insurance per se, suffers from problems like adverse selection, moral hazard, cream-skimming and high administrative costs. This is coupled with the fact that in the absence of any costing mechanisms, there is difficulty in calculating the premium. There is also a need to evolve criteria to be used for deciding upon target groups, who would avail of the SHI scheme/s and also to address issues relating to whether indirect costs would be included in health insurance. Health insurance can improve access to good quality health care only if it is able to provide for health care institutions with adequate facilities and skilled personnel at affordable cost.

Given this scenario, the challenge, then, for Indian policy-makers is to find ways to improve upon the existing situation in the health sector and to make equitable, affordable and quality health care accessible to the

population, especially the poor and the vulnerable sections of the society. It is in a way inevitable that the state reforms its public health delivery system and explores other social security options like health insurance. Implementing regulations would be one, but by no means the best mechanism to contain provider behaviour and costs. This can only be done by developing mechanisms where government and households can together pool their funds. This could be one way of controlling provider behaviour.

There is an urgent need to document global and Indian experiences in social health insurance. Different financing options would need to be developed for different target groups. The wide differentials in the demographic, epidemiological status and the delivery capacity of health systems are a serious constraint to a nationally mandated health insurance system. Given the heterogeneity of different regions in India and the regional specifications, one would need to undertake pilot projects to gather more information about the population to be targeted under an insurance scheme and develop options for different population groups. Health policy-makers and health systems research institutions, in collaboration with economic policy study institutes, need to gather information about the prevailing disease burden at various geographical regions; to develop standard treatment guidelines, to undertake costing of health services for evolving benefit packages to determine the premium to be levied and subsidies to be given; and to map health care facilities available and the institutional mechanisms which need to be in place, for implementing health insurance schemes. Skill-building for the personnel involved, and capacity-building of all the stakeholders involved, would be a critical component for ensuring the success of any health insurance programme.

The success of any social insurance scheme would depend on its design, the implementation and monitoring mechanisms which would be set in place and it would also call for restructuring and reforming the health system, and developing the necessary prerequisites to ensure its success.

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Annex 3

SOCIAL HEALTH INSURANCE IN INDONESIA: CURRENT STATUS AND THE PLAN FOR NATIONAL HEALTH INSURANCE[1]

Executive Summary

The health status of people in Indonesia has improved very slowly over the last two decades. Many factors are responsible for the low improvement of health status in Indonesia, such as low education, low income, difficult geographical access, cultural problems and health care financing. Lessons learned from the World Health Report 2000, despite criticisms over the rank, clearly suggest that health care financing is the most important element in the achievement of health improvement. The level of health care financing affects the availability of human resources, medical supplies, distribution of health care facilities, quality of health services, and other important processes. The main hypothesis of this study is that health care financing is the key component to sustainable and significant health improvement.

The main research question for this study is how health care financing has progressed in Indonesia in the last two decades. The objectives of this study are: (1) to identify health care financing from various sources in the last two decades; (2) to identify gaps in health care financing in relation to health care needs; (3) to assess philosophy and regulations that may affect health care financing, and (4) to identify various feasible options to improve equity in health care financing.

In order to attain the objectives, the team reviewed various documents related with health care financing, both in Indonesia and other countries. National and international journals were reviewed to study the progress of health improvement and health care financing in Indonesia. In addition, the team also compared basic assumptions and philosophies that may distinguish health care in Indonesia with health care in other countries. The team also collected health expenditure data from the government budget. In addition, the team also discussed with prominent health economists to obtain their views about health care financing in Indonesia.

[1] By Hasbullah Thabrany, Ascobat Gani, Pujianto, Laura Mayanda, Mahlil, and Bagus Satria Budi, Center for Health Economic Studies, University of Indonesia, Presented in Social Health Insurance Workshop, WHO SEARO, New Delhi, March 13-15, 2003

The findings show that health care financing in Indonesia has been stagnant for the past two decades and is now moving away from equity principles. Although many speeches addressed by executive governments and legislatives voiced the important of equity, there is currently no written law or policies that assure the people of equity in health care financing in Indonesia. Current transformations of public hospitals into state own companies (BUMN Perjan) or local government own companies (BUMD) have clearly paved the way to increased the gap of inequity in health care financing in Indonesia. After the transformation, most hospitals have increased the price of hospital services. The behavior of health professionals in the transformed hospitals do not have significant concern over the access to services of the poor. Several studies suggest that *swadana* or autonomous public hospitals, or providing a private wing in public hospitals, benefit health professionals more than the low-income people. In the mean time, the transformation of public hospitals into *swadana* and presumably *Perjan* with the assumption of reducing government subsidy to public hospitals, the term in view of the authors is inappropriate, will not benefit the low-income-category. Without adequate channelling of subsidies towards demand, the transformation of health care facilities into autonomous bodies, not to mention companies, will jeopardize the access and equity in health care financing. Out-of-pocket payment for health care, the most regressive health care financing, will increase.

The transformation of hospitals and health centres in several provinces into state or local government companies is, to a certain degree, a response of the recommendation made by many national and international consultants that the government must spend less for health care, especially for those who can afford. The recommendation made has too much emphasis on the burden of government subsidies, without adequate consideration of the nature of health care and the equity aspect. On the other hand, many developed and developing countries are working hard to establish universal coverage to ensure equity in health care. South Korea, Mexico, Thailand, and the Philippines for example are moving towards expansion of insurance for their people, before the transformation of public hospitals. Indonesia seems to have followed the trend of transformation but with no balance in improving access to essential health care by increasing public spending or developing social health insurance schemes. Access to, especially hospital services, has been very low for the middle and low-income brackets.

Data from Susenas 1992 to Susenas 2001 (ten year annual survey) reveal that access to hospital care has been very poor for the bottom 60% of the population. On average, each household must spend more than 100% of the household income for one admission, regardless of public or private hospitals. This amount of health care costs is definitely a catastrophic spending and can impoverish a household. However, there have been very few written policies to fill this access problem. Although during the crisis the government launched social safety net programmes to protect the poor from being impoverished for health care, hospital data show that the proportion of poor and nearly- poor patients to the total patients served by public and private hospitals was far below the proportion of poor to the population. In many public hospitals the proportions of the poor patients admitted was less than 1% of the total patients. In contrast, the proportion of the poor to the community is far above 20% of the total population. The gaps in access to hospital services between the poor and the rich continue to be very high. The gaps for outpatient care in health centres, in which the costs are relatively small, have been narrow and most low-income households could afford fixed payments for outpatient care. The social safety net programing launched during the crisis, funded by a loan from the Asian Development Bank, has improved access to the poor. However, the program was terminated in 2002.

A health care financing scheme for catastrophic illnesses for non-civil servants is currently not available. Apparently the health care financing policy in Indonesia does not follow the analytical framework recommended in the World Health Report 2000. The report clearly recommends public funding for catastrophic illness to ensure equity, even though the care is a private goods. Under the Indonesian health care policy, there is misunderstanding of public-private goods and the financing of goods. Many executives often mention that the government should only finance public goods, while financing of private goods or health services will be the responsibility of the individual. The statement may be misleading if there is no explanation of the financing of private goods, such as hospitalization and expensive surgical procedures being the individual's responsibility. If the individual responsibility is limited to paying the contribution for the social health insurance scheme, the catastrophic care will be covered. In addition, there are also philosophical problems in the definition and the policy regarding affordable health care. Many government executives think that by setting low prices for third-class hospital services, all people could afford the services. This is not true, because the amount of health care needed and the costs of related services is

uncertain. So setting low prices for room and board or a procedure will not guarantee that a member of low-income household could afford services he/she needs. Even if someone pays, often he/she is *forced to pay* rather than he/she is able or afford to pay. The other misunderstanding is in the concept of subsidy on the supply side or public hospital. The concept of subsidy to public hospitals is somewhat misleading, since the concept of subsidy is usually used for financial assistance by the government to non-government agencies. Most policy-makers think that by providing subsidy to hospitals, for example by purchasing expensive equipments and paying salaries to doctors, the poor could receive the services. In reality, most poor people could not get access to hospital services, as the data suggested.

The government financing for health, from the Central Government budget, over the last two decades has been stagnant at a level below US$ 2 per capita per year at related exchange rates. The Central Government budgets normally cover about 80% of the total public spending on health in provinces and districts. As percentage of the total Central Government expenditures, health expenditures during the last twenty years have been stagnant at below 2%. These data suggest that compared to the increasing risks of the more expensive and chronic illnesses, funding for health from the government has been diminishing. In addition, out-of-pocket health expenditures by households have also been stable at the rate of below 3% of the total household expenditures.

In all developed countries, except in the US, more than 50% of financing for hospital services is from the public fund, either directly from general revenues, social security scheme, social health insurance, or national health insurance funds. A very small portion of hospital services comes from out-of-pocket payment, because of regressive policies and concerns about inequity. However, the Indonesian health insurance systems are far from equitable due to distorted implementation. For example, in social health insurance for civil servants (*Askes*), payments to hospitals by the insurers are set much below the public rates by the Ministry of Health and/or by a joint decree between the MoH and the Ministry of Internal Affairs. As the hospitals have been transformed into autonomous hospitals, the hospital managements feel that (and this is justified by the standard public hospital accounting developed by MoH) the hospitals are subsidizing *PT Askes*, the insurance company. This accounting standard creates conflict between *Askes* and public hospitals, as all of them are public entities and are supposed to ensure that

the patient receives services according to his/her medical needs. Because of payment differences, in many cases, the insured must pay the difference. While for outpatient care in health centres, the insured does not have to pay the difference or he may choose to opt out by receiving and paying services from private providers out of pocket. Since the out of pocket costs for outpatient care are relatively small, this payment will not impoverish the insured. The paradox is that when the insured is facing catastrophic costs he has to pay on an average more than 100% of his monthly income, up to 1 000%, as "cost-sharing". This scheme covers 13.8 million civil servants and their families.

The social security scheme (*Jamsostek*) also faces inequity problems because the regulation allows larger companies to opt out, resulting in pooling of low income and small employers in *Jamsostek*. Those who enrol in *Jamsostek* are those in lower income groups. Only 1.3 million workers have enrolled in the scheme since the law was introduced ten years ago. In addition, the *Jamsostek* only covers workers and their families during their active duties. Once the employees retire and their income reduces significantly, there is no coverage at all. Again, this scheme creates bias selection so that social solidarity between workers in high-income industries to low-income industries does not occur. In addition, subsidy between the young to the old is not possible also in the *Jamsostek* scheme.

The JPKM schemes (the Indonesian HMOs) is more regressive than the ones in the US and since the schemes are commercial health insurance, the schemes are not fair health care financing schemes. Under the current Ministry of Health decree, only for-profit companies are eligible for a licence to sell JPKM products. The JPKM products are sold to private employees on risk-based premium that does not provide social solidarity or equity among employees or members. The JPKM products sold by JPKM bapels (HMOs) are health insurance products sold by non-insurance companies but the MoH denies that JPKM products are health insurance products. There are imminent risks of solvency if JKPM products are not recognized as insurance products. Lately, there is significant progress within the MoH that debates on JPKM versus health insurance have reduced and the MoH goes along with other sectors to support the development of a national health insurance scheme. Currently, less than one million people are covered under JPKM bapels. In addition, various health insurance products sold by insurance companies also do not facilitate equity since the products are sold on risk-based premiums.

The health insurance schemes sold by insurance companies currently cover more than four million people.

Financing for the poor and the vulnerable groups, such as pregnant mothers, children under five years of age, and the elderly is severely inadequate. Following the economic crisis, the social safety net programmes terminated and there is no sustainable system currently in place. Many policy-makers were worried about a severe reduction in access to health services in the year 2003. The government is introducing a temporary solution by switching a small portion of oil subsidy for health care. But this subsidy is temporary in nature and the amount is very small, averaging about Rp 1 000 (about US$ 12 cents) per capita per year. The money saved from the reduction of oil subsidy goes more to pay the country debts rather than to finance health care for vulnerable groups. Options to finance these groups adequately to avoid losing generations, and to reduce severe social consequences, must be developed as soon as possible. At present, there are some propositions to establish a more sustainable social protection scheme that will be funded with an ADB loan.

The above findings should create high pressures on the government to establish equitable health care financing system(s). Currently the President has established a Task Force to design and develop a law on a National Social Security scheme, including health coverage. A lot of issues need to be resolved since currently there are many players who already enjoy the cream of commercial health insurance. This study provides alternative options for the National Health Insurance Bill, within the framework of National Social Security, which may work with varying degrees of efficiency, equity level, and implementation. The options and the recommended option are presented in this document. A strong leadership with a good vision and without individual or group interest is absolutely needed to establish a national health insurance system.

In order to meet the goal of universal coverage to ensure fairness in health care financing, it is recommended that the opt-out provision of current health benefit programmes in social security must be repealed. The expansion of social health insurance is integrated, in law, with the other social security programmes, such as pension, provident fund, and unemployment benefits. In addition, to be consistent with the goal to maximize benefits for members the legal status of *PT Persero*--for-profit oriented, of *PT Askes* and *PT Jamsostek* must be transformed into a Trust Fund or a not-for-profit public corporation. If

the opt-out provision is taken out then the number of insured in five years will soon cover about 100 million or almost 50% of the population. Along with its unique characteristics the health programmes will be managed separately from other social security programmes by a National Health Insurance Trust Fund(s). All employers, starting with employers having 10 or more employees and gradually covering employers employing one or more employees, will be mandated to enrol their employees into the scheme. The local district health offices must enrol the poor and the Central Government must share the burden by contributing funds to cover the poor. Until all employees are covered, those who work in the informal sector may join the scheme voluntarily.

In terms of the NHI Trust Tunds, this study proposes five options. The first option is consolidation of *Jamsostek* and *Askes* into a new Trust Fund to be a single payer at national level. The second option is in line with regional autonomy, whereby the compulsory health insurance schemes are decentralized by creating an independent trust fund in each region covering one province, several provinces, or several districts. The second option is creating a single payer on a regional basis. At the national level, a National Trust Fund is established to finance only catastrophic illnesses as an equalization fund among various regional funds. The third option is maintaining current schemes where vertically there are schemes for certain population groups such as civil servants, private employees, farmers, informal sector, etc. The fourth option is to create one independent scheme for various groups on a regional basis. And the fifth option is to have multiple not-for-profit health insurance agencies in various regions and at the national level out of which people freely select an insurance organization for at least two-three years. The options affect the effectiveness, efficiency, portability, and client satisfaction. Efficiency and portability reduced in case of more insurance organizations, while client satisfaction increases in the case of more insurance organizations. Selection of options is a political process. However, the study strongly suggests to base the selection on efficiency and portability while client satisfaction can be improved by management interventions.

Several focus groups discussions held during the study, as well as the Task Force have recommended to go with the first option, i.e., the creation of a single National Health Insurance Trust Fund. For the first five to 10 years, the compulsory health insurance scheme should concentrate on enrolling employees from employers with ten or more employees including pensioners.

The contribution is estimated at 6% of monthly salaries paid: 50% by employers and 50% by employees, applied for government and non-government employees. Self-employed individuals and member of cooperatives may join the scheme voluntarily. In addition, the government should establish a mechanism to cover the poor and nearly poor through public assistance programmes. Gradually, the non-salaried workers must join the compulsory health insurance scheme when a reliable contribution collection system becomes feasible.

To optimize social solidarity scheme and to fulfil the right of workers, the benefits of the compulsory health insurance scheme must be in reasonable and acceptable quality. Otherwise, the higher-income workers will resist to enrol happily. The benefits will be provided to the private health care providers and at least in the form of a second-class hospital bed in public hospitals. This level of care will be acceptable by the majority of workers and will encourage employers and employees to join the scheme. The payment will be negotiated on a regional basis between the Fund and association of providers facilitated by Regional Health Officers. Outpatient care will be delivered through the family physician system while inpatient care will be provided by private and public hospitals paid on prospective payment system. By pooling a large number of workers, the scheme is expected to have a strong bargaining power to negotiate certain standards of care and certain level of prices from health care providers. Therefore, the compulsory health insurance scheme will have a strong power to encourage cost-effective health care financing and delivery system in Indonesia.

Introduction

The health status of the people of Indonesia has improved very significantly but slowly over the last two decades. Many factors have contributed to the slow improvement of health status in Indonesia such as: low education, low income, difficult geographical access, cultural problems, and health care financing. Lessons learned from World Health Report 2000, despite criticisms over the methodology and data used, clearly suggest that health care financing is the most important element in the achievement of health improvement. The level of health care financing affects the availability of human resources, medical supplies, distribution of health care facilities, quality of health services, and other important processes. Therefore, many studies have revealed that there is a strong relationship between health status of a

population and health care financing. Data from the WHO 2000 Report clearly show that health care financing, both in terms of nominal amount and percentage of gross domestic product, is relatively lower in developing countries than in well developed countries.

As a developing country currently hit by severe financial crisis leading to a fall in the national per capita income, Indonesia is struggling to finance health care for the poor known as the social safety net programme. At the same time, Indonesia is undertaking a massive government reform by decentralizing almost all authority, except fiscal, national security, foreign policy, and religious affairs to regional government. The crisis and the decentralization of authority have raised awareness and concern over sustainable health care financing in Indonesia. It is critical to review how current health care financing affects the outcome of health development, as measured by traditional public health indicators such as infant mortality rate or outcome indicator such as access to health services. Additionally, health care financing through health insurance scheme will be reviewed to identify problems and potentials for development. In developed countries, health insurance especially social health insurance, becomes one of the most viable solutions to improve the health status of the population. However, health insurance alone will not be sufficient to overcome many health problems. This study reviews various health care financing schemes in Indonesia and recommends resource mobilization through expansion of the social health insurance scheme.

More than 30 years ago, a health insurance scheme for civil servants was first implemented in Indonesia. The scheme has evolved slowly and continued to evolve, despite many problems and unsatisfactory services complained to by members. The scheme is based on the social health insurance concept and is now administered by a state owned company, a for-profit company, that is not consistent with the concept and philosophy of social health insurance. For more than two decades, only civil servants have been protected by a health insurance scheme. Various initiatives of health care financing in small scales such as community health insurance (*dana sehat*) have been introduced and promoted by the Ministry of Health without any significant effect on the access to health services and on the health status.

Ten years ago, for the first time a comprehensive Social Security Act of Indonesia was passed by the Parliament (*Dewan Perwakilan Rakyat*). The social security includes four basic benefits: provident fund, occupational

injury, death benefits, and health benefits. The health benefits differ from other benefits in which participation is mandatory upon the availability of other health benefits provided by employers. Employers who may offer better benefits from those offered by *PT Jamsostek* may not join the social security scheme. The opt-out-option has resulted in low enrolments of health benefits and low coverage of health insurance for private employees. On the other hand, private health insurance scheme has grown faster than the public one. At the same time, the Ministry of Health introduced and promoted private insurance schemes based on managed care principles of Health Maintenance Organization in the United States called *Jaminan pemeliharaan Kesehatan Masyrakat (JPKM).* The confusion and misunderstanding regarding the managed care roles in assuring equitable health care financing among officials of the MoH and other health professionals have led to intense debates over the continuation of JPKM in health care financing in Indonesia. Despite strong evidence that the development of JPKM was unsatisfactory and has been inconsistent with the goal of equity in health financing, the MoH continues to promote the development of JPKM. A thorough and objective review of managed care and JPKM will help health professionals to understand why Indonesia needs health care financing reform.

The review covers an overview of current health policy and financing, access to modern health care by the Indonesian population and health care financing problems, especially regarding the public sources. In addition, this review examines in detail the conceptual and managerial aspects of various health insurance schemes including *Askes*, *Jamasostek*, *JPKM*, and other private health insurance forms. At the end of the review, we suggest various options for expansion of health insurance and recommend further steps to expand and to achieve universal coverage.

Existing Health Care Policy and Financing

Indonesia is currently at the crossroads between centralized and decentralized governments and between strong state controls and market driven health care. In the health sector, reforms are being undertaken in various levels of governments to accommodate global changes and to respond to the local demand. The Ministry of Health (MOH) has set a vision of Healthy Indonesia 2010 by prioritizing four main elements of health sector development namely: *healthy paradigm*, *professionalism*, *decentralization*, and *development of*

managed health insurance.[2] This vision sets healthy life for all Indonesians in the year 2010. Many public hospitals are transformed into state or local government companies, legally for profit companies.[3] In depth analysis, from the central government officials' viewpoint, reveals that the transformation of vertical public hospitals into *Perjan* (state-owned companies) is to avoid inadequate capacity of local governments to manage the hospitals. The regional government officials alleged that the transformation reflects the hesitation of Central Government to decentralize health services. State-owned pharmaceutical companies, previously appointed to ensure equitable distribution of essential drugs are being privatized to stimulate quicker response to market changes. The privatization of government pharmaceutical companies and transformation of public hospitals into state-owned companies is likely to increase the health care prices while improving the quality of health services. However, this rise of health care costs may reduce the access to necessary health services for the poor and nearly poor residents.

Infectious diseases continue to be a major problem for health services in Indonesia. However, chronic diseases requiring expensive treatment, and HIV/AIDs are on the rise. Therefore, hospitals and other health care facilities must be equipped with resources to cure infectious diseases, as well as chronic and expensive diseases. Cardiovascular diseases have been the number one cause of death since 1992, while tuberculosis and upper respiratory tract infections (URI) remain among the five leading causes of death. Tuberculosis combined with URI, has become the leading cause of death[4]. Very few hospitals provide adequate cardiovascular services in the country. Public hospitals at district levels must focus their services to fight prevalent infectious diseases while public and private hospitals in urban areas must also provide expensive services for the growing chronic diseases' patients. The market mechanism has shaped skewed distribution of specialists and other health care facilities in urban and big cities in Java. The pressure to provide more expensive equipment to accompany specialists in urban public hospitals has absorbed large amount of the government budget for urban residents. It is estimated that more than 50% of specialists are serving population in five big cities in Java. In contrast, the cities have only about 15% of the Indonesian population.

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[2] ____Healthy Indonesia 2010. MOH, Jakarta, Oktober 1999

[3] Djoyosugito, A. Rumah Sakit Perjan. JMARSI, 2002

[4] ____MOH. Health Profile 2000. MOH, Jakarta 2000

Significant policy changes such as providing access to essential health services in Indonesia come from the devolution of health services and health care financing scheme from the public sector. Under the regional autonomy law, financing of public health services is the responsibility of city or district governments, the smallest local government units. The local governments received block grant funds (*dana alokasi umum*) from the Central Government. In addition to block grant funds, local governments receive additional income from local taxes, portions of natural resources, and some earmarked central government budget in health sector. Due to varying degrees of awareness and local capacities, some districts allocate significant portion of local government budget for health, while others spend very little for health. For example, the city of Depok in south of Jakarta spent only one per cent of the local government expenditure for health, while Jambi city spent 13% of government budget for health. In terms of per capita government expenditure also, there are wide variations. For example, in 2001 Solok district in West Sumatra spent Rp 1 141 (US 13 cents) per capita while city of Padang Panjang in the same province spent Rp 80 045 (about US$ 9) per capita.[5] Before the devolution, the central government allocates health expenditure in more equitable ways, depending on the per capita budget. The changes in local government responsibility in financing and delivering public health services threaten equity in access to essential health services across districts.

The pressure for policy changes in health care is reinforced by the recent currency crisis in Indonesia. Among other Asian countries hit by the crisis, Indonesia suffered and continues to suffer the worst. The Indonesian currency (Rupiahs) to US$ plunged from Rp 2 500 in June 1997 to Rp. 13 500 per US$ 1 in January 1998 (the lowest). During 2002 the Rupiah floated around Rp 9 000 per US$ 1, still about less than one third of its value before July 1997. As the crisis began to affect industries and individuals in early 1998, the government suddenly realized that the burden of debts, both in the public and private sector was as high as nearly US$ 150 billion), a little less than the gross domestic product in the year 2002, estimated at US$ 170 billion. To pay the public debts, the government has been selling-state owned companies to domestic and international investors.

[5] __ District Health Account Survey. PT Geosys, Jakarta 2003.

Following the financial crisis of 1997, while the Indonesian currency continued to plunge, there were many political, social, and economical changes through out the country. After July 1997, the cost of living suddenly became four times more expensive for Indonesians compared to the beginning of 1997, while their real per capita income in US dollar fell to only one third of their income in the preceding year. The income per capita that had been around US$ 1,200 at current spending (it was estimated about US$ 3,200 using purchasing power parity) and then declined to around US$ 618 in 1998, is now about US$ 700[6].This condition has driven much social unrest in Jakarta and other parts of Indonesia. At the same time, devolution of political powers from the central government to local governments was unavoidable in all parts of the country, accelerating social and economical changes in Indonesia.

Stagnant Health Care Financing

Traditionally, health care financing for the public sector comes from the Ministry of Health, the provincial health care budget, the district health budget, military health services, other sector spending on health, social health insurance corporations, and foreign aid and loans. The proportion of district health allocation became the largest health care financing source after decentralization. Private sector health care financing comes from out-of-pocket payments by individuals and households, employers, and private insurance companies. The amount of money the private sector contributes on health care each year is not known since Indonesia does not have a reliable health accounts system. However, recent studies indicate that the private sector contributes much more than the public sector. According to the best estimates collected during the last ten years, health care financing from the public sector accounted for about 30-40% of total health expenditure while the private sector contributed about 60-70%. Data on health expenditure show that health care financing in Indonesia is severely under- funded, far below health care financing in Indonesia's neighboring countries. Even if it is compared with a county of similar or lower per capita gross domestic product, such as Vietnam and India, Indonesia spends much less.[7]

[6] Bureau of Census, January 2003

[7] WHO Report 2000, Geneva 2000.

Table 1. *Health care financing in selected countries in Asia, 1997*

Countries	PCHE at exchange rate (US$)	PC GDP at exchange rate (US$)	PCHE in international dollars (US$)	THE as % of GDP (%)	Public share (%)
Indonesia	**18**		**56**	**1.7**	**36.8**
Vietnam	17		65	4.8	20.0
India	23		84	5.2	13.0
Philippines	40		100	3.4	48.5
Malaysia	110		202	2.4	57.6
Thailand	133		327	5.7	33.0

Source: WHO Report 2000

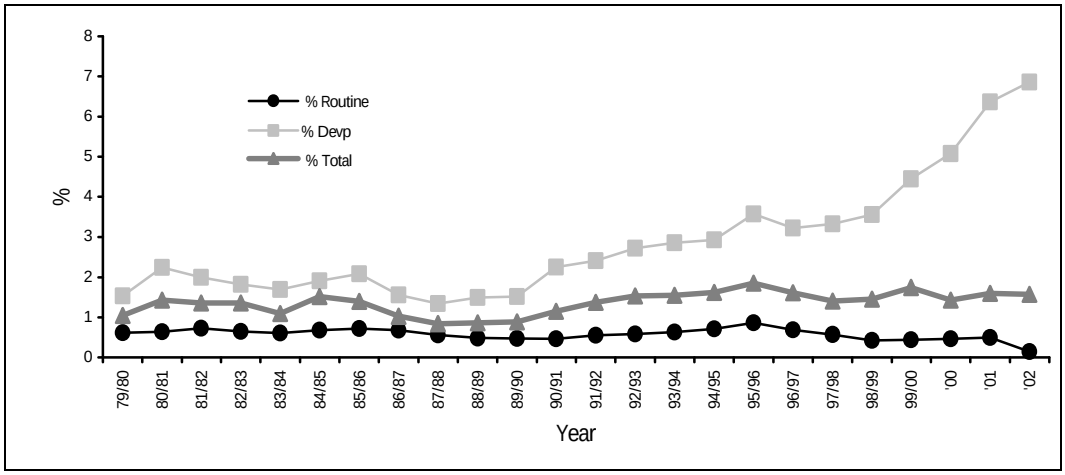
Table 1 shows data summarized from the World Health Organization (WHO)'s World Health Report, 2000 indicating that Indonesia spent only US$ 18 per capita on health in 1997 while the Philippines spent more than double than Indonesia. In international dollars, Indonesia spent even less than Vietnam with much lower GDP per capita. After the crisis when the GDP per capita of Indonesia plunged to about US$ above 700, much less than its per capita GDP in 1997, the health spending was much lower than Vietnam with the GDP per capita being US$ 382.[8] Indonesia only spent 1.7% of its GDP for health while India and Thailand spent 5.2% and 5.7% of GDP respectively.[9] For more than two decades, the Central Government of Indonesia has been spending less than 2% of the total government budget for health (see Figure 1). This finding is consistent with study by Malik (1997) [10] who found that public health care financing from Central and local government expenditures had been below four per cent to total government expenditures. Separate analysis shows that since 1998 there has been significant increase in development budget. However, further in-depth analysis uncovers that the increase has been the result of foreign aid and loans for social safety net to alleviate the impact of severe financial crisis hitting Indonesia.

[8] Asia Week, November, 2001

[9] World Health Report 2000. WHO, Geneva, 2000

[10] Malik, R et. al. Evaluasi Pembiayaan Kesehatan, and Bureau of Planning Data, Jakarta 1997

Figure 1. ***Central government spending on health as per cent of total government expenditures***



In most European and developed Asian countries, the public sector contributes more than 50% of the total health expenditures because of strong social security or social health insurance systems. Among developed countries in the world, the United States, (US) public spending on health is less than 50% of total health care expenditure. The public share on health expenditure in Thailand and the Philippines has been greater than the private sector.[11] Health care financing in Indonesia is dominated by the private sector, between 60-70% of the total health expenditure mainly from out- of-pocket financing. This large portion of private health expenditure leads Roemer (1993)[12] to classify Indonesian health care system and the US health care system as *entrepreneurial health care systems*. This entrepreneurial health care system of Indonesia continues to date. The large portion of private health expenditure in Indonesia leads to regressive and unfair burden of health care financing on the population. The impact is clear. A large portion of Indonesian people could not afford to pay for even essential health services, especially inpatient care and expensive treatments. The high infant mortality and maternal mortality rate of Indonesia may be strongly attributed to this regressive system. Although the World Bank report of 1993 entitle "Investing

[11] __WHO Report, 1999

[12] Roemer. Health System of the World, Oxford University Press, New York, 1993

on Health" [13] reached many decision-makers in Indonesian Ministry of Health, apparently there have been very few changes in health care financing policy in Indonesia. The government had not been convinced to prioritize and to invest more on health. In 2002 the government received taxes from tobacco sales more than US$14 per capita but at the same time the government spent less than US$ 2 per capita on health.

The government spending on health in US$, at exchange rates, varied from US$ 0.46 to US$ 2.49 per capita per year. The highest spending occurred in fiscal year (FY) of 1999-2000 because at that time, there was more money coming from foreign grants and loans for social safety net programme in response to the financial crisis. Although in local currency (Rupiah) the government spending on health increased constantly and significantly from Rp 368 per capita per year in FY 1979-1980 to Rp 13 513 in FY 2001, but in US$ the government spending remains stable on the average US$ 1.40 at exchange rates. This means that the Central government has not payed significant attention to health in the last two decade. Despite the relatively low spending, the health risks increased significantly due to epidemiological and demographic changes.

The local government spending has not offset the low Central government spending on health. Table 2 shows that the total government health expenditures, including Central government, provincial government, and city/district government expenditures since fiscal year 1994 in US$ have decreased. The conversion to US$ is very important since Indonesia imported more than 90% of medical supplies and raw materials for drugs. The high dependency on foreign supplies affects the purchasing power of government development expenditures. In US$, the total government expenditure on health during fiscal year 1994 to FY 2000 on average was only (less than) US$ 3. The government expenditure on health in US$ for fiscal year 1997-1998 decreased 54.8% due to the exchange rate crisis hitting Indonesia in mid-1997.

[13]. World Development Report 1993: Investing in Health. Oxford University Press, New York, 1993

Table 2. *Central government per capita health spending for fiscal year 1979/1980 to FY 2002*

Fiscal year	Per capita (Rupiah)	% increase	Per capita (US$)*	% increased (US$)
1979/1980	368	–	0.58	–
1980/1981	822	123.4	1.30	124.1
1981/1982	h901	9.6	1.41	8.5
1982/1983	909	0.9	1.36	–3.5
1983/1984	916	0.8	1.02	–25.0
1984/1985	1,210	32.1	1.17	14.7
1985/1986	1,492	23.3	1.34	14.5
1986/1987	850	–43.0	0.66	–50.7
1987/1988	767	–9.8	0.46	–30.3
1988/1989	1,055	37.5	0.62	34.8
1989/1990	1,311	24.3	0.74	19.4
1990/1991	2,275	73.5	1.23	66.2
1991/1992	3,048	34.0	1.56	26.8
1992/1993	3,946	29.5	1.94	24.4
1993/1994	4,296	8.9	2.05	5.7
1994/1995	4,680	8.9	2.12	3.4
1995/1996	5,277	12.8	2.29	8.0
1996/1997	5,845	10.8	2.45	7.0
1997/1998	6,343	8.5	1.11	–54.7
1998/1999	11,575	82.5	1.43	28.8
1999/2000	17,832	54.1	2.49	74.1
2000	13,776	–22.7	1.47	–41.0
2001	13,513	–1.9	1.29	–12.2
Average	4,479	22.6	1.40	11.0
Minimum	368	–43.0	0.46	–54.7
Maximum	17,832	123.4	2.49	124.1

*At average exchange rates of the same year

Figure2. ***Central government development budget per capita at 1980 constant prices fiscal year 1980-1981 to 2000***

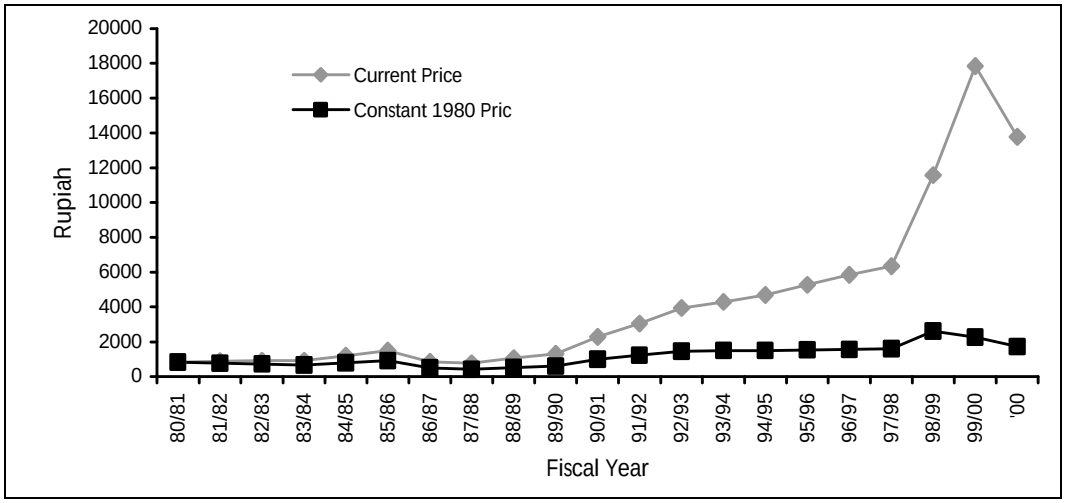


Table 3. *Government development spending from all sources per capita-fiscal year 1994/1995 – 2000*

Fiscal Year	Central (Rp)	Province (Rp)	District (Rp)	Total (Rp)	% Increase (Rp)	US$[†]	% Increase (US $)
1994/1995	4,680	573	1,148	6,401	–	2.90	–
1995/1996	5,277	717	1,242	7,236	13.0	3.14	8.3
1996/1997	5,845	896	1,443	8,184	13.1	3.43	9.2
1997/1998	6,343	755	1,761	8,859	8.2	1.55	–54.8
1998/1999	11,575	531	1,778	13,884	56.7	1.71	10.3
1999/2000[¶]	17,832	[‡]	2,676	20,508	47.7	2.86	67.3
2000	13,776	3,385	1,995	19,156	–6.6	2.04	–28.7

[†] At average exchange rates at the same year
[‡] Some local provincial expenditure is not available, not included
[¶] Total does not include provincial expenditure on health

Conceptual Problems in Health Care Financing

Since the beginning of the New Order government, the health care financing policy has aimed to provide affordable health care for all. The government constructed public health centres, sub-health centres, and public hospitals in almost all districts. To ensure affordable health care, local governments set user charges (now it is often called prices) 'conceptually affordable by all". The charges in health centres and sub- health centres have been affordable for all because the majority charges have been all- inclusive medicines for three days with uniform charges. The public hospital charges have been based on fee-for-services. The concept of affordable health care was understood by setting low room and boards, low charges of medical procedures and examinations, and other ancillary services. This is a "misconception" of affordable health care, since the true charges have been not determined in advance. The users have never been able, and will not be able to estimate how much they have to pay for health care. The uncertain nature of health care will not be met by fee-for-services charges, even though the unit of charges for each item is affordable. It is affordable if the government fixes user charges per admission or per all-inclusive visit (including medicines).

The second problem in public health care financing in Indonesia has been supply side financing. The government provides facilities, health work forces, and all related equipments to public health facilities. To conceptually provide "affordable health care", the government set low user charges for each unit without appropriate costing. The cost recovery rates were low for all levels of services, especially in public hospitals. Since the public hospitals are located in the city or in the capital of districts while the poor normally reside at a distance from public hospitals, the middle class people receive disproportionate public financing. The poor could not get access to the services because of relatively unaffordable total costs (uncertain), higher transportation costs and other cultural barriers. A greater proportion of public financing goes to the better-off than to the poor.

Efforts to establish a more appropriate public financing have been conducted since more than a decade but a significant change has not been conceived. Currently there are discussions to reformulate public-private financing for health care. The concept being discussed is that the government will only finance the public goods aspect of health services, while the private goods aspects will be financed by the private sector, except for the poor. This thought is derived from the concept of public and private goods. While the

concept of public and private goods is clear, there is no direct relationship that the public goods must be financed by the government while the private goods must be financed by individual or a private entity. The WHO report of 1999[14] clearly recommends that certain private goods are justified to receive public finance, regardless of the income status of the population. There are two essential factors to be considered for public financing: externality and catastrophic financing. The current understanding of simplified division of public and private mix in health care financing must be refined to appropriately establish fairness in health care financing. Without adequate understanding of the nature of health care, the appropriate health care financing schemes, and clear division of public and private roles in financing, Indonesia may be trapped into an inefficient and ineffective health care system leading to more health care financing problems in the future.

In the delivery of health services, the trend is that the government will transform public health services into autonomous entities. It could be in the form of for-profit state or local government enterprises (BUMN or BUMD) or in some other form. Health centres are also being transformed into autonomous health care facilities known as *swadana*. Much of this transformation aims at making financial management and the responsiveness of management to local demands more flexible. However, the general trend of this transformation has been the charging of higher user fees by the new facilities, while social protection (insurance) for those who cannot afford to pay health services is not yet established. One serious concern over this transformation is that higher user fees decrease access for the poor or the nearly poor.

Direction of Health Care Reform

After the crisis, there have been strong initiatives to reform Health care system in Indonesia. One of the more significant reforms is the Healthy Paradigm approach introduced by Minister Moeloek and signed by President Habibie in 1999. Under this revival of public health paradigm, the Ministry of Health was taking a lead to the healthy public policy, healthy overall development, and healthy environment. The Ministry of Health set four pillars to achieve Healthy Indonesia 2010, a goal to move toward healthy environment, and universal coverage. The four pillars are: moving to Healthy Paradigm,

[14] WHO Report, 1999

professionalism, development of insurance schemes (*JPKM)*, and decentralization of health services.[15] However, this reform has not been systematically and widely implemented under the new Minister.

The requirement to sell only unleaded gasoline to reduce pollution of lead residues and thereby provide a blue sky is one example of a healthy paradigm. A private, not-for-profit coalition has been set up to promote the healthy paradigm. By promoting healthy lifestyle, the government expects to reduce the incidence of illnesses in the country and therefore there will be more productive days.

To improve professionalism, basic nurse education that has been at high school level is now being upgraded to three years university education after high school (Diploma III). Many universities are now developing bachelor level (four year after high school) nurse education. Medical specialist training is now being transferred from university education into competency-based training run by specialty societies. This transformation is expected to speed up the production of specialists in Indonesia. Currently there are only about one fifth of 50 000 doctors in Indonesia who are specialists. The shortage and maldistribution of specialists creates inequity in access to modern health care across the country.

The law of regional autonomy, including health sector, has been implemented nationwide since January 2001. While decentralization provides faster response and more appropriate policy in many aspects, there are some disadvantages of decentralization of health services. Under the law of regional autonomy, local governments are responsible for providing health services in districts. Many local governments perceive that hospital services could be utilized to generate income for local governments. On the other hand some rich districts, such as Musi Banyuasin, are planning to provide health services for free. So decentralization could end up with regional inequities in health care.

Efforts to expand JPKM had been undertaken through promotion of JPKM Bapels and the creation of pre-bapel, as explained before. However, more than 99% of such pre-bapels were not able to become sustainable and promising organizations leading to the degradation of JPKM concept. A study by Ilyas (2003)[16] indicated that all district health officials surveyed in Sumatra

[15] ___ Healthy Indonesia 2010, Jakarta 1999.

[16] Ilyas, Y. JPKM Pilar atau Galar. J MARSI, January 2003

reported that no pre-bapel had survived. This massive failure of JPKM has given some impetus to reforming the concept of JPKM. Attempt by the MoH to establish a JPKM Law by mandating all citizens to choose a bapel aborted. The bapels—at least by the proposed law are for-profit entities that will maximize profits to the stockholders.[17] This is not consistent with the concept of social health insurance that attempts to maximize benefits to the members. The current *Jamsostek* and similar schemes implemented in Chile[18] have proved that running social health insurance by for profit entities leads to severe bias selection and will only benefit investors, not the people. In addition, the small capital of bapels could lead to serious solvency problems. In 2001, none of the licensed bapels had more than Rp 500 million (US$ 56,000) capital, suggesting very low financial solvability to run high-risk health insurance schemes.[19] Currently, efforts to expand JPKM or health insurance coverage is integrated into the expansion and reform of national social security to be described later.

Existing Health Insurance Schemes

Civil Servant Social Health Insurance Scheme (Askes)

The legal basis of this scheme is based on Government Regulation No 69/1991 and Government Regulation No 6/1992. The number of insured in the civil servant compulsory health insurance (social insurance) scheme this year is a little more than 13 8 million members. The scheme is managed by *PT Askes*, a state owned company. All civil servants and pensioner civil servants, and military personnel are mandated to contribute 2% of their basic monthly salary, regardless of their marital or family status. The government, central and local, had not contributed to the scheme. However, this year the central government is starting to contribute equivalent to half per cent of the basic salary. All members are entitled to comprehensive benefits considered medically necessary regardless of their rank or income. The benefits are provided in provider network, and consist of mainly public health centers and public hospitals. *Askes* pay the providers using prospective payments, mostly on per case and per diem. The Ministry of Health and the Ministry of Internal Affairs determine the level of payment to providers to ensure that *Askes*

[17] ___ Draft RUU JPKM, Jakarta, April 2001

[18] ___ WHO Report 2000, Geneva, 2000

[19] Thabrany, H; Pujianto; and Mundiharno. Survei Kapasitas Bapel JPKM. PT MJM. Jakarta, 2001

maintains its solvency. The only difference is that higher-rank civil servants are entitled to first class room and boards when they are admitted to public hospital, while the lower rank are entitled to second and third class room and board when they are hospitalized.

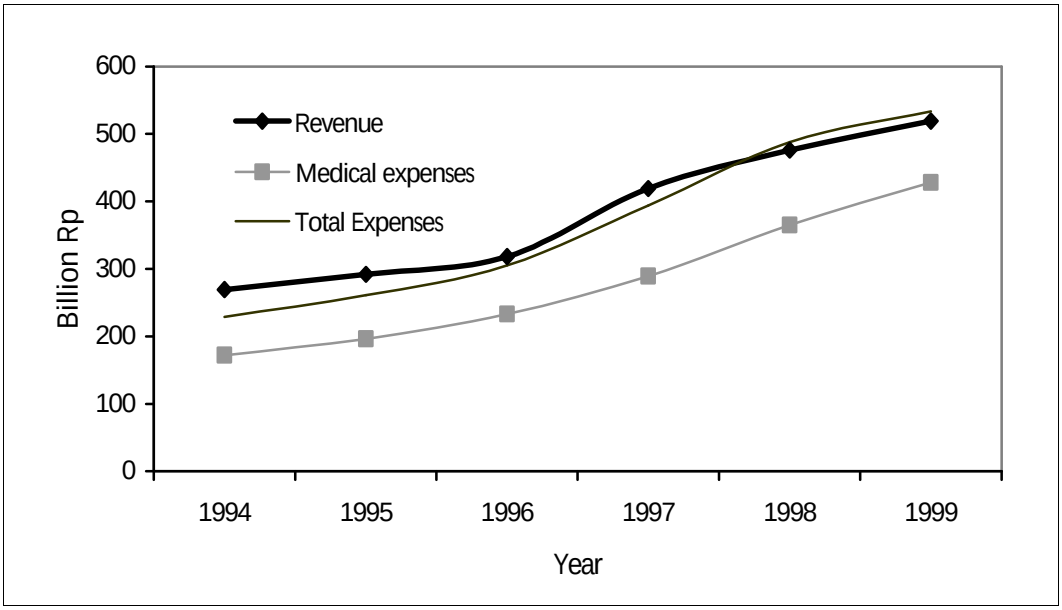
Initially, the scheme was administered by an agency within the Ministry of Health (BPDPK, *Badan Penyelenggara Dana Pemeliharaan Kesahatan).* However, under the Ministry the management of the scheme was tied to bureaucratic fiscal system that was not flexible to respond to the changing needs and demands. In 1984, the agency was transformed into a Public Company (*Perum Husada Bhakti)*, a state-owned company in which the employees of the company maintained their civil servant status. In 1992, the status of the company was again transformed into *PT Persero* called *PT Asuransi Kesehatan Indonesia* (in short it is more popular with *PT Askes*), a higher-level autonomous status of state-owned company where the employees were no longer civil servants. After the transformation from *Perum Husada Bhakti* into *PT Asuransi Kesehatan Indonesia*, PT Askes is allowed to sell commercial products in accordance with the by-laws. Currently *PT Askes* is selling commercial insurance in the form of HMO products to more than 2 500 companies covering about 1.3 million members, an increase from 131 635 members in 1994.

The membership growth of the compulsory scheme increased with the increasing number of civil servants and military pensioners. However, the number of members declined sharply in 1998 after the management conducted an audit of membership. Computerization of member services resulted in reduction of subscribers (families) due to some duplication that existed before computerization was effected. In addition, the number of dependents fell sharply because *Askes* conducted consistent membership policy that covers only the first two children under the age of 21 years or 25 years if the child is a full-time student. As the result, the membership of compulsory scheme in 1998 decreased by 2 173 448 from the number of members in the preceding year. In the year 2002, the compulsory members remained at about 13.8 million.

The growth of premiums for compulsory members on average has been lower than the growth of health service expenses. The government normally determines the salary levels of civil servants every two-three years. Sometimes the basic salary is not adjusted; instead the government provides additional

lumpsum money to supplement the income of civil servants and military personnel, as was the case in 1999. Because the basic salary was unchanged, the premiums received by *PT Askes* did not increase during that year. On the other hand, health services prices were adjusted to offset the high inflation rate of more than 80% in the same year. This trend threatens the sustainability of the social health insurance scheme, especially during the coming decentralization and transformation of public hospitals into autonomous hospitals (Perjan).

Figure 3. ***Askes Financial Performance, 1994-1999***



Source: *Askes* Annual Report, 2001

Although in theory, all members have the right to receive comprehensive health services in the provider network, mostly public health facilities, many *Askes* beneficiaries (especially upper income) did not use services they deserve to. Susenas 1998 showed that of 28.2% members who complained had at least one illness symptom, 16.3% sought treatment and only 7.3% sought treatment in *Askes* provider network. Many upper income members did not use outpatient services provided by *Askes* providers and simply pay out-of-pocket for services outside the network. There is harmful for the

members because the charges for outpatient care are affordable. However, for catastrophic medical care, such as haemodialysis and open-heart surgery, almost all members used the services provided. On average, in 1998, each household member of *Askes* paid Rp 19 200 out-of-pocket for outpatient care and Rp 698 000 for inpatient care (Thabrany, 1999). Upper income members often file complaints that they receive poor quality of services in the provider network. Recent surveys indicated that 80% of the members were satisfied with the services provided in the network (Soetadji, 2002)[20]

Regardless of member satisfaction, the implementation of *Askes* has benefited civil servants, pensioner of civil servants and armed forces personnel, their families, and their survivors for more than 30 years. For higher rank beneficiaries, the scheme has helped beneficiaries in access to expensive medical care and drugs. The scheme has been very helpful for retirees and for major medical expenses (expensive medical care such as inpatient care, haemodialysis, surgical procedures, and cancer therapy). Practically, all beneficiaries utilize their benefits when they have kidney failure and need haemodialysis procedure regularly. About 75% of patients in haemodialysis centres in the country are *Askes* beneficiaries. Susenas data showed consistently that more than two thirds of beneficiaries used their insurance for inpatient care. In contrast, slightly less then half of beneficiaries used their insurance for outpatient care (Thabrany et.al. 1999).[21]

The *Askes* scheme is currently facing several problems. Before 2002, *Askes* members had to pay for cost-sharing that was very high, ranging from 30-60% of the total costs. The high cost-sharing was the result of low reimbursement levels by *Askes* as set by the Ministry of Health while many autonomous public hospitals, especially in large cities, charge the remaining balance to the members. In 2002, the Ministry set new payment levels, in which the *Askes* payees higher-than-published user charges in 40% of public hospitals, but remained below the published charges for the remaining public hospitals. The second significant problem is the perceived poor quality of health services provided in public hospitals. As described before, higher income or higher rank civil servants often do not use their benefits for out patient care due to this perceived poor quality. The third problem related to

[20] Soetadju, O.A. Kebijakan Baru Askes untuk Tahun 2003. Paper presented in Provider Seminar, Bali, December 2002

[21] Thabrany, H. et.al. Potret peserta wajib, Laporan Studi Susenas 98

the goal of universal coverage is the third child and beyond and related pregnancy treatment are not covered. The fourth problem is the relative adverse selection of the scheme from military pensioners. During their active duties, military personnel are not covered by *Askes*. After retirement, when they are at higher risks and receive much lower pension—as compared to their salary, the military personnel and their family members are covered by *Askes*. The fifth problem is the transformation of public hospitals into state own companies followed by increase in prices. Many transformed hospitals express their unwillingness to serve *Askes* members unless *Askes* pays regular prices at set hospitals. The last problem faced by *Askes* is the demand by several local mayors or *bupatis* (head of local government) to manage their employees insurance. This is a misunderstanding regarding the decentralization of power or authority provided under the regional autonomy law implemented just two years ago.

Private Employee Social Health Insurance Scheme (Jamsostek)

The legal basis for this social health insurance programme *(Jamsostek)* is the Law No. 3/92 (social security law), the government decree (*Peraturan Pemerintah)* No.14/93, and the Ministry of Labour decree No. 05/93. All of these regulations also apply for the other three *Jamsostek* programmes namely provident funds, death benefits, and occupational injury. However, the SHI programme differs from other programmes in several ways[22]: (1) The participation of SHI is conditional. Employers who have provided health benefits (self insured) or can purchase more generous health insurance are exempted. Because of this provision, the majority of employers choose to opt out from *Jamsostek* and buy health insurance from insurance companies or JPKM bapels. (2) Employers are mandated to pay a premium of 3% (singles) and 6% (married) of employees' salaries while the employees pay nothing (non-contributory scheme). (3) The wage ceiling has remained at Rp 1 000 000 since 1993, freezing revenues while costs of medical care continue to rise. (4) The benefits are in kind, provided through various health care providers contracted, directly or indirectly, by Jamsostek, except for limited out of network emergency care that is reimbursable. Other *Jamsostek* programmes pay cash benefits to the beneficiaries. (5) The benefits are

[22] Jamsostek. Kompilasi Peraturan Jamsostek. PT Jamsostek, 1999

provided not only to the employees but also to family members—up to the third child.

Operational problems

The regulation mandates all employers, regardless of the legal status of the entities, who employ 10 or more employees, to pay health insurance premiums for their employees except the employers who choose and are eligible to opt out. Employers having less than 10 employees but pay salary, in total, more than Rp 1 million a month are also mandated to enrol their employees into Jamsostek. Under this regulation, many individuals, who have a driver and a housemaid, paying more than one million rupiahs per month are mandated to enrol under *Jamsostek*. If this law were enforced and no opt out option is possible, health insurance coverage would have increased to more than 100 million people or 50% of the population. But, the membership growth of Jamsostek is progressing very slowly (see table-3), increasing from 199 000 in 1991 to 2.9 million people in the year 2002. The average growth of employers enrolling their employees to Jamsostek in the last ten years was 53% a year, but the number of employees enrolled grew only by 40% a year. The number of insured (members, including family members) grew even less at only 38% a year. This means that only small employers (average size of 79 employees per employer) enrolled under *Jamsostek*. Larger employers opted out of *Jamsostek*. As a result, *Jamsostek* covers less than 5% of eligible employees. In 2001, there were 18.8 million employees (of those 9.3 million are active members[23]) enrolled in the other three *Jamsostek* programmes. A national labour survey estimated a figure of 56.2 million workers fully employed in the year 2000.[24]

Data from commercial insurance companies show that total membership of health insurance coverage in the 1999 was about four million people.[25] Health insurance premiums (excluding personal accident insurance) received by commercial health insurance companies in 1999 was Rp 279 billion and it is estimated to reach Rp one trillion in 2002. In 2000, Jamsostek collected only Rp 155 billion, much less than the total health insurance premiums

[23] Jamsostek website data, 2002

[24] __ ILO. National labor force survey, 2000

[25] Djaelani, F. Perkembangan Asuransi Kesehatan di Indonesia. Makalah disajikan pada Seminar Nasional Asuransi Kesehatan, Jakarta, Oktober 2000

received by the private insurers. Without Jamsostek law, the private insurers may not get such sizeable gross premiums from health insurance products. The opt-out option benefited commercial health insurance companies more than *Jamsostek* and its employees. In addition, the cross subsidy and redistribution effects of social security are not achieved.

Table 4. *Memberships growth of social health insurance component of (JPK) Jamsostek, 1991-2000*

Year	Firm	Employees	Insured	Premium (Rp000)	Claim ratios (%)
1991	723	85,926	199,695	4,553,000	63.9
1992	958	110,345	238,022	8,280,000	62.2
1993	3,419	256,402	537,173	13,657,000	59.1
1994	5,624	458,257	963,619	28,263,000	67.5
1995	8,034	698,052	1,414,175	44,365,000	80.7
1996	9,452	961,594	1,725,618	64,314,563	79,7
1997	10,892	989,094	1,949,011	86,233,060	76.1
1998	14,225	1,110,478	2,338,075	100,220,435	88.5
1999	15,628	1,235,818	2,567,576	136,103,858	74,6
2000	16,707	1,321,844	2,699,977	155,360,770	65,4
Average annual growth 1991-2000 (%)	53%	40%	38%	51%	Av. Cl. Rat 71,77

Source: PT Jamsostek, Account Division 2001

In the law enforcement aspect, Jamsostek does not have the authority to enforce the law. The Ministry of Manpower and Transmigration (MoMT) does have the authority but it does not have sufficient understanding of the philosophy and the effects of non-participating employers to the growth of social security. Moreover, many officials at the MoMT may not have a good understanding of what social health insurance means to workers and labour productivity. In addition, there is no incentive for the MoMT to enforce *Jamsostek*. Some officials of MoMT even advocate liberalization of *Jamsostek* using the market mechanism without knowing that there is market failure in

the health insurance and social security. Chile and Argentina have experienced severe adverse selection of their social health insurance systems because of this liberalization. The US experience is a very clear example of serious disaster to the population in financing health care because of the market mechanism.

The management of *Jamsostek* needs strengthening in order to provide evidence that social health insurance scheme can provide an acceptable quality of services. Only through such high quality services, memberships could be expanded. However, the current administration of *Jamsostek* is not ready to take responsibility to manage larger membership. The current relative high claim ratio of an average of 71.8% (compared to the other three programmes) and low revenues from SHI contribute to the lack of impetus to administer SHI compared to other *Jamsostek* programmes. In addition, the benefits in kind have also complicated the management of SHI for which most of *Jamsostek* staff are not prepared.

Due to lack of management capacity, in the past *Jamsostek* contracted the management of health care providers and health services to other parties called main providers (MP). The main MP of is JPKM bapel owned by employees of *Jamsostek* and several others MP are also JPKM bapels (i.e insurers, not health care providers). *Jamsostek* paid capitation to MP and then MP paid other capitation on fee-for-services to providers –a reflection of poor capability of *Jamsostek* to manage contracts with health care providers. Certainly this contracting system leads to inefficient and higher costs since the main providers will take some profits. Taking into account 20% administrative costs spent by PT *Jamsostek* and additional administrative costs spent by MPs, the amount of money that goes to health care providers becomes less than 60% of the total contribution received. Such high administrative costs leads to low quality of health care benefits. In most social health insurance schemes in other countries, the administrative costs can be as low as 3% (Taiwan) and up to 5% in Germany. The economies of scale through making one agency responsible for the administration of health insurance, such as the case in Taiwan, Canada, or even Medicare in the US, can push efficiency up to 4% of premiums for administrative costs.

A lot of complaints from providers and dissatisfaction of contracting MPs led to discontinuation of most of the MP systems. At present, *Jamsostek* is managing directly to contract providers with few exceptions. Several regions contract out patient services only with private providers, while others use a

mix at public and private providers. Several regions use public health centres as primary care providers resulting in poor quality perception by members. Members demand service differentiation from those services usually provided for the poor in public health centres.

The payment system applicable all health care providers cannot be based on capitation, as prescribed by PP 14/93. The capitation payment system is required to assure that health services are delivered in a cost-effective way. By regulation, *Jamsostek* must pay all providers on capitation; however, in practice this system is not always possible. Doctors and hospitals are not ready for risk contracting because they are not trained to accept risks and the market for fee-for-services is still dominant. The Ministry of Health regulation on pricing system of hospitals clearly prescribes fee-for- service payment system. The environment is simply not supportive for capitation payment system, except for a relatively small number of primary care physicians. The capitation payments to primary care providers are easier to make since the required number of members for primary care capitation is low and the variance of prices is also small.[26] Capitation payment to hospitals is performed only in those branches that have sufficient number of members (Purwoko and Mahmud, 1998).[27] Moreover, capitation payments to hospitals require larger number of members due to large variations of costs per admission. Finally, hospital managers are not trained to assume risks for services they provide.

The current information system of *Jamsostek* does not support changes of membership (marital status, family size, change of employers, etc) on timely basis. The main cause of this information lag has been difficulties in updating records caused by employers neglect, employees poor awareness, and *Jamsostek*'s poor information management. It is reported that often hospitals billed *Jamsostek*/MPs for services rendered for *Jamsostek* members using higher than pre-negotiated prices, but *Jamsostek* may pay the bills without noticing the errors. Currently there are more than 70 companies offering health insurance and contracting services to hospitals using unique prices negotiated in advance by many insurers. Staff at hospitals may mistakenly quote prices from other insurance carriers and bill the prices to *Jamsostek*. The second possible reason is that the staff at hospitals deliberately charge higher than negotiated prices to increase income, especially when prices of

[26] Thabrany H. Rasional Pembayaran Kapitasi. Yayasan Penerbit IDI, Jakarta 2000

[27] Paper presented at the First National Conference on Health Insurance, Jakarta, November 9-11, 1998

medical supplies and drugs are not stable. This practice may enable providers to balance overall costs where these otherwise would be lost from other services rendered. This kind of moral hazard is often reported in health insurance literature. The information system of *Jamsostek* must be designed to enable managers to identify moral hazards from health care providers and possibly by members. The existing information system is not designed to signal early warning for moral hazard.

Other problems

The ceiling of salary for premium determination (one million rupiahs) set ten years ago without adjustment is detrimental to *Jamsostek's* financial condition. Under this ceiling, employers contribute only Rp 60 000 (if married) or Rp 30 000 (singles) per month for employees earning more than five million rupiahs a month. If the ratio between employees and total members is 3 (on average two dependents for each employee) then the contribution is only Rp 10 000 – 20 000 per person per month. A commercial product sold by *Askes* costs Rp 20 500 per person per month for less liberal benefits,[28] much higher than contribution for *Jamsostek*. On the other hand, the private sector continues to skim the cream. For example, the average premium received by *Jamsostek* per member in 2000 was only Rp 5 224.[29] Many employers allocate money for health benefits higher than Rp 100 000 per employee. As a result, companies paying high salaries have more incentive to opt out so as to obtain health insurance from private insurance companies rather than enrolling with *Jamsostek*. *Jamsostek* covers only low-income employees and therefore collects relatively low contribution. The low revenues from this social health insurance puts *Jamsostek* in difficulties in improving the quality of services.

Another structural problem of *Jamsostek* is that inpatient services are limited to 60 days, including a maximum of 20 days in intensive care unit. The level of inpatient care is limited to second-class rooms in designated public hospitals or third-class rooms in designated private hospitals. Considering the limited choice of hospitals compared to the traditional health insurance product from the private sector, employers and employees will prefer the product from the private sector. Haemodialysis, cancer treatment, cardiac surgery, congenital diseases, alcoholism, drug abuses, and organ

[28] ___ PT Askes marketing circulations, 2002

[29] ___ Accounting Department, PT Jamsostek

transplant, and all services provided by non-contracted providers are not covered (Supriyono, 1998)[30]. Drugs are covered if doctors prescribe them from a special formulary developed by *PT Jamsostek*. Because some expensive medical cares are not covered, many employees and employers consider that the benefits provided by *Jamsostek* are not sufficient and it is not worth joining it.

Commercial Health Insurance

JPKM (HMOs)

JPKM stands for *Jaminan Pemeliharaan Kesehatan Masyarakat* and is exactly the same as Health Maintenance Organization in the US. It is classified as commercial health insurance providing in kind benefits managed by various care techniques. The JPKM concept was introduced by the Health Act of 1992. More significant actions to promote the development of JPKM have been taken since 1995. Since then, the Ministry of Health has been actively promoting JPKM to various actors such as local governments, private businesses, private insurance companies, and communities at large. The promotion of JPKM aims primarily at encouraging the private sector, mainly businesses, to develop bapels (HMOs). A Ministerial decree regulates requirements to be bapels, which are basically insurance carriers mandated to provide comprehensive health benefits at the network of providers and to pay providers on capitation payment system. Bapels must meet capital requirements that are much less than the capital requirements for insurance companies under the Insurance Act (it can be less than 0.1% of the required capital for insurance company). In addition, bapels must provide comprehensive health services, quality assurance, utilization review, grievance procedures, and other cost and quality controls. Businesses that are willing to comply with and meet requirements will be granted a licence by the Ministry of Health to sell JPKM. However, those requirements are good only in theory; in practice, no bapel provides all capitation payment and quality assurance. Presently, the majority of licensed bapels are actually selling a combination of managed care and traditional insurance products.

There are 22 licensed bapels (commercial HMOs) covering less than 500 thousands individuals. More than 90% of those bapels are in the form of *Perseroan Terbatas* (a limited liability corporation, for-profit entity). Compared

[30] Paper presented at the First National Conference on Health Insurance, Jakarta, November 9-11, 1998

to the regulation of HMOs in America where at the beginning of HMO introduction, 96% of HMO were not-for-profit organizations,[31] the JPKM regulation is much more liberal.

Although the Ministry of Health had to work hard to promote and develop bapels, the result was not promising. All licensed bapels could not expand memberships to poor families since the majority of bapels are for-profit entities seeking profits. Several pilot projects funded by the USAID and the World Bank had been undertaken in Klaten district and five other districts under the Health Project IV. Unfortunately, those pilot projects promoted business of managed care in small and relatively low-income districts. The premiums were set too low, without actuarial calculation, of inferior products. Definitely people, even the poor ones, would not buy those inferior products. The results were obviously very disappointing.

Efforts to encourage businesses and insurance companies to establish bapels and expand memberships have not been fruitful. The conflicting concept of JPKM that combines business and social interests at the same time and low capacity of personnel in the ministry of health did not convince businesses. Many insurance companies and even health officials within the Ministry of Health felt skeptical about JPKM. Currently, under heavy criticism, the expansion of JPKM is on hold.

Traditional Health Insurance

Before 1992, many big companies provided health benefits to their employees on voluntary basis. The scope of health benefits varied significantly from cash benefits, reimbursements, in-kind benefits, or self provision of clinics or hospitals by the companies, depending on the size and location of the companies. There were no regulation-mandating health benefits or regulating health benefit provisions. Many smaller companies often did not (some still do not) provide health benefits at all. The bargaining power of labour unions was normally weak and they rarely demanded health insurance coverage.

An Insurance Act was passed in February 1992 permitting insurance companies to sell health insurance products. The Ministry of Finance was the sponsoring agency to regulate insurance companies. However, this Act does not regulate health insurance contract. It regulates insurance business practice

[31] ___ Managed Care: Integrating Finance and Delivery of Health Care. HIAA, Maryland, 1997

in Indonesia such as life insurance, general insurance, reinsurance, and other supporting insurance businesses. Based on this Act, insurance companies may sell any health insurance products such as traditional indemnity, managed care (similar to JPKM), personal accidents, and other forms of health insurance. The Directorate of Insurance under the Ministry of Finance is in charge to oversee and control mainly the financial performance of all insurance companies.

After the introduction of the Employees Social Security Act (*Jamsostek*) in the same year, both life and general insurance companies, started to sell health insurance as riders or as separate lines of businesses. Many insurance companies that had long relationships with businesses for life or general insurance could easily negotiate to expand their lines of businesses by offering health insurance to employers. Several foreign insurance companies such as Cigna, Aetna, and Allianz that had experiences abroad could easily transfer the knowledge and expertise to sell health insurance in Indonesia. Although there are relatively a small number of companies that can afford to buy private health insurance, since the population is big, the market for health insurance is promising. By 2001, 64 insurance companies were selling health insurance products covering more than four million people. The total premiums earned by those companies in 1999 was about Rp 700 billion, more than five times the amount of health insurance premiums earned by *Jamsostek*. These traditional health insurance products are the fastest growing business of health insurance in the country.

Micro and Community Health Care Financing Schemes

The Ministry of Health introduced the concept of micro financing scheme called *Dana Sehat* or health fund in the 70s. At that time, it was conceived that the government fund for health would be diminished because the government financing would not be sufficient. Under this assumption, the traditional very low user charges in public health facilities would result in government financing for those who really did not need the government subsidies. The government financing for public health facilities had not been reaching the right population groups such as those who deserved government subsidies and therefore there were suggestions to increase the user charges. Recommendations to increase user charges in public facilities were made by Gani et al. (1997)[32] and YPKMI (1994)[33]. However, higher user charges might

[32] Gani, A. dkk. Laporan Analisis Biaya dan Penentuan Tarif Rumah Sakit dan Puskesmas di Propinsi Jawa Timur. Biro Perencanaan Depkes dan LDUI, 1997

pose a threat to access to health services of low-income groups. Therefore, private funds must be mobilized to finance health care of such groups. The *Dana Sehat* initiatives were introduced to respond to such recommendations. The same initiatives have also been introduced in many developing countries such as reported by Musau (1999)[34], Atim et al. (1998)[35], and Edmond (1999)[36]

However, *Dana Sehat* schemes in Indonesia have not addressed the access problems due to very low benefits and limited coverage. Households have been spending very low percentage of their total expenditure on health, ranging from 2-4% of the total household expenditures. This low health expenditure from household sources represents the low ability to pay for health services. Data from Susenas show that many households in low and lower middle income must spend up to 80% of the household income on foods. Therefore there is little money left to purchase other services and goods such as health care and education. The *Dana Sehat* schemes were introduced mainly to the poor and low-income households by setting the contributions based on consensus among those households. This targeting was a big mistake, since the low-income households are supposed to receive financial assistance while those in higher income should actually ought to contribute to the health funds. As a result, the contribution was set at very low levels, ranging from Rp 100 – Rp 1 000 (between US 10-20 cents at the current exchange) per household and the benefits were mostly outpatient care at health centres. On the other hand, in the majority of districts/municipalities, people could get access to health centres for Rp 1 000 (US$ 0.10) per visit. This is one reason why efforts to mobilize resources through *Dana Sehat* have been fruitless and not sustainable. There was no incentive for households to contribute to health funds when the household could pay health centre services for the same prices.

[33] ___ Laporan Analisis Penentuan Tarif Pelayanan Kesehatan di Propinsi Kaltim dan NTB. YPKMI dan LDUI, Jakarta 1994

[34] Musau, N. Community-Based Health Insurance (CBHI): Experiences and Lessons Learned from East Africa .Technical Report 34, Partnership for Health Reform, 1999

[35] Atim, Chris, François P. Diop, Jean Etté, Dominique Evrard, Philippe Marcadent, and Nathalie Massiot The Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care in West and Central Africa: Summary and Case Studies in Six Countries, Technical Report 19, May 1998

[36] Edmond, A H., Mary A. Paterson, Ahsan J. Sadiq, Linda M. Sadiq, Susan Scribner, and Nena Terrell. Establishing a Family Health Fund in Alexandria, Egypt: The Quality Contracting Component of the Family Health Care Pilot Project, Technical Report 42, December 1999

A study by Thabrany and Pujianto using the National Socioeconomic survey in 1998 found that only 1.87% of the population were holding health cards or were members of health funds. The 2001 Susenas indicated that 0.43% of the population were holding this card. There was no significant improvement in the access to inpatient care among the health fund members, but there was about 47% higher utilization of health centre services among the members compared to those who were uninsured or non-members. Studies by Silitupen[37], Iriani[38], and Asnah[39] indicated that very few households paid contribution for more than two consecutive years. The studies found that drop-out rates from the first year to the second year of health funds were between 60-90%. It is not surprising that since the introduction of this scheme in the '70s, there has been very little progress on such health fund schemes. After the social safety net programme for about 18 million poor families was introduced during the crisis, *dana sehat* schemes across the country were discontinued[40].

Social Safety Net Schemes

The social safety net programme concept consists of three different types of financial assistance to ensure that the poor get access to necessary health services. There were three different programmes in the health sector: (1) The first programme targeted high-risk pregnant women by providing a block grant of Rp 10 000 per poor household directly to a village midwife. The midwife then could use the fund to refer high-risk pregnant mothers to a health centre or hospital for further treatment such as drugs, services, or transportation costs. This programme increased access to hospital services for quite severe cases such as bleeding and complicated delivery.[41] (2) The second programme was the promotion of JPKM (a model copied from health maintenance organizations in the US). This programme promoted the development of pre-JPKM bapels (pre-HMOs) by providing a fund of Rp 10 000 per poor family to companies, cooperatives, or foundations seeking to establish an HMO in each

[37] Sillitupen, valens. Evaluasi Perkembangan Dana Sehat di NTT. Tesis, FKMUI, 1998

[38] Iriani, R. Faktor-faktor yang berhubungan dengan kesinambungan Dana Sehat di Kabupaten Bogor. Tesis, FKMUI, 1999

[39] Asnah. Faktor-faktor yang berhubungan dengan kesinambungan Dana Sehat di Lampung Barat, Tesis, FKMUI, 2001

[40] Azwar, R. Evaluasi program JPKM-JPSBK di Jakarta Selatan, Tesis, FKMUI, 2001

[41] Hasan, F. Evaluasi Program JPSBK terhadap Kehamilan Risiko Tinggi., Thesis December 2000

district. The pre-bapel retained 8% of the funds for administration and marketing HMO products to the non-poor households. The objective was that after two years the pre-bapels could expand membership to non-poor by selling HMO products. Immediately, 354 pre- bapels were created–the majority of those pre bapels were established by civil servants, pensioners or cooperatives of civil servants within district health offices. They had no experience of developing and selling HMO products. After one year, under heavy criticism, this programme was terminated and the funds for the second year were not distributed. Evaluation of pre-bapels in east Java and in south Jakarta revealed that the pre-bapels had no prospect to become full HMOs (Ekowati[42] 2000; Azwar 2001[43]). (3) The third programme was the assistance for health centre services by providing block grant of Rp 10 000 per poor family to all health centres. The health centre could use the money to buy drugs for the poor to supplement essential drugs supplied by the government. (4) In addition, public hospitals received some block grants for operational costs to care for the poor. The programme improved the access to the poor significantly. However, those who are marginally poor (not qualified for assistance such as self-employed, part-time workers, seasonal workers, and farmers, who are unable to pay for expensive medical care) still have financial problems to meet their medical needs. It was reported (Khumaedi, 2000) that more than 90% of beneficiaries were actually poor, met the means test, and about five per-cent of the beneficiaries could actually for pay part of the care.[44]

Other Problems in Access to Health Care

Health insurance for Indonesians is available from various sources. The oldest and largest health insurance scheme is the civil servant health insurance *(Askes)* established in 1968. The civil servant health insurance is a social health insurance covering all civil servants, retired civil servants, retired military personnel, veterans, and their families. The premium is two per-cent of monthly basic salary or pension that is deducted automatically by the Ministry of Finance. The benefit is comprehensive and provided in kind in public

[42] Ekowati. Faktor-faktor yang berhubungan dengan kemandirian pra bapel JPKM-JPSBK di Jawa Timur., Tesis, FKMUI, 2000

[43] Azwar, R. Faktor-faktor yang mempengaruhi utilisasi JPKM JPSBK di Jakarta Selatan. Tesis, FKMUI, Depok 2001

[44] Khumaedi. Evaluasi program JPSBK di RSU Tangerang. Thesis, FKMUI, Depok 2000

health facilities, but high cost sharing applies. The second largest health insurance scheme is the social security scheme for private employees (*Jamsostek*). In theory, this scheme should cover all private employees, but the regulation was diverted to have opt out provision. Unlike the *Askes, Jamsostek* started in 1992 after the law of Social Security was passed. The opt-out provision of *Jamsostek* allows private insurance companies to sell various types of health insurance such as indemnity insurance, service benefits, and managed products. In addition, since 1992 the Ministry of Health has been promoting JPKM bapels (Indonesian version of controversial health maintenance organizations) as non-insurance companies selling HMO products. At present there are 67 insurance companies and 22 licensed JPKM bapels selling health insurance in Indonesia.

Health insurance coverage has been very low in Indonesia. A reliable source of health insurance coverage is the National Social and Economic Survey *(Susenas)* conducted annually by the Bureau of Census in Indonesia. Every three years, the survey includes a module of health survey specifically collecting health insurance coverage by types. The *Susenas* data of 1998 showed that only 14% of the population had health insurance of any type.[45] The *Susenas* 2001 showed that 20% of the population had health insurance, but 6% of the population had health insurance from the government social safety net programme for the poor. About eight per cent of those insured are covered by *Askes*; a state-owned company that administers compulsory health insurance. *Jamsostek*, another state-owned company that administers social security schemes, covers less than 1.5% of the population (the potential of this scheme is about 40-50% of the population). The low health insurance coverage by *Jamsostek* is mainly attributed to the "opt out" provision in the government regulation number 14/1993. Other private insurance companies and JPKM bapels cover the remainder of the insured. For more than a decade the proportion of Indonesians who have health insurance remained relatively stable. In 1990, the data published by the World Bank gave the proportion of the population with health insurance as 13% (World Bank, 1993). However, the absolute number of population covered has increased by almost ten million in the last decade due to the population increase. So the growth of health insurance coverage is about the growth of the population. Most of the

[45] Thabrany, H and Pujianto. Asuransi Kesehatan dan Akses Pelayanan Kesehatan.Majalah Kedokteran Indonesia, 50(6), Juni 2000. 282-289

growth of health insurance coverage occurred in the last two years. After the economic crisis, the growth of private health insurance coverage increased sharply due to increasing health care costs in the private sector. The HMO products sold by *PT Askes* currently cover 1.3 million people while the number of people insured by other insurance companies in 2001 has reached almost five million.[46] An employer survey found that 82% of employers having 20 or more employees in Indonesia provide various kinds of health benefits, including purchasing private health insurance for their employees.[47]

Access to health centres

Primary health care in Indonesia is delivered through public health centres and private clinics or doctors in sole practices. For 85% of the population who do not have health insurance, access to primary health care varies according to their economic status, individual preference, and availability of transportation to health facilities. Local governments normally set user fees in health centres at a very low level so that all people can afford. After the Regional Autonomy Law is implemented, local governments will tend to raise user fees in order to recover the costs of providing basic health services that were funded by the Central government. User fees vary from Rp 500 to Rp 5 000 per visit including three days of medications across districts and provinces. The quality of services at public health centres, and sub health centres, are considered very poor such that the majority of the better off do not use health centres' services. Instead, they go to private practitioners in the evening, often the same doctors who provide services in health centres in the morning. Private practitioners in the evening aim to supplement their low income in the form of government salaries. Some policy-makers are considering increasing user fees so that the health centres will have adequate funds to maintain a certain level of quality. The trade off is that the poor or marginally poor may be excluded from services unless another scheme is in place.

Because user fees in health centres have been very low (less than the price of a bottle of drinking water) almost all people can afford to pay for the services.

[46] Djaelani F. Health Insurance Development. Paper presented at the Asia-Pacific Summit on Health Insurance, Jakarta 22-26 May 2002

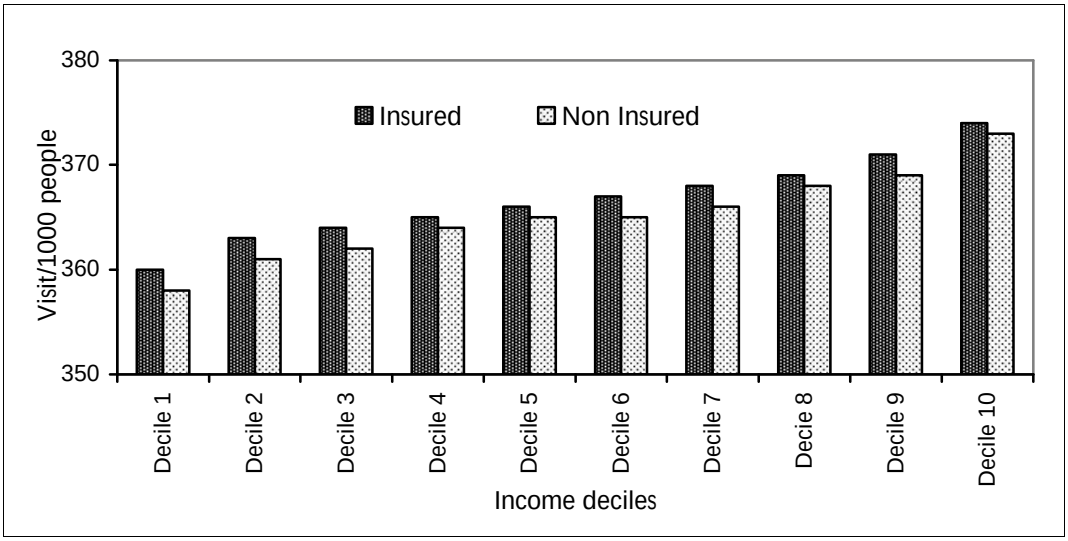
[47] Chusnun, P. et al. Laporan Final Studi Pembiayaan Kesehatan oleh Perusahaan. Pusat Kajian Ekonomi Kesehatan Universitas Indonesia, Depok 2002

Often the problem is not in the price of services, but in the transportation costs. In rural areas, only one health centre or sub health centre is available for several villages or even for one sub-district. The travel costs to health centers can be the same or ten times more than the user fees set by local governments. Numerous studies have reported that access to health centres is good only for those living within one to two kilometers from the health centre. Beyond that, many people have geographical barriers to health centres. Formal workers who normally live in relatively urban areas may not have geographical barriers to the services. To overcome geographical barriers, the government provides mobile health centres which visit remote villages on certain days. The availability of public health centres (stationary, mobile, and sub-health centre) and low user fees make access to primary health services quite good for all levels of communities. The better off who demand better services may visit private doctor in the afternoon. The chart below (Figure 2) depicts the relatively equitable access to primary health care for all groups of the population (Thabrany 2001)[48].

Figure 2 shows that the number of visits to a primary care centre per a thousand people by income deciles, from the poorest ten per cent to the richest ten per cent of the population, do not differ significantly. In other words, there has been equitable access to primary health care in Indonesia. There are some differences, however; 15 visits per thousand people between the poorest ten per cent and the richest ten per cent of the population (Figure 3). The poorest ten per cent on an average had 358 visits per thousand people per month while the richest ten per cent had 373 visits per 1 000 people. There were minor differences in primary health care centre visits between the insured and the uninsured. These minor differences were due to low health centre fees, adequate distribution of health centres, sub health centres, nurses, general practitioners, and mobile health centres. If we examine the rate of visits to private doctor's services, the differences between the poor and the rich are quite high. However, those who had low access to private doctor's services had options to visit public health services with almost no barriers. This equitable access may diminish if local governments transform public health centres into *swadana* facilities and raise user fees.

[48] Thabrany, H. Hospital and Health Insurance. Paper presented at Hospital Seminar and exhibition center, University of Indonesia, August 27-29, 2001

Figure 4. ***Visit rates per 1,000 people for any outpatient care by income deciles, Susenas 1998***



One important factor for equitable access to primary health services is the proximity of those services to the population. The Indonesian health policy mandates local government to build one health centre for every 30 000 inhabitants and one sub-health centre for every 10 000 inhabitants. A public health centre has staff of at least one physician (general practitioner), several nurses and midwives, and administrative staff; while a sub-health centre has at least one nurse or a midwife plus administrative staff. There are currently more than 7 000 health centres and more than 21 000 sub-health centres through out Indonesia.[49]

Access to hospital services

Hospital services are available only in the capital of a city or district. Although the government has built one small hospital for every district with at least fifty beds and four types of specialists (internist, pediatrician, surgeon, and obstetrician), the hospital is quite a distance away from the rural residential areas. A district can cover an area as wide as tens of thousands of square kilometers. In several large districts or municipalities there may be a private hospital. The majority of districts have only one public hospital. Geographical access to public hospital is more difficult than access to a health centre.

[49]. Health Profile 2000. Pusdakes MOH, Jakarta, 2001

Drugs and other medical supplies are neither free of charge nor included in user fees in public hospitals. Patients must pay extra for medicines and medical supplies they need. In addition, a public hospital charges the patient for each item of all other services. These kind of charges act as financial barriers in meeting the medical needs of patients.

Although local governments normally set low user charges for hospital confinements, the true costs of a hospitalization may increase 3-10 times of the low cost of room and board. As an illustration, in one public hospital in Jakarta the room charge for third class services is only Rp 15 000 per day. A patient needing a surgical procedure and hospitalized for three days may end up receiving a bill upon discharge of Rp 900 000 covering the cost of operation, drugs and medical supplies. A blue-collar worker earning Rp 650 000 (minimum wage) in Jakarta and having no insurance must spend more than one month of her/his salary.

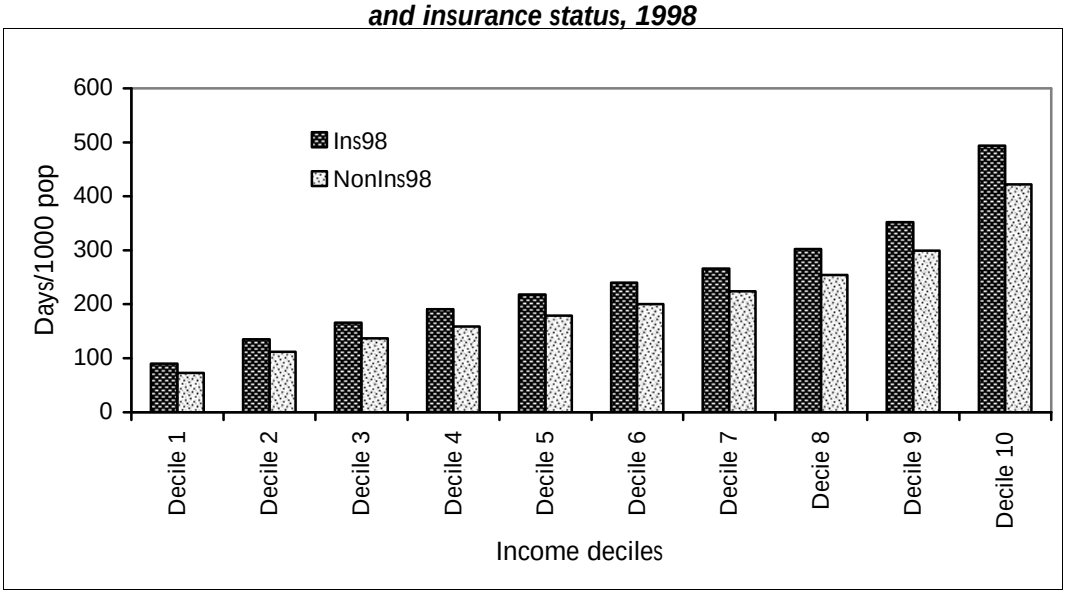
Hospital services are designed to provide secondary or even tertiary care by specialists. However, on many occasions the specialists are not always available in public hospitals because they often spend more of their time in private hospitals or in private wards in the same public hospitals. This is especially true in big cities. The low-income patients feel satisfied if one or two specialists visit them regularly. Such conditions show public hospitals in poor light. Many patients are pushed to utilize second class wards or above to receive better quality services, but then they have to pay more and there is almost no chance to have exemption or reduced charges.

Many low-income families simply do not go to hospitals because they feel that the costs of hospitalization are not affordable. As a result, there is great inequity in access to hospital services, even at public hospitals. The barriers can be geographical, cultural and financial. Financial barriers remain the largest factor. Figure 4 shows the large gaps in access to inpatient care in public hospitals between the poor and the wealthy (Thabrany, 2001). The richest 10% of the population had more than 400 hospital days per 1 000 people and members of *Askes* and *Jamsostek* (insured) had more than 500 hospital days per 1 000 people, higher than those of non-insured. On the other hand, the poorest 10% of the population and uninsured had less than 100 bed days per 1 000 people. The gaps regarding inpatient days between the poor and the rich among *Askes* members remain high because the benefits are inadequate. According to many studies, insured civil servants before the year 2000 had to pay up to 80% of the hospital costs and drugs

(Trisnantoro et al. 2000[50]; Thabrany 2001[51]). However, currently *Askes* pay much more reasonable level after the government increased the basic salary of civil servants and contributed some funds to *Askes*. In several hospitals now, civil servants are exempted from cost-sharing except for few expensive procedures.

A study by Thabrany et al. (2000) found that the poorest 10% of the population had to spend 230% (2.3 times) of monthly total household expenditure for one inpatient care (Figure 5). Even the upper income class households on average have to pay more than one month of their salary to pay for inpatient care of their family members. Despite low cost recovery rate of public hospitals, most low-income households do not get access to inpatient care because of costs of medical procedures and expensive and non-subsidized drugs.[52] Figure 4 and Figure 5 indicate high correlation between low inpatient days, household income, and high financial burden for inpatient care. This financial burden will continue or even become heavier for households in the future because of transformation of public hospitals and lack of insurance coverage.

Figure 5. ***Hospital inpatient days per 1 000 people by income groups and insurance status, 1998***

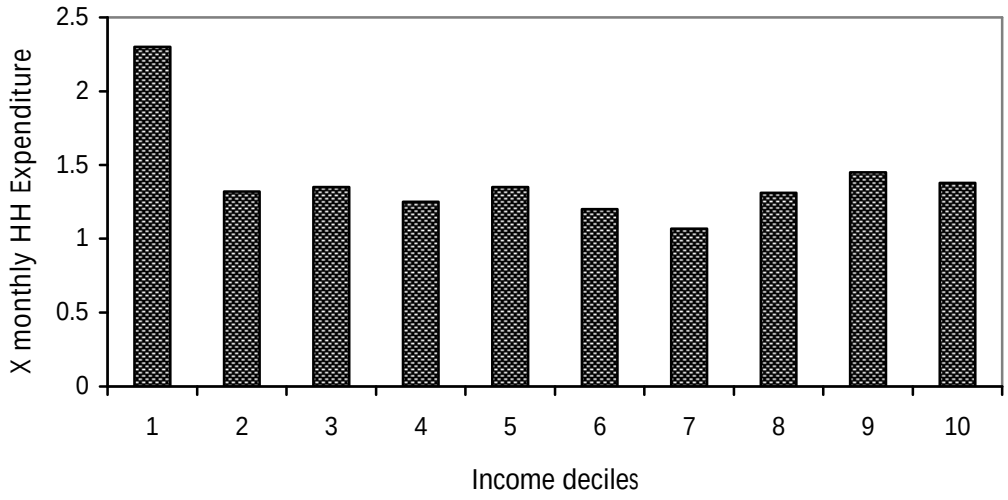


[50] Trisnantoro, et al. Evaluasi RS Pasar Rebo dalam era desentralisasi, PPEK UGM, Yogyakarte, 2000

[51] Thabrany, H. Perbaikan Askes Pegawai Pemda DKI. Unpublished. Jakarta 2001

[52] Thabrany, et.al. Comprehensive Review of JPK in Indonesia. Yayasan Pengembangan Kesehatan Masyarakat Indonesia, Jakarta 2000

Figure 6. ***Average financial burden of households (times household monthly expenditure) for one admission by income deciles***



Quality of health services

The quality of health services, especially in hospitals, is difficult to measure because there is no standard, both in clinical and administrative services. The clinical standard developed by the Indonesian Medical Association provides only about 200 medical conditions/procedures and it is not widely accepted by specialists. Physical appearances of public hospitals and health centres generally are not attractive for middle and upper class. Upper class households generally perceive hospital services, even private hospitals, as providing poor quality services. Therefore, high class people and government officials often prefer to have medical procedures abroad, leading to large trade deficit in health sector in Indonesia.

One of the important measures of quality is user satisfaction. However, no national user satisfaction survey has been conducted in public or private hospitals. In general, policy-makers admit that the quality of services in Indonesia, especially in public providers, is poor. Evidence shows that many patients go to Singapore, Malaysia or Australia for treatment. This is an indicator of poor quality health services in Indonesia. The poor quality of public health providers may also be judged by the fact that middle-and high-

income people tend to use private providers rather than public providers. Few facility surveys showed that 80-90% of patients were satisfied with services of public providers (Warnida, 2001[53] and Neneng, 2000[54]). Some doubt the validity and reliability of such surveys. Accreditation of hospitals is not an indication of quality, since the accreditation process emphasized only structural measures.

One of the more objective measures of quality is to examine how people choose medical care when they have options. The *Susenas* 1998 and 1999 data showed that even those who were covered by health insurance under *Askes* chose private health care facilities not covered by *Askes*. This means that those people prefer to utilize health care from the providers they believe are providing better quality, even though they have to pay out of their own pocket. The proportion of insured civil servants who utilized outpatient care from private providers paid the full costs accounting for about half of the total visits.[55] In general, people perceive that services in public providers, both outpatient and inpatient services, are of poor quality. The *Jamsostek* scheme that uses public health centres as gatekeepers attracts only those in the lower income bracket.

Grand Design of Future Social Health Insurance in Indonesia

Currently two designs have been identified of social health insurance systems. The first one is the design proposed by the Task Force for National Social Security that integrates National Health Insurance into other social security programmes. The Task Force was established by a Presidential Decree to meet the Constitutional Obligation (article 34 item 2) to establish social security for all citizens. This design will be further described in this paper. The other design is the proposal of compulsory health insurance with multiple HMOs submitted by the Ministry of Health. Under this scheme, all people are mandated to contribute to a selected bapel. The bapel must have a licence by the MoH after meeting certain capital requirements.[56] This concept is actually promoting the business of managed care (previously known as JPKM). The second design will not be described in this paper.

[53] Warnida, Faktor-faktor yang mempengaruhi kepuasan pasien di Paviliun Kartika, RSPAD, Skripsi FKMUI, 2001

[54] Neneng. Kepuasan pasien Askes dan Non Askes terhadap rawat jalan di RSU Bekasi, Tesis, FKMUI, 2000

[55] Thabrany, H and Pujianto. Analisis utilisasi peserta Askes dari Susenas 98. Pusat Ekonomi Kesehatan, FKMUI, 1999

[56] Ministry of Health. Rancangan Undang-Undang Jaminan Kesehatan Nasional, Jakarta, February 2003

Indonesia is a very large country with 203 million people scattered in about 7 000 islands. The labour force is estimated at about 98 million people. The labour force comprises: 36.2% of wage earners and salaried workers; 51.9% self-employed; 3.4% employers, and 8.5% family workers.[57] The self-employed people are farmers, individual retailers, and very few self-employed professionals. With only one third of labour force in formal sector (salaried workers) it is not easy to mobilize financial resources to finance health care for the entire population. In addition, income per capita of Indonesians is relatively low (US$ 700 at official exchange rates) with little disposable income for health insurance contributions. The low per capita income significantly affects household expenditures in Indonesia. The National Socioeconomic Surveys showed that between 50-70% of household expenditures in 1995 to 2000 were for foods. The disposable income becomes very small for the majority of the population.

A social health insurance system relies on contribution from employees and employers or employees only for the self-employed persons. The social health insurance system must start from formal sectors without "opting-out" provision, to allow higher income individuals share the risk with low-income workers. There are problems in determining and collecting contributions from those who work temporarily, who are self-employed, or seasonal workers. Many of temporary and seasonal workers work without a contract binding and they are paid daily or weekly by employers. Employers often do not count them as employees. The universal coverage through social health insurance means must be implemented gradually in accordance with the above situation. In addition, the scope of health services covered may be limited in accordance with the level of income and the feasibility in collecting contributions from employees and employers. The design should not enforce the informal sector to join until after all workers in the formal sector are covered.

For those people in low income bracket but in salaried jobs, they may be forced into the system with relatively low effect on their daily consumption. Even if the employees earning a low wage must contribute half of the contribution of 6% salaried workers, it may not affect their normal consumption significantly. However, if the total employee contributions for various social security programmes are above 15% of their wages, the low-salaried employees' may confront significant problems in their daily lives.

[57] Irawan, PB; Ahmed, I; and Islam, I. Labour Market Dynamics in Indonesia. ILO Jakartta, 2000

To be fair, poor and low-income people or non-salaried workers should be entitled to free or subsidized medical care funded from general tax revenues. These kinds of medical care are available in public health centers and some are also available public hospitals. Although the quality of services in public health centres or third-class public hospitals is not good to middle class standard, it is accepted by the low-income people. It is easier and more efficient for the government to provide health cards by which the low-income members are entitled to receive reduced charges or with a small co-payment in public health care facilities rather than asking them to pay regular contribution for a SHI scheme. The poor that are already identified could be provided with membership of a SHI scheme where the government pays the contribution on behalf of the poor.

Figure 6 depicts how the National Health Insurance system will work in the future. The main feature of the design are as follows:

(1) All salaried workers, and pensioners in the public and private sector regardless of their income level, are mandated to join the NHI. The employers are mandated to deduct 3% of their employees' salary (needs further actuarial study) and employers add another 3% of employees' salaries for contribution to the NHI. Pensioners must contribute 6% of their monthly pension income. There will the same level of contribution for singles and married employees to simplify administration and to strengthen the social solidarity principle. Within the next five years the compulsory scheme must be imposed on those employers with 10 or more employees, regardless of the legal status of employers. A for-profit corporation, a private hospital, a government unit, a nongovernmental organization, a university etc. are mandated to join the NHI. Expansion of membership will be enforced gradually to include employers with one or more employees by the tenth year of the implementation. Employers must pay the contribution to Social Security Trust Fund (*Badan Administrasi Jaminan Sosial Nasional)* account along with contributions for other social security programmes.

(2) Those who are not satisfied with the compulsory scheme may purchase supplemental health insurance from private insurance companies or pay directly to providers for differences in prices of preferred services. But they are not allowed to completely opt out of the compulsory health insurance scheme. Their entitlement of benefits from the compulsory scheme can be coordinated with a private health insurance scheme.

(3) Self-employed professionals such as physicians, lawyers, brokers, agents, etc. are mandated to join the compulsory scheme. The contributions

may be based on the mean reported taxable income in a region and paid directly by the professionals on monthly basis along with the payment of monthly income tax. All people in this group must also be covered by 2015. The Actuarial Committee of the NHI will calculate the levels of contributions annually for each region.

(4) On Figure 6, the income curve line of salaried and self-employed professionals (bold line) moves to the right (there will be more people belonging to this group) as time goes by and the economy of the country is improving. This means that the members of the compulsory scheme are automatically expanding as formal employment covers more people.

(5) On the other hand, the incomes curve line for non-salaried workers (dotted line) will not move because this line also represents total population. As economy is progressing and more people are expected to enter into salaried or professional services, the number of non-salaried people will reduce. This process is expected to take 20-25 years.

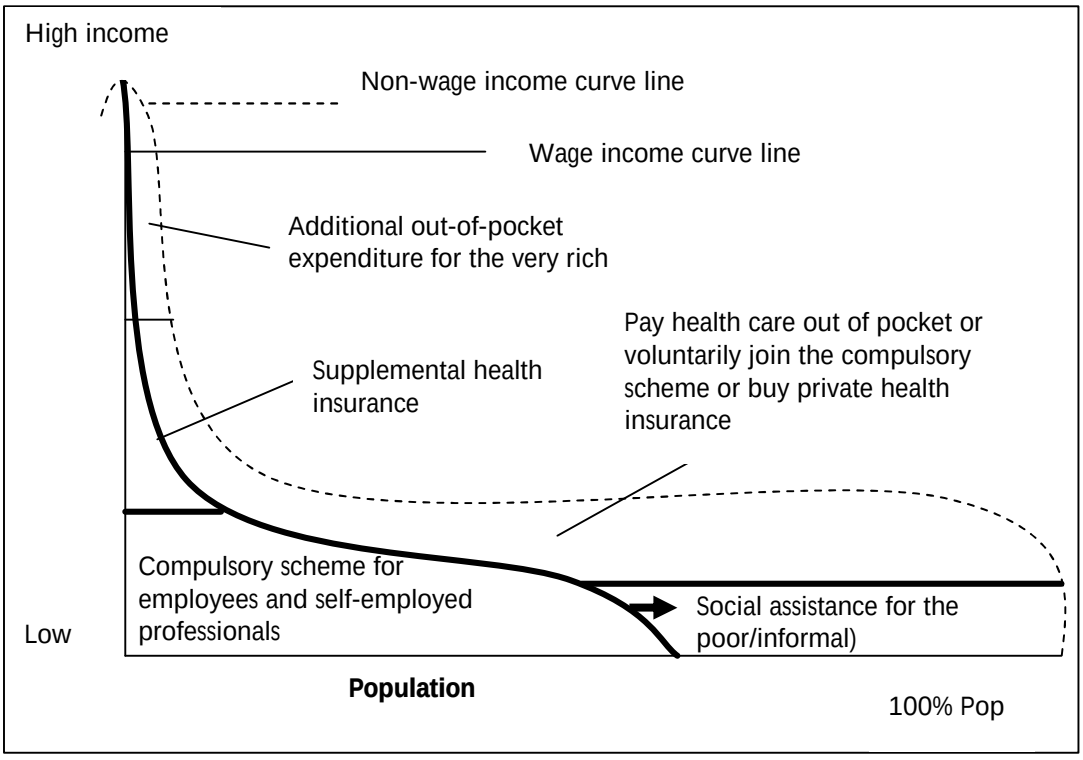
(6) The poor and marginally poor (low-income) in the non-salaried workers (under the bold horizontal line on the right) will be provided with financial assistance from the government and/or other charitable organizations. Financial assistance from the government is subject to a means test. Money for this assistance will be taken from general tax revenues or from the reduction of direct financing for health care providers or other subsidized services. This group can be divided into two sub-groups:

- The very poor will receive financial assistance by receiving membership in the NHI for free. The government will pay the contributions for this group. The number of people in this group varies across regions. Local governments are responsible for identification of the poor by a means test developed nationally and adjusted locally. These people could be covered the same way as the continuation of the existing social safety net programmes that was terminated in 2002.
- The low-income people and non-salaried (self employed) who do not pass the means test (marginally poor) will still not be able to afford the expensive medical care. This group must be provided with financial assistance for inpatient care and surgical procedures. However, this group should pay outpatient care, at least in public providers. The NHI will enforce these people to join the NHI at a later stage. However, they are free to join in the early stages on voluntary basis.

(7) Those who are not in the low-income group of non-salaried workers may pay health care out-of-pocket in public or private providers depending on their income or they may voluntarily join the compulsory scheme or purchase individual health insurance from private health insurance companies. The NHI will enforce membership on this group if all-salaried workers, the elderly, and poor are already covered. Once this group enters the formal sector by becoming employees, then they are mandated automatically to join the compulsory scheme.

(8) If the country's tax system improves significantly, thereby allowing the income of persons joining as members later, to be identified and if contributions, either monthly or annually, could be collected regularly, then they will be mandated to join the compulsory scheme. They may still purchase supplemental health insurance from the market if they perceive that the quality of services provided by the compulsory scheme is not adequate.

Figure 7. ***Grand Design of Social Health Insurance Scheme in Indonesia***



The revised compulsory health insurance scheme will focus (first) on those who are not currently covered either by *Jamsostek*, private health insurance, or enterprise provided health benefits. Gradually, after five years of enactment of the law, those who are not in the system but who are currently covered under various schemes must join the system. This expansion will be accomplished by consistently provided quality of health coverage with less cost to employers and employees. It is expected that those who are currently covered under various health insurance systems will voluntarily join the scheme because they will realize that they can get adequate benefits with less money. The stages will be implemented as per the following agenda (Table 5).

Table 5. *Agenda to cover the whole population under the proposed National Health Insurance*

Year	Stage	People covered	Scheme
2004-2009	I	Formal (waged) employers of > = 10 employees, self-employed professionals, and pensioners in the private sector are mandated to enrol under NHI	Social health insurance
2004-2009	I	Small employers (< 10 employees) and self-employed can enrol the compulsory scheme voluntarily. Those who are currently covered under private insurance scheme may switch over voluntarily to the NHI	Social health insurance is not enforced
2004-2009	I	The poor and the marginal poor of informal sector (non-waged) are covered gradually starting from the very poor. Self-employed in upper income levels may join the NHI or purchase private health insurance	Social assistance, free health care at public providers or from charitable organizations, or buy private health insurance
2009-2014	II	Small employers (< 10 employees) and self-employed in low income are mandated to enrol in the NHI All employers who are currently purchasing private health insurance must join the NHI, but may still continue to purchase supplemental health insurance	Social health insurance is enforced for all employers
2015-2030	III	All groups must be covered by the NHI	Social health insurance and social assistance for the poor

Health Benefits to Be Covered and the Related Contributions

The compulsory health insurance scheme cannot be separated from the existing health care delivery system. Generally, public health care delivery system is considered as providing poor health services in term of amenities and physical appearance of the facilities. The public providers are heavily subsidized, ranging from 70-80% of the total investment and operational costs.[58] In practice, most high-income people do not use health services in public providers except services offered in the private wings of the public providers. On the other hand, private health care providers must provide (perceived) better quality services to be able to attract significant number of users. Under the current regulation, private hospitals are required to provide 25% of beds for the poor to supplement inadequate public providers. In exchange, private hospitals may receive assistance from the government in the form of building construction, medical equipments, or cash money. But in general, the charges for the poor are still relatively more costly than the charges for the same services in third class public hospitals.

One of the important elements of the NHI scheme, for it to be sustainable and attractive, is the benefits that must be acceptable by those in upper-income bracket. The lower-income brackets definitely will be happy to receive better quality services than they normally get from the public providers. Therefore, the benefits must be offered from private providers or private services in the public providers. To be efficient and in order to prevent moral hazards, the benefits must be provided in kind, and not in cash. The scheme should not provide benefits from public health centres or third-class public hospitals, except in areas where a private provider is not available. Inpatient care must be provided at least at the second-class public hospitals and in private providers. Since the level of second-class rooms and boards (semi-private) in public hospitals are lower, the public hospitals must upgrade the semi private rooms and board to be eligible to contract with the NHI. This will finally increase the overall health care expenditures. But this is necessary for a successful NHI. The providers (both public and private) must have certain standards of service to be eligible to contract with the NHI.

The benefits should be comprehensive with some cost-sharing. Cost-sharing for outpatient care must be higher: proposed at 30% of the charges set through negotiations between NHI branch and the association of health care

[58] Gani, A. et.al. Laporan Mobilisasi Sumber Dana Proyek Kesehatan IV. FKMUI-LDUI, Depok 1998

providers in a region, and facilitated by a provincial and district health offices. Cost-sharing for inpatient care and expensive medical procedures is proposed at 10% of the charges, subject to maximum of one-month minimum salary in the region. Drugs will be covered, based on a drug formulary developed by a Committee in the NHI. The NHI will conduct utilization review to audit appropriateness of medical procedures and treatments given by contracting providers. When there are no adequate providers in a region where the number of members is relatively adequate, the NHI is responsible for establishing or contracting providers, even by contracting foreign doctors if necessary.

The actuarial calculation of contributions which would suffice to bring in necessary revenues must be based on the costs of providing the above level of care. The contributions must also take into account the financial requirements to provide services for pensioners. The actuarial calculation must be conducted very soon and the level of contributions must be adjusted periodically to reflect increasing costs of health care. It is suggested that the level of contribution should not be fixed in the law since revision of a law may take years. The Government Regulation will set the level of contributions after careful calculation and study by the Board of Trustees.

Allocation of Health Insurance Revenues

The NHI is the design to be financed by two main sources of revenue: contributions from those who have regular income and contributions from government for the poor. A nationwide employer survey found that in 2001 on average, an employer spent 5.2% of employee salaries for health (Chusnun, et al., 2002). The proposed contribution of 6% salary paid by employer and employee will not be an additional burden for both employers and employees. Additional revenue will come from investment of idle funds and reserves.

Because the nature of SHI is to maximize benefits for all, the NHI is designed to be very efficient. Therefore, the Task Force decided to have a single payer system organized by a National Trust Fund. In the first five years, when the number of contributors will be relatively small, the administrative expenses may not exceed 15% of revenues from contributions. As membership grows, the administrative expenses will be reduced (economies of scale) to a maximum of 5% of contributions in the 11th year of implementation and beyond. Any surplus from the operation will be

deposited as reserve funds. The five per cent administrative costs will be shared for national and regional expenses, including performance incentives for employees of the NHI. Employees of the NHI may not be civil servants. Currently, the *Askes* scheme spends between 10-15% of the total premium revenues for administrative expenses.

Payment to health care providers will be made on prospective basis, but will not be the same nationwide as currently implemented in the *Askes* scheme. Regional offices of the NHI will negotiate with association of health care providers in a region on the payment mechanism and the level of prospective payment. Both public and private providers meeting certain standards of facilities and health professionals, are eligible for being in the NHI network of providers. It is estimated that 80% of revenues in a region may be used to pay providers in the region. About 10% of revenues in a region will be pooled into a national pool for cross-region expenses such as for referral care. The remaining 5% should be reserved for catastrophic reserve fund. The Actuarial Committee of the Board of Trustees will periodically examine the appropriate share of expenses.

Health Insurance Law

Currently a Bill of National Social Security, including chapters of National Health Insurance, is being drafted. The Task Force and Commission VII of the Parliament[59] has already set up dates to discuss the Bill intensively. Both the Task Force and the Commission VII have agreed that the National Social Security Law must be passed before the end of 2003. The law will mandate the employers to enrol and pay contributions for NHI fund. In addition, the law will establish Social Security Trust Funds consisting of one administrative and investment trust fund and two trust funds dealing with delivering of benefits. The first one is the Trust Fund for cash benefit programs covering provident fund, pension scheme, death benefit, and temporary unemployment benefit. The second is the Trust Fund for NHI administering health and occupational injury benefits. The Board of Trustees will supervise all trust funds. The Board is a policy-making body responsible for developing operational guidelines for investment and delivering benefits. The Board consists of 21 elected persons representing the employers, employees, and the government. The Ministers of Health, Labour, Finance, Social Affairs,

[59] This commission is in charge of social affairs, including health, labour, women, and population

National Defense, Industry, and Cooperatives will represent the government in the Board.

The law must strongly mandate employers and members to pay contribution on monthly basis to a SS account along with payment of regular taxes. The SS Administration will manage the memberships, including issuing social security number, investment, and channeling funds to NHI and SS Trust Funds to deliver benefits. The law must be specific and not too detailed.

The NHI Trust Fund

Because of the differences from other cash benefits the in-kind benefits of health insurance will be managed separately from other social security programmes. A special Trust Fund, the NHI Trust Fund, will be established (see Organization chart in the Appendix). The NHI combines programme for civil servants, private employee programmes, and the poor into a single pool. This combination permits cross-subsidy and portability of benefits in decentralized system. At each region, a branch NHI will manage membership administration, payment with providers, delivery of health services, and providers' claims. An oversight committee, representing tripartite parties, may be established in each region.

Efficiency and effectiveness

The combination of compulsory health insurance scheme for civil servants, private employees, and non-salaried workers will improve the overall efficiency in financing and delivery of health care to all citizens (universal coverage). Overall efficiency can be achieved through:

(1) The collection of premiums remains integrated with other programmes and with tax collection. This collection system is much more efficient than collection by each insurers in pluralistic bapel systems.

(2) The information system as well as social security number (SSN) will be unified with all other programmes using a unique and portable SSN for each member/beneficiary. This integrated information system will reduce duplications of coverage and memberships leading to higher efficiency and will ease portability of benefits in the dynamic labour market.

(3) This system will enable a large number of insured to be contracted with health care providers leading to higher possibility to pay providers on a uniform capitation or other prospective payment systems. These payment systems will increase efficiency.

(4) If non-capitation payment is enforced, this system will allow free choice of providers.

(5) The large number of members permits the system to utilize the gatekeeper system and promote the development of family physicians as gatekeepers. Thus this system will improve the overall efficiency in delivering health care in Indonesia.

Advantages

As discussed above, there are advantages to workers and their families as well as to employers if all salaried workers are pooled into one compulsory health insurance scheme in a region. The additional advantages are:

(1) Uniform benefit package for civil servants and private employees creates equity, simplicity and better understanding by members and providers of the uniform benefits (meeting medical needs).

(2) Pooling of people into one pool creates maximum redistribution of income/financial burden for health services allowing effective cross-subsidies from the rich to the poor and from richer districts to poorer districts.

(3) A big pool will improve economies of scale that will maximize benefits to members. Similar schemes in Taiwan, Medicare in the US, Medicare in Australia, and in South Korea spend administrative costs as low as 3% of the total contribution revenues.

(4) The big pool or single payer will create buying power to health care providers that in the end will push health care costs down.

(5) The pooling of all funds allows redistribution of health care providers in all regions in more equitable way. Under this pool, the money will follow the patients. At present, about 25% of all doctors in Indonesia are residing and working in greater Jakarta, Jabotabek (to serve about 8% of the population).

(6) Employers do not need to bargain health insurance premiums and benefits annually with private insurers. Bargaining with health insurers needs special skills and understanding of various benefits

and health care costs. Thus, this system will permits employers to concentrate with their core businesses while their employees do not have to worry about changing benefits and insurers overtime.

(7) This system will build stronger solidarity among employers and employees from various employments and regions. Thus this system will improve the nation building efforts.

(8) The not-for-profit status of NHI, it will not need to pay income tax and dividends for government/stockholders. Any surplus will be returned to members in the form of services or accumulative reserves and thereby maximize the benefits to members.

Disadvantages

There are, however, disadvantages to employees and employers of this national pool as follows:

(1) There is no choice of insurance carrier leading to potential dissatisfaction of some members, especially in the upper income. However, one should realize that choices of providers are more important than choice of insurance carriers. Insurance carriers are just payers with little effect on the treatment process and outcomes. In this single payer system, the free choice of providers can be compared to the pluralistic HMO models promoted by MoH.

(2) Combining PT *Askes* and PT *Jamsostek* into a new Trust Fund could be affected by the previous performances and perception of low quality services created by inadequate premium levels, as well as by the improper structing of the existing *Jamsostek* and *Askes* schemes.

(3) The current use of public health centres and public hospitals for *Askes* and *Jamsostek* members may generate distrust among those who are currently under private health insurance schemes. The private employees may perceive that the NHI will provide poor quality health care as currently provided for *Askes* and *Jamsostek* members. To overcome this problem, for the first five years the new scheme must concentrate on those who are not covered by any scheme. Gradually the compulsory health insurance scheme must improve the quality of services while proving that the scheme

could provide quality services with much less contribution compared to purchasing health insurance from the private sector.

(4) The NHI will manage a huge number of members in very diverse conditions and comprising scattered populations. Nationwide bureaucratic controls and uniform detail policy may create mismanagement. Some autonomous and flexible management styles, but within the framework of a national policy, must be accommodated. For example, decision making methods and the level of payments to providers must be decentralized.

(5) A national pool of NHI will need a strong leadership by national decision- makers and very strong concept to obtain supports from various political parties and the private sectors. The task force must identify clearly and precisely all risks and the type of support needed by various stakeholders.

Potential risks

Given the existing performance and perception of services provided by *Askes* and *Jamsostek*, the risk of failure to administer the proposed scheme is very high. Therefore, a very careful design and preparation to implement the scheme must be organized. The following issues need serious attention:

(1) Currently there are five social insurance schemes managed by state-owned companies covering traffic accident insurance, *Askes*, *Jamsostek*, military social insurance (ASABRI), and civil servants pension fund (*Taspen*). The association of social insurance providers in the Insurance Council (*Dewan Asuransi Indonesia)* may perceive that they will be liquidated and therefore oppose the NHI idea.

(2) The Ministry of Health has already promoted JPKM for about a decade and intensive efforts have been made to establish bapels in each district. The NHI clearly will destabilize previous efforts done by the MoH and Provincial and District Health Offices (*Dinas Kesehatan*). They must be convinced that the NHI will benefit the people more than the current JPKM system. In addition, they must be well informed about the plus and minus of current market oriented JPKM and the pro public NHI.

(3) Transformation of Askes and Jamsostek into NHI will require transformation of assets and liabilities. Identification of assets and liabilities and merging the two is a very difficult and complicated job. This work may take years to finish with some risks of hiding and loosing some assets and increasing liabilities.

(4) Political interests of so many parties currently in Indonesian Parliament may hinder the NHI. Some parties may view that the establishment of NHI and the National Social Security Trust Fund will benefit only the ruling party. They may oppose the notion based on the political interests rather than the national gain.

(5) The open and global market forces, especially those in insurance industries, will see the NHI as lowering the probability of making business in the health insurance field. They will be more likely to oppose the NHI

(6) The availability and the quality of health care providers may not suitable with the expansion of insurance scheme resulting in under serving populations who have contributed to the NHI. Current shortages of specialists, because of monopolistic behavior of medical specialty societies, provide high risks of undeliverable products to the contributors. In this case, the NHI must proactive to establish new providers or hire specialists from other countries.

(7) The requirement of government, as employer to pay 3% contribution in contrast with 0,5% presently, will require addition expenses of about Rp 1.3 trillion annually. In addition, mandating central and local governments to pay contribution for the poor will need additional Rp 5- 8 trillion form central and local governments budget. Current fiscal problems of the government may delay the coverage for the poor.

(8) Employers in the private sector may object joining the NHI in the basis of increasing burden for contributions. Although in the long-run the NHI will be more likely to benefit the employers and the employees, current very competitive markets may push the employers to reduce labor expenses, thus opposing any mandatory contributions.

Strategic issues

To be successful, before the NHI starts expanding and merging *Askes* and *Jamsostek,* several strategic issues must be carefully prepared.

(1) At least a two-year preparation is needed to set up management information systems, and human resources who fully understand and are skilful to run the system.

(2) The government must develop easy and marketable name, vision, mission, goals, and strategic planning of the new Trust Fund.

(3) Detailed standard procedures and forms must be developed in the beginning itself, right after the NHI is passed by the parliament. It is estimated that at least two years preparation, by experts on full-time basis, is needed.

(4) Members of the Board of Trustees and Directors must be recruited professionally and from highly reputable, clean, and dedicated persons. Persons of any doubtful integrity will result in a big failure.

(5) The management should implement a merit system to optimize benefits to the members and reduce the potential at corruption in managing large amounts of money.

(6) In the second year after the law is passed, intensive training must be provided for Board of Trustees, Board of Directors, managers of current *Askes* and *Jamsostek*, all operators of *Askes* and *Jamsostek*, and all providers interested in contracting with the NHI. Training can take several days for BOT to several weeks for operators.

(7) Socialization or social marketing efforts must be executed for all stakeholders intensively through various media (TV, seminars, newspapers, magazines, local networks, web, etc.) at national and regional levels so that all stakeholders are fully aware of the benefits of their NHI to them. They must understand that mandatory membership without exception will benefit them instead of creating more burden. The employers must understand that pooling of all resources into the NHI will give them competitive advantages in the global market by easily predicting labour costs and therefore costing their products competitively.

(8) In addition to socialization, the Trust Fund must always maintain a website providing current information on contributions, financial

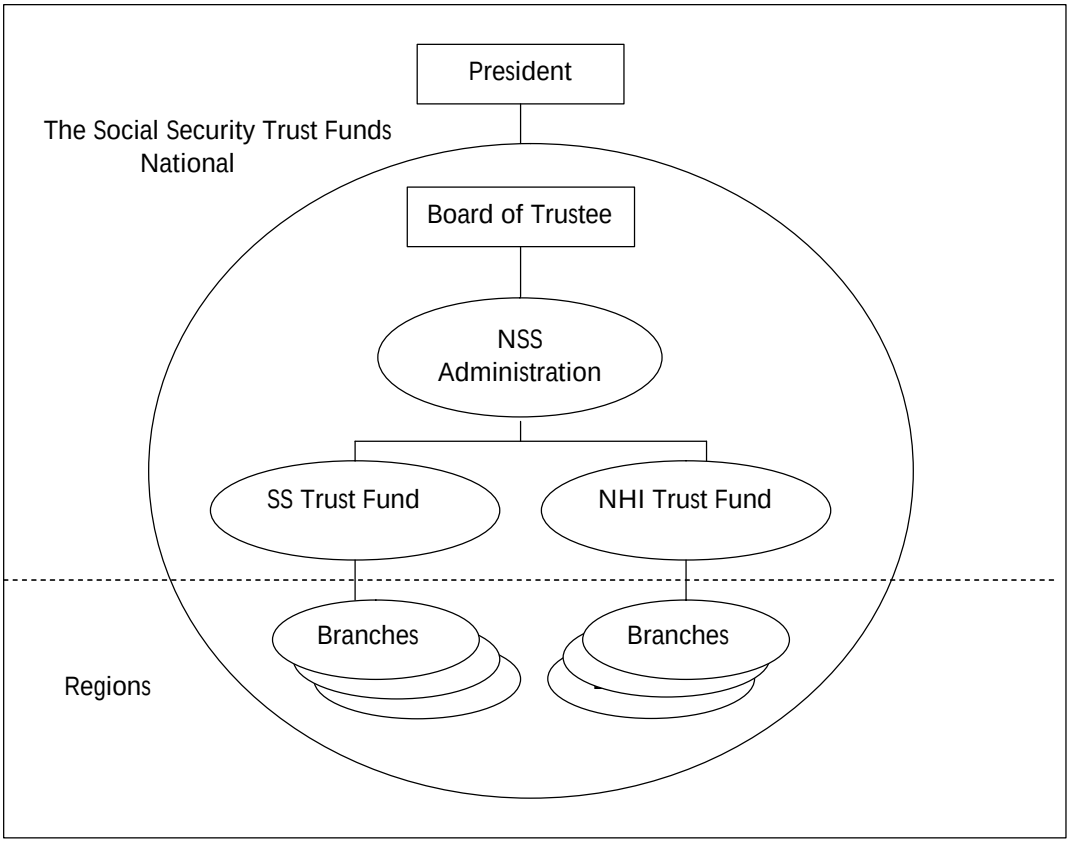
status, administrative expenses, medical expenses (claimed), surpluses, and development plans. This website will provide transparency in the management and must be accessible by any member at any time.

(9) In addition to the website, conventional communication systems such as newspapers, television, and radio must always be provided to members to encourage them any ideas, concerns, criticism, etc. to improve the management of the Trust Fund.

Further Actions

- Subsidized study tours to neighbouring countries (such as Australia, Taiwan, South Korea, Thailand, and the Philippines) for Parliament members, decision- makers, employers and employees associations may help to pass the law smoothly. The aim of these tours is to desensitize employers and employees in resisting the NHI. They must see what other countries are doing with social health insurance/national health insurance system. Legal and policy-makers and other stakeholders need to be convinced that the proposed NHI will provide more advantages than harm to the stakeholders. Part of the travel costs must be borne by employers.
- Publication of various aspects of the NHI in Indonesia and in other countries through professional media (such as journals, text books, etc.) and public media (newspapers, televisions, magazines, and radios). The new scheme must provide at least 0.5% of the revenues in the first five years for these activities. Academicians, professionals, journalists, and independent writers must be given financial incentives to spread the good news of the NHI in this country and in other countries. The main objective of this programme is to make employers and employees who are currently under the opt-out option realize the benefits of joining the NHI.
- Incorporating social health insurance and social security topics in the curricula of medical, economics, nurse, and public health programmes at various universities. Special workshops must be undertaken for medical, nursing, and hospital communities including the students.

Figure 8. ***Organization of the social security and the national health insurance proposed by the task force***



Annex 4

HEALTH INSURANCE MODELS IN NEPAL: SOME DISCUSSIONS ON THE STATUS OF SOCIAL HEALTH INSURANCE [113]

Background

The socioeconomic conditions of Nepal, a rural, agricultural economy with low human development[114] and presence of endemic poverty, have made the health sector a priority for sustained economic development. Equitable access to quality health care to meet the needs of the poor and reduction in poverty by achieving of the Millenium Development Goal (MDG) are the key concerns of the health policy. Delivery of Essential Health Care Packages (EHCP) to all regardless of the ability to pay, availability of the health needs beyond EHCP, regulation of the private health market/sector within the context of decentralization, and public-private/NGO partnership are important features of the health sector reform strategy. His Majesty's Government (HMG) of Nepal has acknowledged this within the context of 20/20 implementation and the declaration to provide essential health care package. Nevertheless, the problem of financing of the health sector is a matter of serious concern to the government since there are indications of paucity of resources in general.

The incremental increase in per capita expenditure of the Ministry of Health (MoH) (proxied for public health expenditure)[115] over the past decade has averaged about one per cent only (Economic Survey, "Various Issues and first appendix) – this is far below the WHO-recommended target of 5% of GDP spent on health. Further the per capita health expenditure of HMG/N is estimated to be around US$5 in the recent Public Expenditure Review carried out by the Health Economics and Financing Unit (HEFU/MOH) which is much lower than the international benchmarks for a package of essential health care

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[114] Nepal is ranked 32nd from the bottom out of 175 (i.e. 143rd of 175) countries in UNDP's Human Development Report 2003 with a per capita income of $236 in 2002 (Economic Survey, 2002)

[115] For caveats, see NHEA (2002)

(US$35-WHO Commission on Macroeconomics and Health 2000). This situation is further compounded with the mediocre performance in economic activity, due in part to the unstable economic environment, implying limited resources flow to the government for meeting the expenditure of the MoH. There is indication that the level of health expenditure will continue to be low with a scarcity of public resources in general, which may have a sharp impact on health expenditure, as it will be unable to meet the growing demands of the people.

Mention may also be made of the geographical reality of the country. The mountainous terrain with altitudinal and climatic variations ranging from sub-tropical to arctic climate within 50 km distance has diverse populations of more than 60 ethnic groups with their own socio-cultural values. The distance to be covered for delivery of the service is for the most part vertical. About 80% of the population live in rural area and are to be provided with health services of reasonable quality as available elsewhere in other parts of the country in the spirit of equity and social justice. Though Nepal is one of the richest countries in the world in terms of biodiversity, it is one of the poorest in economic terms. More than 40% of the population live below the poverty line. Its ranking in terms of Human Development Indicators is low as Health Indicators are still poor e.g. Infant Mortality Rate at 64, Child Mortality Rate at 91, Crude Birth Rate 33, Crude Death Rate 9.6 each per 1 000 population (see the first Appendix for trend). The Maternal Mortality Ratio is nearly 500 per 100 000 population. The indicators point to the need for a large investment in health even to reach the norm of South Asian countries in the context of a significant health financing gap in Nepal.

In the past, this health financing gap had been met largely by out-of-pocket (OOP) expenditure; for example Hotchkiss et al. (1998), in their 1995/96 estimation, find that nearly threequarters of health expenditure are borne by households.[116] This information along with the low level of public health expenditure, suggest that HMG has not been able to effectively meet the health financing demand of the country. This inability of public expenditure for meeting the general health expenditure of the population

[116] This observation is consistent with Adhikari et al (2002), who concluded from a regression analysis of a Nepalese health production function that public health expenditure did not have a significant effect on the social indicators reflected in reduction of the child death rate, child morality rate, infant mortality rate and increase in the life expectancy rate

underlines the need for alternative health care financing mechanisms to bridge this gap – this has been highlighted in the first and second Long-Term Health Plans, Nepal Health Sector Strategy Programme etc. While various alternatives are available, such as user fees, evidence from developing countries suggests that they do not have a beneficial impact in the context of "equity, efficiency and consumer satisfaction" (WHO, 2003). In this regard, there has been greater interest on health insurance in Nepal. While a number of papers overview the health insurance in Nepal, this paper is limited to: an overview of the policy environment for alternative financing; the different models of health insurance existing in Nepal followed by a brief discussion on Health Insurance and Social Health Insurance (SHI) ending with some concluding remarks.

Policy Environment Regarding Alternative Arrangements in Health Care Financing

The above scenario highlights the need for alternative financing for heath care since public health expenditure has been unable to fully meet the inherent demand by the public. This inherit demand by the Nepalese people has been enunciated in the National Health Policy 1991 (NHP, 1991) the primary objective of which is "to upgrade the health standards of the majority of rural population by extending basic primary health care services up to the village level and to provide the opportunity to rural people to enable them to obtain the benefits of modern medical institutions by making them accessible".[117] Unfortunately, the implementation for public health expenditure has been weak which can be reflected in the level of mortality and morbidity which is high especially in children from malnutrition, parasitic and infectious diseases (appendix 1)[118] Likewise complications at childbirth, nutritional disorders and endemic diseases such as malaria, tuberculosis, leprosy, STDs, vector-borne diseases continue to prevail.[119] This weakness has been generally

[117] It has directed towards two important goals: a reorientation of health sector towards basic primary health care, incorporating preventive as well as curative care and improvement in the distribution of health care facilities throughout the country. Hence people will have opportunities to enable them to obtain the benefits of modern medical facilities. It is in line with the wish of most governments to improve accessibility, quality and efficiency of health care services

[118] This is seen in numerous reports and publications such as World Bank (2000)

[119] Absence of service providers in health facilities compounded with shortage of essential drugs and supplies act as a deterrent for the patients to visit the institutions. Naturally they fall trap to the local faith healers and quacks. It must

acknowledged by encouraging the exploring of alternative sources of health financing. In this regard there are a number of documents which further elaborate this vision viz. long-term health plans, development plans and the Medium Expenditure Framework; these are:

- Long-Term Health Plans: Both the First (1976-1996) and the Second Plans (1997-2017) have emphasized the provision of universal access to primary health care.[120] Provisions have been made to make use of public, private and NGO sector. Priorities have been given for establishing baseline data for developing policies for public-private mix and exploring the feasibility of various public-private mix options. The plan has underlined the importance of health sector reform and health insurance scheme in the country. (NHP, 1991)
- Development Plans: While there have been a number development plans since their initiation in 1956, the importance of the health sector was highlighted in the seventh plan in 1975 which still continues. However, it has only been since the ninth plan that emphasis has been given to expand the community drug programmes and to continue to develop health insurance schemes already introduced, though limited, in the country. It also emphasized on various measures to be undertaken for implementing and monitoring the drug policy. Top priority has been given to improve the health of rural people.
- Medium-term Expenditure Framework (MTEF): The MTEF concept has recently been initiated and tries to operationalize the long term health plans and the development plans. In MTEF, the areas of the health reforms have been identified and prioritized which are expected to contribute to both the strategic policy and reform measures, by enhancing efficiency, equity, transparency and accountability.[121] There has likewise been an acknowledgement of

be borne in mind that poverty, illiteracy, lack of health education and socio-cultural factors by themselves act as constraint for service demand. The rugged terrain by itself further limits access. These adversely affect the utilization of service particularly by the vulnerable and socially disadvantaged groups

[120] The second plan is more specific on the provision of essential health care service on priority basis at the district and below and assured that they will not be neglected in term of financial and technical resources

[121] This, along with the concept paper to the 10th Plan embodied in the Interim Poverty Reduction Strategy Paper (I-PRSP), had been presented and discussed at the recently concluded Nepal Development Forum held in Kathmandu

deficiency of public expenditure with cost sharing and cost recovery schemes.

In sum, the above-mentioned are good plans and provide a conducive environment for alternative financing of health care. However, as mentioned above, there has been preference of health insurance since it helps pool the financial risk. As such, the next section discusses the different models of health insurance existing in Nepal.

Models of Health Insurance Existing in Nepal

The problem of financing the health sector has been of serious concern to the government, and the MOH of HMG/N intends to initiate alternative financing schemes as a means to supplement the health sector-financing source.[122] The types of alternative health care financing systems in operation in Nepal include user charges – registration fee etc, community financing schemes, community drug schemes of various types, besides, community insurance schemes. Most of these schemes have in-built mechanism for direct payment by the users though there may be provision of safety net for the poor in some cases. Presently, the formal sector health insurance as such, exists in a limited way. There are a small number of agencies which provide medical benefit packages, including membership of private insurance schemes to their employees. In addition to this, there exists social health support schemes for employees in the government sector, labour organizations and some others in various firms. These are largely involuntary and have some insurance characteristics (i.e. charging contributions), others without and still while some others are without any such characteristics, and still others which have characteristics which are more of a privilege.

There are basically three other models of health insurance presently under operation, namely the hospital based micro-social health insurance scheme; Community, Health Post-based Insurance model; and Health Cooperative Model. These are explained in detail in the first table, given below:

[122] This problem is partly due to the social change in Nepal from the joint family system with community-based initiative e.g. Guthi system, to the present trend of nuclear families

Table 1. *Health Insurance Models Existing in Nepal*

No.	Insurance Model
1.	*Hospital based micro-social health insurance scheme*: Initiated in 2000, the BP Koirala Institute of Health Sciences offers services to rural and urban household members through linkage with Village Development Committees (VDC), co-operatives, business associations, educational institutions etc. The premium for urban areas is four times higher than rural areas and the scheme covers 2 400 members from 565 households. The service package includes free consultations and investigations in Out- and In-patient Departments, free hospital beds and medicines and operation charges beyond certain limit. The entire premium, contributions from VDC etc. go to hospital. The income shows surplus, but does not include expenditures borne for manpower, equipment costs etc.
2.	*Community, Health Post-Based Insurance model*: Initiated in 1976 as Lalitpur Medical Insurance Scheme; this scheme has a coverage of 19 to 52 per cent rural population in six health posts. The premium varies and is set up by the local committee with the drug subsidy coming from the government. Registration fee-based and free clinical service is provided in the clinic, although for the referred cases in Patan Hospital, the charges are discounted. There is no surplus revenue over the expenditure. It is observed that sustainability may be a problem with existing premium.
3.	*Health Cooperative Model:* A Nongovernmental Organization (NGO), PHECT (Public Health Concern Trust) Nepal, offers health service through Cooperative Society with the members maintaining a daily savings of nominal amount to contribute for health, both in rural and urban areas. Community clinics provide primary services and referrals for Kathmandu Model Hospital (KMH). Fifty per cent of total collections go to KMH. Subsidy is provided to the poor on referral cases. There is coverage for 2 038 persons from 438 households. The General Federation of Nepal Trade Union (GEFONT) supports another cooperative scheme for transport and industrial workers. A monthly premium is paid by workers to establish a Health Cooperative Fund, which runs a clinic for primary service and the referred cases go to KMH as above. For the poor, PHECT Nepal provides financial support as solidarity. It covers only 500 families (2 members from each family) out of 300 000 GEFONT members.[123]

Source: British Council; DFID/District Health Strengthening Project, Teku, Kathmandu; and The ILO/STEP programme in Nepal, 2003.

[123] Mention may be made of the ILO's Strategies and Tools against Social Exclusion and Poverty (STEP) global programme in Nepal, which is providing technical assistance to civil society groups to carry out feasibility studies to set up and manage micro-insurance system which are based on solidarity in the grass root level. The aim is to extend social protection measures through health micro-insurance (SPHMI) schemes, which are gender sensitive, accessible and affordable for the poor, vulnerable and excluded workers in the informal economy of Nepal. Support has been provided to the Credit and Savings Cooperatives, GEOFONT, Social protection for porters and their families in Solokhumbu district etc.

The health insurance models discussed above are different variations of the community health insurance (CHI) scheme. CHI seems suitable for informal sector and it covers a variety of schemes with variations in (a) target groups, (b) provider arrangements, (c) benefits of services, (d) exemption arrangements for vulnerable groups, (e) means of contributing, (f) degree and type of cross subsidy and (g) administrative mechanisms. The CHI schemes are attractive in providing an opportunity to link the activities into local management processes and MOH seems interested to work closely with different CHI schemes

Discussion on Health Insurance and SHI

While different models of health insurance are existing, the high level of OOP in the county, which is consistently around three quarters of household expenditures, suggests that there is still a long way to go for Nepal to provide total health financing. Nevertheless there is a move for providing higher levels of health care financing in the country in a sustainable manner. There is justifiable concern that the nature of the above-mentioned CHI, while important for reaching the mentioned objective and which will be started in pilot form, may not be able to capture the deprived and poverty -afflicted portion of society due to its **voluntary** nature. Likewise, there is concern that a CHI may not be sustainable for providing more specialized services, without substantial government support (WHO, 2003 a). Because of this, and from the equity perspective, an alternative form of health care financing which is slowly gaining favor is SHI – this is conceptually attractive since membership and contribution are **mandatory** and pooling it involves of resources and risks of the population with cross-subsidy, leading to overall financial protection.[124] Recently the government has publicly committed to the introduction of SHI for the people and it is considering the implementation of pilot SHI schemes and replicating the appropriate schemes based on experience. (MOF 2003/2004 budget speech) While a true SHI **does not** exist in Nepal so far, support is growing for this model of health insurance.

Beyond doubt, the SHI scheme is an ideal model and something which can be possibly developed for the country. In cognizance of the fact that there

[124] For an overview of SHI, with some examples given in the South-East Asia Region, see Sein (2003); also, see WHO (2003 b)

are many operational difficulties existing in terms of resource management viz. financial, manpower, drug supplies etc.(NHEA 2002) and no less poorer skills in organizational management culture, proper monitoring and evaluation must be in-built in the implementation plan. As Nepal is a country of great diversity, flexibility in the planning and implementation must be seriously considered. Commitment and accountability of the staff to provide service with quality assurance is the key to success.[125] This situation therefore suggests the need for a comprehensive study relating to: (i) the existing economic and political context; (ii) appropriate sequencing, (iii) explicit timetable, and (iv) proper implementation. (An example of programme management at village level is given in Appendix 2)

Conclusion

Insurance is an important mechanism for bridging the health financing gap in Nepal, besides offering greater protection to the poor and the vulnerable groups against high cost of ill-health in the form of social protection. Alternative models exist in Nepal, which largely are variations at the existing CHI model, although presently SHI is a desired form of alternative financing because it addresses equity, fairness of financing and quality of services. It is important that the CHI models currently in operation should be further reviewed in depth and the strengths and weakness analysed. Bold decision should be taken to continue the successful ones only and discontinue the weak schemes. Newer schemes should be formulated based on experiences particularly in rural areas. However, for the effective operationalization of SHI in Nepal, a comprehensive and integrated study is necessary along with appropriate sequencing and sincere implementation, to guarantee success. In our view, and having taken the above factors into consideration, an SHI can be started as a pilot project at the microlevel among government salary workers, whose recommendation is consistent with that of NHEA (2001).

[125] Karki (2003) puts these problems as: Inadequate supervisory/monitoring support; No guideline to utilize the money collected; Local community had no authority to spend the money collected; Money improperly spent or swindled by corrupt staff; Money collected was labeled as illegal and it was directed to be deposited in the government treasury; The basic purpose was to provide drug to all patients all the time; Government had not taken health insurance seriously in spite of it being mentioned even in the 9th plan

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Appendix 1

Input-output model for health sector*

	Fiscal year	MoH of HMG/N Expenditure on health		Per capita RGDP	Outputs				
I		As % of total budget	As % of GDP	At 1984/85 price (Rs)	Infant mortality rate	Child mortality rate	Crude birth rate	Crude death rate	Life expectancy rate
N	1989/90	4.60	0.93	3102.3	128	197	41.6	16.9	53.5
	1990/91	3.84	0.88	3230.7	107	197	39.6	14.8	54.0
P	1991/92	3.62	0.84	3308.5	107	197	39.6	14.85	54.0
	1992/93	3.40	0.64	3329.2	102	165	39.6	14.85	54.02
U	1993/94	4.85	1.08	3501.8	102	165	39.6	14.0	54.0
	1994/95	4.91	1.21	3531.2	102	165	37.5	14.0	54.0
	1995/96	5.99	1.44	3642.9	102	165	37.5	13.8	54.0
T	1996/97	6.19	1.42	3727.1	79	118	37.8	11.9	54.5
	1997/98	5.70	1.37	3766.8	74.7	118	35.4	11.5	56.1
	1998/99	5.69	1.34	3829.9	69.42	111.72	34.54	10.7	57.52
S	1999/00	6.09	0.80	3987.6	66.78	108.78	34.1	10.3	58.25
	2000/01	4.52	0.56	4164.3	65.3	105.44	35.58	10.0	59.0
	2001/02	5.26	1.06	4248.8	64.20	91.00	33.00	9.60	59.7

Note: The following are the raw data for Infant Mortality Rate (per 1000 live births), Child Mortality Rate (per 1000 live births), Crude Birth Rate (per 1000 live births) and Crude Death Rate (per 1000 live births) respectively. The public health expenditure as a percentage of national budgets and the GDP are based on actual figures while the figure for 2001/02 is based on estimate.

* These are figures for expenditures on health made through the MOH of HMG/N Nepal only. Expenditures made in health though other ministries such as the expenditures of Teaching Hospital under the Ministry of Education, Police Hospital under the Ministry of Home Affairs and Army Hospital under Ministry of Defense have been excluded from the present analysis.

Source: Economic Survey, 2002 and various issues of Nepalese budget speeches

Appendix 2

An example of Health Insurance Programme Management

(1) As a first step, a list of all residents in the VDC will be prepared with the help of local VDC secretariat

(2) Respective Sub Health Post (SHP) or an institution as decided by the SHP-HI Committee will collect the premium and deposit it in the account of the Ico/SHP/VDC.

(3) Upon receipt of the list of Insurance Fee Payees Ico will issues ID card and a record book of treatment to all insured people. Since repeated addition and change in the list complicates the whole process effort will be made to make it a one time affair in a year.

(4) HCF will provide health services based on the instruction given to them in the treatment record book

(5) Upon completion of the treatment of the patient or as indicated in the book HCF will immediately request for payment from the Ico.

(6) A Local HI Committee under the Chairmanship of the respective VDC will be formed including NGO or Clubs existing in that VDC. They will be involved in planning, implementing and monitoring this programme.

(7) Large joint family or ethnic group or some form of community group insurance may be decided by the local committee in which a separate rate of premium may be decided by the Insurance Company.

(8) Discussion and decision may be made locally that how other dependent members in the family can be considered to be included in the HI scheme.

Source: Karki, B. B. (2003).

Note: VDC = Village Development Centre; Ico = Insurance Company; HCF = Health Care Facility; HI = Health Insurance; and NGO = Non Governmental Organization.

Annex 5

OVERVIEW OF HEALTH INSURANCE SYSTEMS IN THAILAND [1]

Introduction

The policy of charging for drugs and medical services in public health facilities was established in the Thai health systems in 1945. An informal exemption mechanism for the poor, at the discretion of the health worker, was implemented along with user charges. Informal exemption has gradually evolved into a systematic mean- testing scheme based on household income. A Low Income Card is being issued every three years since 198] for households below a defined poverty line.

Government employees and retirees and their dependents including parents, spouses and not more than three children (less than 20 years old) are generously provided with medical care coverage. An employer liability Workmen's Compensation Scheme for work related illness, injury and death compensation were the foundation for the recent development of tripartite Social Insurance for formal sector private employees for non-work related illnesses, maternity, disability and death compensation. Finally, a voluntary community-based health insurance scheme has now developed into a publicly subsidized voluntary Health Card Scheme. Voluntary private insurance has long existed in Thailand, providing coverage to the better-off groups.

Various social and health protection schemes have developed at different paces resulting in variations in terms of benefit packages, provider payment methods, financing sources, level of government subsidy, efficiency and quality of care. How- ever, by 1996, 30 per cent of the population were still uninsured (1) (the number of uninsured varies due to different estimation methods). The current policy discussions focus on efficiency improvement, reduction of inequity within the insured population, and the extension of insurance coverage to the entire population.

[1] Viroj Tangcharoensathien, Samrit, Srithamrongsawat, and Siriwan Pitayarangsarit, (2002) "Health Insurance Systems in Thailand", Chapter 2, German Foundation for International Development, Health Insurance Office, Thailand, and Health Systems Research Institute, Thailand

This chapter provides an overview of insurance systems in Thailand, describing its principle, objective, trends of coverage, key characteristics and weaknesses. Characteristics of the uninsured will be highlighted. Based on these analyses, recommendation on reform has been proposed to achieve greater efficiency, equity and universal coverage.

Overview of the Health Insurance Schemes

Health insurance provides two basic functions: access to effective health care services when needed, and effective protection of family income and assets from the financial costs of expensive medical care[2]. Tax-based welfare schemes are also considered health insurance. Supachutikul[3] classified various health insurance schemes in Thailand into four categories according to their nature and objectives.

Medical Welfare Scheme (MWS)

This scheme provided free medical care for indigence. For example the poor, the elderly and children up to secondary school and the disabled. It also extends to monks, community leaders, health volunteers and their families.

Civil Servant Medical Benefit Scheme (CSMBS)

This is a fringe benefit to government employees and dependents to compensate low public salary.

Compulsory Social Insurance

- Social Security Scheme (SSS) -a tripartite contribution scheme by the employer, the employee and the government ensures health security for formal sector employees.
- Workmen Compensation Scheme (WCS) -an employer liability scheme to protect the employee from work-related injuries, illnesses and funeral grants.
- Traffic Accident Insurance -ensures access to care by traffic accident victims through compulsory premium paid by all car owners to private insurance firms [4].

Voluntary Schemes

Private Health Insurance a voluntary risk related premium contribution covers mainly the better off [5].

Government Health Card Scheme (HCS) -a voluntary alternative for the uninsured, e.g. rural informal sector workers who are not eligible for low income scheme, the self-employed and employee in small firms of less than 10 employees who are not eligible for the social insurance scheme [6].

Several small-scale community financing saving schemes provide limited health benefits to its members. Payments are made retrospectively to members at the end of the year according to the funds available. Self-help funeral grants are more common than health benefits. The chronological events covering the various scheme developments are summarized in Table 1, showing wide discrepancies.

Table 1. *Chronological events covering the health insurance development in Thailand*

Year	Important Event	SW	FB	CI	VI
1929	Private Insurance Business				✓
1954	First Social Security Act (but not implemented)			✓	
1974	Workmen Compensation Fund			✓	
1975	Free medical care for the Poor	✓			
1978	First private health insurance company				✓
1980	Royal Decree on CSMBS		✓		
1981	First issuance of Low Income Card	✓			
1983	Maternal and Child Health Fund (phase 1)				✓
1984	Health Card Project (phase II)				✓
1990	Social Security Act covered enterprises with 20 and more employee			✓	
1991	Health Card Project – insurance based pilot (phase III)				✓
1992	Free medical care for elderly	✓			
1993	Traffic Accident Victim Protection Insurance			✓	
1994	Social Security Act, extension to enterprises with 10 or more employee			✓	

Year	Important Event	SW	FB	CI	VI
1994	Health Card Scheme (phase IV), equal matching fund provided by government, reinsurance policy and cross-boundary card				✓
1994	Health Card extension to community leader and health volunteer, full government subsidy		✓		
1994	Medical Welfare Scheme, expansion of the free medical care for the poor to cover other indigent groups, elderly and children up to 12 years	✓			
1998	New financial regulation for the Medical Welfare Scheme: management by national and provincial committees, per capita budget allocation to provinces, introduce reinsurance policy for high cost care by using Diagnostic Related Groups and global budget.	✓			
1998	CSMBS: Introducing copayments by CSMBS beneficiaries, only drugs quoted as essential drugs are reimbursed, limited hospital stays in private room and board.		✓		
2000	The Social Security Scheme expanding to cover old age pension and child benefits			✓	

Source: Adapted from Supachutikul A, 1995 [3]
SW = Social Welfare; FB = Fringe Benefits; CI = Compulsory Insurance; VI = Voluntary Insurance

Trend of Coverage

The Health and Welfare Survey conducted by the Office of the National Statistics [1, 7, 8] showed an increasing trend of insurance coverage from 33.5 per cent in 1991 to 60 per cent in 1999. When adjusted for coverage by children under 12 and the elderly, the insured figures were higher (Table 2).

Rapid MWS expansion was due to the extension of coverage to the elderly and children under 12. This accounts for 71 per cent of the total increase in coverage during 1991-1995. Expansion of the Health Card Scheme in its fourth phase (1993-1998) was due to extensive TV and radio advertising and sales promotion campaigns. This could pave the way towards universal coverage. During the 1997 economic crisis, the demand for health cards increased significantly among the uninsured who could not afford out – of-pocket health care and the laid-off social security workers who also lost social security protection.

Table 2. *Percent population coverage and trends, 1991, 1998 and 1999*

Scheme		1991	1996	1999	1996*	1999*
1	Medical Welfare Schemes	12.7	12.3	12.4	29.5	22.5 (32.1)
2	Government employee scheme					
	• CSMBS	13.2	11.3	7.8	11.3	7.8
	• State enterprise	2.1	1.4	1.1	1.4	1.1
3	Social Security including WCS and employer welfare	0	5.5	7.1	5.5	7.1
4	Voluntary insurance					
	• Voluntary Health Card	1.4	13.2	28.2	13.2	28.2 (18.6)
	• Private insurance	3.1	1.2	1.4	1.2	1.4
5	Others	0.9	1.1	1.7	1.1	1.7
	Insured	33.5	46.0	59.8	63.2	69.9
	Uninsured	66.5	54.0	40.2	36.8	30.1
	Total	100	100	100	100	100

Characteristics of the Uninsured

In this part, we describe characteristics of the uninsured at great length using the MoPH provincial health survey [(9)]. In 1996, between 26 per cent and 31 per cent of households in each income bracket were uninsured; 28 per cent of the poorest house holds (monthly income less than 2 000 Baht), who should have been covered by MWS, but were actually not insured [(9)]. Among the 16 659 uninsured persons sampled by the survey, 27 per cent were in the lowest monthly income bracket of less than 2 000 Baht (Table 3).

Among the 16 659 uninsured persons, 80 per cent of heads of households had a primary school education (Table 4). Only 13 per cent of university graduate household heads were uninsured, compared to 33 per cent of primary school educated. Table 5 gives a breakdown of the uninsured population by occupation of the household heads. Farmers took the greatest share of the total insured. Civil servants were least likely to be uninsured (5 per cent), whereas transport operators and traders had the highest proportion of uninsured (44 per cent).

***Table 3**. Household monthly income for insured and uninsured, 1996*

	Monthly Income (Baht)	Uninsured		Insured		Total		% uninsured
		Number	%	Number	%	Number	%	
1	=2000	4451	27	11672	32	16123	30	28
2	2001-8000	9847	59	18446	51	28293	53	35
3	8001-15000	1333	8	3693	10	5026	9	27
4	15001-20000	197	1	565	2	762	1	26
5	20001 +	340	2	859	2	1199	2	28
6	unknown	491	3	1093	3	1584	3	31
Total		16659	100	36328	100	52987	100	31

Source: Ministry of Public Health, 1997[9]

***Table 4**. Education level of head of household for insured and uninsured, 1996*

	Education of household head	Uninsured		Insured		Total		% uninsured
		Number	%	Number	%	Number	%	
1	Primary level	13332	80	27336	75	40668	77	33
2	Secondary level	1644	10	3666	10	5310	10	31
3	Vocation	403	2	1324	4	1727	3	23
4	University	203	1	1301	4	1504	3	13
5	Uneducated	958	6	2415	7	3373	6	28
6	Unknown	119	1	196	1	315	1	38
Total		16659	100	36238	100	52897	100	31

Source: Ministry of Public Health, 1997[9]

***Table 5**. Occupation of head of household for uninsured and insured, 1996*

	Occupation	Uninsured		Insured		% of workforce uninsured
		Number	% of insured	Number	% of insured	
1	Farmer	7896	49	18654	51	30
2	Civil servant	198	1	3658	10	5
3	Transport operator	564	3	716	2	44
4	Worker	904	6	2000	6	31
5	Traders	2849	18	3632	10	44
6	Others	3063	19	4789	13	39
7	Unemployed	613	4	2804	8	18
8	Unknown	33	0	75	0	31
Total		16120	100	36328	100	31

The uninsured is required to pay all medical bills in full in both public and private hospitals. In public hospitals, an exemption mechanism through social workers is available for those unable to pay. An uninsured patient who cannot afford a bill of 7 622 Bahts per admission could damage the household financial security[10]. This accounts for 18.6 per cent of the household annual income. They cope with medical bills by borrowing from either inside or outside the family network and can easily fall into debt traps. Another study showed that poverty (defined as household income eligibility for Low Income Card) and uninsured status were the major factors inhibiting access to antenatal care[11] (Table 6).

Table 6. *Insurance status and maternal and child health policies*

		Urban						Rural						All group
		Uninsured			Insured			Uninsured			Insured			
		Poor	Non-poor	Total	Poor	Non-poor	Total	Poor	Non-poor	Total	Poor	Non-poor	Total	
1	% without ANC	9	4	5	1	1	1	3	0	1	1	1	1	1
2	% <4 ANC visits	43	28	32	12	13	13	41	34	36	18	17	17	21
3	% prenatal risk	34	23	26	29	27	27	26	19	21	22	20	21	23
4	% low birth weight	18	10	12	14	8	9	12	9	10	9	6	7	9
Number of sample		68	208	276	149	499	648	125	253	378	377	564	941	2240

Source: modified from Wongkongkathep S., "A three-day census of all deliveries in April 1999"

The self-explanatory Table 7 describes the characteristics of insurance schemes in regard to the nature, population coverage, benefit package, and financing of the scheme.

Table 7. *Characteristics of health insurance and welfare schemes in Thailand 1999*

Characteristics	I. Medical welfare	II. CSMBS	III. SSS	IV. WCS	V. Health card	VI. Private insurance	The uninsured
I. Scheme nature							
	Social welfare	Fringe benefit	Compulsory	Compulsory	Voluntary	Voluntary	Na
Model	Public integrated model	Public reimbursement model	Public contracted model	Public reimbursement model	Voluntary integrated model	Voluntary reimburse-ment model	Voluntary out of pocket model
II. Population coverage, 1999 HWS							
	The poor, elderly and children under 12 years old, secondary school student, the disabled, veteran, monks	Government employee, pensioners and their dependants (parents, spouse, children)	Private formal sector employee, > 10 worker establishment	Private formal sector employee, > 10 worker establishments	Non-poor households not eligible for Medical Welfare Scheme, community leader and health volunteer family	Better off individuals	The urban, rural marginal poor, traders, self employed, employee in non-formal sectors.
Population 1999 HWS, million	19.8	5.5	4.36		11.50	0.83	18.58
% coverage	32.1%	8.9%	7.1%	Same as SSS	18.6%	1.1%	30.1%
III. Benefit Package							
Ambulatory services	Only public designated	Public only	Public & Private	Public & Private	Public (MoPH)	Generally not covered	–
Inpatient services	Public only	Public & Private (emergency only)	Public & Private	Public & Private	Public (MoPH)	Mainly private hospitals chosen	–
Choice of provider	Referral line	Free choice	Contracted hospital or its network, registration required.	Free choice	Referral line	Free Choice	Free choice
Cash benefit	No	No	Yes	Yes	No	±	No
Conditions included	Comprehensive package`	Comprehensive package illness, injuries	Non-work related injuries	Work related illness, injuries	Comprehensive package	Depends on premium	–
Conditions excluded	15 conditions	No	15 conditions	No	15 conditions	Severe illness, pre-existing conditions, depends on policy	–

Characteristics	I. Medical welfare	II. CSMBS	III. SSS	IV. WCS	V. Health card	VI. Private insurance	The uninsured
Maternity benefits	Yes	Yes	Yes	No	Yes	Possible	–
Annual physical check-up	No	Yes	No	No	Yes	Possible	–
Prevention, health promotion	Very limited	No	Health education, immunization	No	Yes	No	–
Services not covered	Private bed, special nurse, eye glasses	Special nurse	Private bed, special nurse	No	Private bed, special nurse, eye glasses	Depends on policy and premiums	–
IV. Financing							
Source of funds	General tax	General tax	Tripartite 1.5% of payroll each (reduce to 1% since 1999)	Employer, 0.2-2% of payroll with experience rating	Household 500 Baht + tax 1000 Baht	Household, or employer in addition to social insurance	Households
Financing body	MoPH	MOF	SSO	SSO	MoPH	Private companies	
Payment mechanism	Global budget	Fee for service	Capitation	Fee for service	Proportional reimbursement among 1ry, 2ry, 3ry care levels	Fee for services with Ceiling	Fee for service
Copayments	No	Yes, IP at private hospitals, IP private limits only life for threatening care	Maternity, emergency services, if beyond Ceiling	Yes, if beyond the ceiling of 30,000 Baht	No	Yes if beyond the Ceiling, depends on policy and premium	–
Expenditure per capital 1999 (Baht)	> 363 + additional cross subsidy by public hospitals	2106	1558	182	534 + additional subsidy by public hospitals	Na	Na
Per capital tax subsidy 1999	363 + additional subsidy	2106	519	Administrative cost of WCS office	250	Through income tax exemption for private insurance premium, magnitude unknown	Through public hospital subsidizes prices. Magnitude unknown

Problems of Health Insurance

The health insurance system, characterized by fragmentation, duplication and inadequate coverage in some schemes, cannot achieve health systems goals of efficiency and equity. It does not allow collective financing to exert its monopsonistic purchasing power and send the right signals to health care providers towards efficiency. Fee for service, a dominant mode of provider payment, exacerbates cost containment problems, as seen by faster health expenditure growth than GDP growth, even during recession periods [12]. With the lack of effective primary care, most of the poor are taken care of by hospitals which are expensive, have long waiting lines and unsatisfactory services.

Inequity was demonstrated by inequitable per capita tax subsidy, favoring CSMBS against Low Income Scheme, and the gap in the benefit package. However, the cross subsidy mechanism in public hospitals results in a smaller gap of net resources consumption by CSMBS and low income patients.

Medical Welfare Scheme

Targeting the poor is the main problem[13,14] due to seasonal variation and difficulty of income assessment. Exemption through the hospital social work mechanism might not function well and could be stigmatized. Allowing the community [15] to identify the poor has gradually improved the situation. The community themselves have the ability to filter the poor and specify families who are not poor. MWS suffers from a comparatively stringent budget and hospitals are not accountable or willing to provide prompt and decent care[16].

CSMBS

The scheme has three inherited problems of inefficiency (reflected by unnecessary admission and longer hospital stay), cost escalation (real term increase of 14 per cent per annum during 1988-1997) and inequity of per capita budget subsidy[17]. All players have no cost concerns; public hospitals have incentives to overcharge in order to cross- subsidize their MWS patients, for-profit private hospitals have a motive to overcharge the scheme. When beneficiaries were faced with no price tag, they were not cost conscious and took it for granted. Problems were compounded by the fact that the Department of Comptroller-General was neither capable to counteract overcharging nor able to introduce a reasonable policy intervention[18].

Social Security Scheme

The strength of capitation is cost containment capacity[19, 20]. However, the cost quality trade-off has subsequently become a significant problem, especially when workers do not exercise their right to choose the provider with whom they are registered[21]. In addition, they are unlikely to have full information on clinical quality of care when they exert rights to choose contractor hospitals. In fact they do not know which hospitals to choose. Health benefit is linked with employment and terminated when employment ceases, although a six-month grace period is granted (extended to one year after the 1997 crisis). The provision on voluntary enrolment by ex-social security workers was not implemented fully by the Social Security Office, for fear of adverse selection and financially nonviability.

Health Card Scheme

If the sick and potentially sick over-represent membership, adverse results are foreseeable[22]. This increases the average cost per enrolled person. The average cost per card (2 700 Bahts) per annum does not match the revenue from card sales (500 Bahts) and subsidy (1 000 Bahts). Half of the costs incurred are outside the district health system. If the benefit package cover only the district health services, the revenue could cover the cost.

In summary, the poor are more or less protected by MWS even though targeting problems still exist. The marginally poor are not entitled to free health care cards but would generally be partially or totally exempted from large inpatient bills in public hospitals. They could easily fall into a debt trap through borrowing before presenting themselves to the social workers, especially in the case of catastrophic illness.

The CSMBS consumed more resources than any other group. With its fee-for- service reimbursement model, neither CSMBS beneficiaries nor public or private providers are concerned with costs or efficiency. The capitation payment system in SSS contained the costs admirably but cost-quality trade off needs further scrutiny. Social Security has a high potential for coverage extension to dependents, non-formal workers and the self-employed. The voluntary Health Card Scheme has a limited capacity for coverage extension due to its voluntary nature and financial nonviability.

Recent Reforms

The Ministry of Finance and the Ministry of Public Health started reforming the MWS in 1998 by setting up a regulatory framework, improving accountability, decentralizing funds management, making the budget setting transparent and equitable, and strengthening the primary care network. The budget is allocated to provinces according to the number of registered beneficiaries, weighted by health need factors. A re-insurance premium of 2.5 per cent of the budget is deducted by the MoPH, and earmarked to pay for high cost care[2] and some special services[16.23].

Assessments of the CSMBS copayment (introduced in 1998[24] found significant cost savings of 8 per cent for an effective seven months of interventions in 1998. In 1999, when the intervention took full effect, a cost saving of 21.7 per cent was observed, mainly due to decreased inpatient expenditure. There was a 50 per cent reduction in expenditure after the termination of private inpatient care[25].

The SSS has the highest potential for coverage extension of health benefits, especially to spouses and dependents, with a minimal additional contribution requirement. In addition, the scheme has the potential to extend coverage to the self- employed on a compulsory basis whereas voluntary membership suffers from significant adverse selection problems. This brings the uninsured to a cost-effective scheme, and boosts the cost containment ability in the long term. Other reform initiatives that have been planned or recently introduced include the improvement of the Schemes, quality monitoring capacity, improving the information available to workers for their choice of contractor hospitals, and developing primary medical care.

After the reform in 1994, there were minor changes in the Voluntary Health Card[26]. The MoPH improved the targeting by eligibility termination for those who preferred to use private room and board. To combat adverse selection, a qualifying period before eligibility for services was extended from 15 to 30 days. In addition, reimbursements for cross-boundary care were paid by the provincial fund to prevent misuse of the cross-boundary card.

Future Direction of Reform

Increasingly, evidence and intensive dialogues among key stakeholders are guiding the decisions on reforms. There is a general consensus on health

[2] The criteria for high cost care is patient whose DRG relative weight is greater than 2.5

systems goals of efficiency, quality and equity and reforms direction towards universal coverage for the whole population. Different provider payment methods sent distinct signals to hospitals and physicians who are resource commanders for efficiency and quality. Lessons from the ongoing reforms in various schemes [27] could serve as a solid platform for future direction. The content of reform and the process to incorporate participation from civic societies and concerned parties are equally important for a successful, acceptable and sustainable reform.

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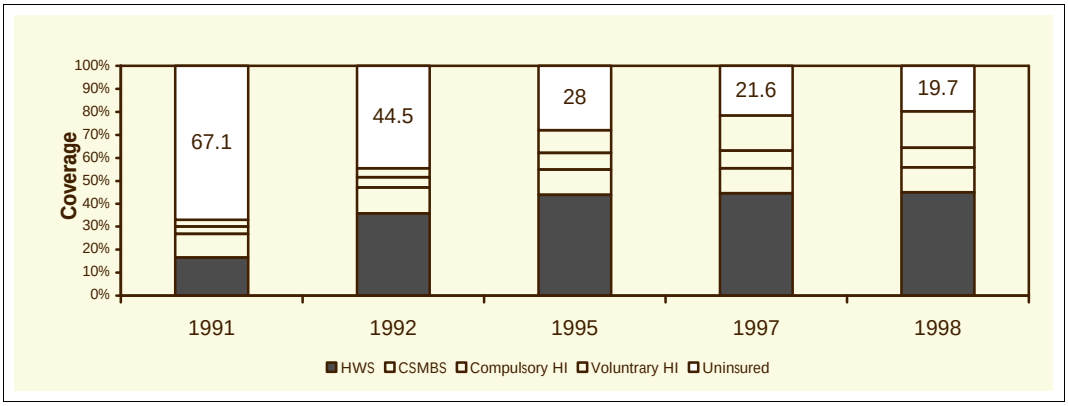
Annex 6

ACHIEVING UNIVERSAL COVERAGE OF HEALTH CARE IN THAILAND THROUGH THE 30 BAHTS SCHEME [1]

Why Universal Coverage of Health Care

Information from various sources indicated that, during 1998-1999, about 20-30% of Thai population was still uninsured[2] [3] [4]. Health care coverage has been increased rapidly during the last decade due to the establishment of the Social Security Scheme (SSS) and the increasing coverage of Health Welfare Scheme (HWS) and the Health Card Scheme (HCS) (see Figure 1). Before the implementation of universal coverage of health care (UC) policy, the majority of population was covered by the Health Welfare Scheme. The existing insurance schemes are quite different in benefit packages, payment mechanisms, government subsidies and these result in different quality of care.

Figure 1. ***Health Insurance Coverage of Thai Population, 1991-98***



Source: Bureau of Health Policy and Plan, Ministry of Public Health

[1] Pongpisut Jongudomsuk, MD., MPH, Health Care Reform Office, Ministry of Public Health, Thailand, Paper prepared for SEAMIC Conference 2001 FY, 14-17 January 2002, Westin Riverside Plaza Hotel, Chiang Mai, Thailand

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[4] Tangcharoensathien V. et.al. Health Insurance System – An Overview: (mimeograph)

Universal coverage of health care has become an issue of increasing concern for the public because of many reasons. First, the people under less privileged health insurance schemes (HWS and HCS) and the uninsured started to compliant more about the quality of care provided and their inaccessibility to necessary care. In 1999, the Foundation for Consumers conducted a research project, supported by the Health System Research Institute (HSRI), to document cases who suffered from the existing health care system. These documents[5] were published and distributed in the first National Forum on Health Care Reform, organized by the Health Care Reform Office (HSRO), and created a lot of public criticism and public concern about the quality and equity in access to care under the existing health care system. Second, the Constitution of 1997, which was the result of political reform, clearly stipulated health as a human right, which must be protected by the State. Health services under the new constitution must respect equity, efficiency and quality, as well as transparency and accountability. The constitution also permits the submission of law to the Parliament through the collection of 50 000 signatures. This constitution provides ground for civic groups to move further in getting their rights.

Previous Attempts to Achieve Universal Coverage of Health Care (UC)

In fact, during the last decade, the Ministry of Public Health (MoPH) has made many attempts to achieve universal coverage of health care. In 1996, the first draft of the National Health Insurance Act was prepared by a sub-committee of the Parliament for its consideration. Unfortunately, because of inadequate policy support, this attempt failed to achieve the stage of policy consideration and adoption. Many efforts were made to increase the coverage of the Health Card Scheme (HCS) to cover the uninsured. However, because of the voluntary basis of the HCS which led to its being a non-recovery scheme, the HCS could only achieve a limited population coverage. Fee exemption for persons who could not afford public health facilities could help improve the access to care of uninsured, but with unacceptable quality. Several research studies focusing on financing and managing health care system under UC policy have been supported by various research institutes

[5] The documents contain a series of 3 books, namely, Suffering from Hospital, Suffering beyond the Disease and Why the Patients Sue the Physicians. The books documented 15 cases of patient who suffered from the existing health care system.

for example, the Health System Research Institute (HSRI), the Health Care Reform Office (HSRO) and the National Health Foundation (NHF). This accumulated knowledge and experiences have provided several options for the implementation of UC policy in the future.

Recently, after the first National Forum on Health Care Reform in December 1999, a network of civic groups was established to campaign for the UC policy. This network of civic groups started to draft their own law, the National Health Insurance Act, with the support of some technical people. The campaign for 50 000 signatories in favour of this law was started in October 2000 and could get more than 50 000 signatories in March 2001. The draft law has already been submitted to the Parliament, with all the signatures, for its consideration.

In January 2001, the current government won landslide vote using universal coverage of health care as one of its major public policy gains. Campaign of the leading political party, Thai Rak Thai Party, used the slogan of "30 Bahts per visit / episode for every disease" or "30 Bahts Scheme" as representative of their UC policy. The policy was implemented in six pilot provinces in April 2001 and incrementally expanded to another 15 provinces in June 2001. In October 2001, the scheme could cover all provinces and part of Bangkok and it is planned to cover the entire country in April 2002.

How Much Do We Have to Pay and Can We Afford for the Cost of UC Policy?

At the beginning of the year 2001, there were at least three proposals on resources needed for UC policy.

(1) **Proposal using unit cost of autonomous hospital (AH):** Due to the economic crisis in 1997, autonomous hospital had been proposed as an alternative management model of public hospital to improve its efficiency and responsiveness.[6] Since universal coverage of health care is one aspect of AH model and the budget needed for AH, 782 Baht per capita[7], had already been proposed. This unit cost has been used for

[6] Chunharas S. et. al., Thai Autonomous Hospitals: Operation Manual, Thailand Health Financing and Management Study Project ADB # 2997-THA, December 1998.

[7] Pitayarangsarit S. et. al., Block Grant for the First Autonomous Hospital in Thailand: Why 782 Baht per Capita? Health Policy and Planning Journal (Thailand) Vol.3 No.1 Jan-March 2000. p 4-19.

further calculation by adding the unit cost of health centre which was 120 Baht per capita[8]. Therefore, it was proposed that the resources needed for UC is 900 Baht per capita.

(2) **Proposal of Pannarunothai S. et al[9]:** In this proposal, the research team used sickness episode and health service utilization of population, obtained from the national survey in 1996-Health Welfare Survey 1996, and unit cost of health facilities at different levels for the calculation. Health service utilization in 1996 had been adjusted by using the change of population structure in 2001, increase of insurance coverage and etc. The team proposed that resources needed for UC in 2001 is 91 930- 148 650 million bahts or 1 482-2 397 bahts per capita based on the way the health care system, including provider payment method, has been organized. If unregulated health care system is selected with fee-for-service payment, the per capita budget needed will be at the high end.

(3) **Proposal of the MoPH:** The MoPH submitted another proposal regarding the budget needed for the UC policy. This proposal used the approach similar to the previous one, using the pattern of health service utilization without any adjustment and unit cost of health facilities from the most updated study for calculation. The MoPH also used the experience of high cost care and accident and emergency care from the Social Security Scheme (SSS) to add to the calculated unit cost. According to the MoPH proposal the budget needed for the UC policy in 2001 was 1 202 40 Bahts per capita[10].

All proposals were considered in the workshop arranged by the MoPH, which was chaired by the Prime Minister, on 17 March 2001. The Prime Minister accepted to use 1 202.40 bahts per capita as the starting estimated budget for the UC policy in Thailand. Details of budget are described in Box 1.

[8] Pitayarangsarit S. et. al., Health Center Costing, 1999 Fiscal Year: Samutsakorn Province. A research supported by Health Care Reform Office, September 2000 (mimeograph).

[9] Pannarunothai S. et. al., Universal Health Coverage in Thailand: Options and Feasibility. Health Care Reform Office, July 2000.

[10] Tangcharoensathien V. et. al., Budget for Universal Health Care Coverage: How was the 1,202 Baht Capitation Rate Derived? Journal of Health Science Vol.10 No.3 July-September 2001: p.381-390.

Box 1. Details of Capitation Rate: 1 202 bahts per capita per year	
Budget for curative care	**Budget for prevent/promotive care**
- ambulatory care = 574 bahts/cap/year	- preventive & promotive care 175 bahts/cap/year
- inpatient care = 303 bahts/cap/year	**Capital investment** = 93.40 bahts/cap/year
- high cost care = 32 bahts/cap/year	**Administrative cost** = 10% of total budget
- accident & emergency = 25 bahts/cap/year	**Contingency fund** = 10% of total budget

At present, there are 6 million people who are covered by the SSS and about 7 million people who are covered by the CSMBS. Considering the rest of the population of 48 million people, most of whom are already covered by the HWS and HCS, and who will be covered by this UC policy[11], the country needs to pay at least 57.7 billion bahts to cover the uninsured. The country has already paid 8.7 billion bahts for the SSS (1 450 bahts per capita per year) and 16.44 billion bahts for the CSMBS (2 349 bahts per capita per year). Therefore, the total cost for this UC policy will be 82.84 billion bahts.

In fact, Thailand had already spent 179.69 billion bahts on health in 1998 and 70.5% of this health expenditure or 126.77 billion bahts was the cost of personal health care. Public sources of finance were responsible for 49.2% of total personal health care expenditure or about 62.4 billion bahts.[12] By adjusting this figure for the year 2001, public sources of finance would increase to 76.55 billion baht[13] and an **additional 7.29 billion bahts would be needed for the UC policy**.

It is arguable whether Thailand's current fiscal space could accommodate an approximate 10 per cent increase in public health expenditure on account of this UC policy. Considering the country's economic recovery after the serious crisis in 1997, there were warning signals about the country economic slowdown due to the delay of its structural adjustment and the slowdown of the world economy, especially the US economy.[14] The US economy started to slow down in the third quarter of 2000. The terrorist attack on the US in September 2001 even made the world economy worse than before. At the beginning of 2001, it was estimated that

[11] The government decides to merge all health insurance schemes under the responsibility of the MOPH and expands it to cover the uninsured.

[12] Phongpanish S. et. al. National Health Account in Thailand 1996, 1998. A research reported supported by the Health System Research Institute, December 2000.

[13] HSRI. Proposal on System of Universal Coverage of Health Care. Health System Research Institute, May 2001. p.30.

[14] National Economic and Social Development Board, Press Release, 19 March 2001.

economic growth rate of Thailand would be 3.5-4%. This estimation was adjusted many times because of changes in the situation in the National Economic and Social Development Board (NESDB) announced that the country's economic growth rate for 2001 would be 1.5% and will increase to 2% in 2002[15]. Under this condition, the government may have to reprioritize their previous budget plan and improve the efficiency of government's budget are spending, in order to get additional resources for the UC policy.

Ultimate Objectives and Main Characteristics of the UC Policy

In addition to the finalization of budget needed for the UC policy, the workshop in March 2001 also considered the main objectives and characteristics of UC policy in Thailand. There was consensus among key stakeholders that the ultimate objectives of the UC policy are;

(1) **Universal coverage**: All Thai citizens should be entitled and should have equal access to quality care according to their needs, regardless of their socioeconomic status and religion etc.

(2) **Single standard**: The benefit package and quality of care provided for all Thai citizens should be of the same / single standard.

(3) **Sustainable system:** system under the UC policy should be sustainable in terms of policy, financial and institutional sustainability. An efficient system, both allocative and technical efficiency, as well as an adequacy and stability of budget is needed for the financial sustainability. Legislation can be used to ensure the policy sustainability and, therefore, the government started to draft the law, the National Health Insurance Act, and submitted to the Parliament for consideration. Institutional sustainability can be secured only if the system, including personnel under the system, is well prepared and additional resources are needed for this preparation.

In summary, the proposed main characteristics of system under the UC policy are[16]:

(1) promoting the use of primary care;

(2) the use of close end provider payment method;

(3) ensuring quality of care by using accreditation;

[15] National Economic and Social Development Board, Press Release, 17 December 2001.

[16] MOPH, Guideline for the Management of Universal Coverage Policy during the Transitional Period. Ministry of Public Health, May 2001.

(4) the use of standard benefit package and payment method;

(5) merging of existing health insurance funds;

(6) decentralization of fund management to the province.

Promoting the use of primary care

Primary care in Thailand have been neglected for a long time and this results in poor and unacceptable quality of care provided by primary care and overcrowding of outpatient department of big hospitals due to the bypass of unnecessary cases[17]. During the last decade, there have been continuous efforts to strengthen primary care in Thailand. In 1992, the first demonstrating model of primary care has been established in Ayutthaya province[18] and has become a successful model. The concept and management model of primary care has been gradually accepted nationwide. Recently, the Consortium of the Deans of Medical Schools has organized a national conference on medical education in April 2001 and has reached a consensus that changing medical curriculum to serve primary care is a priority issue. Unfortunately, existing incentive system, which still favors medical specialists in hospital, makes the reorientation of health care system more difficult. The establishment of the Social Security Scheme in 1990 could be a leverage for the change of health care system. However, because of the immaturity of primary care at that moment, the Social Security Office (SSO), then, decided to contract big hospital, more than 100 bed hospital, as a main contractor and financial incentive remained focusing on hospital care.

Primary care has been identified as a key mechanism for providing health care in UC policy because of two main reasons. First, primary care is a provider with the best setting for providing quality care based on holistic approach[19]. Its location close to the community makes the provider better realize the socio-cultural context of the people. Primary care provider also has better opportunity to perform their proactive role in the community. Second, it is expected that a system with primary care as a gatekeeper will have lower

[17] Srivanishakorn S. et. al. Primary Care in Thailand: Situation and Recommendations for the Development. Health System Research Institute and Thailand Health Research Institute, 1996.

[18] Pongsuparb Y. Development of Family Practice in Thailand: Ayutthaya Case Study. Health Care Reform Office, 1996.

[19] Valayasewee A. et. al. Relevant Health Care System for Thai Society in the Next Two Decade: Proposal for Reforming Medical Education. Health Care Reform Office. November 1999.

overall health care cost.[20] [21] [22] Strengthening and promoting the use of primary care in the UC policy has been done through many policy details as follows:

- **primary care is the main contractor and unit for population registration:** instead of assigning a big hospital as a main contractor, a primary care unit will be a main contractor and a unit for population registration in the UC policy. Primary care provider is entrusted for the provision of comprehensive care for their registered population.
- **primary care is a gatekeeper:** direct access to hospital care is not permitted, except in case of accident and emergency care.
- **primary care is a fund-holder:** in addition to the provision of comprehensive care by their own health facilities, primary care providers can use their budgets to contract other health facilities to provide care for their catchment population- a fund-holder approach. This will promote the network of primary care providers.

A primary care unit will be responsible for no more than 10,000 registered population and minimum requirements of primary care provider who would like to be a main contractor in the UC policy (Contracting Unit for Primary Care –CUP) are described in Box 2.

Box 2. Minimum Requirement of CUP

Inputs and Structure

1. One facility for no more than 10,000 population
2. Facility is located close to the responsible pop. (transportation time < 30 min.)
3. Adequate health personnel
- physician 1: 10,000-20,000*
- dentist 1: 20,000-40,000*
- pharmacist 1: 20,000-30,000*
- register nurse 1: 5,000
- health personnel 1: 1,250
- personnel work in CUP more than 75% of their working time
- available laboratory system for the investigation
- available vehicle for the referral

Provision of Services

- service available at least 56 hours/week
- be able to provide comprehensive care
- be able to provide in-house service and community based services

* the lower proportion of health personnel to population are proposed to use in rural areas where there are severe shortage of health personnel

[20] Martin D.P. et. al. Effect of a Gatekeeper Plan on Health Services Use and Charges: A Randomized Trial. American Journal of Public Health. 1989; 79: 1628-32.

[21] Walker L. Is the Gatekeeper a Dying Breed? Business Health. 1998: 16: 30-36.

[22] Delnoij, D. et. al. Does General Practitioner Gatekeeping Curb Health Care Expenditure? Journal of Health Service Research Policy. Vol. 5 No.1 January 2000: 22-26.

The use of close end provider payment method

Experiences of countries with universal coverage policy confirm that health care cost of those countries would increase because of the moral hazard unless appropriate provider payment method and cost sharing system have been adopted. Cost sharing, as a demand side intervention, has limited effect on cost control especially when compare with supply side interventions. Introducing only co-payment of 30 Baht per visit, therefore, may not be enough to contain the health care cost. Thailand has quite impressive experiences in using capitation payment to control the cost of the Social Security Scheme (SSS) since all the financial risk has been transferred to the provider. Recently, the proposal on the reform of the Civil Servant Medical Benefit Scheme (CSMBS) has proposed a further modification of capitation payment by splitting payment for ambulatory care and payment for inpatient care. Capitation payment is proposed for ambulatory care while case payment, Diagnostic Related Groups (DRG) with global budget, is proposed for inpatient care.[23] Inclusive capitation, as still used in the SSS, and the new proposal, exclusive capitation, become the two main provider payment methods proposed for the UC policy. Payment in the UC policy can be divided into two levels.

(1) **Budget allocation from central to province.** Budget needed for the UC policy will be allocated to the provinces on a capitation basis according to their registered population. Adjusted capitation rate, according to morbidity and mortality of provincial population and other related factors, was also proposed in the policy but it has been postponed for the implementation.

(2) **Paying providers in the province.** There are two options, inclusive and exclusive capitation, which the provincial committee can choose for paying providers in the province. It's expected that there will be a single provider payment method in the future.

Ensuring quality of care by using accreditation

The use of capitation payment to control cost of health care system may have negative consequences on quality of care. The SSS has encountered the quality impairment under the capitation payment by using additional fee-for-

[23] Sriratanaban, J. Civil Servant Medical Benefit Scheme: Unregulated Fee-for-service and Cost Escalation. Health System Research Institute, 2001 (mimeograph).

service and lump sum payments for some specific services for example; accident, emergency and high cost care. Accreditation is also needed for the participating hospitals to ensure good quality of care.

In fact, quality assurance and quality improvement of public health facility has become an issued concerned by the MOPH since the last two decades. The MOPH has tried many approaches until recently hospital accreditation (HA) has been accepted as the main approach for quality assurance and quality improvement for both public and private health facilities[24]. Hospital Accreditation Institute has been established for this long-term mission. HA is also accepted as a basic requirement of health facility who would like to participate the UC.

The use of standard benefit package and payment method

As mentioned earlier, one of the ultimate objectives of the UC policy is to have a single standard of health care for every Thai citizen. Standardization of benefit package of people under different health insurance schemes may be the first priority. However, this needs legislation change and may create a lot of resistance. Standardization of benefit package, therefore, has started from the schemes under the responsibility of the MOPH i.e., Health Welfare Scheme (HWS), Health Card Scheme (HCS) and 30 Baht Scheme. All these schemes cover the majority of Thai population, more than 75% of total population. The proposed benefit package has been derived from the benefit package of the SSS but includes personal preventive and promotive services as part of its package. It is expected that this proposed benefit package would be a standard for the adjustment of other schemes in the future.

Standardization of provider payment method is also necessary since it determines the quality of care provided. At the moment, there is a tendency that all schemes are going to reform their provider payments to a more acceptable one.

Merging of existing health insurance funds

Merging of existing health insurance funds is expected to increase the management efficiency and also to decreases problem of overlapping.

[24] Supachutikul S. and Sriratanaban J. Quality of Health System. Health System Research Institute, August 2000. p.61-64.

Although single payer system is accepted as the most appropriate model, proposals on the optimal number of health insurance funds during the transitional period are quite controversial. Network of civic groups proposed to have only single health insurance fund while the academic people proposed that dual health insurance system for formal and informal sectors might be more appropriate during the transitional period.[25] The government agrees to have dual health insurance system during the transitional period and even proposes in the law that merging funds to be a single fund would be done on the voluntary basis.

Decentralization of fund management to the province

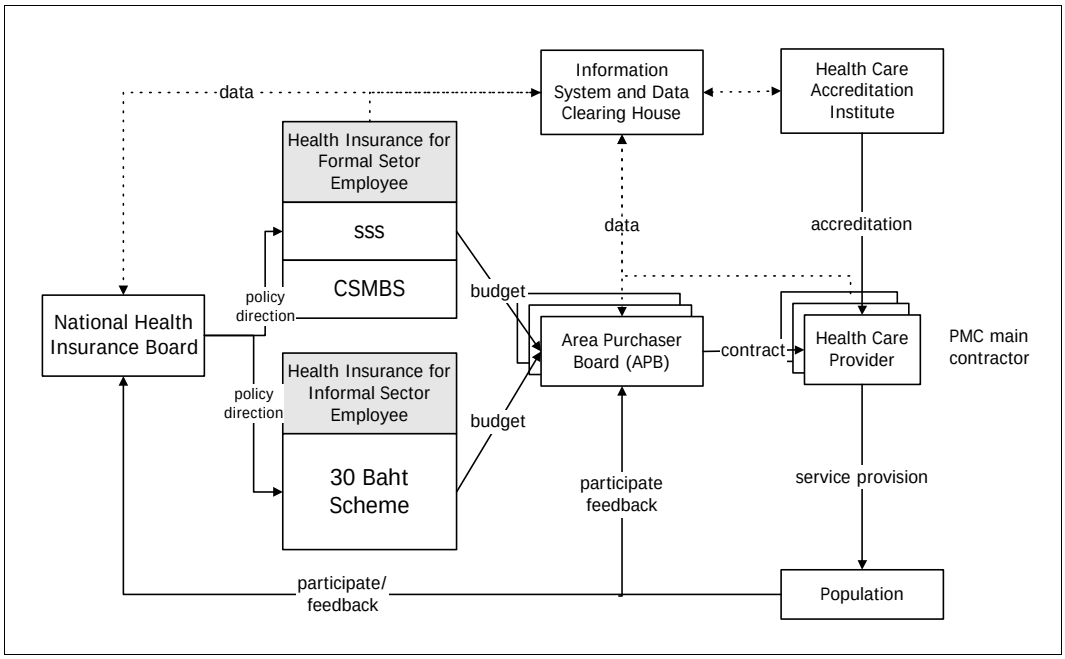
The UC policy proposes that the National Health Insurance Fund will act as a fund-holder while the purchaser will be a decentralized office. There are a lot of debates about where should be an appropriate level for this decentralized office. The academic people purposed that a decentralized office, Area Purchaser Board-APB, should be located in areas with more than 3 million populations to ensure adequate risk sharing and economy of scale. According to this proposal, APB will be a regional office and there will be 21 APBs nationwide.[26] The MOPH proposed to have a decentralized office at the provincial level where a devolved health structure, Area Health Board-AHB, is located. AHB has been established, according to the Decentralization Act of 1999, to manage all public services, including health service, in the province. Assigning AHB as a provincial purchaser will help improving the integration of personal health care and public health programs. The government decides to decentralize the fund management to the provincial level during the transitional period. The Provincial Health Office (PHO) is assigned to be a provincial purchaser while the AHB is just an advisory board due to its immaturity.

The proposed system under the UC policy during the transitional period, which will be a dual health insurance system for formal and informal sectors, can be described in Figure 2. The National Health Insurance Board (NHIB) will be the main mechanism to steer all reform processes of each scheme to ensure a single standard health care for every Thai citizen in the future. The National Health Insurance Office (NHI) will be the secretariat office of the NHIB and perform all supportive and coordinating tasks.

[25] HRSI. ibid. p.67.

[26] HSRI. ibid. p.77-79.

Figure 2. ***Proposed system under UC policy during the transitional period***



Policy Development and Policy Implementation before the Establishment of the NHIB

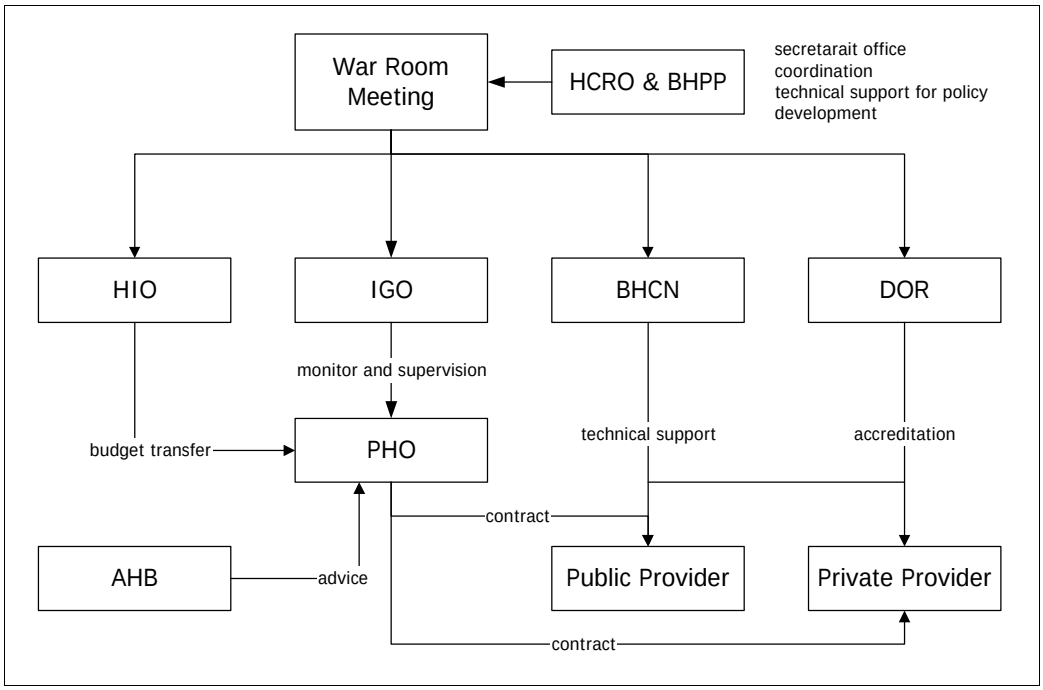
Although it has been proposed that the UC policy is a national policy and should be responsible by a national body which can coordinate all related organizations. The MOPH may have conflict of interest in performing this role since it own the majority of public health facilities. Assigning the MOPH to be a national purchaser/fund-holder will create a system without purchaser-provider split and it would be difficult for the MOPH to be an effective health care purchaser under this situation. However, because of the delay establishment of the National Health Insurance Board (NHIB) and the National Health Insurance Office (NHIO) and the need to have a rapid implementation of the policy. The MOPH, then, has become the most appropriate responsible agency for the implementation of the UC policy in the early stage.

At the beginning of the year 2001, the MOPH set up a core team responsible for the policy development. A proposal developed by the core team has been considered in the workshop in government house on March 17, 2001 and has been used as a framework for further policy development.

After the workshop, the MOPH set up 10 working groups, comprising of people from various sectors including representatives of consumer groups and private health care providers, to develop detail policy. The result of this participatory policy development process has been used as a guideline for further policy implementation[27].

The main responsible organizations in the MOPH include; the Health Insurance Office (HIO), the Bureau of Health Policy and Planning (BHPP), the Bureau of Health Care Network (BHCN), the Inspector General Office (IGO), the Health Care Reform Office (HCRO) and Division of Registration (DOR). Role and responsibility of each organization can be summarized in figure 3. Since there are several organizations involved in this policy implementation, the MOPH decides to set up a committee, called War Room[28], to coordinate and monitor policy implementation and to solve obstacles of policy implementation.

Figure 3. ***Internal structure of the MOPH for the Implementation of the UC policy***



[27] MOPH ibid.

[28] The War Room committee is chaired by the Deputy Minister of Public Health and has a regular meeting on Monday morning.

The policy has been implemented in 6 pilot provinces in April 2001 and expanded to another 15 provinces in June 2001. Health care providers were limited only the MOPH's providers in the first six provinces but extended to other public health care providers and private providers in subsequent provinces. The policy has been implemented almost nationwide, 75 provinces and part of Bangkok, in October 2001. The rest of Bangkok will be incrementally covered in January and April 2002. Policy implementation in Bangkok has been delayed because of its system complexity.

Immediate Effects of the UC Policy

Population coverage and health service utilization of beneficiaries under the UC policy

In the first six provinces, the scheme could cover about 1.47 million people or about 40.7 percent of population in those provinces. In the second phase of policy implementation in June 2001, it could cover additional 4 million people or 28.9 percent of population in provinces in the second phase. There were 97.6 percent of registered population registered with public providers while 2.4 percent of them registered with private providers. In October 2001, the scheme could cover 37.3 million people in 75 provinces and part of Bangkok and private providers still shared the same proportion, 2.3 percent of registered population. The MOPH's providers are the main public health care providers and are responsible for 95 percent of registered population.

Health service utilization of beneficiaries in the first 6 provinces can be presented in table 1. It was found that health service utilization of those who were covered by the scheme was quite low, 0.58 visits per capita per year for ambulatory care and 0.03 admission per capita per year for inpatient care, when compared with other schemes (table 2). Reported health service utilization of beneficiaries in the second phase in the first month was also low, 0.67 visits per capita per year for ambulatory care and 0.03 admission per capita per year for inpatient care[29]. For the uninsured, who should be the beneficiaries of the UC policy, the national survey in 1996 found that utilization of ambulatory care by the uninsured was 1.9 visits per capita per year and admission rate was 0.05 admission per capita per year. It means that

[29] Bureau of Health Policy and Planning, MOPH, Universal Coverage Policy: Evaluation of Policy Implementation in the Second Phase. A reported prepared for the meeting on August 15, 2001.

some beneficiaries of the UC policy still utilize services outside assigned health facilities. Explanation for this low utilization may be because the beneficiaries don't realized about their right and also hesitate about quality of care provided by the scheme.

Table 1. *Population covered by the UC Policy in the first pilot provinces and their health service utilization, April-September 2001*

				Ambulatory care			Inpatient care			Utilization	
	Total population	Registered population	%	OP visits	OP reported expenditure	OP baht/visit	IP cases	IP reported expenditure	IP baht/case	Visit/cap/year	Case/year
Pathumthanee	655,095	306,557	46.8	81,607	9,022,218	110.56	3,286	9,161,309	2,787.98	0.53	0.02
Samutsakorn*	332,994	155,122	46.6	60,402	8,565,594	141.81	2,874	10,956,902	3,812.42	0.78	0.04
Nakornsawan	1,128,574	551,124	48.8	123,406	16,993,531	137.70	8,089	10,358,744	1,280.60	0.45	0.03
Payao	511,622	167,630	32.8	47,988	6,370,156	132.74	2,339	11,677,136	4,992.36	0.57	0.03
Yasothorn	554,932	191,979	34.6	71,104	6,545,932	92.06	3,267	8,767,440	2,683.64	0.74	0.03
Yala	443,744	101,791	22.9	45,866	7,381,289	160.93	3,467	11,330,995	3,268.24	0.90	0.07
Total	3,626,961	1,474,193	40.7	430,373	54,878,720	127.51	23,322	62,252,526	2,669.26	0.58	0.03

Source: Health Insurance Office
Provider payment in 6 provinces was capitation for ambulatory care and DRG with global budget for inpatient care. Budget allocated to each province was 416 Baht/cap/year, excluding personnel cost
* exclude population in Banphaew district where the first autonomous hospital is located

Table 2. *Number of illness episodes and health service utilization of people under different health insurance schemes in 1996*

	MWS*	CSMBS	SSS	HC	Private Insurance	Uninsured
Number of illness	5.9	4.5	2.6	5.0	4.4	3.3
Visit per capita/year (pub/priv)	3.7 (3.0/0.7)	3.2 (2.0/1.2)	1.5 (0.7/0.8)	3.2 (2.5/0.7)	3.2 (0.8/2.4)	1.9 (1.1/0.8)
Admission/cap/year (% pub/priv)	0.09 (93/7)	0.08 (74/26)	0.05 (52/48)	0.09 (92/8)	0.15 (28/72)	0.05 (79/21)

Source: Health Welfare Survey, 1996, the National Statistical Office.

* Only for LIC

Effect on public and private health care providers

Public and private health care providers are extremely effected by the provider payment mechanism adopted the UC policy. The specific changes of provider payment method which effect providers are:

(1) **The change of resource allocation criteria from supply to demand side:** The sudden change of provider payment method from supply to demand side resource allocation, capitation payment, makes providers face difficulty in adapting themselves since there are serious mal-distributions of health facilities among regions and among urban and rural areas. Health facilities in areas with over supply, therefore, will face the problem of budget deficiency. It was found that hospitals in big cities were forced to downsize their structures and to increase their management efficiency.

(2) **The change of main contractor from hospital to primary care unit:** According to this change, resource will be re-channeled to the primary care unit first based on registered population. Secondary and tertiary hospitals will be paid, from primary care unit or provincial fund for inpatient care, according to their performances determined by number and type of referred cases. Hospitals are forced to provide primary care because of two main reasons. Firstly, there are severe shortages of primary care providers in urban areas where hospitals are located. Secondly, hospital managers are afraid of inadequate budget allocated to hospitals based on performance criteria. Performing dual functions, providing primary and hospital cares, of hospitals is expected to increase hospital revenue and to ensure hospital financial viability. However, because of limited experiences of hospital personnel in providing primary care, especially those in private hospitals, this will effect quality and coverage of basic services in some areas.

It is anticipated that with the new payment method there will be at least 26 provinces where the MOPH health facilities will face the financial problems[30]. The MOPH has realized this foreseeable problem and has requested a special additional budget, contingency fund, for solving this problem in public health facilities. In November 2001, there were requests

[30] Estimation by a subcommittee appointed by the War Room. The estimation was made by using information available on November 9, 2001 which comprised of information from 60 provinces. The criteria for selection of province with financial problem are the provinces where regional/general hospital have deficit more than 50 million Baht and at least one district hospital has negative balance.

from 29 provinces for contingency fund in the amount of 3.2 billion Baht. Public health facilities who request for contingency fund need to submit plans to reform their health facilities to ensure long term survival.

Effect on the role of provincial health office

During the transitional period, the Provincial Health Office (PHO) is assigned to perform as a provincial purchaser. This is quite a new role of the PHO and the present PHO now has no experience and very limited capability in performing this role. In addition, the rapid policy implementation and inadequate preparation of provincial health personnel even make the situation worse than expected. The PHO can be only a passive health care purchaser under this situation.

Effect on the MOPH budgeting system

Since budget for the universal coverage policy has already included part of fiscal budget plan which used to be allocated directly to public health facilities according to proposed projects or programs. In order to follow the new provider payment method, it is necessary to have a clear separation of the previous fiscal budget plan for which part should be a budget for universal coverage policy (UC budget) and which part should not be (non-UC budget). The non-UC budget will be managed and allocated to the public health facilities in different ways. All budgets for providing personal care are identified as budgets for universal coverage policy and will be allocated to provinces according to the registered population, per capita resource allocation. The budget separation which leads to different ways of budget management according to their purposes, UC and non-UC budgets, creates another management difficulties.

(1) **Limited space for vertical programs related to personal care:** since all budgets will be allocated to and managed by the provinces in a decentralized way. This effects some vertical programs which central management is still necessary because of its efficiency. Purchasing and managing vaccines to ensure their availability for the National Expanded Immunization Program (EPI) is an example of this necessity and it is agreed to separate cost of vaccines, 14.70 Baht per capita, from budget allocated to provinces and to manage it at the national level.

(2) **Limited budget for administration and supporting activities:** at the provincial level, normally the PHOs will keep part of the budget, intentionally prepared for public health facilities in the provinces, and manage by themselves to cross subsidize their inadequate budgets for administration and supporting activities. In the new budgeting system, UC budget is clearly specified for health facilities and the PHOs can not use it for other purposes. Budgets for administration and supporting activities are separated budgets but their amounts are quite low when compared with the previous budgeting system. The same situation also occurs at the national office and limits the flexibility to mobilize supports for the policy implementation.

Conclusion

Thailand may be one of a few countries who try to achieve universal coverage of health care policy during the economic slowdown period. Attempt to achieve universal coverage has had a long evolution but it has been speeded up during the past couple of years. The policy has been adopted and implemented incrementally, in terms of area and comprehensive of policy package, and has reached the national coverage rapidly within one year. The policy content seems to have a sound direction which is a result of accumulated experience and knowledge in the society. The policy development and policy decision making was a participatory process at the beginning but is limited to the MOPH personnel at the present time. Rapid policy implementation may threaten policy achievement since the existing structures have limited capabilities to perform their new roles and time is needed for the preparation. Time is also needed for the development of policy details and at the moment, there is limited technical support for this. Resources needed for all these preparations are also limited because most of them are mobilized to health facilities for providing services for the beneficiaries.

It is too early to conclude whether the universal coverage policy in Thailand is a successful or failure policy. It is obviously that this policy is welcome by the public and is also well supported by the politicians, both from the government side and the opposition parties. However, good intention may not be enough to make the policy succeed if without a good management system. Assigning the whole responsibility, for policy development and policy implementation for the universal coverage policy, to

the MOPH may limit the system capacity to handle this challenging policy. Despite the fact that the MOPH may have a conflict of interest in performing this role since it owns the majority of public health care providers, the bureaucratic system of the MOPH will also limit its flexibility and efficiency to manage the whole system. Establishment of the National Health Insurance Office, a new national body which doesn't own any health care provider and has an efficient management system indicated by law, can be an immediate solution to face with all difficulties.

Annex 7

HEALTH FINANCING TECHNICAL BRIEF
REVIEWING THE IMPACT OF USER FEES: THE AFRICAN EXPERIENCE[1]

(Draft March 2003)

Introduction

This paper reviews user charges as a financing option for health care in terms of its impact on service utilization, quality of care and revenues raised within the context of the overall objectives of the health system.[2] The study uses evidence from the African experience in implementing charges in an attempt to draw some conclusions about what makes a system of fees 'successful' or otherwise. It will show that effective implementation of fees is subject to conditions that are difficult to satisfy and that fees are at best a used as a co-financing mechanism.

Much of debate on fees at the global policy level has focused on the efficiency and equity aspects of user charges. Proponents in favour of user charges suggest that fees could make the health system more efficient by guiding demand to cost-effective health care at appropriate levels. Further, they argue that the approach could also improve equity as well if revenues raised (or freed up) are allocated to addressing the health needs of the poor[3]. The opinion on the other side argues that this reallocation is not in fact guaranteed and, in the absence of effective exemption policies or other forms of financial protection, user charges actually price the poor out of the market for health care with potentially dire consequences for their health status.[4]

The essentials of both arguments found a place in the African design of user charge policy - promotion of utilisation of primary health care centres

[1] This draft was prepared by A. Singh, Department of Health Financing and Stewardship, WHO, Geneva, in close collaboration with G. Carrin and W. Savedoff and with comments from numerous WHO colleagues, including P.Hanvoravongchai, P. Davies, K. Kawabata, E. Villar, J. Perrot, C. James, N. Sekhri, and M.Takeuchi.

[2] These have been stated as Improvement in health status, fairness of financial contribution and responsiveness (WHR, 2000) .

[3] See for example Griffin, 1988.

[4] For a recent review see Ahin-Tenkorang, 2001.

(PHCs) and protection of the poor. The emphasis on fee as a financing mechanism was in response to a resource crisis in the health sector and were endorsed as a means to raise additional revenues. It was envisaged that this bridge the resource gap in improving access and provision as well as allow for investments in better quality, especially the availability of drugs, which in turn was expected to promote utilisation of PHCs. Also, implementation was anchored at the community/facility level to facilitate targeting benefits to the poor.

Since their wide-spread introduction under the Bamako Initiative (BI), the user fee experience in Africa has been reviewed extensively with respect to actual versus theoretical and planned outcomes.[5] Given the specific BI goals, these assessments focus on the revenue, utilisation and quality impact of user charges based on household and/or facility level data and using qualitative and/or quantitative information, though only about a fifth employed used 'before and after' scenarios, control groups or statistical/econometric techniques in their analysis. The findings of these studies are briefly discussed below in Section III. The purpose of this study is to update these reviews relying on quantitative studies that measure utility and quality responses to fees in an attempt to establish robust relationships between determinations of 'successful' or 'unsuccessful' implementation of charges. The large body of more descriptive literature is also used, to support these findings or to establish apparent patterns regarding an 'enabling environment' (particularly policy and institutional issues) that could be areas of further empirical research.

The next section introduces the analytical framework provided by household demand for health care and discusses each of its determinants in detail. The following section on the African experience puts the user fees in a situational context and outlines the specific policy objectives in Africa; and the findings of existing reviews mentioned earlier are presented here as well. The following sub-section turns to evidence compiled by the current review and first presents findings on the utilisation and quality impact of fees using the framework of household demand and then it draws inferences from the descriptive materials on the policy and institutional prerequisite that may contribute to these findings.

[5] See for example McPake, 1993; Creese and Kutzin, 1995; Nolan and Turbat, 1995; Gilson,1997.

The Basic Economics of User Fees

As an approach to understanding the basic economics of user charges within the context of the financing function and overall health systems goals, this sections discusses how household demand for health care is influenced by fees - if a goal of the health system is to improve health status then demand for care would be a relevant framework in which to discuss policy options to achieve it.

A simple expression of the determinants of consumer demand for care from a particular provider may be stated as:

demand = function (price $_{provider}$, price $_{alternative}$, income, quality, other)

i.e. household demand for health care is a function of four main variables: the price of the particular provider; the price of alternatives; household income; and quality of care. These are the four main determinants of demand and are examined separately below. Other factors may also have some influence demand e.g. age, sex, severity of illness, but these have been left out of the current analysis.

Introducing or raising fees for a service increases the price of that care faced by households. In terms of the relationship described above, an increase in price causes household to reduce demand or utilisation of the particular service. This utilisation response to a fee increase may be quantified by the price elasticity of demand which measures the change in demand brought about by a unit change in price. Evidence suggests that prices elasticities tend to be negative and less that 1 in absolute value i.e. an increase in fees will cause households to decrease utilisation but less than the proportionate increase in charges - e.g. a 1 per cent increase in prices would bring about a fall in utilisation but of a magnitude less than 1 per cent of current demand. Importantly, this measure may differ between groups - studies have found the price elasticity of demand to be higher among women and children as compared with adult males[6] - implying that a fee increase may impact the utilisation of certain groups more adversely than others.

How a fee increase by one provider impacts *net* utilisation will depend on the size of the additional charge as well the relative price and price response of alternative providers. If households have various health care options to choice from, a fee increase by one provider may simply redistribute consumers across providers in which case there would be little impact on net

[6] Gertler and van de Gaag, 1990

utilisation of services. This concept is measured by the cross price elasticity of demand - the change in demand for alternative provider services when the price of the initial provider changes. Studies estimating cross-price elasticities suggest that an increase in price by one provider results in some increase in the utilisation of service of alternative providers i.e. cross-price elasticity of demand is positive. However, if in response to a fee increase by one provider, alternative providers raise their prices as well, the switch from the initial provider may be restricted. Thus the magnitude of a switch from one provider to alternatives - and thus *net* consumer response - depends on the relative price of alternative providers, which in turn, is determined by both the increase by the initial provider and the subsequent response of alternative providers.

Household consumes a variety of commodities, one of the being health care, and distribute their income over all of these expenditures. In the context of the present discussion, higher fees for health services implies that to maintain levels of utilisation of health care, the share of household income allocated to health care must increase, necessitating a reduction in the consumption of other commodities. For poorer households, where health expenditure may already be a significant proportion of consumption expenditure, any additional layouts to health care at the cost of other basic consumption needs may not be viable. Effectively then, price elasticities are higher for the poor than for higher income groups.

The final determinant of household demand for health care examined here is quality. Improvement in the quality of services is predicted to increase utilisation as better quality adds additional value to the commodity - the quality elasticity of demand is positive. Thus, should higher fees be accompanied by quality improvements in health services, the negative utilisation response to an increase in charges may actually be dampened or even outweighed by the positive impact of quality. i.e. the quality elasticity of demand and price elasticity of demand work in opposite directions and the quality effect may cancel out (all or part of) the price effect on utilisation. However, quality has proved difficult to define and quantify. A comprehensive measure would capture both structural attributes, e.g. drug availability, as well as process indicators, e.g. quality of interaction between providers and patients[7] but due to problems of definition and measurement, most studies use drug availability as a proxy for quality.

[7] Mariko, 2002.

In summary, the four main determinants of household demand for health care - provider price, price of alternatives, income and quality - offer a useful framework to assess the impact of user charges on utilisation. The model predicts that an increase in provider fees will cause demand for that provider's services to fall. However, the *net* impact on utilisation will be determined not only by the size of the additional fee but also the relative price of alternative providers. Further, this utilisation response to user charger is higher for lower income groups. And finally, the negative impact on utilisation is reduced if higher fees are accompanied by improvements in the quality of service.

Using the framework developed here, the next section considers the evidence from Africa on the impact of user charges on utilisation, quality and revenues.

The African Experience with User Charges

This section examines user fee implementation in Africa vis-à-vis its impact on service utilisation, quality improvements and additional resources raised. Before evaluating the experience, the policy decision to introduce or raise charges is put into a contextual background, importantly, the specific aims in Africa of such a financing choice.

The context of a systems of user fees in Africa

One of the first attempts at using charges as a financing mechanisms in the health sector was the Pikine Project in Senegal in 1975[8]. In response to severely limited government funding in a poorly served and rapidly growing urban centre, in 1975, communities organized and financed their own primary health care services. Health committees at the local level were responsible for over-seeing a system of fee-for-services, with variations across types of service as well between adults and child charges introduced at PHCs. Revenues raised through fees were apportioned across recurrent cost categorises, the distribution rules established by an association for health promotion formed by health committees and legitimated by the government. Between 1980 and 1987, 77% of total PHC costs came from community contributions and as much as 85% of this revenue was pre-assigned for the

[8] Carrin, 1992.

purchase of drugs, making facilities quite self-reliant in terms of this essential input. There is little accurate information on the Project's impact on utilisation though it does not appear to have increased substantially and, particularly, fees may have impacted the poor adversely. Two factors were noted here for more attention: setting a level of fee needed to take into account non-medical costs, particularly travel time costs and fee adjustments needed to follow set guidelines avoid over-adjustment due to ad hoc procedures. Overall, Pikine Project was considered an 'encouraging experience' in terms of self-financing primary health care.

The central features of the Pikine Project formed the blue-print of health sector reform in Africa in the 1980s be it through a general approach or as part of the Bamako Initiative. The driving force was, again, the lack of resources to improve a poorly functioning primary care system. User charge was the policy choice to increase revenue and its use towards improving the availability of drugs the key to increasing utilisation of PHCs. On the managerial/administrative aspect, the Bamako Initiative model emphasized that revenue be raised and controlled through community based activities which were national in scope. Community participation in management was seen as the critical mechanism for ensuring that resources were used in ways which address the persistent quality weaknesses of primary care (especially drug availability), that exemption policies to protect the poor were implemented effectively and that there was accountability to the users of health care.

All countries in Africa have some form of user charges, enforced through either national polices, the Bamako Initiatives or pilot projects. As Table 2 (a,b,c) indicates, the stated objectives of a system of fees are almost uniformly to raise revenues to improve utilisation and quality of primary health care centres (PHC), particularly the supply of drugs.[9]

Table 2 (a,b,c) also illustrates the different structure of fees and the arrangements for revenue sharing across countries. In keeping with the objective of improved availability of drugs, almost all countries have introduced fees for drugs for both outpatient and inpatient care. However, other charges vary from registration, per visit, and treatment fees or some combination of these. While the expressed aim is to promote PHCs, only a

[9] Raising additional revenues for ensuring drug supplies was in fact a specific aim of the Bamako Initiative and some countries earmarked revenues raised for a drug revolving fund.

third of the countries implement a system of fee waiver for referrals or fee variations between levels of care that would encourage the use of primary facilities. Also, the community focus is diluted as well - only half the countries having a policy that allows at least a proportion of revenues raised to be retained at the facility level with fee sharing arrangements ranging from full retention at community/health centres to 100 per cent remitted to the Ministry of health. A related financing issue is 'budgetary protection' which safeguards current health budgets from dollar-for-dollar reductions against additional revenues raised through user charges. There is very little evidence on this – either on policy stance on the issue or if budgets were actually reduced once revenues were raised through the fee option – though some countries did secure budgets against such.[10]

Evidence on the impact of fees in Africa

Quantitative evidence

Previous reviews[11] indicate that predicted levels of resource mobilisation have not been realised and that, in fact, revenues raised from implementing user fees fell well short of estimates, being on average about 7% of non-salary costs rather than the anticipated 15%[12]. This has limited both the envisaged increase in utilisation, through an improvement in the availability of drugs, as well as reallocation of resources, through exemptions schemes to protect the poor. The reviews emphasise the importance of establishing a supporting institutional infrastructure has a key first step to ensuring the feasibility of a system of fees: policy directives for fee structures, revenue collection, retention and expenditures; exemption guidelines; and motivated staff with the capacity to enforce these rules effectively with the community.

This review examines the evidence on user charges using the framework outlined in Section I. To reiterate, household for health care may be expressed by the following relationship:

demand = function (price $_{provider}$, price $_{alternative}$, income, quality, other)

Table 1 tabulates evidence on elasticities of demand.

[10] e.g. Kenya.

[11] Prominent reviews include McPake, 1993; Creese and Kutzin, 1995; Nolan and Turbat, 1995; Gilson, 1997.

[12] As predicted by the World Bank when advocating greater use of fees.

Price *provider*

Evidence on price elasticities of demand indicates a wide range for overall elasticities, from -0.10 to -0.79. The evidence on demand response by level of care is mixed: in Ghana hospital care is more price elastic than lower levels of care - the measure for inpatient care is in fact greater than 1 in absolute value (-1.82) indicating that fees would cause a more than proportionate fall in utilisation of inpatient hospital care; evidence from Cote d'Ivoire on the other hand indicates a higher utilisation response to an increase in charges at health clinics vis-à-vis hospitals. Further, in a simulation exercise for rural Cote d'Ivoire, it was found that user fees seemed to have a greater negative effect on the utilisation of children than that of adults. Thus while there is evidence that an increase in fee will cause utilisation to fall, more so among children than adults, the size of the overall decrease varies across levels of care and is also very different across countries.

Price *alternative*

There is very little information on *net* impact on utilisation via an change in user fee. While not calculating cross-price elasticities between specific providers but, rather, substitution between groups of providers, a study in rural Cote d'Ivoire found that households faced with an increase in the price of one provider would more likely turn to other providers that to opt for self-care. For Kenya, measures of price elasticity are available separately for different types of providers with mission and private provides have elasticities much higher than ¦1¦ - -1.57 and -1.94 respectively as compared with -0.10 for government providers. Clearly then establishing the 'swtich' between providers is crucial to estimating the *net* utilisation response of an increase in public sector fees.

Income

Studies on price elasticities by income group indicate that this measure can be substantially higher for the poor: -1.44 versus -1.12 in Burkina Faso. Evidence from the Cote d'Ivoire suggests this disparity holds between levels of care as well - both groups have higher elasticities for health clinics versus hospital services but, for each level of care, elasticities for the poor are higher than for the rich. This finding highlights the importance of including a strategy to

safeguard the poor through exemptions for example, as past of a user fee policy.

Quality

As discussed earlier, quality is difficult to define and measure and hence there is limited evidence its impact on utilisation based on a precise measure. Three studies have modelled quality along with the other determinants of demand using with different definitions: a study for Nigeria[13] used three provider quality variables based on facility surveys - expenditure per person in population served, proportion of times drugs were available and evaluation of physical condition of facility - and found that while price effect was important but relatively small, public providers could actually increase prices by 87% to private facility levels if they matched their quality as well without an adverse impact on utilisation. The second study in Niger[14] used drug availability as a proxy for quality and suggests that the quality effect of a fee may outweigh the price effect on utilisation, implying quality improvements are an important in ensuring long-term success of cost-sharing policy. The third econometric study emphasises the importance of accounting for both structural - e.g. drugs - as well as process attributes of quality - e.g. 'good' consultations. Its findings for Mali[15] suggests that both these attributes of quality impact utilisation and that omitting the process quality variables from the demand model produces a bias not only in the estimated coefficient of the price variable but also in the estimated coefficient of some structural attributes of quality.

A comprehensive before and after study with controls in Cameroon[16] suggests that the probability of using the health centre increased significantly after the introduction of fees - travel time and costs involved in seeking alternative sources of care were high and with the improved availability of drugs, the fee charged for public provision represented an effective reduction in the price of care and thus utilisation rose. Further, this impact was found to be most true for the lowest quintile - care sought increased at a rate proportionately higher that the rest of the population. Quality, even using one of its component namely drug availability, clearly has a positive impact on

[13] Akin et all, 1995

[14] Chawla and Elis, 2000

[15] Mariko, 2002

[16] Litvack and Bodart, 1993.

utilisation and may even outweigh the negative effect of a fee increase. However, in estimating its impact in its entirety, structural attributes would need to be combined with process ones and the issue of definition and measurement of these still needs to be tackled satisfactorily.

Notes:

The 'primary' studies used as evidence above also make two other relevant points:

1. The importance of including all *associated cost of accessing care in total costs and these may be context specific - in Uganda for example there are significant 'unofficial costs' which must be taken into account while assessing the impact of increased costs.*[17]

2. In modelling the impact of quality along with the other determinants of demand the study in Niger observed an increase in the probability of utilisation in districts with indirect payment schemes.

Summary points

- *price* $_{provider}$
  - an increase in fee causes utilisation to fall though the size of this response has a wide range across countries and between levels of care.
  - before setting levels of fee, is important to account for *all* costs, including travel and unofficial costs.
- *price* $_{alternative}$
  - to estimate the net utilisation response of an increase in fee, the relative price of alternative providers needs to be taken into account. The net utilisation impact of user charges may in fact be lower than that predicted by looking at the fee-raising provider alone.
- *income*
  - price elasticities of demand for health care higher for the poorer emphasising the need for protection of lower income groups.

[17] McPake, 1993

- *quality*
  - in defining and quantifying quality both structural and process attributes need to be included.
  - quality improvements positively impact utilisation and this can outweigh the negative impact of an accompanying price increase, even among the poor.

The evidence on the impact of user charges on utilisation is mixed across countries with some countries experiences large falls in demand while the change in others has been more modest. Also, the experience between levels of care has been similarly varied - in some cases lower levels of care were more effected in terms of a utilisation response to fee increases while in others, the impact on demand for hospital care was greater. There is little information on the response of alternative providers to draw any conclusions about the *net* utilisation impact of a price increase by public providers. However, two conclusions may be drawn from the available evidence: first, that the poor are more susceptible to an increase in fees than the better off and second, quality improvements that accompany a price increase may balance out the drop in utilisation, even among the poor.

Other evidence

There is substantial literature, relatively more descriptive in nature, that suggests factors other than those modelled above may be very relevant to the outcome of a system of user charges - specifically, policy and institutional issues - especially as some of these were stated goals of the BI. Also, this exercise may be used to point the way to research areas that require further study in understanding fees better. Accordingly, the more descriptive data available is used to draw patterns that emerge from outcomes of increased/decreased utilisation in response to user charges vis-à-vis strategies used to implement them - fee structures and related policies, community participation and exemption schemes. Given the difficulties in measuring quality, perceptions on quality improvement also included here. Particular country examples are used as illustrations on any additional observations.

Studies from 22 countries have been consolidated to provide as complete a picture possible on their fee experience. Tables 2 and 3 (a,b,c) distinguishes these by utilisation outcome and an almost even mix confirms the varied evidence on the strength of the price elasticities discussed above.

Negative utilisation response to user fees

Seven countries reported a fall in utilisation after the introduction of user charges. Only one of these showed an improvement in quality ratings. All but one had exemption policies in place to protect utilisation levels of the poor against the negative impact of user charges, supported by community/local participation in identifying beneficiaries.

The fee structure in these countries where utilisation fell relied on fees for drugs combined with variations of registration, per visit and treatment charges at outpatient facilities and offered waivers for referral and/or variations across levels. For inpatient care, the reliance was more on fees per day with some countries also implementing drug charges. Waivers/variations were less common for this type of care. The retention policy for this set of countries was mixed - some remitted 100% to the MoH while others retained substantial proportions at the facility/local level. Overall revenues raised were limited to less than 5% of recurrent costs in most cases.

Measures of price elasticities of demand for Ghana and Kenya presented earlier were quite low but both countries appear to record a clear fall in utilisation with an increase in user fees and it may be useful to examine the specifics of each country. One study in Ghana[18] found a 'sustainable inequity' after the introduction of fees - fee setting and collection practices have been decentralised but as a result have been difficult to monitor. Local staff have been active in setting, collecting and using fees to purchase essential inputs (and flexibility to this has in fact been identified as the crucial for better health service delivery by local medical administrators - 2/3 to 4/5 of non-salary operating costs have been recovered in the region investigated and for those able to pay for care, quality has improved. However, official exemptions have been largely non-functional leaving the poor out of the public health care system - less than 1 in 1000 surveyed was granted exemption when as estimated 15-30% lived in poverty[19]. Kenya[20] introduced phased (top-down) out-patient treatment fee after an initial period of implementation and subsequent suspension of registration fee due to implementation problems - patient dissatisfaction with quality in spite of higher prices; procedures for

[18] Agyepong, 1999

[19] Nyonator, 1999

[20] Collin, 1996; McPake, 1993; Mgubua, 1995; Mwabu, 1995

waiver were poorly understood; overall revenue collection was low due to unclear claim procedures for those insured and, for cash collections, managers could not/did not control or monitor what was being waived, exempted or collected: overall, the system suffered from poor information - on part of both consumers and providers. This registration fee caused utilisation to fall by about 1/3 or more at all levels, being particularly high at the district level (where alternative care was available). The subsequent treatment fee caused a smaller decrease (6%) - the difference from the previous regime being a fee for tangible services, broader exemptions, comparatively high prices for all commodities and wider acceptance of fees. Also, community pharmacies eased the financial burden of drug payments. Perceptions of quality changes differed between provincial and district hospitals - as mentioned the former had smaller falls in utilisation, greater revenue generation and better cost sharing management systems (though the main components of quality required little financial investment - cleanliness, staff attitude)

Positive response to user fees

Utilisation increased after the introduction of fees in eight countries. Seven of these had marked improvements in the availability of drugs. Only half had exemption policies, all with community/local participation.

The main type of fee imposed was for drugs in these countries combined with charges for treatment in some countries - for both out- and in- patient care. Some, though lesser, reliance was placed on registration charges and only one country had an explicit policy of waivers/variation of fees. Evidence available for six countries on retention indicates the bulk of revenues raised were retained at facility level (at least 75%). Revenue collection figures are available for only three countries, in all cases substantial proportions - upto 100% of recurrent costs were recovered.

There are some relevant country illustration here as well. In Cameroon[21] the success of provincial health funds, built on fees for drugs (and services) and managed by the community. By its third year they raised over 60% of recurrent non-salary costs of public health services and were projected to cover the entire cost by the end of the fourth year. In Mauritania[22] the

[21] Sauberborn, 1995

[22] Audibert, 2000

introduction of cost recovery at the first level of care resulted in improvements in both structural and process aspect of quality - drug availability improved and so did staff motivation as indicated by an increase in preventive activities. However, given the success of pilot programmes of user fees, there was a move to substitute the regular health budget with these additional collections and reduce government contributions to the sector.

Mixed utilisation response to user fees

Seven countries reported mixed utilisation responses to user and utilisation in two settled at previous levels after an initial increase/fall. All reported some improvement in the availability of drugs. Four countries protected the poor with explicit exemption policies with participation from the community/local staff in identifying beneficiaries. The exemption and better revenue observations included the two countries that maintained utilisation levels.

The fee structure in these countries varies between the options of registration, per visit and treatment charges with the main focus on fees for drugs in both out- and inpatient facilities and mixed policies on waivers/variations. Most countries had a retention policy that allowed revenues raised to be retained at the facility/local level. Of the two countries that experienced an initial decrease/increase in utilisation before previous levels were maintained, one implemented per day charges for in-patient care, else the reliance was on payment for drugs and registration (or per episode)/treatment fees. Also, both countries had provisions for revenue retention at the facility levels or expenditures were earmarked for drugs. Revenue collections were mixed as well, three countries recovered substantial proportions of recurrent but the rest were limited to less than 15%.

One of the few studies that examines the health outcome of user fees reports on the impact of charging for insecticide for treatments of nets in Gambia.[23] It found that the overall mortality and prevalence of malaria in children increase with an increase in cost of impregnation.

A comparative survey of NGO and public facilities in Uganda[24] found that the latter where able to raise up to 40% of recurrent costs from user fee

[23] Chaun, 1999

[24] Okello, 1998

while collection in the latter amounted to at most 7%. The recovery system in public facilities was not standarised, both with respect to collection as well as expenditures of revenues raised and therefore difficult to implement. Notably, also, staff at NGO facilities where better trained and better paid (further, some received in-kind rewards for performance) which, combined with better availability of drugs at NGO facilities, meant higher utilisation of these services particularly at lower levels of care (at higher levels of care public hospitals were favoured). Uganda has in fact the most reported informal charges in the health system and a recent study found that informal activities act as incentives, impacting both quality and utilisation of public health workers - informal charges are associated with better performance regarding hours worked and utilisation rates; drug leakage was associated with poor performance with respect to both these[25].

A large study in Zambia[26] for a 5 year period found a dramatic decrease of 1/3 in general attendance for both hospitals and PHCs over a two-year period followed by continued though slower decrease. Results also showed an increase and shift to health centres of specific care - vaccinations, general admissions and deliveries - though the intended overall shift in outpatient care from hospitals to PHCs did not come about. However, a study of referral pattern in Lusaka found that national referral hospitals may indeed be functioning as PHC but as additional *not* substitute facilities. Also, any by-passing lower levels of care has more to do with drug availability than a perception of better overall (technical) quality of care. Importantly, there remains substantial unmet need for health care and equipping health centres to meet this was more urgent that an attempt to decongest hospital outpatients through price (dis)incentives[27]. The importance of improving PHCs is emphasized by another finding that indicates that inequalities in access costs, especially between rural and urban areas - what seems to contribute to inequality in the cost of access is not the user fee per se but the travel cost and cost of time spent in reaching the health facility[28].

[25] McPake, 1999

[26] Blas 2001

[27] Atkinson, 1999

[28] Hjortsberg, 2002

Summary points

- Health outcomes
  - may be negatively impacted by an increase in user charges
- The context
  - influences consumer response to user charges: if some form of fee already existed, if the increase in price of health care was in line with prices of other commodities or if fees (and quality changes) meant a relative fall in the price of public services vis a vis accessing alternatives.
- Revenues raised
  - at best a modest portion of recurrent (non-salary) costs
  - this proportion is highest when fees are aimed at specific cost items e.g. drugs.
- Quality
  - important determinant of demand for care, which may, even without other factors maintain or even increase utilisation when user fees are introduced.
- Fee structure and related policies
  - the structure of fees needs to such that incorporates a clear link between charges and how it benefits the consumer i.e. payment for drugs or treatment rather than fees per day/per visit.
  - revenue retention, at each level of care as well as within the health sector itself, may provide an important incentive to facility staff for both collection as well as appropriate use to improve quality.
  - reducing the health budget in response to additional revenues raise through user fees recreates financial stress on the system.
  - incentives to consumers in form of waivers/variation in fees according to levels have limited value where 'inappropriate use' is not an issue.
  - on the provision side, a structure of fees that specifies its purpose, e.g. charges for drugs gives the necessary instructions for spending revenues raised, else, it is important that the policy set out expenditure rules for facility staff.

- Exemption
  - exemption polices need to include guidelines to identify beneficiaries that are simple to implement by the community and/or facility staff.
- Community financing and management of resources
  - may have some potential for positively impacting systems performance.

Conclusion

This review examined the African experience in implementing user fees as a financing alternative in terms of its impact on utilisation of services, quality of care and additional revenues raised. Given the limited robust literature available, any conclusions drawn can be tentative at best.

In keeping with the predictions of the analytical framework used, household demand for health care fell with an increase in charges though this measure was very varied in size across countries as well as between levels of care. However, the poor were clearly more vulnerable to a price increase than the relatively better-off though improvements in quality accompanying a fees seemed to reverse this trend, even for lower income groups.

The study also used the more descriptive information to ascertain an 'enabling environment' with respect to policy and institution issues for better implementation of fees. This literature indicates that overall revenue collection from user fees has been limited to a proportion of recurrent (non-salary) costs. It reiterates the importance of quality improvement in maintaining or increasing utilisation levels and suggests that both a clear link between increased contributions and better quality (e.g. drug availability) in the fee structure as well promoting staff motivation through revenue retention and expenditure at the facility level may contribute toward improving quality. While there is evidence to indicate that a negative utilisation response to fees may be reversed through quality improvements even among the poor, viable exemption polices need to be in place to ensure their protection. Also, community participation in administration/management and financing may have some potential for positively impacting systems performance. This, along with forms of prepayment noted earlier to have a positive effect on utilisation,

are being explored in other papers in this series. The other policy and institutional conditions discussed here all need further study.

Table 1. *Estimates of price elasticity of demand for health care*

Country	Service type	Data type	Overall	Low income	High income	Source
Burkino Faso	Public provider	All ages	-0.79	-1.44	-0.12	Sauberborn et al (1994)
		Age 0-1	-3.64			
		Age 1-14	-1.73			
		Age 15+	-0.27			
Cote d'Ivoire	Health clinic			-0.61	-0.38	Gertler and van der Gaag (1990)
	Hospital outpatient			-0.47	-0.29	
Cote d'Ivoire	Health clinic		-0.37			Dow (1996)
	Hospital outpatient		-0.15			
Ethiopia			(-)0.5 - (-)0.50			Jimenez (1985)
Ghana	Hospital inpatient		-1.82			Lavy and Quigley (1993)
	Hospital outpatient		-0.25			
	Dispensary		-0.34			
	Pharmacy		-0.20			
	Health clinic		-0.22			
Kenya	Government provider		-0.10			Mwabu et al (1993)
	Mission provider		-1.57			
	Private provider		-1.94			
Sudan			-0.37			Jimenez (1986)
Swaziland			-0.32			Yoder (1989)

Table 2a. *Objectives, structure and retention plans of user charge systems (Countries where utilization fell)*

	Country	Objectives	Fee Structure										Retention
			Outpatient					Inpatient					
			Registration	Per visit	Care	Drugs	Waiver/ Variation	Registration	Per day	Care	Drugs	Waiver/ Variation	
1	**Burkina Faso**	Improve PHC, ensure drug supplies			Yes	Yes	Yes			Yes	Yes	Yes	40% at hospitals
2	**Ghana**	Raise revenue, improve services, ensure drug supplies		Yes		Yes	Yes						Distributed between district, MoH and treasury
3	**Kenya**	Raise revenue to improve services, promote appropriate use			Yes	Yes	Yes		Yes			No	75% at facility and 25% at district
4	**Lesotho**	Raise revenue, promote approriate use	Yes			Yes	Yes	Yes	Yes	Yes	Yes	No	100% to MoH
5	**Mozambique**	Raise revenue, improve services, ensure drug supplies	Yes			Yes	No		Yes		Yes	Yes	Not known
6	**Swaziland**	Equalize public and NGO fees		Yes			No		Yes			No	Revenue to MoH/Treasury
7	**Zimbabwe**	Raise revenue, strengthen position of MoH, improve equity		Yes		Yes	Yes		Yes	Yes	Yes	Yes	Full retention by nation hospital; all other revenue remitted to Treasury

Table 2b. *Objectives, structure and retention plans of user charge systems (Countries where utilization rose)*

	Country	Objectives	Fee Structure										Retention
			Outpatient					Inpatient					
			Registration	Per visit	Care	Drugs	Variation	Registration	Per day	Care	Drugs	Waiver/ Variation	
8	**Benin**	Improve PHC	Yes		Yes	Yes	Yes			Yes	Yes	Yes	75% at facility, 25%
9	**Burundi**	Not stated	Yes		Yes	Yes		Yes		Yes	Yes		100% in community
10	**Cameeron**	Improve PHC, ensure drug supplies			Yes	Yes				Yes	Yes		100% at health centres; 50% at hospitals
11	**Guinea**	Improve PHC, ensure drug supplies	Yes			Yes		Varies					100% at facility
12	**Mauritinia**	Improve PHC, ensure drug supplies				Yes					Yes		
13	**Senegal**	Improve PHC, ensure drug supplies			Yes				Yes				
14	**Sierra Leone**	Improve PHC, ensure drug supplies				Yes	No				Yes	No	Most goes to DRF, rest retained at facility
15	**Togo**	Ensure drug supplies				Yes				Yes	Yes		100% at facility

Table 2c. *Objectives, structure and retention plans of user charge systems (Countries where the utilization response was mixed)*

	Country	Objectives	Fee Structure										Retention
			Outpatient					Inpatient					
			Registration	Per visit	Care	Drugs	Variation	Registration	Per day	Care	Drugs	Variation	
16	**Gambia**	Ensure drug supplies	Yes			Yes	No		Yes		Yes	No	Earmarked at MoH or DRF
17	**Guinea Bissau**	Improve services, ensure drug supply		Yes		Yes	Yes			Yes	Yes	Yes	National goes to MoH; BI retained for community, facility and region
18	**Mali**	Improve PHC, ensure drug supplies			Yes	Yes	Yes			Yes	Yes		National policy
19	**Nigeria**	Improve PHC, ensure drug supplies	Varies				No	Varies				No	Varies from facility to state level
20	**Uganda**	Improve community services	Varies				No	No official fee					Retained at community level
21	**Zaire**	Improve PHC	Yes			Yes			Yes	Yes			100% at health zones
22	**Zambia**	Raise revenue, improve community services	Yes				No	No information					Full retention of project revenue at community level

Table 3a. *Countries where utilization fell after introduction of user charges*

	Country	Revenue raised	Quality	Exemption	Community/ local participation
1	**Burkina Faso**	Low proportion of facility costs	No improvement reported	No	
2	**Ghana**	5% of recurrent expenditure	Drug shortages persisted	Yes	Facility staff
3	**Kenya**	Upto 7% of recurrent costs at provincial hospitals; lower (1%) at PHC	Improved rating provincial hospitals	Yes	Both
4	**Lesotho**	Upto 9% of recurrent costs	No clear pattern	Yes	Both
5	**Mozambique**	Below target'	Not clear	Yes	
6	**Swaziland**	Less than 5% of recurrent cost	No obvious change in quality	Yes	Facility staff
7	**Zimbabwe**	Less than 5% of recurrent cost	No evidence	Yes	Facility staff

Table 3b. *Countries where utilization rose after introduction of user charges*

	Country	Revenue raised	Quality	Exemption	Community/ Local participation
1	**Benin**	Upto 40% of costs in BI districts	Improved drug availability in PHC	Yes	Facility staff
2	**Burundi**	Not known	Improved drug availability in PHC	Yes	Community
3	**Cameeron**	Not known	Improved drug availability in PHC	No	
4	**Guinea**	Upto 100% of non-salary costs in some projects	Improved public perception	No	
5	**Mauritinia**		Improved drug availability in PHC	Yes	Both
6	**Senegal**		No evidence	Yes	Facility staff
7	**Sierra Leone**	Varies, some district covering most of drugs cost	Improved drugs availability	No	Community
8	**Togo**	Not known	Improved drug availability in pilot PHC	No	

Table 3c. *Countries with mixed utilization response to introduction of user charges*

	Country	Revenue raised	Quality	Exemption	Community/ local participation
1	**Gambia**	Upto 40% of drug costs	Drugs availability improved	Yes	Facility staff
2	**Guinea Bissau**	Minimal (less than 1% of recurrent); bit higher in BI pilots	Improvement in drugs supply in some facilities	No	Local management committee
3	**Mali**	100% of drug costs; 30% of other costs at pilot PHCs (less than 2% of recurrent MoH costs)	Improved drug availability	Yes	Health committee
4	**Nigeria**	Low	Improvement in drugs supply in	No	Community/facility staff
5	**Uganda**	Low	Improvements varied	No	Community
6	**Zaire**	Varies across zones - upto 80% of operating costs	Facilities improved	Yes	Community/facility staff
7	**Zambia**	Limited revenue nationally, community projects raising 10-15% of costs	Improvements varied in community projects	Yes	

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Annex 8

HOW CAN PRIVATE HEALTH INSURANCE SERVE THE PUBLIC INTEREST?[1]

What is Private Insurance?

As policy makers consider how to move towards financing mechanisms that will promote greater equity, they have a number of options to consider. All of these options combine prepayment and risk pooling, which lead to greater financing fairness, a key objective of any health system[2]. It is this transition towards prepayment that results in "universal health coverage,"[3] an important goal in ensuring affordable and equitable access to health care services for the entire population.

Analysis of high and middle income countries that have achieved some degree of universal coverage shows that all have mixed systems of financing combining both public and private sources of funding to meet different health care needs, and the needs of various segments of the population. For example, most countries use general taxation to fund or subsidise care for the poor, while those employed in the formal sector may contribute to health care costs through payroll deductions for social insurance or private insurance. In many countries, non-core services, such as eyeglasses, are funded through direct out-of pocket payments, except for the most vulnerable populations. There are three prepaid funding methods available to policy makers.

- General taxation
- Social insurance
- Private Insurance
  - Community health insurance
  - Not-for profit private insurance
  - For-profit commercial insurance

[1] Paper presented by Neelam Sekhri, HFS/PHF/WHO/Geneva, at the Regional Consultations on SHI, Bangkok, July 2003

[2] WHR, 2000. In addition, some countries use medical savings accounts but, with the exception of Singapore they do not play a significant role in health financing. External Aid, is also an important source of funds in developing countries, but it is not part of a sustainable financing system.

[3] USanguan and Mills 'Achieving Universal coverage', 1998,p.3: "Universal coverage is defined as a situation where the whole population of a country has access to good quality services (core health services) according to needs and preferences, regardless of income level, social status or residency"

Technically, all forms of prepayment, including general taxation can be considered "insurance" because they protect against the risks of facing uncertain medical costs through pooling risks with others.[4] In this paper, the term "insurance scheme" is used in a more limited context to include only those programs that explicitly provide a defined set of health care benefits through earmarked or direct payment to an "insurance entity", either public or private (Figure 1.1).

Social insurance and private insurance both fall under the rubric of *insurance schemes*, though considerable confusion exists on the distinction between these two types of coverage. Many of the criteria traditionally considered unique to social insurance programs can be found in private insurance systems as well, and the boundaries between social and private insurance are increasingly blurred. There are a spectrum of arrangements that range from purely private for-profit commercial insurance to purely publicly funded and managed social insurance. Figure 1.2 shows the continuum between these two extremes based on three key dimensions:

(1) Whether insurance is mandatory or voluntary

(2) Whether contributions are risk rated (minimal risk transfers between members of the pool) or income related (significant transfers resulting in greater equity)

(3) Whether management of the scheme is commercial for-profit, or public.

Although it is common to discuss private insurance and social insurance in terms of the extremes, in fact, the most common arrangements are in the centre. Generally, private insurance is financed directly through employer, employee, individual or family contributions. It is usually voluntary, but can also be mandatory and cover large segments of the population (as in Uruguay and Switzerland). Private insurance can be provided through community based health insurance schemes, through private for-profit insurers, or through private not-for-private entities (e.g. mutual aid societies, co-operatives etc). It can be risk rated, but in many countries where it plays a prominent role, it is community rated and contains varying levels of cross subsidies.

Private health insurance is used in two primary ways to provide coverage for health care services:

[4] Cutler, p.571

- **Principal Coverage:** Private health insurance is the primary form of prepayment available to all or certain parts of the population. This can be true for large segments of the population, (as for example in the U.S, where private health insurance is the primary coverage for the non-poor who are under 65 years of age). It may also be true in countries that have social insurance systems but certain segments of the population are not entitled to participate in them or can opt-out (such as the Netherlands where those over a certain income do not participate in the sickness funds). Policies that provide principal coverage usually include a broad range of interventions often mirroring a public package of services and covering the spectrum of primary, secondary and tertiary care interventions.
- **Supplementary Coverage:** Private health insurance augments coverage provided by a publicly funded system. Policies that provide supplementary coverage usually contain a limited set of interventions which address the particular gaps in a country's public financing system. For example, policies may cover residual health care costs (such as co-payments in France), services not included in the basic publicly funded package (such as outpatient drugs or dental care in Slovenia), or allow easier access to services and payment for private providers (such as in the U.K. and Australia where private policies enable faster access to specialists and elective hospital care).

Can Private Insurance Support Universal Coverage?

Unlike social insurance which is commonly viewed as promoting equity, functioning in the general interest of society and leading to universal health coverage, private insurance often conjures up visions of unequal access to care for the poor, large segments of the population left uninsured and market forces creating elitist health care for the rich. Experience indicates that unregulated or poorly designed private insurance systems can indeed exacerbate inequalities, provide coverage only for the young and healthy, and lead to cost escalation.

History shows however, that the social insurance systems of many OECD and middle income countries evolved from voluntary, private insurance schemes based on professional guilds or communities. This evolution may be useful to inform policy discussions in developing countries as they consider private coverage. The use of private insurance as one pathway leading

towards broader coverage through publicly funded schemes, is supported by the World Health Report 2000 which recommends that *"Low income countries could encourage different forms of pre-payment- job based, community based and provider based- as part of a preparatory process of consolidating small pools into larger ones".*[5]

Figure 1.3 illustrates that countries with high rates of private insurance coverage also have lower out-of-pocket spending, suggesting that private insurance plays a role in substituting for out of pocket expenditures and moving the health system towards more equitable financing. This may be of particular interest to developing countries with very high out of pocket payments, that have large informal sectors and limited taxation ability. In the short term, these countries will find it difficult to achieve universal coverage primarily through public spending and may consider private insurance as a method to move some segments of their population towards greater prepayment. In Asia (figure 1.4), where rates of out-of-pocket expenditures are the highest in any region in the world, moving towards prepayment through insurance is particularly attractive.

Key Issues for Policymakers

Although no country uses private health insurance as its only mechanism to achieve universal coverage, private insurance schemes well structured and regulated, can be used to provide one source of funding towards this goal.[6] In every country that uses private health insurance as principal coverage for a large segment of its population, vulnerable groups are provided cover through publicly funded programs. In some cases the government may "purchase" coverage on behalf of these vulnerable populations through private insurers, but this is not considered private insurance, because it is financed through the State.

Whether a country considers private insurance as a transitional mechanism that will lead to broader social insurance schemes, or whether private insurance will form the basis of a country's long term health financing strategy, depends on a variety of factors, including how the government

[5] WHR 2000, page xviii

[6] In Australia for instance, well-regulated private insurance is being fostered as a safety valve to the resource constrained public system. Based on a policy decision that those who can contribute to their health care costs should do so, Australia has implemented tax and early enrolment incentives to encourage the purchase of private insurance. Private insurers also contract with public hospitals, thus generating additional funds for public facilities.

chooses to define its role in financing personal health care services. In some countries, universal access and coverage for these services is considered a primary responsibility of the State**.** In others, the State's role is to provide access to health care for the most vulnerable groups or those that the State has a responsibility to protect. These important policy decisions should be considered prior to embarking on the creation of any type of formal insurance system.

Regardless of whether the State defines its role in health financing as limited to certain groups or more broadly, it has a critical responsibility in providing stewardship and oversight of both public and private financing mechanisms. Particularly in countries with large out-of-pocket expenditures, introducing risk rated private insurance without safeguards can lead to insurers selecting the lowest risks, leaving the most vulnerable groups out of the pool. As insurance money flows into the system, providers will raise prices and may leave the public sector. All of this will affect the publicly funded system which will be left under-resourced, and responsible for providing care to the sickest patients.

Developed countries that rely on private insurance to cover large segments of their population, or in which private insurance plays a prominent role, intervene often quite significantly, in the market to ensure adequate consumer protection and equity. Through policies, incentives and regulations they essentially *"conscript private insurance to serve the public goal of equitable access".*[7]

This is a particularly important issue for countries in the South-East Asia and Western Pacific regions, because introducing private insurers into the market will have important long-term consequences for the entire financing system. Many countries in these regions have already opened their doors to foreign insurers and are confronted by a largely unregulated private insurance market which is growing. The challenge for these policy makers is to exert influence on this market in the public interest. Table 1 summarizes the key policy issues that they might consider in regulating the private health insurance sector.

Regardless of where a country is in its development of prepaid financing, a strong but flexible regulatory framework is required to manage all types of insurance: for-profit and not-for-profit; social, public and private. In countries

[7] Jost, p 479

that have achieved this, private insurance systems have contributed significantly to providing high quality, accessible and affordable health care for everyone.

Table 1. *Key Areas for Regulating Private Insurance Markets*

Regulatory Area	Key Policy Issues
Regulating who can sell insurance, rules of participation in the market and consumer protection	1. What will be the importance of private insurance in health financing? 2. What role will private insurance play in the health system (principal or supplementary or both?) 3. To what extent is private insurance a mechanism to increase consumer choice? 4. How much competition should be encouraged and how many insurers should be allowed? 5. How much collaboration should be encouraged among insurers?
Regulating who should be insured	1. How broadly should private coverage be extended? Will coverage be mandatory or voluntary? 2. If insurance is not mandatory, how can low risk individuals be encouraged to join the risk pool? 3. To what extent will private insurance be used to cover high-risk persons? 4. What will be the basis of affiliation in insurance plans e.g. group, individual/ family?
Regulating what should be covered	1. If insurance will be principal, should a core package of interventions be mandated? 2. If insurance will be supplementary, are there particular things that should be explicitly covered or restricted from private coverage? 3. If enhanced consumer choice is a key objective, what level of customisation of benefits best serves the consumer? 4. How should mechanisms to curb unnecessary demand of services (e.g. consumer cost sharing) be balanced with providing appropriate access to those who need care?

Regulatory Area	Key Policy Issues
Regulating how prices can be set	1. To what extent is private insurance intended to promote equity goals through transfers between high and low risk groups, and the rich and poor? 2. If insurance will cover high-risk groups, how can insurers be encouraged to enrol these individuals while retaining a viable market? 3. Are premiums intended to cover current costs or provide a reserve for future health expenditures?
Regulating how providers are paid and aligning incentives between providers, insurers and consumers	1. What is the relationship between the public and private systems of provision and what impact do prices in one system have on the other? 2. How can the consumer and the overall system be protected from provider price inflation as a result of insurance? 3. How can provider efficiency be encouraged while maintaining access? How much risk is it appropriate to transfer to providers and how should this be governed? 4. Is consumer choice of providers an important policy objective? If so, how can costs be contained without limiting consumer choice?