Social Health Insurance

Selected Case Studies from Asia and the Pacific

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Preface

Health development in countries of Asia and the Pacific is constantly facing new challenges. Just as we approach the eradication of poliomyelitis, new and emerging infectious diseases are being reported, requiring intensive efforts at prevention and control. At such times, it is realized that financial constraints prevent people from seeking timely health care and completing the treatment regimen. This, in fact, can defeat the best plans for preventing and controlling diseases.

Many countries in Asia and the Pacific have introduced cost recovery and cost sharing mechanisms by charging for publicly provided health services, as part of their health sector reform measures. As a result, the share of private financing in total health care spending has significantly increased in the past two decades. Such reforms in health care financing, however, were carried out without adequate measures to enhance financial and social protection systems for people who cannot afford the charges and fees for services. Evidence shows that private out-of-pocket financing is an inequitable and inefficient way of funding health services. However, there is potential to convert out-of-pocket payments into prepayment schemes. Health insurance is one form of such a scheme. Recently, there has been growing interest in health insurance not only as a financing mechanism, but also as an effective social safety net that provides greater protection for the low-income population against health care cost.

The World Health Organization (WHO) is now intensifying efforts to work closely with its Member States in developing appropriate health care financing options to provide stable and adequate resources for health. The Regional Office for the Western Pacific has introduced a series of Round Table Discussions among Ministers of Health during the annual sessions of the Regional Committee since 1999. The topics covered were: social safety nets, health and poverty, essential public health functions and regional strategies on improving access to essential drugs. All these topics touched on health care financing options.

The Regional Office for South-East Asia has also organized similar discussions and debates on health care financing policies and options. The latest was at the 56th session of the Regional Committee in September 2003 which adopted a resolution on health care financing. It urged Member States to study and explore social health insurance (SHI) as one of the alternatives for health care financing, especially for countries that have not yet adopted it on a national scale.

Social health insurance was discussed at the 114th session of the WHO Executive Board in May 2004 and at its 115th session in January 2005. The discussions focused
on the goals and process of development of SHI, especially in low- and middle-income countries. It was stressed that guidelines on the key design features are needed to develop social health insurance systems in countries. It was also underscored that the “purpose of health care financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care”.

Governments are mainly responsible to oversee SHI development in collaboration with all stakeholders. WHO needs to work with all the organizations and agencies concerned with developing health insurance, to facilitate protection for populations excluded from the formal sector schemes.

Asia and the Pacific have a wide variety of experience on SHI development. Some high-income countries, such as Australia, Japan, the Republic of Korea and New Zealand have developed broad health care financing arrangements based on prepayment, including social health insurance, and have achieved universal coverage. Others like China, India, Indonesia, Lao PDR, Mongolia, Philippines, Thailand and Viet Nam have introduced social health insurance in recent decades and their major task is to achieve universal coverage in the near future. The main challenge for WHO at the national, regional and global levels is in strengthening the capacity to respond efficiently to the increasing demand for technical advice and cooperation in all areas of health financing and policy, including social health insurance.

This publication is a step in this direction. It is the outcome of joint efforts by the WHO Regional Offices for the Western Pacific and South-East Asia, the Asian Development Bank, and health care financing experts in the two regions. An attempt has been made to document regional experiences in health care financing arrangements through prepayment with critical analysis on factors linked to success, failures and lessons learnt in various socioeconomic settings.

While experiences from 12 selected countries have been highlighted, the lessons are relevant for all countries in Asia and the Pacific. The publication will therefore be useful for policy makers and for international development partners undertaking technical assistance in the field of social security and/or social health insurance. It will be a valuable source for specialists engaged in such programmes/projects, since it provides recent perspectives and the factors associated with the expansion of social health insurance in Asia and the Pacific.

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<th>Description</th>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<td>ASEAN</td>
<td>Association of South East Asian Nations</td>
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<td>BTC</td>
<td>Belgian Technical Corporation</td>
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<td>CBHI</td>
<td>Community-based Health Insurance</td>
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<td>CGHS</td>
<td>Central Government Health Scheme (India)</td>
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<td>CHS</td>
<td>Community Health Station (Viet Nam)</td>
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<td>CSMBS</td>
<td>Civil Servants Medical Benefit Scheme (Thailand)</td>
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<td>CSS</td>
<td>Civil Servant Scheme (Lao PDR)</td>
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<td>DFID</td>
<td>Department for International Development (United Kingdom)</td>
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<td>DHC</td>
<td>District Health Centre (Viet Nam)</td>
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<td>ESIS</td>
<td>Employees’ State Insurance Scheme (India)</td>
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<td>FDRG</td>
<td>Diagnostic Related Group</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GSO</td>
<td>General Statistical Office (Viet Nam)</td>
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<td>HCFP</td>
<td>Health Care Fund for the Poor (Viet Nam)</td>
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<td>HI</td>
<td>Health Insurance</td>
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<td>Health Insurance Commission (Australia)</td>
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<td>HMO</td>
<td>Health Maintenance Organization</td>
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<td>IHPP</td>
<td>International Health Policy Programme</td>
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<td>IEC</td>
<td>Information Education and Communication (Viet Nam)</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>ISSA</td>
<td>International Social Security Association</td>
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<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Papers</td>
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<td>RCMS</td>
<td>Rural Cooperative Medical System (China)</td>
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<td>SEARO</td>
<td>(WHO) South-East Asia Regional Office</td>
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<td>SSO</td>
<td>Social Security Office (Laos and Thailand)</td>
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<td>UNDP</td>
<td>United Nation Development Programme</td>
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<td>VHC</td>
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Part I
An Overview
1

Introduction

1.1 Finding the Optimal Methods to Finance Health Care

Countries all over the world have always been concerned with developing their health care financing systems so as to ensure access to health care for all their citizens. They have sought to develop systems that would provide adequate financial resources and be affordable to all those sharing in the costs, through mechanisms that will not entail financial barriers to seeking care, particularly at the time of illness.

In addition, the systems that are established need to have mature and transparent managerial and administrative structures which would enable cost and quality control as well as adaptability to changes in demography and disease patterns. Governments are also seeking an appropriate mix of systems that would allow all members of society to maintain dignity and receive care as a right rather than as charity.

Health care financing systems that enable the entire population to be covered would, in general, include two main funding mechanisms: financing from general tax revenues and through social health insurance (SHI). Before universal coverage is reached in most countries, voluntary social health insurance schemes have played an important role in expanding coverage. Of the two main funding mechanisms, social health insurance as the main source of health care funding is gaining greater attention in developing countries.

One simple reason is that many developing countries have a relatively small tax-base and there is some systemic deficiency in increasing government funding to a level that would meet both public and personal health care needs. Some countries are also to experimenting with reforms in health care financing by achieving an optimal balance between tax-fund and social health insurance, before developing the more rigid legislative measures required for compulsory SHI.
Many countries of Asia and the Pacific (AP) region are among those actively seeking ways to reform health care financing systems to meet the above conditions. This publication deals specifically with sharing the experience of social health insurance development through a study of the existing schemes in 12 selected countries, in the South-East Asia and the Western Pacific Regions of the World Health Organization. These two WHO Regions include both the largest and the small countries in the world. Some have been relatively free of conquest and conflict while others attained independence from colonial rule, and have seen major political and economic transitions in the last several decades.

A small number of these countries have reached universal coverage mainly through social insurance or prepayment mechanisms, and are now battling with changes related to ageing of their populations, different burden of diseases and the need to contain rising health care costs. The common aspect in the development of SHI systems in these countries was that it started in periods of concerted efforts to accelerate economic growth. In process, it was recognized that social protection was necessary for the health and productivity of workers to further strengthen sound economic growth.

Social health insurance is part of the development of social protection, especially for people who can contribute for health care as prepayment on a regular basis, either through their employment benefits or by state social assistance for the population groups who are not economically active. The process of development progressed through stages by covering both salaried and self-employed workers and their family dependants in both the public and private sectors.

In these countries, such as Japan and the Republic of Korea (RoK), economic development may have played a greater role than health system development or reform in achieving sustainable health care financing systems that allowed for equity in access to health care. The extension of coverage occurred in parallel with the formalization of the entire labour force, so that very few individuals were excluded by their employment status by the time universal social health insurance coverage was achieved.

The social health insurance systems in these countries have undergone significant reforms, particularly during the last decade. The changes were made because of the shifts in demography and in economic development. It also took account of patient and provider preferences. The well-established administrative structures and adherence to the legislative requirements for change facilitated the implementation of change without creating new gaps in coverage and inequities in access to basic health care.

Besides those countries that have reached universal coverage, many others in Asia and the Pacific are still in the early stages of developing and implementing
appropriate health care financing policies and reforms. A majority of countries had launched the compulsory social insurance systems as part of broad social security systems or as independent health insurance systems. However, the coverage of such system is still generally limited to the formally employed labour sector. With the majority of the population being associated with the non-salaried and informal labour sector, the current situation in many countries, especially in least-developed ones, has more individuals excluded from social health insurance than those covered.

Some countries have started community-based health insurance (CBHI) schemes with mixed results. Despite the increase in government interest and sponsorship in such schemes for the excluded populations, total membership in such schemes has not yet significantly altered the proportion of the total insured populations in the same countries.

Health care financing, as a major component of health sector reforms is now underway in many countries of Asia and the Pacific. There are some concerns in developing appropriate financing mechanisms which respond to factors beyond stability and the level of funding to provide services for basic health care needs. In addition to the concept of equity in access, there is concern with developing systems which would enable:

- affordable, fair and progressive contributions by households and other partners;
- optimal pooling levels to reduce risks and foster solidarity among different populations;
- increased efficiency in the purchase of health care;
- relationships between the scheme, providers and members that discourage moral hazard and abuse;
- improvement in the quality of health care delivered;
- improvement throughout the health care system through increased financial resources and more appropriate allocation of these resources, as well as rational use of an appropriate mix of services, and
- the delivery of health care with greater consideration for patient preferences and increased satisfaction among health professionals.

Health care financing methods also need to be responsive to changes in the roles of ministries of health. Many countries seek to relieve the governments from their responsibility for the direct delivery of personal health care services and to limit government provision to services within the context of public health.
The changes in ownership of health care facilities ultimately lead to more private provision. There is a need to provide access to a changing mix of public and private health care providers, in which the private component may include non-profit as well as for-profit facilities.

In some countries, this mix has changed in favour of private for-profit providers before appropriate regulations and accreditation mechanisms have been put in place. In others, this situation has also promoted the unregulated growth of private for-profit commercial health insurance before social health insurance, with its advantages of broad pooling and potential for health system improvement could be implemented for a critical mass of the population.

Where governments provide a significant proportion of personal health care, there has been some transfer of financial autonomy to the public health care providers as well as decentralization in management functions. To increase revenue for their facilities, particularly the self-financed autonomous hospitals and health clinics, many countries have formally introduced user charges, for example in China, the Philippines and Viet Nam.

The public providers face new pressures to raise revenue to replace the government allocations, and soon realize that the simplest and fastest way to do so is by generating demand for services in a population with low levels of knowledge about health care.

Low-income populations, who may have low utilization patterns and low expectations of health care, find it difficult to understand why health services are no longer free of charge. When faced with having to pay for health care in an environment in which government services are perceived as being of poor quality and entail long waiting periods, scarcity of staff and drugs and outdated physical conditions, there may be a tendency to seek care from private providers.

Often, the reasons for seeking care from private providers are not related to the perceived quality or convenience in receiving care, but to the fact that some private providers are prepared to be flexible with regard to payment for their services. They may accept payment in kind or defer part of the payment in order to establish their own market. That is, changes in the health care financing system, which impose user charges without social safety nets, can promote the use of unregulated and poor quality care from private providers.

One may argue that the imposition of user charges in public facilities usually has a in-built strategy for exempting the poor. Even when the exemptions are reasonably efficient in determining the poor or poorest families, there remains a large proportion of the population whose incomes may be seriously decreased by the combination of having to pay for health care at the time of illness when the patient’s
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role in decision-making regarding the type and volume of services needed is low, and income may be reduced because of the illness.

There is now some urgency in developing stable and equitable health care financing for all countries. This stems from the realization that paying for health care has become a leading cause of family impoverishment. The situation is aggravated in some countries by the introduction of user charges for health care in public health facilities without prior establishment of social safety nets. Poverty reduction measures have so far not been able to solve this problem significantly; the establishment of social health insurance mechanisms was included as a new strategy in the Poverty Reduction Strategy Papers (PRSP) of most developing countries.

There is increasing understanding that charity or donations cannot replace equity in providing health care for the poorest families and individuals. Protection of the poor through complicated exemption mechanisms has proved to be expensive and inefficient. Evidence also indicates that exemption mechanisms often fail in reaching the targeted individuals and many countries are trying to formalize these failed mechanisms with government-funded social insurance, as in Viet Nam (1-5).

Concerns with the links between poverty and health have demonstrated the necessity to provide access to health care for all households in all income levels, through health care financing systems that also protect wage earners in times of economic recession or restructuring. Populations excluded from compulsory social insurance systems are likely to be those excluded from other social security benefits, such as income replacement in old age, during maternity leave and due to illness(6).

Health care financing systems therefore need to be both pro-poor and effective to combat poverty caused by illness. They also need to be conducive to economic development through reasonable and controlled levels of contributions and health care expenditure.

In countries where the development of social health protection may be most urgently needed, the ultimate goal has to be universal coverage, that is, coverage of the entire population including those who would be excluded from conventional schemes. The issue of covering dependants of the contributors of social health insurance is particularly important where the compulsory social health insurance systems start with employed/ salaried workers.

Many women will reach old age without ever having being employed or receiving retirement benefits and the only opportunity for them to be covered may be as the spouse of an active or retired salaried worker. Children cannot be economically active and the practice of exempting children from user charges means that, de facto, they may be dependant on under-funded public health care systems, as in China and Viet Nam.
Just as the value of social health protection in economic development and in poverty alleviation is recognized, the need for sound design of such systems is increasingly understood. Any form of social protection dealing with contingencies requiring income protection or replacement in illness, old age, disability and during pregnancy, needs legislation and regulations. These cannot be easily changed to meet deficits created by weak financial control, pressures created by providers or by the irrational use of benefits by the insured populations.

Because of the need for a sound legislative base, universal coverage cannot be reached through ad hoc extensions of pilot projects and even opportunities to learn from pilot schemes may be limited by political pressures to expand coverage, as in China, Laos PDR and Viet Nam. New social health insurance schemes may acquire experience and professional maturity over time, but their initial design has to be sound. Appropriate design will also enhance the opportunities that social health insurance implies for better financial planning and resource management.

There is now a considerable body of global literature on the various forms of health insurance, covering both the evolutionary stages and later developments. However, it is difficult to find the analyses that might look at the response of social health insurance systems to defined problems. Such analyses are likely to be in the files of the social health insurance institutions that dealt with the issues rather than in international or even national publications.

In Asia and the Pacific, there is a paucity of up-to-date national monographs and case studies that provide comprehensive information on the evolution of social health insurance which would define the current problems and lay out plans for expansion of both coverage and benefits. Despite the differences among countries in the AP region, there is some added value from learning from the experience of countries with similar economic development and from first-hand knowledge gained by visits and through dialogue among the countries.

1.2 Case Studies

The primary purpose of the collection, compilation and analysis of country case studies on social health insurance schemes and their potential development in 12 selected countries in Asia and the Pacific is to expand the literature by including the recent records of comprehensive reviews. The second purpose is to facilitate the development of social health insurance through the review at national level of, technical cooperation between countries and of advice from the international development partners.

Advice to governments on how to develop equitable and stable health care financing mechanisms has always been a complex issue. The necessary
considerations of demography, economic development and employment and cultural differences as well as prevailing morbidity patterns and the availability and dispersion of health system resources, make it different for standard models being followed.

Sound principles of social health insurance have been available for many years through the Convention 102 of the International Labour Organization (ILO) issued in 1957\(^{(12)}\). These basic principles are still valid. Subsequent amendments were made in response to changes in technology and scientific knowledge, rather than any change in the principles of social justice and equity. WHO and ILO later disseminated various guidelines and manuals on the development of social health insurance\(^{(13, 14)}\).

So far, the development of SHI in many countries has not followed even some basic tenets of the aforementioned ILO Convention, although the same countries may have ratified the Convention. The global and regional activities of the International Social Security Association (ISSA) also provide important opportunities for Member Countries to learn, based on publications and open dialogue on the real experiences of social health insurance systems (see [http://www.issa.int](http://www.issa.int)). Again, the ISSA is an organization of members linked to ILO, and many new social health insurance systems are not yet aware of the benefits of membership.

While there are no fixed standard policy packages for social health insurance, there certainly are advantages in following basic principles and guidelines. This is particularly important when the schemes are based on practical experience rather than on theory.

It sometimes appears that there has been very little consideration of basic principles and that recent social health insurance development was dictated by inappropriate financial motives, without due concern for all members of the population and without adequate legislative and regulatory mechanisms.

In countries where there has been little or no development of social health insurance as is the case in most Pacific Island states, the understanding of this health care financing mechanism is biased by the practices (and limitations) of for-profit commercial health insurance.

The above should be kept in mind for future action by the international development partners that they been have less successful to some extent in the provision of policy and technical advice, and that it is time to improve the technical capability and advocacy for policy both at international and national levels in this important field.

There is also a need to strengthen the knowledge and experience acquired so far to develop a good presentation in the optimal context, addressing appropriate
decision-makers, and to appreciate the technical nature of the development of social health insurance. This publication is an attempt to fill the gaps.

The level of government financing of health care in many countries in the AP region may be low, with an added feature of very low salaries for health care professionals in the public sector. The optimal health care financing systems with affordable prepaid contributions by households should not replace government funds when the overall funding level is low.

Technical advice for the development of social health insurance may, therefore, have to include references to a mix of health care financing sources. The advice may also deal with possible shifts in the allocation of government funds from acute curative services to public health functions, as well as to the financial support of the population that cannot pay its own health insurance contributions.

Another area for technical support may relate to the link between the acceptance of social health insurance by health professionals, and the improvement in their regular incomes that may be expected from the new financing mechanisms.

A review of the country case studies and the comparative presentation of the major factors could provide information to assess the applicability of the various forms of health insurance in their own context. The analysis attempts to put forward responses to specific development questions based on the selected experiences in the countries of Asia and the Pacific.

The development of SHI in many other countries in the AP region and elsewhere is recognized, but has not been included in the comparative analysis. The understanding of the issues in these countries should result in the design of a social health insurance system or a mix of financing systems within the appropriate policy framework and legislative foundation, and in a feasible plan to reach universal coverage in each of the countries in the AP region.
2

Study Methods

2.1 Countries Where Study Was Conducted

The case studies were collected from 12 selected countries from Asia and the Pacific namely; Australia, China, India, Indonesia, Japan, Republic of Korea, Lao People’s Democratic Republic (PDR), Mongolia, the Philippines, Thailand, Singapore and Vietnam. Beyond the obvious differences in geography and population sizes, these countries range in two major aspects of their health insurance development.

One group of countries consists of low population coverage to universal coverage through mandatory social health insurance and social assistance. Another group ranges from a single national system to pluralistic social health insurance, including compulsory social security framework and parallel development of voluntary community-based health insurance. Differences in other characteristics, such as contribution partners, range of health care benefits and provision of health care by public and private providers were not considered in the selection of countries.

2.2 Sources of Information

The two Regional Offices approached the selected countries and relevant experts/institutions to collect and compile the case studies based on the basic sets of questionnaires on the existing and proposed social health insurance schemes. The guidelines for preparation of the case studies covered the following areas:

- **Background** - basic information about the country and its socioeconomic factors for considering changes in health care financing and social health insurance.
- **Development of prepayment/health insurance mechanisms** - initiatives to develop compulsory and voluntary prepayment mechanisms, development plans and strategies including legislative aspects, government participation and commitment towards universal coverage.

- **Compulsory prepayment social health insurance mechanism** - organizational and institutional arrangements, insured population, contribution level and payment, benefit types and provider payment arrangements.

- **Voluntary prepayment health insurance schemes** - documentation on existing voluntary prepayment mechanisms, including community micro-health insurance and other social solidarity practices.

- **Social security programmes, covering risks of maternity, disability and old age and social assistance for the non-economically active and indigent populations** - existence of social security welfare, social assistance programmes, their operational linkage and affiliation with compulsory and voluntary prepayment and risk-pooling mechanisms.

- **For-profit commercial health insurance** - the scope and development of for-profit commercial health insurance schemes, and the current legislation on their operations.

- **Critical analysis of health care financing through prepayment/earmarked taxation and health insurance mechanisms** - current population coverage on compulsory and voluntary basis, changes in health-seeking behaviour, key factors associated with success and failure and major current challenges.

- **Conclusion** - overall conclusion including the role of health care financing through prepayment mechanisms in enhancing equity and achieving the country's socioeconomic development goals.

In general, the initial country case studies received from the contributors adhered to the framework. After an initial review, the country case studies were returned to the contributors for clarifications etc. edited and put into a standard format. It is important to note that the country case studies were written by national experts who have first-hand knowledge of social health insurance development in their own countries. Technical assistance was provided in some countries and, in some cases, this was limited to translation and clarification of terminology.

These country case studies provide authentic descriptions of the complex issues involved. They serve the first purpose of this study, which is to expand available literature through actual country sources. Most country case studies include recent
government policies and plans for the extension of social health insurance. The case studies on each country are provided in full text in Part II of this publication. Annex 1 contains brief profiles on the contributors of each country case study.

A critical objective of social health insurance is equity in access to health care, which may be reflected in the use of health care. Patterns of utilization are obviously very important with regard to the impact of provider payment mechanisms.

This publication, however, does not make any attempt to request information on the rates of utilization of health care of the insured and non-insured populations. In the best case and with considerable effort at national level, it may have been possible to obtain partial information on the use of major categories of health services. With the exception of some countries that have reached universal coverage, age and sex specific rates are not available and there is almost no information on the use of health care in private facilities.

In retrospect, it may have been worthwhile to request more data on additional specific factors such as the scope of information systems and the distribution of expenditure by type of health insurance benefit. The main objective of the study was to expand the knowledge on what exists within a fairly short time and with limited resources so that the benefits of the experiences could be made available as soon as possible.
3

Main Issues in the Country Case Studies

The section covers major development issues, characteristics and recent changes summarized from each country case study. These are generated for their relevance to other countries and may not necessarily be major concerns in the respective countries. The brief descriptions are by no means actual summaries of the case studies, but illustrate a range of differences in social health insurance systems at all stages of development.

3.1 Australia

In Australia, the private insurance schemes were the "Friendly Societies" set up in the 1850s by the middle and higher income employed workers to protect themselves from health care costs. These were non-profit funds patterned along the lines of the European Mutual Sickness Funds. Many of these funds employed doctors on capitation basis. The first action in Australia was through the Health Act of 1953 which called for government subsidies for voluntary private health insurance, and created the Pharmaceutical Benefits Scheme.

The "Friendly Societies" covered around 70% of the population by 1972, when the first compulsory social health insurance scheme, Medibank was created by law. Medibank started operating in 1975 with funding from general tax revenues to cover health care at public hospitals and under the supervision of the Health Insurance Commission (HIC). The target population was all citizens and other legal residents in Australia. One year after implementation, the programme became Medicare, with funding through a means-tested 1.5-2.5% levy on taxable income. The HIC was then allowed to establish a private health insurance fund to cover health services by private health facilities.
Australia has universal coverage since 1975 through parallel mechanisms to cover different populations and different benefits. Despite changes due to pressures from political sources, market forces and the medical profession, a combination of public and private health insurance schemes guarantees universal access to medical and hospital services while the Pharmaceutical Benefits Scheme covers drugs and medical supplies. Long-term care is covered by a separate compulsory Nursing Home Programme.

The current combination of public and private health insurance schemes is working with a mix of public and private providers. The Australian government provides funding for all three public Programmes through a general and health levy, while it also subsidizes private health insurance. While public ownership is dominant for hospital care, Australia’s doctors usually practice as independent private practitioners.

Publicly owned community health centres are not established throughout the country, and access to primary health care is hampered by the non-availability of practitioners in rural areas and low-income urban neighbourhoods, where population have difficulty in to pay for services. The growth of private for-profit hospitals and insurance companies has also led to an additional problem.

As this trend shifts resources from the public to the private sector, problems grow in access to hospital-based care by the low-income population, who tend not to have the private insurance that could enable shorter waiting times. There is an ongoing political debate on the extent of public involvement in the organization, funding and provision of health care, linked to concerns regarding both equity and market forces in health care.

### 3.2 China

The development of social health insurance in China has followed two separate and parallel paths. One path is the development of rural cooperative medical systems (RCMS) for rural workers and another is the development of social insurance schemes for urban salaried employees. Both schemes target individuals rather than families.

While the RCMS could cover all members within a household, the urban schemes have no provision for the dependants or other non-employed people. The Ministry of Health is traditionally responsible for health care of the rural population, while social protection for the urban population is the responsibility of the Ministry of Labour, later termed the Ministry of Labour and Social Security.

It is extremely complex to describe the process of expansion of coverage of SHI in China. In the rural areas, the scope of protection is lower than that before the
economic transition. The RCMS was established in the mid-1970s and within a
decade, it covered nearly 90% of the villages. The rural communes provided the
financing for the RCMS, while the leadership of the commune and the party directly
influenced the provider behaviour. Local governments at the provincial and county
levels planned and supervised essentially low-cost services.

Most of the RCMS throughout the country collapsed during the late-1980s and
mid-1990s, when China transformed its system of collective agricultural production
to that of private household production. Many rural communities, particularly in the
remote areas where members of the households did not have regular income from
employment in the new township and village enterprises, faced major problems in
paying the typically unregulated user charges for health care, from the basic primary
health care in their own village health centres to the services at the township and
county hospitals.

In 2000, 87.3 % of sick people in the rural areas had paid their own medical
expenses in full, with 25% having to borrow money from others to cover the cost of
health care. Out-of-pocket payment for health care became the major reason for
poverty among rural families (16). More than 60% of patients from the rural areas left
the hospitals before they completed their in-patient treatment, due to non-
affordability of user charges (17).

Around the mid-1990s, the Ministry of Health estimated that less than 10% of
the rural population had any form of protection from the increasingly high costs of
paying for care. The Ministry of Health began implementing a series of pilot projects
to re-establish the RCMS.

A majority of these projects were funded and carried out in collaboration with
international development partners, such as the Sichuan Province study by the
RAND Corporation, the 14 county RCMS projects supported by WHO, the Poverty
County Survey and Intervention Experiment in 10 counties with UNICEF, the
International Health Policy Programme Project in three Poor Counties, a UNDP rural
health project, the Poverty Alleviation Component of Health VIII Project of the World
Bank and a DFID project in several counties.

The variation in design and management of these projects was enormous while
financial viability, attractiveness and sustainability were low. In 2001, UNDP
conducted a review study of these RCMS projects to identify the best practices (17).
The study involved many national experts from various government agencies and
academic institutions, who had been battling with various efforts to re-establish the
RCMS. The study highlighted its findings which were given serious consideration by
the System Reform Office of the State Council, the State Development Planning
Commission, and the Ministries of Finance, Agriculture and Health.
In 2003, the Chinese Government issued national guidelines on the implementation of Rural Medical Assistance, to address existing problems of illness and health care charges that led to poverty. The new design emphasized the need for government subsidies at all levels of the administration: township, county, principal and central. By the end of 2003, 60 million individuals had enrolled in the new form of RCMS and the long-term plan for RCMS development is to cover all rural farmers by 2010.

Reforms for social health insurance in the urban areas were undertaken within the framework of the social security reforms for employed people, first by the State Commission on Economic System Reform and later by the new Ministry of Labour and Social Security in the 1990s. The earlier social security schemes entailed insurance packages for workers - active and retired - employed at enterprises. Health benefits were not extended to the dependants of workers. In some cases, employees' family members who were unemployed were entitled to a 50% reduction from the current user charges.

The first thrust of the reform launched by the State Council in 1998 was to shift the level of pooling from the single enterprise level to the municipal level and, in some cases, to the whole county. The second reform measure was the creation of both individual accounts and pooled funds, with individual accounts to be used for minor illness and pooled funds for major illnesses requiring hospital care.

The reform process was slower than expected in expanding the coverage to new cities and regions, and had been hampered by complicated systems of accessing various funds and lack of clear legislation with necessary mechanisms to increase compliance. The participation of employees in the private sector is still very low, as China still has no standard law on social insurance.

The reforms covering in the rural and urban populations since the mid-1990s had left several significant gaps in both coverage and benefits. In rural areas, inclusion of the rural residents working in the township and village enterprises or in private enterprises may be at the discretion of the local rural or workers' scheme and the approach to coverage is still aimed at individuals rather than families. In urban areas, there is still no provision for self-employed, migrant workers and the non-economically active population. The local governments' social assistance funds were inadequate to cover the health care needs of the urban poor.

In both rural and urban workers' social security schemes, benefits are still limited. This has created high dependence on commercial finance companies for supplementary insurance. Private for-profit health insurance schemes have become extremely lucrative in China, spurred by both the inadequacies of public schemes and the increase in income of salaried employees in the private sector. Unfortunately, the purchase of private insurance by the high-income salaried employees does
influence compliance in participation in the public schemes. The public schemes face increasing financial problems, particularly as the proportion of retired workers among the insured population increases.

The current reform efforts in social health insurance in China are focused on expanding the coverage in each of the two defined population groups – rural farmers and urban workers. The problems in this split are recognized and the agencies responsible for the reform now suggest to plan and implement pilot projects, with integrated health insurance systems, in both urban and rural areas, with universal coverage as the ultimate goal.

3.3 India

India with its huge population of over a billion and the inter-state variations makes generalization in any sector difficult. At the national level, the economic growth in recent years is impressive and there is significant advance in the reduction of unemployment and the rapid development of information and technology. Despite this, current government spending on health lags behind all other forms of development. Low-income population has also faced with increased out-of-pocket spending, in order to get access to health care, often of poor quality in an unregulated private sector.

Population coverage by any form of health insurance is still very low in India. The principal social security law, passed in 1948, a year after Independence, was aimed to provide health care for the working population – particularly low-salaried state employees and their dependants. By 1954, the government has created a compulsory health insurance scheme for central government employees.

During the last decade, there is increasing collaboration between states and nongovernmental organizations (NGOs) to extend the social protection, including health protection, through state-sponsored, community-based or micro-insurance schemes. Through the various compulsory and voluntary health insurance schemes, they have covered around over 85 millions of beneficiaries. Since the benefit packages and various systems for access to different levels and types of providers had led to variation in the quality and access to health care.

De facto, India has not yet developed or implemented a policy to meet the basic objectives of providing equity in access to health care and adequate stable funding to meet health care needs. Social health protection has not been a major political issue for some years.
The opportunities to extend social health insurance coverage through mandatory systems is still limited, since salaried employees do not constitute the majority of workers and the tax base is still relatively small.

The best case in the short term is considered to be the merger of the Employees' State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) with improvement in the provision of benefits under a merged scheme. The challenge remains the huge population of the informal sector.

In contrast to China, India is responsive to greater involvement of NGOs. Various interested parties are now looking at the potential of NGOs to extend coverage through promotion of health care as part of social protection schemes for the respective population, and the accelerated establishment and expansion of community-based health insurance schemes.

3.4 Indonesia

Indonesia introduced a national compulsory social health insurance scheme for civil servants in 1968. The scheme is managed by the state-owned company, PT Askes. After reforms in 1992, it now manages compulsory social health insurance for all civil servants and their dependants. The contribution of 2% of the monthly salary was borne solely by the employee till 2003, when a central government contribution of 0.5% of basic salary was added. This government contribution is expected to increase to 2 per cent after some years. The beneficiaries include about 14 million civil servants, their spouses and two children less than 21 years old.

In 1992, Indonesia also introduced another SHI scheme for private sector salaried employees, managed by PT Jamsostek. The scheme had covered about 3 million employees and their spouses, and children below 21 years (up to the third child) by 2003.

The Jamsostek scheme is compulsory for all private sector employers with 10 or more employees or with a monthly payroll exceeding Rupiah (Rp.) one million. Employers contribute 100% premium on the basis of 3% of basic salaries for single and 6% for married employees, while the employees do not need to contribute.

Employers who provide better health benefits than those offered by the scheme are exempted from joining the scheme. Due to this exemption clause, many employed workers were not covered by the scheme. Some employers provide health benefits or purchase commercial for-profit health insurance. As a result, it is estimated that the scheme only covered about 10% of the enterprises with 10 or more employees.
The Ministry of Health, through the Health Act of 1992, introduced a nationwide “Managed Health Care Scheme” called Jaminan Pemeliharaan Kesihatan Masyarakat (JPKM), using the model of the voluntary Health Maintenance Organizations (HMO) in the United States. It was promoted as a socially oriented scheme to provide comprehensive health benefits through a network of health care providers managed by public and private health maintenance organizations.

By the end of 2002, there were 24 licensed JPKM bapels (Indonesian HMOs), which are basically health insurance carriers, mandated to provide comprehensive health benefits through public and private health care providers and to make payment to providers on a capitation basis. The total estimated population covered under the JPKM scheme is around one million.

Since the 1970s, Indonesia has introduced many community-based risk-sharing schemes, including the nation-wide programme called, Dana Sehat (community-based micro-health financing schemes). After the economic crisis in the late 1990s, the government introduced different approaches for providing subsidies for health through the nation-wide Social Safety Net Programme in order to reduce the financial burden of the people, especially the poor. According to available information, around 12 million people have benefited from this programme and its introduction has significantly reduced the need to re-establish or expand Dana Sehat schemes by the communities.

In 2002, the President of the Republic of Indonesia established a “Presidential Taskforce on Social Security” to look into the restructuring of existing SHI schemes with a few possible policy options (all inclusive): (a) to integrate public and private employee schemes into one scheme, creating specialized SHI management under a National Social Security System, with uniform benefits for all; (b) to possibly merge the PT Askes and PT Jamsostek into a single independent SHI agency at the national level, like “National Health Insurance”; (c) to make the new carrier independent, non-profit, controlled by a tripartite body (representation from employees, employers and the government).

The National Social Security Bill passed in mid-2004 covers social health insurance as part of social security measures and is expected to lay the foundation for universal coverage in Indonesia. The Bill will also resolve an anomaly in the development of social health insurance in Indonesia.

In the past, all insurance schemes or companies have been governed by the commercial insurance regulations which stipulate the payment of dividends on revenues. This has led to confusion regarding the status of PT Askes and PT Jamsostek schemes as for-profit enterprises. Though there are, in fact, no major profits generated and the revenues are derived from contributions, partly provided by government as employers, there is a conflict regarding whether these revenues
should be taxed. The legal status of social insurance will be shifted to that of non-profit state enterprises under the National Social Security Reform Bill.

3.5 Japan

The development of social health insurance in Japan has a long and interesting history. The first solidarity mechanism to cover health care expenditures was the voluntary community health insurance or “Jyorui”, set up at the village level in 1835, based on rice contributions. A survey carried out by the Japanese Ministry of the Interior in a rural agricultural district in 1933 showed that most families had heavy debts and that medical expenditure was the major cause. In an attempt to improve the health situation in rural districts, the government decided to introduce community-based health insurance systems. The planning of the systems took lessons from the previous “Jyorui”.

The Community-Based Health Insurance Law was approved by the Diet of Japan in 1935 and implemented in 1938. The initial system was designed to meet the needs of low income families in underserved rural villages, but the law stipulated that membership could be opened to all population groups. As a result, the membership increased dramatically.

The first formal sector system of compulsory prepayment for health care was introduced based on a trial of the German model, implemented in 1905, for selected government employees such as railroad and steel workers. The system was extended to all salaried employees through the passage of the Workers’ Insurance Law of 1922. This law was drafted at the time that the labour movement in Japan was gathering momentum in the early 1920s. Although it faced a financial crisis shortly after its establishment in 1929 due to the global financial depression, the system gradually developed as the nation’s economy grew.

When implemented in 1927 there were two separate systems under the Law. The first and centrally administered system was for companies with five and more employees. The second system was society-managed, and a society was established as an independent insurer by companies with more than 300 employees. This feature of the Law explained the vast number of health insurance societies that operated in Japan, until legislation allowed for mergers to enable broader pooling and a reduction in administrative costs. The recent reforms have permitted companies with over 300 salaried employees to consolidate their insurance “societies” with those of other companies.

By 1943, 74.6% of the total population of Japan was covered by various types of health insurance schemes. After an interruption during and for several years after World War II, all health insurance schemes grew in their membership as the
economy boomed at the same period. By the late 1950s, the two forms of health insurance (Workers' Insurance and Community-based Insurance) covered almost 90% of the total population. Universal coverage was achieved when new legislation in 1961 made participation in any insurance scheme mandatory for all citizens.

The interesting feature in the universal coverage in Japan is the pluralistic approach, that is, the vast number of social health insurance societies. This approach required a long process of standardization of benefits and other conditions, and information systems that enabled monitoring of membership and financial data to feed into national records. Efforts are being made to accelerate the consolidation of schemes, as Japan still has over 50,000 schemes covering compulsory health insurance for a population of 127 million.

Later developments included legislation of the Elderly Insurance system in 1983 and long-term care insurance in 2000. Earlier, the Elderly Welfare Law of 1963 had provided health care free of charge to elderly citizens (over age 65). However, an increase in utilization to levels considered to include unnecessary services coupled with the increase in life expectancy created huge financial pressures on the continuation of the free care approach.

The Elderly Insurance Law introduced a new and separate fund, with contributions from the specific previous insurers (Community-Based or Workers' Scheme) and from general tax revenues. With the number of elderly in Japan still rising, many of the schemes face difficulties in covering their previously contributing members through old age. To alleviate at least the long-term care burden, a Long-term Care Law was implemented in 2000 to cover home care for the elderly and long-term institutional care for the population over 40 years of age, through a separate pooled fund.

Both the Elderly Insurance System and the Long-term Care Insurance Laws have not significantly changed the financial problems of appropriate health care for the elderly, who are expected to constitute one quarter of Japan's population by 2015. The creation of an independent health insurance system for the elderly is now under consideration.

Another interesting aspect of health insurance development in Japan is the way in which the private for-profit sector has developed. Private insurance is attractive to cover the costs of care in private facilities and authorizes user charges and co-payments. However, private insurance does not function as supplementary or top-up insurance, as patients choosing to use private facilities cannot be reimbursed by the social insurance. That is, patients have to choose whether they use the services (and facilities) covered by their social insurance or whether they use private facilities and pay the entire amount or use private health insurance for that episode.
3.6 Republic of Korea

The Republic of Korea (RoK) started its SHI scheme with the enactment of health insurance legislation in 1963. Compulsory health insurance initially covered employees of formal sector establishments (with more than 500 workers). In the 1980s, the scheme expanded to cover all 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. Universal coverage was essentially attained by 1989, with almost 96% of the 47 million population of the country, covered under the mandatory social health insurance scheme. The remaining 4% of the population were covered by the medical aid programme for the poor, which is financed through general taxation revenue.

The rapid expansion of compulsory social health insurance to all population sectors, including the agricultural sector and the self-employed in cities and villages was mainly contributed by the rapid and high growth in GNP, which was an average of 13.3% during the period 1977-1989 (18, 19).

The SHI schemes in the RoK in a sense represent a trade-off between social protection for all and the expansion of health care benefits. Probably in order to keep labour costs low, the contribution rate for salaried workers was set at 3.5% of the salary (amended to 3.9% in 2003). This rather low contribution rate cannot fund all services at all times, particularly in a fee-for-service situation with high utilization rates.

The financial balance is achieved by high co-payment rates for most services, and the people still have to bear around 50% of the costs at the time of illness. Furthermore, many types of high-cost diagnostic services such as magnetic resonance imaging (MRI) were not included as insurance benefits. The co-payments are waived only for people covered by the medical aid scheme.

A profit-oriented private health care delivery system has always dominated the health care delivery and the social health insurance funds managed to extend coverage and deal with cost control through several unique mechanisms. The main feature is the umbrella organization, the "Korean Health Insurance Corporation", which centralized several administrative functions including those based on a well-managed computerized membership database. Claims review is carried out as a central service for all the funds, and enables a regular quality assurance approach. The organization also negotiates fees and conditions with providers.

The vast data banks have recently enabled introduction of some interesting innovations focused on health promotion as health insurance benefit (20). Information on health services utilization enabled the creation of a “Record to Prevention and
Social Health Insurance Promotion” programme. The data banks are used to alert regional authorities about vulnerable populations and thereby prioritize their disease control programmes. The database also provides the insured persons with guidelines on “economic” utilization (bearing in mind the high cost-sharing in the Korean health insurance system).

Another step initiated by the SHI in RoK was improvement of emergency services. While this may not strictly be seen as health promotion, the improvement was significant in reducing complications and residual disabilities resulting from needs for acute care and trauma, and thereby reducing the costs of care borne by the health insurance funds.

The costs of health care, both from insurance funds and out-of-pocket payment (co-payment) by the consumers have 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 Korean Parliament passed the ‘National Health Insurance Act’, which mandates the consolidation of all health insurance funds into a single fund, bringing the pooling level to the maximum. This should be considered a tremendous achievement, particularly in the light of the political dimensions involved.

3.7 Laos People’s Democratic Republic

The Laos People’s Democratic Republic (Laos PDR) is one of the least developed countries that lately introduce social health insurance through a parallel approach to cover different population segments. Basic health care package was included in the contributory Civil Servants Social Security Scheme that started in 1989. A single contribution is made by Civil Servants at all social security branches, and there is no separation of funds to allow for a clear commitment regarding an allocation for health care, while the priority is the payment of old age pensions. Actual reimbursement for health care is made according to capacity to pay back when the claim is made. The result is late and inadequate payment after considerable paperwork, which has led many civil servants to forego submitting their claims.

The reform in the social security system in late 1990s took these deficiencies into account. The Social Security Decree of 1999, implemented in 2001, covered a broad compulsory social security system for employees in the private sector in enterprises with over 10 workers. The administration of the Social Security Office (SSO) maintains a separate fund for health care, managed by a separate Medical Division and also supervised by a separate Medical Board. Health insurance for workers and dependants was included in the Decree, and the first stage of operation covers the capital city, Vientiane (spouse and children up to 6 years in the first stage, now being
extended to all family members). The scheme is now being extended to other provinces as administrative capacity is developed, though with some delay. The SSO contracts with the three hospitals in Vientiane on a capitation basis, which has served to control expenditures and to vastly simplify the administration of the new system. The capitation provider payment was supported by the timely development of the information system, covering both the membership database and the utilization of care by both insured and non-insured patients in the contract hospitals.

The Ministry of Labour and Social Welfare is responsible for the SSO in Laos PDR. From the beginning, coordination with the Ministry of Health was emphasized, since it was critical for the determination of benefits, particularly for the positive acceptance of the capitation payment method in the Ministry of Health’s hospitals. An indirect but very important result of this coordination was the interest developed in the Ministry of Health on the potential of social health insurance in improving access to health care for the population excluded from the SSO.

A first step was the establishment of a Health Insurance Policy Unit in the Ministry and training of core personnel. This national team then served as national counterparts in a community-based health insurance project, which run under the technical assistance of WHO. The project has set up voluntary community-based health insurance (CBHI) schemes in three places, with minor adaptations of the same design in each site, and in accordance with regulations and guidelines developed by the Ministry of Health.

As in the SSO, the CBHI includes ambulatory and hospital care benefits, and uses capitation as the provider payment method in contracts with public providers. The information system too is an adaptation of the SSO system. The commitment and ownership by the CBHI already made an improvement in the quality of care given by the providers. It has also led to an increase in the typically very low health care utilization rates. The Ministry of Health is now planning expansion of the number of project sites and coverage within each site, so that the CBHI will form a network of SHI across the country. Laos PDR, therefore, serves as an example of separate but parallel government-sponsored social health insurance development both for the formal and informal sectors. Through compulsory and voluntary schemes, Laos PDR should eventually reach a level of coverage that will serve as the foundation for compulsory universal coverage.

3.8 Mongolia

Mongolia even though having a relatively small population, decided to implement social health insurance for the entire population in the mid-1990s, which was a very ambitious move. There were two major interlinked factors which supported the political ideology, in a new government concerned with the transition of a centrally
planned to a market-oriented economy. The first was the need to maintain the levels in equity and access to health care that was achieved during the previous periods. The second factor was the need to create financial protection of the population during the transition period. The vulnerability of this population to the transition was well understood. A relatively well-resourced health system was in place and universal coverage was considered a feasible goal for a population of 2.5 million at the time.

Intensive preparation for the introduction of the system was made by the Ministry of Health over the two years preceding implementation of the Citizens’ Health Insurance Law in January 1994. Implementation in the initial stage had several features: the system was set up as an independent social insurance system for health care, and the State owned commercial insurance company was contracted to operate the scheme.

At that critical time in economic transition, there was an element of competition between the initiators of health insurance and other social security benefit branches and indeed, health insurance came first. Another initial feature was the very heavy subsidization by government to ensure universal coverage. Contributions for several groups were paid by government, regardless of the actual incomes of the individuals. For example, government paid for cattle-breeders, students and women with young children. The approach was individual rather than family coverage, and fee-for-service was chosen as the provider payment model. The benefits covered only hospital care in the first stage.

The first years of operation were very difficult, as it became increasingly clear that the high level of subsidization was untenable. The health care system in Mongolia could then be characterized as having a high supply of human resources, but with low salaries, and a high supply of hospital beds but with outdated medical technology.

The public providers (hospitals and clinics) anticipated increased revenues through the new health insurance system with its fee-for-service provider payment method. Hospital admission rates and length-of stay increased within a short time. In the capital, Ulaanbaatar, the rates after two years of operation essentially meant that 30% of the population was hospitalized in a given year while the average length of hospital stay doubled compared to the preceding period.

As the privatization of state-owned enterprises began, and alternative employment was not easily found, unemployment and poverty increased. Many adults lost entitlement to health insurance when they lost jobs and universal coverage was seriously compromised. The relatively new social health insurance system had to establish new mechanisms to register and collect contributions from
self-employed workers. For those who were covered, co-payments for health care created new burdens for the lowest income households.

The inputs from technical support from international development partners were, to some extent, lost in the sudden transfer of the health insurance system from the Ministry of Health to the State Social Insurance General Office in 1996. While there was some gain in efficiency through the joint collection for all social security branches, there was a vacuum in technical capacity, including capacity to develop information systems, which took several years to fill.

Although the direct responsibility for the operation of social health insurance had been taken away, the Ministry of Health maintained its role in policy development. The Ministry was always cognizant of the problems and willing to correct the design faults. The first major improvement was the introduction of the Family General Practitioners Programme, through which ambulatory care benefits were added, with the payment of doctors on a capitation basis.

The social health insurance system therefore responded to the need for primary health care in the community. The information system was then improved and budgetary problems related to inequities in utilization of health insurance benefits and the rationale for subsidization of specific populations could be assessed.

The next stages of development focused on steps to control utilization through accreditation of providers and payment mechanisms, better linkage between the Ministry of Health and the broad social security framework, and revision of the policies on subsidization. The changes were made through amendments to the existing law, until a new Citizens Health Insurance (CHI) Law came into effect in January 2003.

The new (CHI) law paves the way for several critical changes. The unit of coverage will be changed from individual to family. This will enable the government to stop paying contributions for most students, as they will be covered through their parents’ contributions. The accreditation of providers will have to be expanded to include standards for the delivery of care. The experience with capitation in the Family General Practitioners Programme has been positive and the new law enables capitation for hospital-based services.

This development process in Mongolia is not unusual for a country in economic transition and illustrates the problems in achieving maturity in a new social security system. The main challenges for the system now are improvement in management and technical capacity. Emphasis will be placed on developing the capacity of the system to negotiate with providers and ensure quality. Throughout the country with its dispersed population including nomadic cattle herders, improvement in the capacity to register and collect contributions is a priority. A far better legislative basis
Social Health Insurance

for universal coverage through social health insurance is now in place. The return to
de facto coverage of the entire population needs to be achieved before the currently
unregulated private commercial and for-profit sector is allowed to take over the
higher-income population.

3.9 Philippines

The development of health insurance in the Philippines has moved through initial
efforts to provide broad social protection to the population to more focused
concern with access to basic health care, and is now a priority area of the Health
Sector Reform agenda. The Philippines embarked on social health insurance as an
integral part of social security from 1960s, before several countries in the Region that
have already reached universal coverage.

The original Medicare Programme launched in 1969 made health insurance
mandatory for salaried workers in the private and public sectors, through existing
separate social security systems for each sector, and regulated by the Philippines
Medicare Commission. This Programme had several characteristics, which could
have accelerated universal coverage. Dependents of the workers were covered,
entitlement was continued on retirement and the law included provisions for
voluntary enrolment of the self-employed and informal sector population in Phase 2.

There was no significant extension over the next three decades, as a result of
slow and unstable economic development, problems of both accreditation and
fraudulent claims in the Medicare Programme and low compliance with the law.
Contribution rates were low (2.5% of salary with low ceilings and shared equally
between the employer and employee) but benefits were limited to inpatient hospita l
care and the total amount of reimbursement per admission was below 50% of the
hospital charges. Phase 2 was limited to small pilot projects and attempts to extend
benefits to ambulatory care were hampered by widespread fraud in the fee-for-
insurance reimbursement for hospital care.

By the end of the 1980s, the Medicare Commission had been discredited by
claims of fraud and inappropriate accreditation of providers, and the overall lack of
compliance with the social security legislation left many salaried workers outside the
system. In the meantime, private investors set up health maintenance organizations
(HMOs), which offered prepayment plans linked to the use of specific health care
providers.

Although the premiums were far higher than the social health insurance
contributions and HMOs were established only in the largest cities, this form of
prepayment for health care was attractive for highly-paid employees and self-
employed professionals. Interest in the HMOs played some role in improving the
knowledge and awareness about prepayment for health care, and NGOs began community-based health insurance schemes on a non-profit basis.

Health care financing through social health insurance for the formal sector and for the informal sector became parallel priority areas of international development aid. The work done through a large USAID project provided the basis for the drafting and passage of the National Health Insurance Act of 1995. This Act created a National Health Insurance Programme and the Philippines National Health Insurance Corporation, or PhilHealth, to administer the new Programme. The Act stipulates that universal coverage should be reached within 15 years of implementation, and recognizes the role of community-based schemes in reaching the entire population. The new scheme effectively ended Medicare, and links with the social security systems for the private and public sectors were broken when PhilHealth began its own registration and contribution collection.

The new administration later took over the voluntary health insurance coverage of overseas Filipino workers and their dependants, numbering several million persons. A priority area for PhilHealth has been the coverage of the indigent population, through subsidization of the contributions for the poorest families. The introduction of user charges in public hospitals and the change in public hospital budgeting towards self-financing obviously created urgency to cover the indigent population.

The high proportion of the population living below the poverty line in the country has led to considerable delays in this effort, as it involved developing appropriate mechanisms to identify the poorest families and to develop fair guidelines for the transfer of national funds to provinces with a low tax base and a high proportion of the indigent.

A major problem is the inadequacy of funds to support the entire indigent population, particularly with the high administrative costs involved. However, implementation of the Act has had several positive effects.

Recognition of the needs of the population for primary health care led to pilot schemes and the ultimate inclusion of ambulatory care benefits, and accreditation of health facilities led to the establishment of standards and regulations, which should ultimately lead to improvement in the quality of care for all population sectors. Efforts are now focused on finalizing accreditation criteria for community-based schemes and their incorporation into the universal coverage target.

Despite all the efforts, the overall coverage is less than half of the population and the households still bear about half of the health care expenditures under the new National Health Insurance Programme. As with the previous Medicare Programme, this is in part due to the low compliance by employers in registering
their employees, and in part due to the limitation of reimbursement, or support value as it is termed. Both of these areas have yet to be addressed before significant extension of coverage can be expected.

### 3.10 Singapore

Compulsory prepayment and social health insurance mechanisms in Singapore consist of the 3-M schemes of Medisave, MediShield and Medifund. The three schemes were developed over a decade, following a policy of both personal responsibility and government commitment, taking into account changes in health care needs and demands related to the ageing of the population and developments in medical technology.

The first component, the Medisave Programme launched in 1984, is a form of compulsory savings in individual accounts, at a rate linked to wages, and covers the health care expenditures of family members. Pooling in the Medisave system is therefore only at the level of the family. The individual savings accounts were designed to encourage individuals to stay healthy and minimize the use of unnecessary medical services. The ideology leading to the individual (or family) account system was based mainly on the cultural approach to saving for unforeseen contingencies as a manifestation of self-reliance and through strong family ties. Medisave was also designed to counter the potential for unnecessary health care in a well-resourced health care system. To discourage over-utilization from the demand side, co-payment by the patient at the time of use was applied.

As it became clear that Medisave individual accounts were not sufficient to cover high-cost health expenditures, the government recognized the need and demand for broader pooling through a social insurance mechanism. MediShield was introduced as a catastrophic insurance plan in 1990, financed by premiums deducted from the Medisave, unless the account holders request otherwise. The threshold to reach the expenditure for entitlement to reimbursement through MediShield was high. Supplementary MediShield Plus Programmes were offered to enable different levels of coverage, based on deductible or excess amounts per policy year, claim limits per policy year, and claim limits per lifetime.

The third scheme - Medifund was established through the government endowment funds in 1993 to support health care for the poor. This component does not cover individuals identified as poor or indigent, but considers requests for financial assistance on a case-by-case basis with preference given to low-wage Medisave/ MediShield contributors and elderly persons whose accounts are not adequate to cover expenses. Medifund therefore completes the scope of the arrangements to enable universal coverage.
The limitation of all three components to hospital-based services is sometimes overlooked. The 3M financing system covers expensive hospitalization and limited outpatient procedures. It includes non-acute care in community hospitals, which provide post-acute and rehabilitative care, and hospices. Yet, Singapore has a public primary health care system with a wide range of general practitioner and public health services delivered in community health centres.

Singapore’s health care financing system represents an experiment in the development of individual medical savings later supplemented by social insurance. Several countries have tried to copy the medical savings component but have not reached the same results in terms of equity in access to health care, possibly as some of the conditions were omitted.

The public health services cover a wide range of primary health care, with a strong emphasis on prevention and health promotion activities. The individual accounts in the Singapore Medisave system cover family members and not only the contributing individual. At the time of its launching, the differences in earnings among the population were not vast, so that there were not large differences in the amounts accrued in each account. Variation in the actual number of dependants who could access the same account was somewhat reduced by the government’s success in lowering family size and the account can now be used to cover the health care costs of extended family members.

By the time Medisave was extended to the self-employed in 1992, this sector was completely formalized, that is, the self-employed as well as salaried employees were registered and there was a very high level of compliance with legislation and regulations.

Despite the strong cultural value of savings, the government did not see individual medical savings as a single solution to all health policy problems and accepted responsibility in developing a supplementary system through social insurance as well as the tax-funded allocation to cover the population, which could neither save nor contribute towards their own health care.

The same ideology, involving redistribution, savings and insurance has been applied in a new programme to cover the health needs of the growing elderly population in Singapore. There is no comprehensive system for financing long-term care, and financing currently draws on direct payments from older individuals and their families, community assistance to voluntary welfare organizations which secure up to 50% or more of their recurrent expenditure from fund raising, and government funding through grants-in-aid to voluntary welfare organizations.

Currently, there is an on-going review of the 3-M system to be followed later by a review of the optional health insurance products. Despite the range of components
to cover different expenditure levels and contingencies, there are still gaps in the system, which could increase with changes in demography (ageing) and morbidity (more chronic diseases). Some of the gaps are created by an increase in people who opt out of Medishield (the only component which is not fully compulsory). Early policy announcements point to the need for compulsory enrolment and greater enhancement of benefits through strengthening of the insurance components of the 3-M financing mechanisms.

3.11 Thailand

In October 2001, Thailand has achieved universal access to health care through a combination of social health insurance and government-funded schemes, through more than two and a half decade of targeting approach by successive governments. The first form of social protection was the Social Welfare Scheme for poor and low-income households as part of the national social welfare scheme in 1975. This welfare scheme was developed for the indigent population and enabled free-of-charge care at public facilities for ambulatory and inpatient services. By 2000, around 20 million people were covered under this scheme. The budget was allocated through the central tax revenues. The major criticism of the scheme focused on the difficulties in means-testing for identifying the poor, due to which many of the poorest households were not effectively included.

In 1978, Thailand introduced the Civil Servant’s Medical Benefit Scheme (CSMBS), to cover health care for all civil servants (including employees of state enterprises), pensioners and their dependants (parents, spouses and upto 3 children under 18 years old). The total number of retired and existing civil servants and their dependants was over six million in 2003. The scheme started with a fee-for-service reimbursement model for all services, which resulted in lengthy hospital stays, overuse of prescribed drugs and diagnostic tests. The source of funds is the general revenue of the government and the scheme is managed by the Comptroller’s General Department (CGD) in the Ministry of Finance. Following various studies and the after effects of the economic crisis in the late 1990s, the government, initially accepted the recommendations of Health Systems Research Institute of Thailand, on the payment mechanism reform of the CSMBS toward capitation for ambulatory care and global budget and diagnosis-related groups (DRG) for inpatient care. Unfortunately this was not actually implemented. The CGD instead adopted a co-payment policy by beneficiaries, after the economic crisis in 1997 in view of cost savings. Through this, beneficiaries had to pay drugs outside items listed in the National Essential Drug List. In addition, the Scheme does not allow beneficiaries to use private admission, except emergency care.

The first community based health insurance (CBHI) scheme developed in Thailand was the Voluntary Health Card (VHC) project started in 1983 initiated by
the Ministry of Public Health. The scheme initially covered mother and child-care in rural areas. Coverage was extended in 1994 through the involvement of local leaders, and benefits were expanded to primary health care and in-patient care in district hospitals. By the mid-1990s the VHC covered around 11 million persons. The MOPH proposed a reform from CBHI to a publicly subsidized voluntary health insurance, whereby families had to pay 500 bahts per year for their Family Card membership and government, regardless of the income level of the rural households (who are not covered by the social welfare scheme), matched this.

The first compulsory social health insurance system came through the integration of health care and the social security scheme for private sector-salaried workers. Based on the Social Security Act of 1990, the government introduced national mandatory social health insurance for all private enterprises with more than 20 employees using a capitation, low-cost contract model. The Social Security Organization (SSO), under the Ministry of Labour, manages the scheme. In 1994, coverage of SSO was extended to the private or commercial establishments with more than 10 employees. By 2002, it included small enterprises with more than one employee. The scheme now covers over seven million employees, and also provides limited benefits for the spouses of insured workers.

The financial contribution was progressive with a five-fold gap between the contribution of the highest and lowest wage earners, based on 4.5% of payroll equally shared by the employers, employees and the government for sickness, maternity, invalidity and funeral grants. Health care benefits was comprehensive include both outpatient and inpatient care, and the providers are contracted through capitation.

An interesting feature of the system is the participation of the private for-profit hospital sector. Currently, about half the number of contracted hospitals is in the private sector and these receive the same capitation payment as public hospitals. Failure to extend coverage to workers' dependants (non working spouse and dependant children) has been a major reason for the limited growth in coverage of the population through the SSO.

Thailand's Universal Coverage Scheme, notably known as the “30 bahts Scheme” began in October 2001, with the idea of replacing the Social Welfare Scheme and the Voluntary Health Card Scheme. The programme was operational nationwide by mid-2001 and now covers almost all citizens except civil servants and their dependants and those covered by the Social Health Insurance Scheme. The Universal Coverage Scheme provides comprehensive health care with virtually no co-payment by users, apart from a nominal fee of 30 bahts per each health visit or hospital admission. The scheme is mainly funded by general tax revenue, with an estimated budget of 1400 bahts per capita per year (currently about US$ 35) which is paid directly to designated providers as a capitation payment, based on the positive experience of the SSO capitation model.
Due to the low cost scheme, the Universal Coverage Scheme demonstrates a long term financial sustainability and affordability by the government, which in fact applies the same approach to all beneficiaries, regardless of income. The scheme requires a financial commitment that has to stand up to economic shocks, and the lack of progressivism attracts some criticism. Recent evidence from EQUITAP study indicates a concentration index of direct tax of 0.9057 and indirect tax of 0.5776. Thus, the concentration index of combined direct and indirect tax was 0.6996, indicated progressivity of general tax financed health insurance scheme. Though evidence from the study indicated that the UC scheme is progressive due to its finance from general tax system, it also covers all individuals who are engaged in the informal sector.

The coverage of the “30 bahts scheme” by the end of 2002 was around 76% of the total population. The remaining population is still covered by the CSMBS (11%) and SSO (13%). Thailand has therefore reached universal coverage through a mix of public and private financing and public and private health care providers. It remains to be seen whether the SSO can significantly expand coverage to dependants of its insured members and thereby reduce the burden on government.

3.12 Viet Nam

Viet Nam introduced compulsory social health insurance for active and retired civil servants and for private sector employees in enterprises with over 10 workers through the Health Insurance Decree of 1992. The Viet Nam Health Insurance (VHI) was set up as a national administrative structure, initially under the Ministry of Health. The VHI was also charged with extending coverage to social health insurance on a voluntary basis to dependants of the insured workers, through the same provincial administration. These efforts were largely unsuccessful, with the exception of coverage of about four million school children. There was significant success in mobilizing provincial welfare funds to purchase health insurance cards for the indigent population in several provinces. By 2000, about 12 million individuals were covered by VHI. However, the financial viability of the VHI was threatened by several factors:

- The fee-for-service provider payment system, which led to charges for unnecessary services for the insured;
- The insured public sector population had a high proportion of retired civil servants, with the associated health risks of the elderly, and
- Compliance with registration and contribution payments was very low in the private salaried sector, which had higher wages than the public sector employees.

The last point is particularly significant. As in Thailand, the VHI did not extend coverage to the workers’ dependants, which essentially led to low interest in the...
social health insurance scheme. For this sector, compliance increased from around 15% in 1995 to 50% in 2000, as more attention was paid to registration of small enterprises in the private sector, and intensive promotion campaigns were carried out by the VHI.

Since mid-2001, several important developments have occurred. The VHI was merged with the Viet Nam Social Insurance (VSS) agency, directly under the Prime Minister's Office. The Ministries of Labour, Invalids and Social Affairs and Health are represented on the governing board of the VSS through their Vice-Ministers. The Central Government of Viet Nam has set up a special health care fund, 75% of which comes from the Central Government budget to provide a social safety net for about 14 million people. With WHO technical assistance and an Asian Development Bank (ADB) project, voluntary insurance is now being extended to at least half of the country's provinces, at community level and through the administration of VSS. The conditions will be the same as the health cards for the poor, that is, family membership, comprehensive health care benefits, no co-payment at the time of use, and capitation payment to providers. There is political pressure to extend coverage as rapidly as possible, prompted by the realization that current user charges and even co-payments in the public system create high financial burdens for the majority of the population.

Viet Nam is now actively introducing changes to increase coverage in both the formal and informal labour sectors. The principle of having one system is maintained, and the mechanisms to increase coverage in the informal sector, in both rural and urban areas, take the form of decentralized implementation of community-based health insurance, albeit under the administration of the VSS within the national system.

The development of social health insurance in Viet Nam has taken an ambitious path since the Health Insurance Decree of 1992. From the start, there has been concern with the vulnerable populations, such as the retired state workers (all workers from the pre-transition period), the disabled and the poor as well as citizens to whom Viet Nam gave meritorious status. The government insisted on maintaining one national scheme with compulsory and voluntary components, and nongovernmental community-based schemes were discouraged. Decentralization of the major functions of the social health insurance scheme was carried out in a planned and rational way, with a fixed allocation for administration and training within the system.

The major challenge now is to make the necessary adjustments to cover a population in which the majority of workers are in the private and informal sectors, including the elderly who reach retirement age without prior employment in the formal public sector. Another challenge is how the social health insurance system can improve the quality of health care within its budgetary constraints.
4

Comparative Analysis of Experiences

As stated in the Section 1.2 on the purpose of the case studies, the comparative analysis attempts to provide some direction on how the different health care financing systems have to deal with major issues facing the political decision-makers and the administrators especially in planning and implementing various social health insurance schemes. Some of the issues involve crosscutting that may come out in more than one part. Based on the comparisons, the potential impact of changes in some critical aspects of the schemes are discussed.

4.1 Can Universal Coverage be Achieved only Through Compulsory Mechanisms?

The answer to the question of the necessity of compulsory measures for health insurance schemes to achieve universal coverage is therefore “yes”. All countries that have achieved the universal coverage have implemented necessary legislation to achieve compulsory participation. The following table (Table I.1) and the respective analysis provided information on the processes involved in reaching universal coverage.

Table I.1 shows the countries that have achieved universal coverage (100% with minor reductions for some categories of residents) and the estimated total coverage in the rest of the countries, as indicated in the study questionnaires mentioned earlier. These figures are only estimations, since it is not possible to derive the total population covered by the various community-based schemes. The estimates do not
include coverage by private for-profit insurance. Comments on some factors that may affect the extension of coverage are included.

Both Australia and Japan started with voluntary, mutual or community-based prepayment systems. Compulsory HI systems were launched on the basis of this experience and in response to labour developments and positive economic growth. The political action in the form of legislation to achieve universal coverage was taken when coverage through voluntary schemes (Australia) or a mix of compulsory and voluntary systems (Japan and the RoK) reached a relatively high proportion of the population.

Singapore began its first social health insurance scheme on the foundation of a compulsory savings scheme applied to the entire population. In all these countries, it was clear to the policy-makers that universal coverage could only be reached by compulsory mechanisms, and the burden on the government to cover the non-economically active and indigent populations was accepted as an integral part of the policy.

Economic growth at the time created optimism that universal coverage could be sustained. Perhaps Mongolia was different in this regard as it attempted to cover the entire population in one stage, without the prior experience of partial coverage through contributory prepayment before steady economic growth, and at an extremely high and ultimately unsustainable government cost. The decisions in the case of Mongolia were taken at the very beginning of economic liberalization (and cessation of free public services) and were strongly driven by the political desire to avoid exposing the population to a long period without health protection.

In a number of countries with compulsory social health insurance for the salaried sector and some community-based schemes, social health insurance coverage has still not reached a critical level. While it is difficult to define this level, one could consider coverage of over 30% as the level that may influence government action towards universal coverage. However, there are several reasons for the slow extension or even stagnation in coverage and these may differ by country.

Table 1 also showed several significant differences in design factors that may determine the potential for extending coverage and may explain some stagnation in the growth of social health insurance. The individual country case studies lend support to the hypothesis that it may be easier to launch legislation for universal coverage when there is a critical mass of the population covered by compulsory and/or voluntary social insurance, and in public and non-government schemes. The country case studies also provide details on how governments cover the indigent and non-economically active populations so coverage is effectively “universal”.

Selected Case Studies from Asia and the Pacific
<table>
<thead>
<tr>
<th>Country/Scheme</th>
<th>First Law/Decree</th>
<th>Year started</th>
<th>Current Estimated Coverage</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Medicare (C) *</td>
<td>1972</td>
<td>1975</td>
<td>Universal All citizens and legal residents are eligible. Family as the unit of coverage</td>
</tr>
<tr>
<td>India</td>
<td>ESIS (C) CGHS (O) CBHI schemes (V)</td>
<td>1948 1954 from 1950s</td>
<td>2018 2018 20% of total population (all schemes)</td>
<td>Family members covered but scheme excludes higher-salaried workers, and small enterprises. Very different arrangements by location, occupation and benefits.</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>National scheme merging the existing schemes (compulsory)</td>
<td>1976 1977</td>
<td>1977 Universal</td>
<td>Gradual extensions to different occupational sectors, family coverage.</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>CCS (C) SSO (C) CBHI (V)</td>
<td>1989 2000 2002</td>
<td>1989 2001 2002 5% of total population</td>
<td>All have family coverage. Reimbursement very limited by fund capacity. Still limited to capital city. Controlled extension of pilot projects.</td>
</tr>
<tr>
<td>Country/Scheme</td>
<td>First Law/Decree</td>
<td>Year started</td>
<td>Current Estimated Coverage</td>
<td>Comments</td>
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<td>----------------</td>
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</tr>
<tr>
<td><strong>Mongolia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National scheme (C) (G)</td>
<td>1993</td>
<td>1994</td>
<td>78%</td>
<td>Initial universal coverage dropped, new systems will register self-employed.</td>
</tr>
<tr>
<td>The Philippines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhilHealth (C) (G) CBHI (V)</td>
<td>1994</td>
<td>1995</td>
<td>55% of total population</td>
<td>PhilHealth National Health Insurance Programme combines previous systems.</td>
</tr>
<tr>
<td><strong>Singapore</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medisave (C)</td>
<td>1983</td>
<td>1984</td>
<td>Universal</td>
<td>Three layers enable universal coverage for hospital-based benefits, with low cost public primary health care.</td>
</tr>
<tr>
<td>Medishield (O)</td>
<td>1989</td>
<td>1990</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medifund (G)</td>
<td>1992</td>
<td>1993</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Thailand</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSO (compulsory)</td>
<td>1990</td>
<td>1991</td>
<td>(13%)</td>
<td>Dependants not covered. Dependants covered in non-contributory scheme. Rest of the population, completing universal access.</td>
</tr>
<tr>
<td>CSMBS (civil servants)</td>
<td>1978</td>
<td>1978</td>
<td>(11%)</td>
<td></td>
</tr>
<tr>
<td>“Universal Coverage”</td>
<td>2001</td>
<td>2001</td>
<td>(76%)</td>
<td></td>
</tr>
<tr>
<td><strong>Viet Nam</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VSS (C)</td>
<td>1992</td>
<td>1992</td>
<td>Universal</td>
<td>Dependants not covered. Students informally covered. Informal sector. Acceleration of government programme to subsidize health insurance for the low-income populations, including family members except children under six years (still government-funded)</td>
</tr>
<tr>
<td>VSS (V)</td>
<td>1993</td>
<td>1994</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VSS-CBHI (V)</td>
<td>2002</td>
<td>2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCFP (scheme for the poor (G))</td>
<td>2002</td>
<td>2003</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* (C) Compulsory, (V) Voluntary, (G) Government-funded programme, (O) Individuals can opt out.

While several countries have passed legislation on universal coverage for some period, actual coverage is behind target. Obviously, the legislative mechanisms need to have appropriate sanctions to assure high compliance for the salaried as well as non-salaried sectors. The next section would look at some of the limitations which might explain the lag in expansion.
4.2 Are There Limitations Which Inhibit the Extension of Coverage?

There are indeed many limitations in various schemes that could hamper the expansion of coverage. Most limitations are of design issues that may influence the attractiveness of a particular form of health protection among the population at large.

**Limits in covering dependants** - As discussed above, several countries limit the benefits to workers only, or limit the number of dependent children covered by the schemes for the formal sector. This limitation is usually a feature of the schemes in which both employer and employee share the contribution burden as in the case of China, Thailand and Viet Nam (will deal in details in the next section). Indonesia limits the number of children to be covered to two, and till to the age of 21 years.

Limiting the number of children to be covered as dependants to insured persons may be questioned. If the intent is to encourage smaller families, this may not be the most effective mechanism. In any case, limitations on the number of children covered in families which have more than two children are likely to lead to a greater moral hazard: the insured member is more likely to cover the child with existing health problems than healthy children.

There are some objective difficulties in the extension of benefits to children. In schemes in which the employer is liable for the collection of contributions, registration tools to record all dependent children need to be developed. Decisions have to be made as to whether children are registered under the working father or mother in case both are working, as duplication in registration should be avoided. Other decisions will consider up to what age children should be considered dependent (usually 18 but often 21 as in Indonesia and the Philippines), and whether they should be insured as individuals if they are working and over 16 years of age (as required in Japan and Australia). The issue of how to cover children residing outside the home was debated for several years in Mongolia, where school-age children of the nomadic population usually spend most of the year in boarding schools far from home. Finding solutions to all these problems depends to a large extent on the sophistication of population registries and the maturity of the schemes.

Beyond estimates of the total number of persons who could be covered if the spouse and legal dependants (generally children up to the age of 18) were covered, the attractiveness of “worker only” health protection should be considered. Active workers are generally healthy adults, whose incomes generally support their non-economically active family members. Schemes, which cover their own reduced health needs, but leave them vulnerable to high costs of the health needs of their families, may not be attractive. It is reasonable to assume that workers would exert more
pressure on non-complying employers to ensure their registration and continued participation if all their dependants were covered.

**Limits on earning level and enterprise size** - may have a negative outcome on the substantial extension of coverage. The ESIS in India earlier had the limits on compulsory membership to a fixed amount of salary. This condition was part of the design to protect low-income workers. Another limitation of ESIS is that very small enterprises with low reported annual incomes are not included, while the Law only applies to enterprises with more than 10 workers (20 for some categories of enterprises). Over the 50 years, some adjustments have been made in the salary limit for membership. The changes still have not matched the increases in average wage, so that ultimately the proportion of workers covered has not increased. Earners of wages above the set amount find it difficult to meet health care costs in a period of rapidly rising costs; and there have been cases of workers with chronic health problems in the family refusing to accept promotion if the higher wages would bring them above the fixed level for entitlement.

In parallel, the growth of small enterprises, including family businesses, has been significant in the past decades. The ESIS still has no provision for these salaried workers or for the self-employed sector, whether formal or informal. At the end of 2003, only 8.5 million workers were enrolled and 33 million persons were entitled to benefits through the ESIS.

Another SHI scheme for government workers – the CGHS covers about half of that number, bringing the total number of insured persons under compulsory schemes to around 45 million persons or less than 5% of the population. While it may be a sheer size, it is indeed a very small proportion of the total population of India. One can only speculate as to what extent, the coverage could have been extended, at least to individuals in the families of private sector workers, if the salary ceiling had been lifted and provisions had been made to cover enterprises with less than 10 workers.

Similar issues may have been faced in Indonesia. The Jamsostek scheme for private sector salaried employees is not compulsory for all enterprises. Small enterprises with low salaries are also not covered. At the other end of the scale, enterprises that provide health care benefits considered better than those of Jamsostek are exempted to be part of the scheme. These enterprises are generally better paying establishments, which tend to purchase commercial for-profit health insurance schemes, at higher costs.

The exclusions and exemptions also limit the pooling as well as the financial viability of social health insurance funds. The lowest paid and less-secure workers employed in the small enterprises are excluded; those covered by Jamsostek will have
a weak fund for essentially low-and-middle income workers, without the benefit of the higher contribution amounts coming from higher paid workers. These conditions are generally not conducive to the steady growth of social health insurance through solidarity. On the contrary, such systems limit the ability to achieve equity in access to health care.

In countries which have not reached universal coverage, stagnation in the extension of coverage may also mean stagnation in the development of technical capacity in the existing schemes to improve management. Particularly when the vast majority of the insured members are low-paid workers, the internal pressure on the scheme to improve may be low. The private sector and even better paying public sector workers like those in China, India, Indonesia, the Philippines and Viet Nam, for example, essentially remain outside the social health insurance schemes.

The inclusion of enterprises with high-paid workers will improve pooling between low-and high-paid earners, and also increase pressure on the funds towards improvement in the quality of benefits and transparency in management.

**Inclusion of both public and private sector workers** - In countries where universal coverage is achieved, public and private sector workers and their families will usually be covered by the same scheme (as in Australia, Mongolia and Singapore) or by separate schemes (as in Japan and the Republic of Korea). It is worth considering whether specific labour conditions for civil servants have kept them out of social health insurance schemes in the other countries. In the past and as currently practice of in many countries in the Region, civil servants were provided health services free of charge at public institutions. This arrangement was often a fringe benefit for the generally low-paid government workers, and no deductions were made from their salaries for this benefit.

The shift to universal coverage necessitates a contributory mechanism for civil servants, in which the government has to undertake to pay its part as the employer of civil servants. Apart from the issue of imposing contributions on the typically low-paid civil servants, schemes for civil servants can be problematic for some developing countries.

In countries in which the Ministry of Finance previously paid all civil servants’ salaries, as in Viet Nam, this Ministry may take the responsibility for contributions for all public sector and state enterprise workers. As in the reform of urban employees in China, coverage of civil servants necessitated budgetary allocations to respective government agencies to cover their own workers’ contributions.

The ministries of health now tend to favour shifting from free care for civil servants to social health insurance coverage. Free-of-charge services in government
facilities are essentially funded by the budget of the Ministry of Health. Government hospitals may not receive payment for the health care provided to civil servants but are expected to bear the costs within their allocated budgets. The introduction of user charges at the public health care facilities puts the emphasis on revenues and expenditures within each institution. The care of non-paying patients, including civil servants, becomes a source of resentment and also a real financial burden, this time for the public providers.

The reformists in Thailand have been trying for several years to introduce financing reform of the Civil Servant Medical Benefit Scheme (CSMBS), from fee for service reimbursement model to a more close-end provider payment, such as capitation for ambulatory care and global budge with Diagnostic Related Group (DRG) for inpatient services.

The failure to create a contributory insurance system stems mainly from the reluctance of the beneficiaries to contribute since the public sector salary was still low, and a general perception that it is a fringe benefit, to compensate low salary. A similar situation exists in Laos PDR, where the Ministry of Finance has resisted initiatives to merge a contributory social insurance system of civil servants with that of salaried workers in the private sector.

Similar to the inclusion of family dependants, the inclusion of civil servants under the social health insurance coverage is important for expanding universal coverage, particularly in countries undergoing the streamlining of their public services. One of the benefits of covering both the public and the private sectors is the flexibility of movement between public and private sector employment and between salaried and self-employed status. Universal coverage effectively provides the security in mobility between sectors without the fear of loss of entitlement to health protection.

Limits in the legislative instrument - Legislative instrument itself may have been a constraint or reason for stagnation in the growth of social health insurance coverage. In China and Viet Nam, the nature of the legislative tool could be the root cause of low compliance. In these countries, all social security schemes are governed by decrees rather than laws. Decrees may be faster and easier to enact, but do not have the punitive sanctions needed for compulsory memberships involving regular contributions by both employer and employee. Viet Nam is now in the process of formulating a social security law for passage in 2005 and is considering of including social health insurance in this law. The alternative would be a separate law, which could take several years. The advantages of a law as the legislative instrument and the joint collection of contributions for all social security benefit branches are likely to increase compliance in Viet Nam.
India and Indonesia have national laws, but again with exclusion of the better-off enterprises and employees. Thailand’s the Social Security Law of 1990 allows no exemptions and has extended coverage to smaller enterprises by stages since its implementation in 1991. With the additional advantage of joint contributions collected for all social security benefits, compliance in the Social Security Office’s health insurance is over 80%. An additional factor was the flexibility shown by the scheme during the period of economic crisis starting in 1997. The contribution rates for employers and employees were reduced (from 1.5% to 1.0% of salary each) for over two years. Entitlement to benefits was extended from three to 12 months after termination of employment for those workers who lost their jobs. This at least minimized the loss in membership due to the economic crisis.

The Philippines’ Law covers all enterprises regardless of size and level of salary of the employees. Even enterprises with single workers and domestic workers are covered. However, overall governance is weak, and workers’ interest is low and non-compliance is common. Employers also take advantage of the stipulation contained in the law that workers are covered after three months of employment. Evasion of registration is made possible by the firing and rehiring of workers every three months and thereby maintaining the same worker over years on temporary contracts without proper coverage of social security. This situation may also be affected by high unemployment rates in the Philippines, when low-paid workers are more concerned with having a job and income than social protection.

The above factors do not by themselves lead to expanding universal coverage. But at least they create the legislative, financial and administrative structures on which universal coverage schemes can be built upon. One can argue that some of the factors, such as the capacity to enrol dependants, depend on the maturity of the system. Other factors such as the level of compliance are linked to the legislative instrument, which mandates registration and regular payment of contributions. On the other hand, even when the appropriate instrument is in place, good governance will probably be the main determinant in the extension of coverage. External technical support may facilitate the maturity of a social security system, but good governance needs to come from internal or national efforts.

**Limits in technical capacity:** Particularly during the first years of operation, limited technical skills and experience can inhibit the extension of coverage and benefits, as was noted in the country papers of Laos PDR and Mongolia. Part of the problem is the tendency of government to employ the top posts in new social health insurance schemes with political rather than professional appointments while the training of health insurance managers has been very limited.
4.3 Does Exclusion of the Informal Sector Limit the Extension of Coverage?

The issue of whether universal coverage can be achieved when the labour force has a large informal sector is an important fact; due to the majority of workers being in this sector in most countries. The answer is simply ‘yes’. The exclusion of this informal sector does limit the extension of social health insurance coverage.

Most countries that have achieved universal coverage do not have a real informal sector, since most economically active individuals are registered for income tax purposes. Certainly they have self-employed workers and small-scale family enterprises, with unpaid family members as workers, who would constitute as an informal sector, if they were not registered as operators of businesses, service providers or independent artisans.

In countries with large number of labour forces in the informal sectors, the tendency of the governments is to adopt social safety nets, exclusively for this population, rather than improving the coverage through the existing social insurance schemes. There are several plausible explanations. While there may be an overall intention to increase the national tax base, law enforcement on the registration of small businesses, including entrepreneurial activities of single vendors or service providers may not be a priority. There are reasons linked to the management capacity of the social health insurance schemes themselves.

It is indeed difficult for fledgling SHI schemes to take on the tasks of registering individuals rather than employers, particularly when there are few forms of registration of the target members. It is also far easier to tackle non-compliance in registration and contribution payments when a law stipulates employer liability for these functions. If health care is integrated, a broad social security system that collects contributions for pensions, invalidity and maternity benefits and a funeral grant, there is some reluctance by the schemes to cover populations who opt for only one benefit branch, that is, for health care. This benefit is not only the most frequently used (compared to pensions, maternity and invalidity allowances), but also complex in terms of the expertise required in dealing with health care providers.

An additional complication is determination of the base rate for contribution for the informal sector. In a population that is generally not registered for income tax purposes, a contribution rate set as a percentage of income can be difficult to apply. When compulsory social health insurance was extended to the self-employed in Japan and the Republic of Korea, contributions were set according to household income categories, based on family size and assets. The number of groups was eventually minimized in Japan to simplify calculations while the number of factors entered into the assessment of assets of farmers in the RoK was reduced.
In most systems that cover the informal sector, and as in CBHI, flat rates are set, sometimes according to family size as in Laos PDR, and in a small number of broad income groups as in some schemes in India and Indonesia. A key factor in the coverage of the low income self-employed and informal sector was the subsidization of the contributions by government like in Japan and Republic of Korea. The new guidelines for the RCMS in China acknowledge the necessity for subsidization of farmers’ contributions by all levels of government.

The experiences from the selected country case studies already show that it is indeed possible to develop schemes for the formal and informal sector populations, through a national approach similar to Viet Nam, or through a parallel approach, promoting compulsory social security schemes for the salaried population and CBHI for the rest of the population like Laos PDR. In both cases, the major issues influencing enrolment and sustained membership by the informal sector is the affordability of contributions, with the family as the unit of coverage, flexibility in collection and a balanced range of health care benefits.

4.4 Is Universal Coverage Dependent on the Contribution Burden and Sharing?

The comparison of contribution rates across the selected countries shows that both the level and the sharing of contributions are not linked to the achievement of universal coverage. In most countries studied, the SHI schemes have contribution rates that could be considered at low level compared to European countries. As shown in Table 2, the flat rate amounts paid by employers and employees or households vary from less than 1% of income in the RCMS to 8% in the urban workers’ schemes in China and the workers’ scheme in Japan.

The comparison of the contribution levels is difficult to make because of some added amounts by the governments, similar to the case of Australia. Government funding towards SHI may be in the form of full or partial subsidies for all insured, or for specific populations such as the self-employed in the Republic of Korea, rural residents in China and the indigent populations in several schemes, or for specific functions as in Japan, where government funds subsidize the management of the social health insurance schemes.

It is also difficult to add the rates and amounts in order to determine the total amount of contribution revenue per person or family as opposed to expenditure. The total amount of savings in the individual accounts in Singapore’s Medisave is considerable, but contributions are only made until age 55 and this constitutes savings accounts for future expenditure on health care over the age of 55. That is, the scheme pools payments across the contributor’s lifespan rather than across
populations. The individual accounts in China come from 5% of the total 8% of salary (including employer and employees). This division has already been seen as inappropriate since the insured tend to attempt to avoid accessing their savings while the pooled fund is inadequate. Local authorities can now decide on the proportions to be placed in individual and pooled accounts.

The data in Table 2 are extracted from the country case studies and from replies to questionnaires. While very specific rates were provided for some schemes, the response was a general statement in others, such as “rates set according to household income” as in the compulsory community scheme in Japan. In any case, the rates cannot stand up to any meaningful comparison, as the benefits and the co-payments are different among the schemes. For example, all three of Singapore’s schemes only cover hospital-based care (including outpatient care) as health insurance benefits, while primary health care is provided through the government-funded community clinics or by employers. Prescribed drugs are included as health insurance benefits in most of the schemes, but are covered under a separate Pharmaceutical Benefits Scheme in Australia. Australia’s Medicare also provides limited dental benefit in public hospitals, while Singapore does not cover dental care at all and Japan reimburses 70% of dental care expenditure.

Table 2: Contribution levels in the Social Health Insurance Schemes
(by Country/Scheme)

<table>
<thead>
<tr>
<th>Country/Scheme</th>
<th>Employer % of salary</th>
<th>Employee/HH% income or flat rate</th>
<th>Government</th>
<th>Total</th>
<th>Comments (on co-payment and benefit limits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>0%</td>
<td>1.5-2.5% of income</td>
<td>Rest of budget</td>
<td>NA*</td>
<td>Co-payments: 15% of primary care fee, some others. Separate drug scheme.</td>
</tr>
<tr>
<td>China</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban workers</td>
<td>6.0%</td>
<td>2.0%</td>
<td>0.5% in some cities</td>
<td>8%</td>
<td>Co-payments: 20% for most services. Partially in individual account. High co-payments and ceilings.</td>
</tr>
<tr>
<td>RCMS (new)</td>
<td>NA</td>
<td>Flat rate, less than 1% of income</td>
<td>May reach matching amount</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESIS</td>
<td>4.75%</td>
<td>1.75% Flat rate</td>
<td>As employer</td>
<td>6.5%</td>
<td>No co-payments, care in scheme facilities. Most have ceilings for reimbursement.</td>
</tr>
<tr>
<td>CGHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBHI schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country/Scheme</td>
<td>Employer % of salary</td>
<td>Employee/ (% of salary) HH% income or flat rate</td>
<td>Government</td>
<td>Total</td>
<td>Comments (on co-payment and benefit limits)</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------</td>
<td>--------------------------------------------</td>
<td>------------</td>
<td>-------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Indonesia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASKES</td>
<td>0.5%</td>
<td>2.0% Wide range</td>
<td>As employer</td>
<td>NA</td>
<td>No co-payment. Ceilings on reimbursement.</td>
</tr>
<tr>
<td>Jamsostek</td>
<td>3-6%</td>
<td>0%</td>
<td>Some subsidy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBHI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Japan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers</td>
<td>4.0%</td>
<td>4.0% Varies by income Transfers</td>
<td>Mgmt 50% paid by local govt. 33% of expenditure All costs</td>
<td>NA</td>
<td>30% co-payment. 30% co-payment. 66% transfer.</td>
</tr>
<tr>
<td>Community</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td>4.0%</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare</td>
<td>2.0%</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Republic of</strong></td>
<td><strong>Korea</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHIP salaried</td>
<td>1.95%</td>
<td>1.95% According to assets</td>
<td>20-45% of contribution for self-employed Pays in full</td>
<td>NA</td>
<td>High co-payments, according to service, reaching average of over 50%. Same benefits as other sectors</td>
</tr>
<tr>
<td>Self-employed</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical-Aid (3%)</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lao PDR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCS</td>
<td>-</td>
<td>6% for all social security</td>
<td>As employer</td>
<td>NA</td>
<td>No co-payment but amount limited. No co-payments. No co-payments.</td>
</tr>
<tr>
<td>SSO</td>
<td>2.2%</td>
<td>1.8% Flat rate, About 2% income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBHI</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mongolia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaried</td>
<td>3.0%</td>
<td>3.0% Flat rate</td>
<td>-</td>
<td>-</td>
<td>5-15% co-payments for hospital care. 50-90% co-payment for drugs.</td>
</tr>
<tr>
<td>Self-employed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigent/ vulnerable</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Philippines</strong></td>
<td><strong>PhilHealth</strong></td>
<td></td>
<td>Central and local level pay for indigent families</td>
<td>NA</td>
<td>Ceilings for most care create low &quot;support value&quot;. Some have ceilings Low support.</td>
</tr>
<tr>
<td>CBHI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigent</td>
<td>1.25%</td>
<td>1.25% Flat rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Singapore</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medisave/</td>
<td>3.0-4.0%</td>
<td>3.0-4.0% 5% net income</td>
<td>Funds all</td>
<td>NA</td>
<td>Percentage linked to age group. 20% Co-payment.</td>
</tr>
<tr>
<td>Medishield</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaried</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medifund</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Table I.2

<table>
<thead>
<tr>
<th>Country/Scheme</th>
<th>Employer % of salary</th>
<th>Employee/ (% of salary)</th>
<th>Government</th>
<th>Total</th>
<th>Comments (on co-payment and benefit limits)</th>
</tr>
</thead>
</table>
| **Thailand**  | 1.5%                 | 1.5%                    | 1.5%       | 4.5%  | No co-payments  
Government benefit scheme for civil servants  
Government-all others through UC system. |
| **Viet Nam**  | 2.0%                 | Flat rate about $4-5/ person | As employer  
Fully supports “Merititious Persons”  
Subsidies and Full support | 20% co-payment  
(pensioners/ meritorious exempted)  
No co-payment. |

*NA – not available*

Table I.2 also shows differences in the partners sharing the contribution burden. In some countries, including those which have reached universal coverage, employer and employee share the burden (Japan, RoK, Mongolia and Singapore), while in Australia, the employer does not contribute to health care other than through general income tax, which forms a substantial part of the source of funding.

In Australia and Singapore, co-payments at the time of use were introduced mainly to create awareness and partnership in cost-sharing in universal coverage arrangements. In Japan, the RoK and Mongolia, co-payments were applied to limit demand, although the capacity of providers rather than patients in generating demand was recognized. Co-payments were introduced in Viet Nam after several years of operation, mainly as a mechanism to increase hospital revenues. It was then easier to implement co-payment rather than increase the fees on a more cost-related basis.

There are also differences in maternity care benefits. In some schemes, as in Laos PDR and Thailand’s scheme for the private sector salaried workers, maternity benefits are provided as part of the health insurance branch. Or, maternity care may be covered by a separate social maternity insurance programme, which also includes cash allowances as income replacement during maternity leave. In Japan and the Philippines, health care costs for normal deliveries are not covered at all while the cash allowance for salaried-working women is provided through maternity insurance.
In all the schemes that have achieved universal coverage, government covers a significant part of the financial burden. In some countries (as in Japan, the RoK and Singapore), government funding is targeted to the support of indigent or other vulnerable populations. In Australia, the government not only uses general tax revenues to support health insurance benefits in the public delivery system, but also subsidizes supplementary private health insurance to enable access to private facilities. Government funds are also the major source in the Pharmaceutical Benefits Scheme through the subsidization of a defined list of drugs.

In countries with low coverage, governments are now increasing commitments to cover the indigent and other vulnerable populations through substantial or even full payment of contributions. This is an important shift from the previous ideology of free care for the poor or exempting poor from user charges in public hospitals.

The purchase of “health insurance cards for the poor and vulnerable” as in Mongolia, Viet Nam and now in the Philippines essentially means that the contributing and non-contributing insured persons should have the same access to health insurance benefits. In Viet Nam, the purchase of health insurance cards for the poor is expected to apply to around 14 million individuals (about 18% of the population) in the next few years. For this population, there will be no payments at the time of receiving comprehensive benefits.

An often missed issue is the extent to which these programmes are indeed “poor friendly”. In the Philippines, the local government funds (from local taxes) are inadequate to allow subsidization of all families living below the poverty level, which may be over 40% in some very low-income provinces. Even with additional national funds, some provinces may not be able to support more than around 25% of their indigent populations. An environment of competition between poor families to be identified as “poorest” has developed. Free health insurance cards do not mean that all benefits are fully covered, as the same low support value still applies whereby the patient has to find cash to cover a significant portion of a hospital care bill. A recent positive change was the inclusion of ambulatory health care benefits for the population covered by the Indigent Programme (other insured persons are still limited to hospital-based benefits). The expansion of benefits to ambulatory care answers the need for access to primary health care and reduces the likelihood that patients will be requested to pay additional charges.

There appears to be some trade-off between maintaining low contribution levels, and the benefits covered as well as the level of co-payment. One example is the Republic of Korea, where the rate could be considered very low for a newly industrialized country. The decision to allow only very minor adjustments to the contribution rate is driven by economic policies, linked to the need to keep labour costs from negatively affecting the price of exported goods. In recent years, the
Republic of Korea has made very significant efforts to reduce expenditures rather than increase revenues from contributions. The measures taken have included the merging of funds and a campaign to encourage rational health care seeking behaviour. Efforts are now turning to a more stringent review of providers and to changing provider payment from the purely fee-for-service system. In the recent efforts in Japan to merge social health insurance schemes, the motives are not only to increase the level of social pooling. An important by-product of the mergers is the potential to reduce administrative costs, leaving a high proportion of the contribution revenues for the provision of health care benefits.

A very different situation regarding low contributions, limited benefits and high co-payment prevails in the rural health insurance schemes in China. The contributions in China even with subsidies from the local and central governments are too low to enable an attractive benefit package, and involve considerable uncertainty in the actual amount which may be charged at the time of use. Although the flat rate contributions were low, the schemes requested annual payment in advance, which many rural residents found difficult to make. The combination of a lack of experience in prepayment for goods and systems, lack of flexibility in contribution collection plus the uncertainty of the real value of the prepayment at the time of use make such schemes unattractive for the target beneficiaries. It is hardly surprising that the extension of coverage is very slow in these populations.

The question posed is whether universal coverage is dependent on the contribution burden and sharing. With the wide range of contribution levels, even considering the differences in the benefits covered and co-payments at the time of use in some schemes, it would be incorrect to link universal coverage with the level and sharing of contributions. Universal coverage has been achieved with both low and higher contribution rates, and with different combinations of sharing between employers, employees or households and the government.

Two factors related to contributions probably increase the potential to reach universal coverage. First reason is the formal commitment by the government to support the poor and other vulnerable populations. There is no standard definition for the latter category. Who is considered vulnerable and deserving may depend more on historical and cultural values than any other factor. This is the case in Viet Nam, where the government has always paid the contributions of about one million individuals categorized as “meritorious citizens” for their past contributions to society (mainly in the liberation of the country). The government subsidies for the self-employed in Japan and the RoK were probably critical to cover this population. The Thai government has recently decided to reach universal coverage by taking on the financial responsibility for all the population excluded from the public and private salaried sector schemes. In this case, the responsibility is linked to a fixed amount per person paid to specific providers. The viability of this financial burden
has not yet been established, and the government is in favour of expanding the proportion of the population that can be covered by the social insurance system.

The second essential factor is good governance. The revenues accruing from contributions are dependent upon the honest reporting of salaries by employers and income or assets, especially in the case of the self-employed. These are dependent on good governance. The financial viability of social health insurance funds generally determines to what extent both the SHI benefits and management can be improved. In the transition from limited coverage to universal coverage, the attractiveness of social health insurance and interest among the non-insured populations will be linked to the performance of the existing schemes, in terms of registration, the payment of contributions including co-payments, the provision of benefits and provider payment, all of which depend on good governance within the social insurance schemes.

4.5 How Important is the Provider Payment Mechanism?

A priori, it is not possible to specify which provider payment method is appropriate to achieve universal coverage through social health insurance. The different method or mix of methods of payment mechanisms is important in achieving cost control, with which it is very difficult to extend both coverage and benefits.

As shown in Table 3, the different countries used all the conventional provider payment methods including fee-for-service, capitation, case payments, some applying DRG and flat amounts per in-patient day. In some schemes in India and Indonesia, where most health care benefits are provided directly by the scheme’s own health facilities, the provider payment is essentially a budgetary allocation to operate the services.

The question which could then be asked is whether specific provider payment methods have any impact on improving coverage. The previous sections noted the importance of the attractiveness of the schemes. This factor is not only dependent on affordable contributions and flexibility in collection. Attractiveness and long-term interest are more likely to be linked to the perception of the quality of health care benefits and satisfaction among both the insured and providers. These factors may be directly and indirectly affected by the provider payment methods.

Australia and Japan both developed their universal coverage schemes on the foundation of their original voluntary schemes which used ‘capitation’. Yet, fee-for-service was adopted as the main method when universal coverage was legislated, possibly following the then current patterns in the West, where fee-for-service was perceived as enabling more professional freedom and greater choice by the insured person[27]. In those countries with almost universal coverage through SHI and using
fee-for-service as the main provider payment method (like in Australia, Japan, RoK and Singapore), measures are applied to limit payment to providers and to prevent abuse. All of them use fixed-fee schedules, negotiated between the insurance agencies with providers and updated according to regulations. While in Australia and Singapore, there is virtually no over-billing by the doctors, additional gratuities are commonly given to the doctors in Japan and the RoK, especially when treatment involves a hospital admission. On the other hand, Thailand’s system of universal coverage through SHI and other government-funded scheme uses capitation as the main provider payment method.

Australia, Japan, RoK and Singapore have sophisticated computerized claims review systems, with the capacity to target patterns of inappropriate provision of care by specific providers. As noted in the Singapore country report, provider payments methods based on the volume and type of service require very efficient management of the claims processing and billing systems with computer linkages between providers and the schemes.

Many health insurance schemes are generally faced with provider pressure to be paid (or patient pressure to be reimbursed) and their own pressure for reliable review of all claims. Claims of inappropriate use, misuse or abuse are often difficult to prove when clinical decisions of health care professionals are involved. The tasks can be done at high administrative cost with sophisticated information systems, even incorporating financial caps on the earnings of providers whose incomes from insurance go above set levels. It has taken these well-established health insurance systems many years to reach such procedures.

Despite the tight controls that are imposed on levels of income of providers through these systems, fee-for-service has remained the preferred method for providers in these countries. The social health insurance schemes, however, are keen to shift to other mechanisms, such as more case payment and capitation.

The situation becomes more complex when fee-for-service is used, especially in the lower-income countries and in schemes that are still in the developmental stage and have only rudimentary health and financial management information systems. In the Philippines, problems with fraudulent claims from hospitals were a major reason for not extending benefits to ambulatory care and delaying the enrolment of the informal sector in the previous Medicare scheme.

The practice of submitting fraudulent claims was facilitated by the lack of an appropriate claims review procedure. Under the new administration of PhilHealth there are now efforts to cover ambulatory care, but through capitation contracts with providers. The limitation to hospital-based care has been a strong factor in the lack of attractiveness of the scheme, and the country case studies of fraud obviously did not increase credibility with regard to the financial management of the scheme.
Mongolia faced similar problems, particularly in the first two years of implementation, and quickly shifted from a strictly fee-for-service method to prospective flat amounts per day for inpatient benefits. The change did not solve all the problems, as hospitals began to increase the length of stay, and retroactive case payment was then applied. When benefits were expanded to ambulatory care in the community, capitation payment was agreed with the general practitioners from the start.

An important issue in the development of new schemes is the capacity to control costs and safeguard the financial viability of the schemes, while keeping administrative costs as low as possible. The capitation method, which facilitates cost control and requires a less complex and less costly billing system, has therefore been adopted by several new social health insurance schemes, as in Thailand and Laos PDR (in both the formal sector and the community-based schemes). Contrary to their initial expectations, capitation is now preferred by the providers. The method implies that the provider is paid in advance, regardless of actual use by the insured population. Particularly after decentralization of the Ministry of Health budgets and the transfer of some financial autonomy to public hospitals, the directors of hospitals are interested in having a regular input of funds from a third party source, which does not necessitate follow-up individual patients for payment.

Any payment method can be problematic in countries with new social health insurance schemes. If public hospitals are under-funded to start with, the low and irregularly paid staff may not welcome patients who have prepaid for their care. Opportunities for under-the-table payments are reduced by such schemes. Until hospital revenue from health insurance became a significant factor in the budgets of hospitals in Viet Nam, there were complaints of a negative attitude by the staff towards the insured population. The same problem was faced in Thailand, at the start of the social health insurance system for private sector salaried workers, which uses the capitation method.

The fee-for-service method may be more popular among providers in high-income countries with established social insurance schemes - with well-developed information systems. Capitation, with the potential for regular income and exclusion of the patients from the financial transaction, may increase the popularity of the health insurance scheme among health workers and the insured population in low-income countries. This interest and satisfaction among all parties, and the financial viability of new social health insurance schemes, are important determinants of the rate of extension of coverage, and ultimately the potential to reach universal coverage.

Acceptance of the new schemes will obviously increase if health workers see direct benefits in the form of increased income, and the provider payment method is
Selected Case Studies from Asia and the Pacific

an important consideration in assuring that increase. If provider income is dependent on the volume of care provided in a fee-for-service system, conflict develops between the scheme, provider and the insured, as occurred in Mongolia, Viet Nam and the Philippines. Providers want to generate use, patients are angered by the co-payments (the amount can be substantial and the percentage system is regressive) while the schemes run out of funds. The conflict is particularly difficult to resolve when the Ministry of Health is responsible for both the public providers and the health insurance scheme.

Table 3: Provider payment methods in Social Health Insurance Schemes by country

<table>
<thead>
<tr>
<th>Country/Scheme</th>
<th>Main Payment method for Community Ambulatory Care</th>
<th>Main Payment Method for Hospital Care</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Fee-for-service</td>
<td>Per in-patient day in private hospitals</td>
<td>Fixed fee schedules. Most hospital benefits provided in public hospitals where staff are salaried. DRGs widely used.</td>
</tr>
<tr>
<td>China</td>
<td>Fee-for-service</td>
<td>Various methods Fee-for-service</td>
<td>Most pay fee-for-service, but some areas now use case payment, per inpatient day and capitation. Few use capitation.</td>
</tr>
<tr>
<td>India</td>
<td>Salaried staff</td>
<td>Salaried staff</td>
<td>Most services in ESIS/CGHS facilities Fee-for-service for outside services Schemes facilities. Some have own health facilities.</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Salaried staff Fee-for-service</td>
<td>Salaried staff Fee-for-service</td>
<td>Askes own health care facilities. Some schemes use capitation.</td>
</tr>
<tr>
<td>Country/Scheme</td>
<td>Main Payment method for Community Ambulatory Care</td>
<td>Main Payment Method for Hospital Care</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>Japan</td>
<td>Fee-for-service</td>
<td>Fee-for-service</td>
<td>Case payment in university hospitals, Some now use adapted DRGs. Government budgets for specific services (e.g. for new and emerging infections).</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>Fee-for-service</td>
<td>Fee-for-service</td>
<td>Fee-for-service remains the only method Fixed-fee schedules</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>Salaried staff Capitation Capitation</td>
<td>Fee-for-service Capitation Capitation</td>
<td>Based on hospital user charges Capitation paid to hospital as main provider. Capitation paid to hospital as main provider. Fee-for-service payment by SSO for services outside capitation agreement.</td>
</tr>
<tr>
<td>Mongolia</td>
<td>Capitation</td>
<td>Case payment per admission</td>
<td>Capitation is paid to the family general practitioners.</td>
</tr>
<tr>
<td>Philippines</td>
<td>Fee-for-service</td>
<td>Fee-for-service</td>
<td>Guidelines for fees in public hospitals, private hospitals can set own fees. Capitation now tried. Some schemes have own primary health care facilities.</td>
</tr>
<tr>
<td>Singapore</td>
<td>Fee-for-service</td>
<td>Per inpatient day</td>
<td>Fixed-fee schedules, but private practitioners and hospitals charge more.</td>
</tr>
<tr>
<td>Country/Scheme</td>
<td>Main Payment method for Community Ambulatory Care</td>
<td>Main Payment Method for Hospital Care</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------</td>
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<td>-------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Thailand SSO</td>
<td>Capitation</td>
<td>Capitation</td>
<td>Capitation paid to hospital as main provider. Fee-for-service payment by SSO for services outside capitation agreement.</td>
</tr>
<tr>
<td>Viet Nam VSSI – compulsory and voluntary VSSI – Poor</td>
<td>Fee-for-service Capitation</td>
<td>Fee-for-service Capitation</td>
<td>Total amount to single provider is capped. Trials with capitation for community (voluntary) populations and health cards for poor started in 2003.</td>
</tr>
</tbody>
</table>

Social insurance systems cannot easily increase their contribution rates to deal with deficits, particularly when the cause is the provision of unnecessary benefits. As the capitation method implies a fixed amount at regular intervals regardless of use, the revenues can be used to increase the incomes of the provider’s health workers according to a plan or negotiated agreement with the staff. This may be more difficult to do under fee-for-service payment. The major disadvantage of the capitation method is the potential for under-service to the patient, and this needs to be controlled through an appropriate quality assurance and utilization review system.

4.6  What Role Can Voluntary and Community-Based Health Insurance Play in Reaching Universal Coverage?

As noted above, voluntary health insurance, through community-based health insurance (CBHI) or micro-insurance schemes, is now gaining support as an option for the informal sector. Evidence of this interest is the recent publications on the subject, which have moved from descriptions of the establishment of specific schemes through lists of reported schemes and recently to more in-depth analyses of specific aspects of CBHI. In Thailand, efforts are being made by national formal SHI schemes to enable coverage on a voluntary basis for individuals who have shifted from salaried to self-employment status. Viet Nam is now intensifying efforts to cover the informal sector through its national scheme.

The difficulties in extending coverage to this large population sector by the small formal sector schemes are now better understood by the international
development agencies dealing with social protection and ILO has launched new initiatives to find solutions for “excluded populations”. The informal sector generally does not have the same leadership through association with fellow workers as in the formal sector (through unions). Their priorities for household expenditure may not include regular prepayment towards the contingency of ill-health. Other efforts to develop CBHI relate to concern with poverty and the linkage between poverty and paying for health care (37-39). National authorities are currently reviewing the potential for voluntary community-based schemes to provide access to health care, and some countries have included plans to develop social health insurance efforts at the community level in their Poverty Reduction Strategy Papers (PRSP).

As discussed below, voluntary schemes have an important role to play in extending social health insurance coverage, both through voluntary membership in compulsory schemes and CBHI schemes. However, the potential of such schemes to help reach universal coverage may depend on the perception of their attractiveness in terms of real financial protection at the time of illness and perception of the quality of care provided as benefits. As with compulsory schemes, limitations in their design may be the major reasons for problems in creating and sustaining positive perceptions.

The governments of Australia and Japan proposed legislation for social health insurance to cover all population sectors when there was positive experience with voluntary health insurance. The Friendly Societies in Australia and the “Jyorei” in Japan were open to all interested individuals for membership, and all dependants were covered. Undoubtedly, this positive exposure to prepayment mechanisms to protect all family members against the risks of paying for health care, and to eliminate financial barriers at the time of use, paved the way for public acceptance of the universal coverage concept (40). The long delays in implementation of universal coverage in Australia were not caused by the lack of interest of the public at large, but mainly by opposition from the medical association and political concerns with increasing forms of compulsory taxes.

If the recent development of CBHI is examined in more detail, there are crucial differences in the development environment compared to the early voluntary schemes in Australia and Japan. The first members of these schemes generally had the financial capacity to enrol and maintain their contributions. In Australia, if not in rural Japan, there was some familiarity with other non-life insurance systems, such as property and motor vehicle insurance. There is still negligence familiarity with these concepts for example in rural India or Indonesia.

The capacity to pay contributions on a regular basis has been a major problem in several of the countries. In China, the State Council decision in 1993 was to develop health insurance for the rural population by re-establishing the RCMS that prevailed before the economic transition. The reason for not wanting to create a new entity was the positive perception of the rural population to the RCMS. The initial lack of success was not due to the lack of willingness to pay, but capacity to pay. In
addition, registration and contribution collection were only possible once a year in an administrative environment that was not “user-friendly” and not geared to social marketing. The new RCMS had very low contributions but also provided limited benefits at low quality and a low level of reimbursement after long delays. The lack of capacity soon became a lack of willingness to pay.

The country report of Viet Nam covers voluntary affiliation in the national social health insurance system, aimed at the dependents of insured workers, the informal sector population and students. The first two groups showed little interest, again because of the lack of familiarity with prepayment, the lack of flexibility in registration and contribution collection as well as benefit limitations. Affiliation was minimal until the recent efforts starting in 2002 to encourage enrolment among the informal sector population. Voluntary coverage was more successful in terms of numbers in the student population. In an effort to boost voluntary coverage through the VHI, students’ health insurance was introduced to cover several million schoolchildren as the Ministry of Education became an active partner in registration and collection of contributions through the schools.

The coverage of the family including all dependent children is obviously preferable to covering workers through compulsory insurance and then attempting to cover non-economically active family members through voluntary mechanisms, including a special programme for schoolchildren. One of the disadvantages of the students’ programme has been the exclusion of children who are not in school, either because they are homebound due to disabilities or because they are drop-outs. The programme still had some advantages. The students insurance in Viet Nam made an important “contribution” by creating awareness of the value of the prepayment mechanism among the families of the millions of children.

The country case studies of India, Indonesia, Laos PDR and the Philippines provide the development of CBHI in detail. The growth of voluntary CBHI in these countries has been more haphazard and problematic in terms of the level of pooling and capacity, to provide an appropriate spectrum of high quality health care to meet the populations’ needs. Despite the strong community ownership that was an integral part of their development, many schemes collapsed after several years of operation.

Very few of the CBHI schemes developed in India, Indonesia and the Philippines offer membership to individuals or families outside their own immediate group. In addition to the low level of pooling as noted above, common reasons are problems with financial viability, which may be caused by high drop-out rates in populations with little understanding of the principle of insurance, and changes in their capacity to pay regular contributions. The lack of flexibility in registration and contribution collection exacerbates these problems, as noted in the descriptions of CBHI in all countries. In each of the countries, there are successful schemes, but there are few cases of significant expansion and replication or adaptation to other communities.
The experiences in India and Indonesia in particular show that voluntary CBHI cannot be imposed on populations but needs to be developed in partnership, through civil society organizations and following government policies if not in full partnership with local government. The process recognizes that successful schemes cannot become models for replication, but that core elements need to be identified, and adaptation is required for each new population. Basic tools, such as information tools with membership data base management and benefit definitions, can be transferred, but some adjustment to deal with local conditions.

At the same time, the involvement of all stakeholders can mean that the growth of voluntary CBHI schemes is slower than initially envisaged, and slower than the usual pace of work of international development agencies. It takes time to appreciate that slower may be better in the long run, and to understand the local politics which hinder or help the growth of the scheme. Experience in the Philippines has shown that local government can be extremely helpful in providing support and extending coverage to new populations over which it has some leverage, such as associations requiring licences for vendors or service providers. On the other hand, local governments can create significant delays in growth by proposing alternatives that may not be better ideas but simply plans based on vested interests or jealousy regarding the success of the schemes developed by community organizations.

The new interest in CBHI is promising. Governments are now becoming involved in efforts to establish CBHI for vulnerable populations, and have committed resources to the process. These resources may be limited to developing guidelines and technical assistance in setting up the administrative mechanisms, as in the Philippines and Indonesia. In India, state governments are also sponsoring the establishment and subsidization of CBHI for specific vulnerable groups.

Perhaps the most interesting example of government involvement is in Laos PDR, where the Ministry of Health has regulated the establishment of pilot CBHI schemes and is an active partner in their planning, implementation and evaluation. These schemes are in very different parts of the country but follow the same design with minor adjustments for local conditions related to household income or the provision of health care. The Ministry of Health is now keen to expand these schemes to other parts of the country as fast as possible.

Community-based health insurance can provide more than access to basic health care. A secondary benefit is the empowerment that comes from enabling access to an essential service, and the development of a sense of pride in the realization of dignity rather than charity in accessing health care. This is a central principle in strategies towards social justice and emphasizes the creativity of people living in poverty and of local communities as the source for social improvement.

Even the smallest voluntary schemes remain important today for low-income populations in countries that have not yet reached universal coverage. There are two major reasons for this: first, they provide access for the low income populations (which obviously cannot afford the high premiums of commercial for-profit
insurance) and second, these schemes increase the knowledge and awareness of the benefits of health insurance, therefore stimulating interest in other population groups and political leaders.

The interim goal should, therefore, be to expand membership in existing and new CBHI schemes until a critical mass of social health insurance is reached and legislation on universal coverage can be introduced. Optimally, the introduction of compulsory social health insurance will also facilitate broad social protection for the population excluded from such mechanisms for the formal salaried sectors, through appropriate sharing of the burden between households and government.

The impetus for the development of community health insurance may have come from a vacuum in access to health care and exclusion from existing social health protection mechanisms. The efforts to reach the critical mass of coverage will need far more coordination and regulation than before. This is where government support in determining best practice in all aspects of CBHI, setting minimal standards and creating networks becomes crucial.

If it is necessary to go through a phase of extending social safety nets for health through small voluntary insurance schemes, the challenge will be to develop networks of community-based schemes that follow the same basic principles and design. It would also be unfortunate if the development of social health insurance becomes an area of donor competition. The uncoordinated development of small voluntary schemes by a variety of donors and other development partners could also undermine appropriate assessment of the impact of voluntary health insurance over time.

When universal coverage legislation is launched, it will mean that membership in a social health insurance scheme, including community-based schemes, will be compulsory for the entire population. It should also mean that these funds will be pooled with the social health insurance funds of other population sectors, so that CBHI does not continue to cover the low-income population with low contributions. Universal coverage should also mean the optimal spread of risks and pooling of funds, with solidarity enhanced by the sharing of interest and ownership between all population sectors.
5
Conclusions

5.1 Social Health Insurance as the Major Financing Mechanism

Policy makers around the world are continually reviewing their own health systems – especially the way the health care financing mechanisms are adopted. After reviewing the experience in the selected 12 countries of Asia and the Pacific, the interest in social health insurance as a major health care financing mechanism appears to be stable and confirmed. Most of them tried to achieve the goal of universal access to health care, until more citizens can be covered by compulsory and voluntary prepayment mechanisms. It is still difficult for many developing countries to have universal coverage through compulsory and voluntary prepayment schemes, due to the existence of large informal sector and difficulty in premium collection and enforcement.

Realizing the universal coverage of access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost is dependent on organizational mechanisms that would ensure financial-risk protection and equity in financing. A key common characteristic of successful health financing is that some part of the financial contributions of households is prepaid and pooled. However, no health systems would meet the full cost of health services out of the prepaid and pooled funds collected by tax or insurance contributions. Many of them required co-payment, sometimes of an informal nature.

The countries that have reached universal coverage are now dealing with changes necessitated by shifts in the demography and disease patterns of their populations. With the percentage of insured population over 60 years constituting between 10% and 20% of total membership, all these countries have introduced additional insurance mechanisms, to cope up with the ageing of their members. The focus now is on activities to promote health and apply preventive measures to reduce the onset and progression of chronic diseases. The social insurance schemes of Australia, Japan, the RoK and Mongolia are now integrating personal preventive care and health promotion as health insurance benefits for individuals and for the insured population at large. Singapore is increasing its public health activities in collaboration with the social insurance systems to enforce the prevention of chronic
diseases. However, experience in reducing chronic illness and disability shows that all social health insurance schemes, regardless of whether they are old or new, compulsory or voluntary and large or small, should cover prevention and health promotion (20).

The prepayment element in social health insurance, whether as a single national scheme or through the pluralistic approach as in Japan and RoK, creates commitment between the contributors, the scheme and the health care providers. The commitment in turn promotes sensitivity to changes in consumer culture. Members now tend to be more demanding as patients and have new knowledge and preferences regarding their own health care. Australia has been responsive to these changes by developing private health insurance as supplementary health insurance on a voluntary basis to enable the use of private facilities that are not generally covered. Private for-profit health insurance has also grown in Japan and RoK, mainly to cover the high co-payments. In all cases, persons with for-profit private insurance cannot opt out of the public schemes (as in Indonesia), so that private insurance has not weakened the socially pooled funds.

The previous Chapter reviewed the countries' experience based on six essential questions. As noted, it might be necessary to reach a critical mass for coverage, before the government can enact legislation on universal coverage. It is, not yet, possible to predict on what would be the exact percentage of the population that should be suitable for any specific country to start with. For some countries, positive experience with SHI coverage of around 30% of the population may suffice. Others may need to cover more than half the population, before debating a compulsory mechanism. Possible intervening factors are the dispersion of the population, the categorization of populations between urban and rural residents and the maturity or capacity of the existing systems to take on new populations.

The analysis shows that there are no simple and replicable models for social health insurance. There are general principles, objectives and components that may be common to all schemes. Within a geographical area such as Asia and the Pacific, the social, cultural and economic differences would prevent the simple replication of successful SHI schemes from one country to another. Even within each country, simple replication for expansion to other geographical regions may not be effective. Differences in levels of income in urban and rural populations, as well as differences in the administrative structures on which to build the social health insurance schemes may dictate how the principles might be followed to achieve the goals of social protection.

The transition to universal coverage may take several years, even several decades. The length of time is also not predictable. There could be some interruptions in the middle of best-laid plans, because of changes in government policies,
particularly when the changes include different political ideologies regarding solidarity and equity in access to social services and privatization (43). There may also be delays because of economic crises.

On the other hand, epidemics of new and emerging communicable diseases such as Avian Influenza and HIV/AIDS, or the re-emergence of diseases such as tuberculosis and malaria could spark acceleration in the process, as it becomes clear that early access to health care is crucial to prevent the spread of such diseases.

Essential elements that would determine the speed of transition are the relative acceptance of the value and concept of solidarity in society, the effectiveness of government stewardship/governance, and the people's trust in the government and its institutions. Another element is the availability of skilled managerial personnel to facilitate the effective management of a nation-wide SHI schemes.

While the length of time for achieving UC cannot be predicted, the analysis of social health insurance experiences in selected countries of Asia and the Pacific yields a few sets of recommendations on how to increase the potential for achieving universal coverage.

5.2 Recommendations to Increase the Potential to Reach Universal Coverage

The need for compulsory mechanisms:

- The laws and regulations for compulsory social insurance should be based on national legislative tools and frameworks, rather than on laws and regulations taken from other countries.
- The core principles need to be defined in the basic legislation while components needing amendment or updating over time should be covered in implementing rules and regulations attached to the law.
- The legislative instrument should include strong sanctions to ensure compliance, particularly in the registration of the target population and the collection of contributions.

Design factors to overcome limitations:

- All members of the family should be entitled to health insurance benefits through a family contribution, with the definition of family adapted to suit the cultural and religious values of the population.
Family coverage should respect the principle that each member of the family is covered in his/her own right.

Contributory social health insurance schemes should apply to both public and private sector salaried workers, and their dependants.

Social health insurance should be compulsory for salaried employees in enterprises of all sizes and among employees at all salary levels, with the appropriate ceilings for the calculation of contributions. That is, very low and very high wage earners should not be exempt from the schemes.

Health care benefits should include ambulatory and inpatient care, and cover preventive, curative and rehabilitative services.

The comprehensive health care benefits should have a strong primary health care base, with continuity, and an efficient referral system for secondary and tertiary care.

The law governing social health insurance should include procedures for the regular updating of health insurance benefits.

**Coverage of the informal sector and community-based health insurance:**

- Compulsory social health insurance or broad social security schemes should be strengthened to extend coverage to the informal sector.
- If the existing social insurance schemes cannot cover the informal sector, or cannot cover rural populations due to a lack of representation in some areas, community-based or micro-insurance schemes should be developed for such excluded populations, at all income levels and through the support and collaboration of government and non-government initiatives.
- All established schemes should follow national regulations and basic guidelines covering the core principles of social health insurance and in ensuring the administrative integrity of the schemes.
- All community-based or micro-insurance schemes should be covered by a network, sponsored by governments, to assist their operation through the provision of training activities, monitoring and evaluation and the exchange of information on experiences.
- Government and development partners should take an active role in increasing awareness among the population about voluntary coverage and community-based schemes.
- Linkages should be established between the compulsory social insurance schemes, and community-based and micro-insurance schemes to ensure...
basic compatibility in entitlement and benefits across the schemes, and enable the eventual creation of conditions for universal coverage.

The contribution burden and partners:

- The contribution rate and amount borne by all partners should be affordable by the majority, with family contributions based on an agreed formula rather than contributions for each individual in the family.
- Where relevant, the contribution should be shared between employers and employees, with employers responsible for at least 50% of the burden.
- Sources of funding, from different levels of government, need to be identified and committed through legislation to share the contribution burden for the low-income, self-employed and informal sector workers.
- Contribution collection for the self-employed and informal population sectors should be regular but flexible and take account of the capacity to pay in this population.
- For families and individuals that cannot contribute, sources of financing should be identified and committed through legislation to subsidize or fully cover the contributions as social assistance programmes.
- In new schemes and until there are justifications for change the prepaid contribution should be the only form of payment into the social health insurance scheme made by the insured. That is, co-payments and limits by cash amount and volume of services should be avoided, particularly when the newly insured population has low utilization patterns.
- The law governing social health insurance should include regulations on the procedures and frequency of changes in contribution rates.

Provider payment:

- The methods and conditions of provider payment should be defined in contracts with accredited providers of the benefits covered by the social health insurance scheme.
- The provider payment method should not facilitate the generation of demand by providers but promote the rational use of health care benefits with maximal satisfaction among both the insured and the providers.
- The provider payment method should be compatible with the capacity of the scheme to deal with the financial transactions involved, through information systems that adequately cover entitlement of the insured,
identification of providers, the type and mix of health care benefits, and permit linkage with quality assurance systems.

- To the extent possible and particularly in new schemes, capitation payment to providers should be applied as the optimal method to enable cost control, with very limited fee-for-service payment for defined exclusions from the list of services covered by capitation.
- Provider incentives should be incorporated through guidelines on effective ways to use health insurance revenues at the local provider level.
- The use of health insurance revenues at local provider level should include regular and sustained improvement in health worker income, as a direct result of the introduction of social health insurance. This increment may be linked to the number of families or persons covered by the insurance but should not be linked to the volume and type of services provided.

Inter-dependence:

- The financial viability of the fund does not depend on any single management function. The financial sustainability of a scheme should also be assured by the design factors linked to revenues by reaching the maximal rate of compliance in contribution collection, and to expenditure factors, by using the appropriate provider payments method and the appropriate benefits. Preventive services and health promotion can be important in controlling costs related to both acute infectious diseases and chronic conditions, and in both new as well as mature schemes.
- There is inter-dependence between many recommendations stated above.
- The inter-dependence between these factors also points to the importance of partnerships among all stakeholders in developing social protection, including health care. In most countries in Asia and the Pacific, public sector health facilities are still providing essential health care. Effective collaboration and coordination between the Ministry of Health and the social insurance schemes at all levels (national, regional and local) will impact a range of factors. These include procedures for the accreditation of both public and private health care providers and agreement on pricing policies (including the capitation amount) between the providers and the scheme. Effective collaboration will also facilitate responsiveness to changes in the needs and preferences of the insured population. Procedures to update health care benefits over time, and the reinforcement of prevention and health promotion, depend on collaboration between the
social health insurance scheme and public health authorities, regardless of their role in the direct provision of health care.

**Countries' commitment and solidarity:**

- In all of the above, the underlying conditions are government commitment to solidarity and to equity in access to health care. The crucial factor is making social health insurance work through good governance. Compulsory social health insurance to reach universal coverage requires the enactment of appropriate legislation. The enforcement and periodic amendment of regulations to deal with changes in the needs of the insured population require good governance.

- Well-managed social health insurance schemes can provide stable funds for continued improvement in the health system. It is reasonable to expect that credibility in the system will come from a better-funded scheme based on broad pooling of low and high-income earners, and low and high-risk populations. Providers should then have the ability to operate their services efficiently and health workers should derive satisfaction from being able to practise their professions in an efficient environment and with reasonable remuneration. The greatest gains are for the insured, whose regular and fair prepayment should guarantee timely access to health care of assured quality without facing financial barriers at the time of use and for any family member.

WHO views universal coverage, which is secure access to basic health care for all at an affordable price, as the ultimate objective of social health insurance. Timely technical expertise from international development partners and technical cooperation among the countries in the Regions can assist the process of reaching universal coverage.
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Part II
Country Case Studies
1. Background

The Australian health system has been very successful by a number of criteria while it has had a few significant failures. The health of most Australians has improved significantly over the last 30 years: in 1970 the life expectancy of Australians was ranked 17th in the world, by 1987 it ranked 9th and by 2000 it ranked 3rd, almost equal to that of Sweden and just lower than Japan (AIHW 2002).

The life expectancy at birth for males was 76.6 years and for females 82.0 years (based on the years 1998-2000). While many social and economic factors have contributed to this improvement, it is likely that the equity of access by both high- and low-income people to well-organized and funded health services has contributed to this success. Some of the health programmes in Australia, such as the HIV/AIDS programme and the Pharmaceutical Benefits Scheme, have been used as models by many countries.

On the other hand the health of Aboriginal and Torres Strait Islanders is among the worst of any indigenous peoples in the world. The estimated life expectancy at birth for Aboriginal and Torres Strait Islander males and females is 19-20 years lower than for other Australians. This is comparable to the life expectancy of the whole Australian population in 1910-1920 (AIHW 2002 page 199).

There are still significant differences in mortality rates between income groups within Australia, although this is, in part, due to the health of higher-income Australians improving faster than that of lower-income groups, rather than a deterioration of health for lower-income groups.

In 2001-2002 Australia spent Australian (A) $66.6 billion on health services, A $3,397 per person – 9.3% of GDP. Health expenditure, as a percentage of GDP, is about average for high-income countries. Australia is regarded as having been successful in controlling the rate of health care costs increases and, on average, achieving significant improvements in health.

Australia is a large country (7.7 million square kilometres), with a relatively small population (20.03 million in January 2004). The World Bank classifies Australia
as a high-income country. The Gross domestic product per person in Australia during 2002-2003 was A$ 37,192 (US$ 21,805 using direct exchange rate conversion).

The World Bank World Development Indicators Database (July 2003) ranked Australia 27th on the basis of gross national income per person in 2002 with an income per person of US$19,740, just lower than Singapore which was ranked 26th with an income of US$20,690. The Australian economy has been growing strongly for about 10 years with an average rate of growth of around 3-4% (GDP per person) and it is generally considered that there are good prospects that this strong rate of growth will continue.

2. Development of Compulsory and Voluntary Prepayment/Health Insurance Mechanisms

Unlike many European countries, which have single ‘systems’, which integrate most aspects of health service financing and delivery, Australia has a number of separate financing and organizing streams. Some of these, such as the Pharmaceutical Benefits Scheme (PBS), have been relatively stable for 50 years. Despite the existence of large pressure groups like the international pharmaceutical drug industry, the PBS has evolved in a systematic and consistent manner over its lifespan.

The history of funding medical and hospital services in Australia is one of continuing change - movements between ‘market’ models and universal models of financing of hospital and medical services. There are strong views within the Australian community that support each of these polar positions and the organized medical profession has been active to promote its own interests, which generally correspond to that of the market position – though with significant government subsidies. That the system regularly moves from the more market-oriented position to a universal coverage position suggests that the majority of the population probably supports the universal position, but that the political processes make this unstable. This section describes this Australian experience in seeking to develop stable health funding systems.

Many of the debates about the best ways of organizing and funding health services can be traced back to the values and attitudes of early European settlement in Australia. In the early 1800s the colonial administrations were expected to provide

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1 The Exchange Rate US$/A has varied significantly over the 12 months. It was US$0.568: $1 in December 2002, but was US$0.77: $1 in January 2004.

2 Using the World Bank Atlas method of determining GNI/person. This method basically uses exchange rates to compare GNI/person. If Purchasing Power Parity (PPP) is used to rank GNI/person Australia ranks 18th while Singapore ranks 32nd. The comparisons using PPP method provide a better measure of the relative purchasing power of people to buy goods and services within their own country.
hospital services to convicts, soldiers and administrators. Some of the convicts had been sent to Australia because they had been advocating for greater freedom and equality in Britain, and when they were freed they continued with these beliefs.

When free settlers arrived from Britain, they brought with them the belief that they and their families should make their own provision for health services. Some also brought middle class attitudes that charity hospitals should be established to provide limited free services to the ‘deserving’ poor. Over time a compromise was reached whereby the charity and community hospitals accepted subsidies from the colonial administration. The Australian ‘public’ hospitals started to have a different character to the US and English voluntary hospitals which were entirely privately funded. Religious hospitals were established in the mid-to-late 1800s, which provided another element, which is still found in the Australian health care system.

From the mid-1800s onwards, the middle class and better-off workers sought to protect themselves from the costs of medical services and medicines by establishing Friendly Societies that provided basic insurance against these costs. Many of these Societies employed doctors on a capitation basis to which doctors objected - but the Societies did provide doctors with much needed income.

From early colonial times there have been three sets of interests that have shaped the debate about funding and organizing health services in Australia: groups wanting equity of access to health services and supporting a significant government role in the provision of health insurance and health services; those who had ‘a residual concept of social welfare which holds that the family and the market are the main structures of social support and income distribution, and that the government should not intervene unless they break down’ (Sax, 1984, page 27); and the doctors who believed that they should determine how they should be paid and how much they should be paid. These forces have been engaged in major conflict in Australia during the 1940s, 1960s, 1970s and again since 1998. In general, medical profession was aligned with conservative/ market-oriented political parties, while the equity of access/ government intervention views has been supported by the leftist Australian Labour Party.

The other factors that shaped the form of health financing in Australia have been the Australian Constitution which defined the powers of the Australian (Commonwealth) government and of the State and Territory governments, and the historical fact that the large majority of hospitals in Australia have, since the late 1800s, been owned or funded by state governments. The 1901 constitution gave the powers in relation to the provision of health services to the states and shared the taxation powers between the Commonwealth and the states.

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3 This section draws mainly on Sax (1984) and Gray (1991).
4 Doctors were paid a fixed amount per person insured per year and had to provide all requested services.
During the first 30 years of the 1900s, organized medicine in the form of the British Medical Association (BMA) was often in conflict with the Friendly Societies about the form of payments to doctors and the amounts of payments to doctors. These conflicts resulted in higher payments to doctors, but the proportion of the population covered by these societies declined significantly (Sax, pages 20-1). During the great depression of the 1930s, the declining membership of Friendly Societies, together with increasing numbers of unemployed who sought health services from ‘free’ state hospitals, led the (conservative) United Australia Party government in 1937 to develop a proposal for a National Health Insurance programme. Though the programme had been agreed with the Council of the British Medical Association in Australia, the membership of the BMA opposed the proposal, and the government withdrew its proposal from the parliament (Scotton, 1993, page 7).

In 1942, during the Second World War, the states agreed that the Commonwealth would exercise the state income taxing powers. During the war the Australian Labour Party government introduced legislation to allow the Commonwealth government to make certain types of social security payments and to provide pharmaceutical benefits. In 1945 the medical association challenged the constitutional validity in the High Court of the Pharmaceutical Benefits Act and the Court found it unconstitutional. In 1946 the ALP government sought to change the constitution by referendum to validate its wartime legislation and to allow it to pay medical and dental benefits also. The referendum was passed – one of the few constitutional changes ever agreed to by the voters of Australia. In 1949, with the cooperation of a conservative state government, the medical profession challenged in the High Court the legality of regulations made for the implementation of the Pharmaceutical Benefits Scheme. The court again upheld the challenge to the scheme (Gray, 1991, pages 69-71).

The ALP was defeated in the national elections in 1949 and the Coalition (conservative) Government, with the support of the medical profession, made minor modifications to the PBS programme and implemented it in the early 1950s.

The developments leading to universal health insurance and changes that occurred in private health insurance are discussed further in Section 3 and 4 respectively.

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5 Following the war, the Commonwealth maintained control of these taxing powers, and over the next decades used its control of the major source of taxation to influence state policies, especially in relation to health.

6 During the war, the United Australia Party dissolved and became the Liberal Party. Since the end of the war it has formed an alliance with the Country Party, later renamed the National Party. Both parties are ‘conservative’ - oriented towards business and farming interest. The term Coalition Government is used to describe their time in government.
3. Voluntary Health Insurance Schemes

There has been a long history of voluntary prepayment/health insurance schemes operating in Australia. These schemes were established and operated without receiving any government subsidies or tax benefits. By far the largest ‘voluntary’ pre-payment systems were the Friendly Societies into which people paid annual contributions, and received medical and some hospital services which were funded by the societies.

These have existed in various forms since the late 1800s. Doctors were generally paid on a capitation basis – an annual fee to provide all necessary care to the members of Societies. The membership of Friendly Societies was at its peak in the 1920s – about 30% of the population were members (Scotton pages 5-6; Sax pages 19-20), but membership declined significantly during the depression in the 1930.

Some were still in existence in 1953 when the Coalition government supported the establishment of, and subsidized, ‘voluntary’ hospital and medical insurance funds. Many of the largest health insurance funds were established by doctors and their organizations at that time. Insurance then covered mainly medical and hospital costs and paid for both services on a fee-for-service basis, the preferred method of the medical profession (Sax, pages 58-64).

The National Health Act of 1953 laid the basis of development of private health insurance for the next 20 years. The Act established government subsidized ‘voluntary’ hospital and medical insurance, and a limited Pensioner Medical Service, which provided limited free medical services to Age Pensioners.

Health insurance membership increased to about 70% of the population by the mid-1960s (Scotton p10-15). There were concerns throughout the period about the level of benefits paid by the insurers and administrative costs of 23%, and different concerns about the availability of services for uninsured people. There were also concerns about the regressive nature of tax deductibility of health insurance contributions, which resulted in high-income people paying proportionately much less than low-income people.

When an Australian Labour Party (ALP) government was re-elected in 1972, it established the Health Insurance Commission to implement its Medibank Programme– a universal, tax funded health insurance scheme that provided public hospital services free of charge (by agreement with the State and Territory governments) and highly subsidized medical services (free services if doctors bulk-billed – which 60-70% soon did).

When Medibank was introduced in 1975 medical insurance was effectively eliminated and private funds offered Ancillary Insurance (providing payments for a part of the expenses for dentistry, optometry and some allied health services) in place
of medical insurance. Little publicity was given to the change and most people who had been insured continued to pay the premiums, but the low rate of expenditure from funds showed that most people were unaware of their entitlements under the new ancillary insurance. As stated in Section 3, private health insurance increased during the period 1975 to 1983 until Medicare was introduced by a new ALP government. Membership of private health insurance again fell after the introduction of Medicare. By 1998 (after the election of the coalition government in 1996) 30% of the population were insured.

Since 1998, the Australian government has introduced a range of incentives for people to take out private health insurance and disincentives for high-income groups not to. In 1997 it introduced a 30% subsidy for health insurance premiums and a Medicare Levy Surcharge (tax) of an additional 1% of income for high-income earners – these resulted in an increase in coverage from 30% to 31% of the population. The government encouraged the funds, doctors and private hospitals to develop payment methods whereby privately insured patients had certainty about the cost of treatments in private hospitals – this had been identified as a major cause of dissatisfaction with private health insurance. There has been slow progress on this issue as it implies that doctors should submit to private sector cost control.

In 2000 the government required health insurance funds to charge age-related premiums for people who joined after a specified date – Lifetime Cover. This allowed funds to charge people over 30 years of age an additional 2% for each year of age over 30 years, up to a maximum loading of 70% (at age 65 years). The Lifetime Cover resulted in an increase of coverage to 45.5% of the population in 2001, and then declined slightly to 43.4% of the population by 2003. In 2003, the average premium for hospital insurance for a family was approximately $1,800 (estimated from PHIAC Annual Report (Tables 4 and 6 and text).

This policy of increasing the private health insurance coverage was justified on three grounds:

- People who could pay for their own health care should take out private health insurance and leave access to public hospitals to those who could not (a return to arguments of the 1800s and 1950s);
- People should be able to choose where they received hospital care, and
- More private health insurance would increase access for lower-income people to public hospitals.

When elected, the government said that it would ‘maintain Medicare’. It argued that this was consistent with its commitment.
The policy was opposed by many groups on several grounds:

- It could destroy the universal coverage of Medicare and would lead to a two-class health care system with lower standards of care being provided to low-income groups;
- It encouraged people to use private hospitals which were more costly than public hospitals;
- It provided Australian government subsidies for high-income groups to pay for dentistry and a range of other services, which were not subsidized by the Australian government for low-income people. In fact, the government had recently withdrawn subsidies for dental services for aged and poor people which had cost about half of the amount that the private health insurance subsidy provided for dentistry for high-income groups, and
- Administrative costs of private health insurance are very high (over 10% of premiums go to administration and not to paying for health services).

There is considerable debate as to whether access to public hospitals has improved for low income groups as only less than half of private health insurance spending goes to hospital services. It appears that the subsidy has substituted for out-of-pocket spending for higher-income groups and done little to increase access to public hospitals for low-income people (Deeble 2003). Robertson and Richardson (2000) have argued that if patients move from public to private hospitals, the resources to treat them will move with them. An increase in private services must almost inevitably result in fewer resources for public services.

At the time of writing this report membership of private health insurance was falling slowly, and those leaving were people who contributed more than they drew from the funds (Ian McAuley, ABC News OnLine, August 21, 2003). Private health insurance premiums are set to rise by 7% in 2004. The instability that has been evident in private health insurance since 1975 is still present.

4. Compulsory Prepayment Social Health Insurance Mechanisms

As described in Section 3, Medibank was the first universal health insurance programme in Australia. It provided:

- Universal coverage to all Australians and migrants who intended to reside in Australia;
Free access to State Government owned public hospitals as ‘public’ patients (i.e. people accepted the care of doctors employed by hospitals) on the basis of medical need. People who wanted to be treated as ‘private patients’ or wanted to go to private hospitals could purchase private health insurance and would receive a (small) subsidy towards the costs of their hospital fees. The Australian government entered into contracts with each State and Territory government and agreed to pay the hospitals 50% of their operating costs in return for providing services to Medibank patients;

Insurance against fees charged by doctors (A subsidy of 85% of the standard fee was charged. Doctors could bulk-bill the Health Insurance Commission and receive the subsidy directly instead of having to wait for the patient to submit the claim and be reimbursed. A large proportion of services were bulk billed; and

There were other parallel initiatives such as the creation of community health programmes and community health centres.

Though Medibank was established as the first universal compulsory health insurance mechanism, it did not stay in the original form. The ALP government was defeated in the elections in December 1975. The Coalition Party government, though elected on the promise of “maintaining Medibank”, cited budgetary considerations as the reasons to make major changes to the scheme over the next eight years. Tax incentives were introduced to ‘encourage’ people to opt out of Medibank and join private health insurance funds, which about 50% of the population did.

There were also significant reductions in Commonwealth funding of public hospitals. Compared to the earlier private insurance arrangements, the changes to Medibank (called Medibank Mark I, II and III) had the virtues of maintaining universal coverage and not providing higher tax benefits to high-income earners than low-income earners. When the ALP won the national election in 1983, the Health Insurance Commission had become Medibank Private – the largest private health insurer in Australia although it still processed Medibank public’s claims.

When re-elected in 1983, the ALP government introduced Medicare, which had most of the same features of Medibank. Medicare remained largely unchanged until 1996, when the Coalition parties won office again. Over the period 1983 to 1996 private health insurance had declined to about 30% of the population.

When the Coalition won the election in 1996, promising to ‘maintain Medicare’ (instead of Medibank in 1975), it reintroduced incentives for people to enrol in private health insurance. It introduced a 30% government subsidy to people taking out insurance in 1997, which resulted in an increase of membership to 31%, and, as described in Section 3, it introduced Lifetime Cover. This resulted in an increase of membership to 45.5% in 2003, but it has declined by about 2% since then.
A decline in bulk-billing by doctors in 2002-2003, has seen the government move, through the 'Fairer Medicare' then 'Medicare Plus', to change access to direct billing by offering doctors an additional $5 to bulk-bill Concession Card holders (see Section 5 for an explanation of the Concession Card).

Health consumer and welfare groups are concerned that this will lead to doctors only bulk-billing Concession Card holders, and not bulk-billing other low-income families who miss out on the cards. This government considers that this is the best way to ensure that Concession Card holders are bulk-billed. Health consumer and welfare groups are also concerned that it will undermine the principle of universality of Medicare and could slowly lead back to the two-class health care system that existed during the 1950-60s.

Medicare is generally described as having three pillars:

- Free treatment as a public patient in a public hospital;
- Payment of a Medicare rebate at 85% of the schedule fees for a visit to a doctor outside hospital, and
- Affordable pharmaceuticals through the Pharmaceutical Benefits Scheme. (Prime Minister’s Press Statement, 18 November 2003).

This is a ‘universal’ programme in that all Australian citizens and non-citizens with certain residency qualifications are eligible for the benefits. Some foreign nationals living in Australia may also be eligible for these benefits if their country of citizenship has a reciprocal agreement with Australia for provision of health services. In general, Australia has reciprocal agreements with countries from which it derived large number of migrants (UK, Italy, Greece etc).

Medicare (Hospital) - The Australian government has agreements - Australian Health Care Agreements – with all State and Territory governments for their public hospitals to provide treatment free of charge (inpatient and outpatient) to all eligible persons. The agreements also cover psychiatric services. For inpatient services in public hospitals, treatment is free if people are ‘public’ patients - that is they agree to be treated by doctors nominated by the hospitals. The agreements require public hospitals to provide access to services on the basis of medical need (not on the basis of income).

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7 The term Medicare is used to describe both the universal programme and the system of subsidies for medical service costs. In this report, Medicare will be used to describe the entire programme and Medicare (Medical) will be used to describe the medical services insurance programme. Medicare (Hospital) will be used to describe the funding of hospital services.

8 Hospital doctors are usually salaried, but most public hospitals also employ private doctors on a 'sessional' basis, whereby they pay for half-day sessions to treat public patients. It is common for both salaried doctors and sessional doctors to have 'private practice' rights to treat private patients in public hospitals and charge fee-for-service.
of ability to pay). Hospitals provide all services (including medical, surgical, diagnostic, drugs, allied health professionals etc.) free of charge to public patients.

Public hospitals also treat ‘private’ fee-paying patients but in 2001-2002 only 13% of inpatients were private (AIHW 2003a, Table 6.1). Most State and Territory governments have contracts with private hospitals to provide services for "public" patients but fewer that 3% of public patients are treated in private hospitals. In 2001 and 2002, 68% of all overnight patients were treated in public hospitals and 56%\(^9\) of all same-day patients were treated in public hospitals.

**Funding - Medicare (Hospital)** - In 2001-2002, the total expenditure on Medicare (Hospital) was A$17.1 billion. The Commonwealth provides 46.8% of public hospital expenditure, the State and Territory governments funded 47.4%, and the remaining 5.8% is from health insurance, injury insurance and out-of-pocket payments by private patients (1.5% - from private patients). The Commonwealth, State and Territory funding for Medicare (Hospital) is raised taxation in one form or another.

**Medicare (Medical)** - The Australian government funds the Medicare Programme\(^{10}\) that is operated by the Health Insurance Commission (HIC). The HIC pays part of the medical costs incurred by individuals. Medical services related to workplace injury and motor vehicle third-party insurance are not eligible for subsidy under this programme.

There is a Medical Benefits Schedule (MBS) that defines approximately 4,700 services: consultations with general practitioners and specialists, diagnostic and radiological tests, surgery and a small number of dental and optometric services. The Schedule lists a fee (set by the government) for each service and a “benefit” that is paid to the person who incurs the cost. The benefit is either 85 per cent of the Schedule fees for outpatient services or 75% of the Schedule fees for inpatient services, or the Schedule fees less an amount of up to $57.10, whichever is greater (HIC Website). Doctors are not required to charge the MBS fee so patients may pay a larger ‘gap’ (the difference between the fee and the benefit) than is described in the HIC website.

Some specialists charge well above the scheduled fee, but sometimes there is price discrimination whereby higher fees are charged to richer people and low-income people are bulk-billed or charged lower fees (see Performance of Medicare (Medical) in Section 8). ‘Bulk-billing’ is a process whereby the doctor agrees to accept the medical benefit defined in the MBS in full payment for the service and the HIC

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\(^9\) In 2002, 44% of the population had private health insurance. See later discussion.

\(^{10}\) The discussion on Medicare is correct at time of writing this report, but the Australian government is seeking to make changes to the Programme. The majority of Senators in the upper house of the Australian Parliament are currently delaying or opposing the changes.
pays the benefit directly to the doctor. Claims can be made electronically; about 67% of all services were bulk-billed in 2003.

**Medicare (Medical) Funding** - In 2001-2002, total expenditure on medical services was A$ 11.2 billion. $ 515 million (4.6%) were spent on services related to workplace injury or motor vehicle injury which are not eligible for Medicare (Medical) rebate. Services covered by Medicare (Medical) totalled A$ 10.6 billion of which the Commonwealth\(^\text{11}\) paid 85%, the private health insurance funds 4% and individuals 11.2%. Most of the funds were provided from general taxation revenue. There is a Medicare Levy of currently 1.5% of taxable income with exemptions for individuals and families with low incomes\(^\text{12}\).

In addition, there is a Medicare Levy Surcharge of 1% which was is applied to high income (taxable incomes in excess of about A$100,000) individuals and families who do not have private health insurance - this was intended to ‘encourage’ high-income people to take private health insurance. In 2001-2002 these levies raised about $ 5 billion - less than half of the cost of Medicare (Medical). The levies were never intended to fund Medicare or Medicare (Medical) – the levy was imposed to cover the difference between the health insurance programme that operated before Medicare (Medical) was introduced and the additional costs of Medicare. The levies are paid to Consolidated Revenue, and not directly to health funding.

**The Pharmaceutical Benefits Scheme** - The Australian government funds the Pharmaceutical Benefits Scheme (PBS) and it is operated by the Health Insurance Commission. The scheme seeks to ensure that all Australians have access to affordable, safe and cost-effective prescription medicines. There is a Therapeutic Goods Administration to ensure drug safety and quality of manufacture of all medicines sold in Australia; a Pharmaceutical Benefits Advisory Committee, which examines the cost-effectiveness of medicines to ensure that only medicines that provide value-for-money are listed on the PBS; and a Pharmaceutical Benefits Pricing Authority, which negotiates prices with drug manufacturers.

Medicines subsidized on the PBS are only available on prescription by doctors. In many cases, doctors have to follow prescribing protocols that include both safety and cost. Doctors and pharmacists who participate must register with the Health Insurance Commission.

All Australians, permanent residents and persons with defined categories of visas are eligible for medicines subsidized under the PBS. In 2004, there are three levels of patient co-payment for medicines provided under the PBS: A$ 23.70, A$ 3.70

\(^{11}\) The Commonwealth subsidy to private health insurance is included as a Commonwealth outlay.

\(^{12}\) In 2002-03 The Medicare Levy of 1.5% applied fully when an individual’s taxable income exceeded $ 16,283, and a two person family, combined income exceeded $ 34,301. The limit was raised by $ 2,334 per child. Pensioners did not pay the levy until their incomes exceeded $ 20,000.
and A$0. Patients with ‘Concessional Cards’ paid $3.70 up to a maximum payment of A$197.60 (52 prescriptions) in any year - after that the medicines are free.

A wide range of social security beneficiaries (such as recipients of age pensions, disability pensions, unemployed beneficiaries, and supporting parents) have concession cards. All other people, general beneficiaries, pay A$23.70 per medicine up to a maximum payment per person or per family\textsuperscript{13} of A$726.80 (about 31 prescriptions) after which the charge is A$3.70. General beneficiaries receive a Safety Net Card when they reached the safety net limit. The Safety Net arrangements operate on a calendar year basis. The Health Insurance Commission is moving to operate the safety net arrangements entirely on an electronic basis - it currently operates as a part paper-based and part electronic system.

**PBS Funding:** In 2001-2002 the total sales of medicines in Australia were A$9 billion of which A$5.6 billion were eligible for benefits under the PBS. The large majority of medicines not eligible for benefits were not prescription medicines. The only prescription medicines not listed on the Pharmaceutical Benefits Advisory Committee are new medicines that have not been considered for listing, or those that have been considered but are not considered cost-effective. Medicines that have been found by the PBS to be not cost-effective generally do not survive in the market place because they do not receive a subsidy and are generally more expensive than comparable medicines. In 2001-2002 the Australian government paid 85\textsuperscript{14} of the costs of medicines listed on the PBS.

**High Level Residential Aged Care** - This is a universal programme but is not regarded as part of the Medicare Programme. It provides ‘nursing home’ care to old people who can no longer be maintained in their own homes even with significant Commonwealth funded community-based nursing and home care. The programme is ‘universal’ in that all Australians are eligible for support under it.

The Commonwealth allocates ‘beds’ to private (some for-profit, some not-for-profit) organizations to build and manage the facilities. There were about 92 000 high-level residential aged care places (beds) in Australia in 2002. There are often waiting lists for entry to most places. This programme is an important element of health care in Australia. Of the total expenditure of A$4.1 billion in 2001-2002, individuals paid about 20\%. (A significant proportion of these payments would have been from Australian government provided aged pensions.)

\textsuperscript{13} A family can include children up to 16 years old and students up to 25 years old.

\textsuperscript{14} It is a coincidence that this 85\% subsidy level is the same as for Medicare (Medical). The level of PBS subsidy has traditionally been lower than 85\%. For decades it was about 65\%, but as medicines became more expensive and the proportion of persons eligible for Concession Cards increased, the Commonwealth share of costs has increased.
Private Health Insurance - Though Medicare is a ‘universal’ programme - available to the entire population - 44% of the population have private health insurance. This has been discussed in more detail in Section 4 above.

5. Social Security and Social Assistance Programmes

Australia has an extensive set of social security programmes which provide income support, rent assistance, employment training activities, travel allowances, rehabilitation services, child care support and other support including access to free or low cost health services.

There are three main ways in which low-income people can access affordable health care:

- Their general entitlements under the Medicare Programme;
- The availability of Concession and Health Care Cards issued by Centrelink (the agency that administers a wide range of government programmes); and
- The availability of income support from social security benefits (listed below).

Entitlements under the Medicare Programme - All eligible persons are entitled to free inpatient and outpatient services at public hospitals. About two-thirds of all primary care and other medical services are bulk-billed (i.e. the doctor accepts the payment from the national insurer - the Health Insurance Commission - as full payment for the service. The patient makes no payment to the doctor) and doctors tend to provide these free services to low-income people and charge higher-income people fees that are above those recommended by the Australian government.

Concession and Health Care Cards - Centrelink issues three types of health care cards which provide a range of benefits to cardholders.

- For low-income earners, a Health Care Card helps with the cost of medicines and a limited number of concessions;
- For low-income earners (receiving selected payments), a Pensioner Concession Card helps with the cost of medicines and a range of concessions, and
- People who are of Age Pension age but do not qualify for the pension may be able to get a Commonwealth Seniors Health Card (these are middle-income retired persons).

Card holders must meet residence requirements to get a concession card. All three cards ensure that medicines available under the Pharmaceutical Benefits
Social Health Insurance Scheme (PBS) are provided at reduced costs. Persons with a Health Care Card or a Pensioner Concession card are entitled to a range of additional subsidies including health, transport and educational concessions. These concessions may vary from state to state.

Of the 161 million prescriptions subsidized under the PBS in calendar year 2003, 102 million were provided to concession card holders at A$ 3.70 per item and 32 million were provided free of charge (under the Safety Net arrangements).

Financial Support Available to Low-Income People - The Australian social security system is based on the ‘safety net’ principle, whereby financial support is set at a relatively low level, and unlike social security in the USA and many European countries, support is not based on the previous income or earnings of individual beneficiaries. In addition, most social security payments are ‘means-tested’ – the level of support provided takes account of other income received (earnings, interest) and is sometimes adjusted to take account of the assets of the beneficiary (generally the value of a persons home is not counted as an asset but other real estate, shares and savings are counted). Social security payments in Australia are not time-limited like many earnings-related schemes overseas are.

Social security support provides direct income support as well as a wide range of other forms of support. The main income support programmes (but not the only income support programmes) are for:

- Aged persons (1 785 554)
- Persons with disabilities (623 926)
- Unemployed persons (Newstart Programme 514 004 – there are other programmes for specific groups)
- Single parents (424 614)
- Youth Allowance (to support young people who are studying, 308 663, and young people entering the workforce, 84 542). There is also a special support, accommodation and travel programme for aboriginal students.
- There also are special benefits for War Veterans, who usually receive more generous support than other people.

[The numbers in brackets indicate the number of people receiving support as of 30 June 2001. Data are from the Commonwealth Department of Family and Community Services (2003)]

The programmes listed above provided support to more than 3.7 million persons in the year 2001, about 19% of the total population. Almost all the programmes were means tested. There were many other programmes that provided...
support to smaller numbers of people with special needs: carers allowance for people who provide support to disabled or old people; Widows Allowance; Special Benefit for persons who do not fit in any specific category.

Payment in most of the above programmes is made on a two-weekly basis and amounts to $452.80 for single adults (or $756 per fortnight for a couple). Payments for young people are at lower amounts. In all cases there is a range of additional cash assistance available, such as rent and travel allowances.

Payments are also made to support families with children through a Family Tax Benefit A and B. Payments vary with the number of children and with the income of the family. The major forms of child support for families with two incomes, or where the people are in receipt of social security benefits, is through the Family Tax Benefit A. There are a number of conditions attached to the payment of this benefit but most people in Australia with dependent children are eligible for some payment. Families with incomes of $31,755 per year, currently receive $3401.80 per year for each child under 13 years old, $4314.30 for each child 13-15 years, $1,095 for each child 16-17 and $1,470.95 for each child 18-24. The payment declines by 30 cents per $1 by which the income exceeds this amount until the payment reaches $42 per two weeks for children under 18 years of age, and $56.52 for 18-24-year olds. A family with one child continues to get some additional child support payment until the family income exceeds $72,000 per year.

There is an additional benefit (Family Tax Benefit B) for families in which one of the parents does not work.

In 2001, the total number of families receiving Family Tax Benefit A and/or B was 1.8 million and benefits were paid on behalf of 3.5 million families.

Additional benefits available to families with children include the Large Family Supplement, Multiple Birth allowance and Rent Assistance. A large number of additional conditions apply to the payment of these benefits.

Maternity Benefits: A lump sum payment of $833.52 is made, usually paid with the first instalment of Family Tax Benefit for the child. In a case of multiple birth, Maternity Allowance is paid for each child, for example, for twins $1,667.04 is paid. The same means-test applies to this benefit as to Family Tax Benefit A.

Unlike many European countries, Paid Maternity Leave is not a workplace or social security entitlement. Governments and a small proportion of employers do provide paid maternity leave but this varies from workplace to workplace. Maternity leave is more likely to be available for women in higher paid employment and it is generally not available for men. This has been an issue of political debate in Australia for several years.
6. **For-Profit Commercial Health Insurance**

There are two major forms of commercial insurance that cover some health care costs: Workers Compensation Insurance and Motor Vehicle Third Party Insurance (which pays for the costs of injuries to persons other than the owner of the vehicle insured). In all States and Territories in Australia, these types of insurance are mandated by law, but are generally administered by regulated private insurers. It is illegal for an employer not to have Workers Compensation Insurance and it is illegal to drive a motor vehicle on a public road without Motor Vehicle Third Party Insurance. In 2001-2002 these types of insurance made up the bulk of the ‘Other’ sources of health expenditure reported in Australia – about 3.7% of total health care costs.

**Workers Compensation Insurance and Third Party Insurance** - Workers compensation insurance covers the costs of health services related to workplace injury or disease, income support, and death benefits. Income support is generally income related for a period of time, but in most cases only lasts for a defined period of time. At the end of the period of support from workers compensation insurance, injured workers are eligible for social security payments.

‘Third Party insurance’ covers the costs of health care, income support and compensation that results from injury caused by motor vehicles. The structure of benefits for Third Party insurance is similar to that for ‘workers compensation’ and, in many cases, people will eventually be eligible for social security payments.

Persons with a claim against workers compensation insurers or third party insurers are not eligible for Medicare (Medical) or Medicare (Hospital) benefits for costs associated with insurance claims but are eligible for benefits for all other health-related costs.

**General/Commercial Insurance** - The National Health Act regulates health insurance in Australia. It requires that any organization that wants to offer health insurance must register under this Act. The Act imposes a number of financial and reporting requirements on potential insurers and requires that they offer age-based ‘community rate’ health insurance (that is, an insurer must offer insurance to all at premiums defined for each age group and the premium for a family, regardless of size, is to be set at twice the rate for a single person. The age adjustment is set in the regulations and not based on the individual insurer’s assessment of age-related risk).

If an insurer produced a product that was not covered by the National Health Act, persons would not be eligible for the Australian government health insurance rebate of 30%. Also, persons with higher incomes would still be required to pay the Medicare Surcharge Levy of 1% of taxable income, as exemption from this levy requires individuals to have health insurance from a fund registered under the National Health Act.
Thus general insurance is unlikely to be commercially viable if it competes against health insurance that is subsidized and free from surcharge.

Given that the Australian population appears to support the ‘universal’ nature of the current Medicare Programme, it seems unlikely that commercial insurance is likely to be viable as a policy option in future.

7. Critical Analysis of Health Care Financing Though Prepayment/Earmarked Taxation and Health Insurance Mechanisms

Australia has had universal health insurance in one form or another since 1975, and since then, life expectancy has increased by about seven years. In 1970 Australian life expectancy was ranked 17th and it now ranks 3rd after Japan and Sweden.

This rapid change in health cannot be directly attributed to the effectiveness of the health care system since some of the causes of this improvement were evident from the mid 1960s, when a rapid decline in mortality from cardiovascular disease started. The analysis of factors that have contributed to this improvement in life expectancy has attributed significant proportions of this improvement to factors such as a reduction in cigarette smoking (probably accounts for more than half the increase), improved diet (less fat), social attitudes that accepted public health-inspired social controls (seat belts, random breath testing) and a harm minimization approach to managing HIV/AIDS.

Over the period there has been a large increase in expenditure on health services. It is likely though that the method of financing health services, and accessibility to services for the rich and the poor and the old and the young have made some contribution to the improvement. For Aboriginals and Torres Straits Islanders, there is little doubt that their poor health status is, in part, related to their inability to access high quality health care.

It is difficult to attribute changes in health to specific health care interventions or to specific methods of financing health care. However, it is possible to look at the impact of health financing on access to health services and to look at the extent to which health financing arrangements may obstruct access.

Use of Health Services and Socioeconomic Status

In 1992, the National Health Strategy published a report Enough to make you sick: how income and environment affect health (Research Paper No 1 September 1992). The study was conducted when the Medicare programme had been operating for 10 years; there had been some form of universal health insurance since 1975. This report
examined the relationship between health, health service use and socioeconomic status in Australia.

The report found that ‘There is a definite pattern of health service use according to socioeconomic status. Compared with people of high socioeconomic status, those of low socioeconomic status make greater use of hospitals, outpatient clinics and doctors.

It also found that disadvantaged groups make low use of preventive and dental services. It established that, by most available measures of health status, people who are disadvantaged have much poorer health than do people with higher incomes. The study found that there were many factors such as educational attainment, smoking and diet that influenced the poorer health outcomes of disadvantaged people. The Whitehall studies in the UK have found that, even after adjusting for these factors, the health of low-income people is generally much worse than people on high incomes. It has been suggested that the degree of control that an individual has over his or her life has a significant influence on their health, and that poorer people have less control over their lives than do richer people. There are elements of the structure of society that influence health differentials.

It appears from the National Health Strategy study that universal health insurance does provide poor people with high access to hospital and medical services, but not sufficient to overcome their health problems. The health sector can ameliorate some of these factors, but cannot overcome the social factors. The low use of dental services by the disadvantaged was almost certainly the result of there being no dental benefits under the universal health insurance system. The National Health Strategy went on recommend a dental health service for the poor and it operated for several years until funding was withdrawn by the Australian government around 1998.

**Access to health services in rural and remote areas**

There are problems of providing enough health services to rural and remote communities and people in these areas have restricted access to services. Experience in many countries shows that paying doctors more to work in rural and remote communities does not increase access to doctors. British Columbia (Canada) tried such incentives for many years and was not successful in altering significantly the number of doctors living and working in these areas. It is well recognized that there are social and cultural factors in the selection and training of doctors that result in them not wanting to work in these communities. Australia, like many other countries, has a number of programmes specifically designed to support health
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professionals, not just doctors, to work in rural and remote communities. This is an area in which the type of health financing system is unlikely to be a significant factor in improving access to health services.

Quality of Care

The Responsibility for maintaining quality of care is very diffuse. The Australian Council for Safety and Quality in Health Care was established in January 2000 by Australian Health Ministers to lead national efforts to improve the safety and quality of health care provision in Australia (see http://www.safetyandquality.org for details, work programme etc). Over time, this organization will probably play an important role in ensuring safety and quality in Australian health care, but it is still in the development phase.

The Australian Council on Health-care Standards is the most active vehicle for monitoring and improving the quality of care. It is an ‘independent, not-for-profit organization, dedicated to improving the quality of health care in Australia through continually reviewing the performance, assessment and accreditation’ (ACHS website, http://www.achs.org.au). While it is not mandatory to be accredited a large proportion of all health care providers, both public and private, are accredited with ACHS.

All States and Territories require doctors, nurses and several other health professions to be registered with State and Territory Registration Boards. Only registered persons can practice legally. All of the Boards have procedures which could result in health professionals being de-registered if it is found that their standard of practice was not adequate. De-registration for poor quality of care is fairly unusual.

All of the medical specialities (including General Practice) and some of the allied health professions have processes to maintain quality of care – requirements for continuing medical education, audit and inspection programmes of varying degrees of intensity etc.

The Health Insurance Commission has a programme to review the ‘patterns’ doctors practise (doctors who are registered for benefits under Medicare), mainly to discourage overservicing and/or fraud. It also engages in programmes designed to encourage good practice and good prescribing.

There are a large number of small programmes designed to encourage good prescribing and a range of other good health service practices.
Overview of the Medicare Programme

This section reviews the performance of the Medicare Programme in terms of barriers to access by user fees and a number of service use indicators. It provides some evidence that this programme does not impose financial barriers to needed care. It also provides some evidence consistent with the National Health Strategy report on use of services by low-income people – in this case, by social security beneficiaries, who do appear to have good access to care.

The three programmes that constitute Medicare: Medicare (Hospital), Medicare (Medical), and the PBS cost A$ 33.9 billion in 2001-2002 and accounted for 54% of total recurrent health care expenditure (see Table 4). These programmes guarantee access to hospital services, medical services and affordable drugs. Direct costs to individuals provided only 6.7% of the revenue. Sixty seven per cent of medical services (bulk-billed) and 62% of hospital admissions (public patients) were provided without charge to patients.

Table 4. Health expenditure in Australia - 2001-2002 - major programmes and services

<table>
<thead>
<tr>
<th>Programmes</th>
<th>Commonwealth</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total Expenditure $ Million (%)</th>
<th>% Recurrent Health Expenditure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital</td>
<td>46.2</td>
<td>0.6</td>
<td>47.4</td>
<td>1.6</td>
<td>1.4</td>
<td>2.8</td>
<td>100.0</td>
<td>17,087</td>
<td>27.3</td>
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<tr>
<td>Medical services</td>
<td>79.4</td>
<td>1.5</td>
<td>0.0</td>
<td>3.9</td>
<td>10.7</td>
<td>4.6</td>
<td>100.0</td>
<td>11,187</td>
<td>17.8</td>
</tr>
<tr>
<td>Pharmaceutical benefits scheme</td>
<td>85.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15.1</td>
<td>-</td>
<td>100.0</td>
<td>5,586</td>
<td>8.9</td>
</tr>
<tr>
<td>Total Medicare</td>
<td>63.5</td>
<td>0.8</td>
<td>23.9</td>
<td>2.1</td>
<td>6.7</td>
<td>2.9</td>
<td>100.0</td>
<td>33,860</td>
<td>54.0</td>
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<tr>
<td>High-level residential aged care</td>
<td>74.8</td>
<td>0.0</td>
<td>5.1</td>
<td>0.0</td>
<td>20.1</td>
<td>0.0</td>
<td>100.0</td>
<td>4,137</td>
<td>6.6</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>14.8</td>
<td>18.3</td>
<td>-</td>
<td>47.8</td>
<td>6.0</td>
<td>13.1</td>
<td>66.9</td>
<td>5,149</td>
<td>8.2</td>
</tr>
<tr>
<td>Dental</td>
<td>2.0</td>
<td>7.1</td>
<td>9.9</td>
<td>18.5</td>
<td>62.2</td>
<td>0.3</td>
<td>100.0</td>
<td>3,689</td>
<td>5.9</td>
</tr>
<tr>
<td>Aids and appliances</td>
<td>4.1</td>
<td>3.7</td>
<td>9.6</td>
<td>80.4</td>
<td>2.2</td>
<td>100.0</td>
<td>2,403</td>
<td>113.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Other</td>
<td>23.3</td>
<td>3.1</td>
<td>29.7</td>
<td>8.1</td>
<td>39.1</td>
<td>4.9</td>
<td>113.7</td>
<td>12,456</td>
<td>19.9</td>
</tr>
<tr>
<td>Total recurrent health expenditure</td>
<td>45.4</td>
<td>3.1</td>
<td>19.7</td>
<td>8.1</td>
<td>20.0</td>
<td>3.7</td>
<td>100.0</td>
<td>62,693</td>
<td>100.0</td>
</tr>
<tr>
<td>Total recurrent health expenditure</td>
<td>28,445</td>
<td>1,950</td>
<td>12,370</td>
<td>5,087</td>
<td>12,512</td>
<td>2,329</td>
<td>62,693</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Performance - Medicare (Hospital) - There are some concerns that waiting times for some procedures in public hospitals for public patients are too long. Public hospitals are the major (in many locations the only) provider of emergency services and though there is often criticism of the performance of individual hospitals there is generally strong support for public hospitals.

Performance - Medicare (Medical) - In 2003 about 67% of all services were bulk billed by the providers, so that patients did not need to pay their doctors directly for these services. About 66% of primary care services (general practitioner services) were bulk-billed while the proportion for specialists’ services that were bulk-billed varied considerably: 27% of specialist attendances; 20% of obstetric services; 84% of pathology services; and 58% of diagnostic imaging services. It should be noted though that many specialist services are available free of charge through public hospitals.

Performance - Pharmaceutical benefits scheme - There are concerns in government about the increasing costs of the PBS. However, almost all countries, rich or poor, have similar concerns. While not every drug is listed on the PBS and while there are some disease specific health consumer groups, which want additional drugs listed, there is widespread recognition that the PBS serves Australian’s well as both consumers and taxpayers. The PBS is regarded as a leader in the field of national medicines programmes and its processes have been studied and emulated by many countries. Comparisons of the cost of medicines in Australia generally find that, on average, prices in Australia are 60-70% of those in comparable countries. The National Medicines Policy in Australia, of which the PBS is a part, also calls for the development of an Australian-based research and manufacturing medicines industry. As part of the NMP, the Australian Department of Industry pays subsidies to companies, Australian and foreign-owned, that undertakes research and development in Australia. This programme has also been successful in increasing manufacture and export of pharmaceuticals from Australia.

Dental Services - This is the largest area of health expenditure for which there is no universal programme. Of the total expenditure of A$ 3.7 billion in 2001-2002, 62% was paid directly by individuals, 18.5% was paid by individuals through their private health insurance contributions, State governments paid 10%, the Commonwealth paid 7% for privately insured people and 2% for others (mainly war veterans), and other sources paid 1.5%. The State government payments would be mainly for services provided by public dental clinics, often attached to large public hospitals. These State services are very strictly means-tested and have long waiting lists. The Commonwealth did fund a dental programme mainly for low-income and older people until 1997. The abolition of the Commonwealth programme corresponded to the introduction of the private health insurance subsidy. Commonwealth funds then went to dental services for higher-income groups.
The absence of a significant dental programme has long been identified as a limitation of the Medicare Programme.

**Aids and Appliances** - Another major limitation of the Medicare Programme is the limited range of aids and appliances available under it. Government sources cover about 5% of these costs, although most of this goes to privately-insured people. Some of these items are included under public hospital expenditure but it is not a large amount compared to that used by the community. The Commonwealth does fund incontinence aids, in part to reduce the pressure to admit incontinent old people to residential aged care facilities. The incontinence programme is paid for by the Commonwealth but administered by the States. The States provide a range of equipment through public hospitals but only to people with very limited financial means. As can be seen from Table 1, individuals pay 80% of the costs of these items out-of-pocket, their health insurance contributions pay about 10%.

**Services not covered by Medicare** - There are a number of major health services that are not considered part of the Medicare Programme. Some of the programmes are universal, others are selective, and, for services such as dentistry virtually non-existent.

**Performance of the Medicare Programme** - The Annual Report of the Commonwealth Department of Health and Ageing reported that:

‘Each year the HIC, which administers subsidies under the MBS and the PBS, produces a customer satisfaction survey that shows the level of support and public attitudes towards Medicare. The 2002–2003 survey showed that support for Medicare remains high, with consumer satisfaction at 93%. The survey also showed high levels of satisfaction among doctors (75%) and pharmacists (91%) with payment arrangements administered by the HIC.’

8 Conclusion

The problems that most countries face in health care are remarkably similar: how to get more money into health care; how to provide low-income groups with access to health care services; how to provide health services to remote and rural areas; how to ensure that preventive services are not starved of funds so that hi-tech equipment can be bought for large city hospitals where the Minister for Health and other important people are treated; how to ensure that services that are provided are of sufficiently high quality that they do more good than harm; how to decide which drugs should be subsidized etc. Though most of the problems in different countries are the same, the solutions will be country-specific. As this Australian case study shows, solutions are largely determined by history, values and local political processes.
For over a century Australia has been one of the richest (on a per capita basis) countries in the world - the level of health funds has almost always be sufficient to ensure high quality (to the extent that this can be determined) health services for all. Australians have been innovative in producing solutions to problems as international recognition given to programmes such as the Harm Minimization Policy for HIV/AIDS and the PBS show.

This report shows that the values of a society are important in determining whether health services are made available to all. It also shows how special interest groups such as the medical profession can, by allying itself with political groups, produce changes to the health care system that look after its interests but which are not necessarily in the best interests of all health consumers.

The Australian experience shows that when there is universal insurance for hospital and medical services, low-income people used high amounts of treatment services. However, low income people do not access some of the preventive health services. This suggests that, at the time the study was undertaken, there was not enough emphasis placed on promoting these services to low-income people and in ensuring that there were no previously unrecognized barriers (such as the availability of child minding services or the like) that impeded access. Dentistry was not included in the universal health insurance programme, and low-income people did not access preventive or restorative dental services. When considering the design of a universal health care system, especially where there are limited resources, consideration needs to be given to which services should be funded to have the greatest impact on national priorities - health, social and economic.

The Whitehall Studies on the impact of social differentials on health status highlighted the fact that even if there is reasonable access to health services, significant health differentials still persist because of other social factors. In Australia, before the introduction of the first universal health insurance in 1975, low-income people were subjected to means tests at hospitals that were regarded as invasive and, in the view of many people, humiliating. It is quite possible that the existence of a good quality universal system with access according to need, could narrow the health differentials by giving low-income people a greater sense of dignity and entitlement within the society - issues that were discussed in Australia at the time.

In general, health systems do what they are paid to do. If sufficient emphasis is not placed on prevention, the funding systems should be designed (or redesigned) to ensure that incentives are provided to individual health care providers and organizations.

There is still much to be learned about the financing of health care. Despite large differences in the ways health services are funded, recent reports in Australia, the USA the UK and Canada have all highlighted the problems of coordinating
chronic care. There is a danger for low income countries in the lure of hi-tech and integrated computer networks etc. These may be readily financed in countries that spend US$ 2000 - 4000 per person per year, but what is often not recognized is that, as well as requiring large investments in hardware and software, it often takes a decade or more for clinicians and managers to develop the culture and skills to use these systems.

It is possible to adapt complex universal health financing systems to operate in simpler systems at much lower cost. However, there are many effective systems for organizing and funding major health care sectors that could serve as models to others. Universal health insurance is one of those systems. By careful research countries can find systems that they can adapt to their own social and economic conditions.

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1. Background

China is the largest developing country in the world, located in the east of Asia, on the west coast of the Pacific Ocean with a land area of 9.6 million square kilometres. By 2003 the population in China amounted to 1,292,270,000 with 768,510,000 in rural areas and 523,760,000 in urban areas, not including those in Taiwan, Hong Kong SAR and Macao SAR. According to the Fifth National Population Census in 2000, the average life expectancy in China was 71.4 years old (male 69.6 years and female 73.3 years). In recent years, the natural growth rate of population in China has witnessed a downward trend, from 1.661% in 1987 to 0.601% in 2003, or a decrease of 1% over 15 years, in which a transition to a population type with a low birth rate, low death rate and low growth rate was completed. The rapid decrease in the natural growth rate of the population and the increasing average life expectancy resulted in the ageing of population. In 2003 the population over 65 was 969,200,000, accounting for 7.5% of the overall population.

In 2003, the GDP in China reached 11.67 trillion Yuan, which was more than US $1.4 trillion based on the current exchange rate, ranking the sixth in the world, while the GDP per capita reached US $1,090, a medium or even low level in the world. With rapid economic development, constant increase of income level per capita, the mounting health care service charges and pharmaceutical prices and the aging population, total health expenditure also witnessed a swift increase from 225.78 billion Yuan in 1995 to 568.463 billion Yuan in 2002, up from 3.86% to 5.425% of GDP. In 2002, government health expenditure, the social health insurance and individual payment contributed 15.21%, 26.45% and 58.34% of the total health expenditure respectively. Per capita health expenditure was 932.93 Yuan in urban areas, while 268.61 Yuan in rural areas.

There are five levels of government in China: central level, provincial level, municipal or prefecture level, county or city level, and township level with independent financial systems at each level. There are 31 provinces, autonomous regions and municipalities directly under the Central Government, 332 administrative units at prefecture level under the 31 provinces, 2860 administrative units at the county level under the prefectures and 44822 administrative units at the
township level in China. Great disparities of economic and social development exist in urban and rural areas. In 2002, per capita GDP ranked highest with over 40,000 Yuan in Shanghai, nearly 13 times of the lowest at 3,140 Yuan in Guizhou. In 2003, the per capita income of urban residents was 8,500 Yuan, 3.2 times that of rural residents of only 2,622 Yuan per capita.

To better understand the development of the health care system and also the background of health insurance policy in China, we have to be fully aware of the basic national conditions. China, with a huge population base and vast land resources, is a developing country in full gear of economic development but still has a huge inter-regional gap in urban and rural areas.

2. The Development of Health Insurance in China

Since the founding of the People's Republic of China in 1949 and till the late 70s, China undertook a planning system with the characteristics of high centralization and separation of urban from rural regions. At that time, health insurance mainly covered the urban population, which was adapted to the new planning system. This entailed free health care in government organizations and institutions, while Workers Insurance schemes at enterprise level were established in urban areas.

Free Medical Care (FMC) meant that the government covered the medical care expenditures for employees in government organizations and institutions as well as students in universities and institutes, through "government insurance". Concrete standards of FMC were set to satisfy the employees' real demands for medical services within the national fiscal capacity and health sector's capacity. The Employees' Insurance Scheme (EIS) for all the employees as well as for the retirees in State-owned enterprises was supported by the net income of the enterprises. Some collective enterprises also followed the practice. During the first phase, employees contributed 3% of their total income, which was adjusted from 4.5% to 5.5% in 1957. In 1969, welfare funds for employees in government-run enterprises were established, and provided for salary bonus, allowance and medical subsidies. The welfare funds were derived from 11% of the total salary. Under the EIS, those employees' family members who were unemployed were entitled to a 50% reduction from the current user charges.

Since the 1980s the traditional FMC and EIS both showed drawbacks and disadvantages that were incompatible with the current needs. These were linked to several factors. First, along with the intensified market oriented reform, government loosened the control of medical service charges and drug prices and changed the policy of reimbursement in public health facilities. These facilities were becoming market players that made maximizing profits their goal. Since the medical costs were
mainly borne by the governments and enterprises, the FMC and EIS lacked effective cost control mechanisms. Medical expenditures soared, which added heavier financial burdens on Government and enterprises.

Secondly, with the strengthening of the reform of the state-owned enterprises, restructuring of the economy and increasingly intensified market competition, the status of some enterprises was changed. Some enterprises faced difficult financial conditions and went bankrupt because of low efficiency. With no stable financial resources, the security of the employees’ basic medical care could not be sustained. Thirdly, the FMC and EIS were systems implemented by individual enterprises with low levels of socialized management. Under such systems, each person or employee belonged to the individual enterprises or government agency, which prevented mobility in the labour force and prevented the country from establishing a standardized labour market. Moreover, many heavily burdened enterprises failed to compete with others on an equal basis when it came to providing free medical care for those who retired early due to some historical and institutional reasons.

For these reasons, reform in health insurance for urban salaried employees was undertaken since 1980 and different mechanisms were tested in many regions. Examples are the linking of medical expenditures with the interests of hospitals, employers and employees; hospitals controlling the FMC funds; and establishing social pooling funds for catastrophic diseases. Such measures helped to control the medical costs and also avoid over consumption.

To strengthen the Employees’ Health Insurance System Reform, the Commission of Economic System Reform of the State Council, Ministries of Finance, Health and the newer Ministry of Labour and Social Security issued the Guidelines on the Pilot of Workers’ Health Insurance System Reform in April 1994. This led to the pilot project of establishing new Employees’ Health Insurance Systems in Zhenjiang, Jiangsu Province and Jiujiang, Jiangxi Provinces. After a one year trial period, the New Employees’ Health Insurance System started to bear fruit. On April 1996, the State Council decided to further expand the pilot reform to 57 cities in 29 provinces, autonomous regions and municipalities directly under the Central Government. Based on the experience of pilot reform, the State Council issued Decision on the Establishment of Urban Employees’ Basic Health Insurance System on December 1998, marking the start of Urban Employees’ Basic Medical Insurance System Reform. On July 2000, the State Council held a Symposium on the National Urban Workers’ Basic Health Insurance System Reform and Health System Reform in Shanghai. It was then decided to accelerate the Urban Employees’ Basic Health Insurance System Reform and meanwhile promote the health system reform by introducing market competition mechanisms; standardizing national drug production and distribution and improving the quality of medical services with controlled costs.
3. **Design of the Urban Employees' Basic Health Insurance System**

**State Council’s framework of health insurance systems**

At present, China has no standard Law on Social Insurance. The State Council’s Decision on the establishment of Urban Employees’ Basic Health Insurance System in 1998 and other documents promulgated together with the Ministries of Finance and Labour and Social Security defined the health insurance system and also laid a framework for the basic health insurance for urban employees.

**Coverage**

Basic medical insurance is compulsory in many countries, while in China the health insurance system is now compulsory for urban salaried employees but not for all urban residents. All the urban employers, including enterprises, organizations, institutions, social groups and private enterprises, and their employees have to join the Urban Employees’ Basic Health Insurance System. The Provincial Government can make the decision regarding whether village and township enterprises and their employees and urban owners of private enterprises and their employees will join the system.

**Financing**

The premium of the basic medical insurance is paid mainly by employers and employees. In principle, the employers should pay an equalising at 6% of their employees’ salary and the employee should pay at 2% of salary. According to the regulations, retirees covered by the system will not pay anything as their individual contribution to the premium. Local governments can entrust the taxation authority or social insurance agency to collect the health insurance contributions.

**Pooling tier**

In principle, the fund pool of the basic health insurance should be established in administrative areas at prefecture level and above, including prefecture and municipality. In principle, the three municipalities directly under Central Government Beijing, Tianjin and Shanghai, should establish the fund pool at the municipal level.

**Combination of individual account and social pooling**

The basic health insurance system has established a mechanism to combine the social pooling and individual accounts for the fund management. A proportion of the...
contribution paid by the individual is put into the individual account, while part of
the contribution by employers is used for social pooling funds and around 30% is put
into the employee’s individual account. The exact proportion can be decided by the
local authorities with the consideration of the scope of medical expenditures covered
by the individual account, employees’ age and other factors. The social pooling funds
should cover the expenditures for catastrophic diseases and inpatient medical
services. Deductibles are set at 10% of the average amount of local employees’
salaries. The ceiling has been set at 4 times the average amount of local employee’s
salaries. Medical expenditures to the amount between the deductible and the ceiling
amount should be paid by the pooled funds and a proportion of the expenditure
should be borne by individual. The funds in the individual account should be used
for the expenditures of common diseases, outpatient services or for expenditures at
the amount below the deductible.

Fund management
Since China has not developed a mechanism to determine a social security budget,
the basic health insurance funds are not incorporated into a budgetary management
system. At present, the social security funds are controlled under the mechanism of
Special Accounts with the characteristic of “special funds used for special purposes.”
The administrative expenses for the social insurance agencies’ operation come from
the fiscal budget at each level; and basic health insurance fund cannot be used for
operational expenditures. The basic health insurance system has to adhere to the
principle of keeping expenditures below income and balancing the revenues and
expenditures.

Designated facilities
The employees’ basic health insurance system uses a mechanism of designated
hospitals and designated drug stores, which are selected by the operational agencies
of the social health insurance system. The selection of the hospitals is based on the
consideration of Western medicine and traditional Chinese medicine services in
hospitals, appropriate conditions in all categories of hospitals: community, specialty
and general hospitals. The principle of the selection is to provide the insured
population with maximum convenience.

Reimbursement
The method of reimbursement or provider payment of medical expenditures covered
by the basic health insurance is selected according to the capacity of the operational
agencies and the different types of designated hospitals. The specific methods
include global capitation, fee-for-service, diagnostic-related-group (DRG) and
combinations of some of these. When the DRG method is used, the diagnosis of a
disease, outpatient services and the inpatient services can be taken as category or group for reimbursement. Medical expenditures are reimbursed to hospitals directly by the health insurance operational agencies. In the places where direct reimbursement cannot be made, the medical expenditures can be paid by the patient or employer first and then be reimbursed by the operational agencies.

Special groups of people

For some of the employees in poorly managed enterprises, the amount of the contribution paid by the employers can be lowered. The reduced amount can be used for the establishment of pooled funds while the establishment of individual accounts can then be postponed. In this way, the employees in enterprises with financial difficulties can be incorporated into the basic health insurance system and they can enjoy the benefit of the system. Employees who do not have a clear labour relationship with their employers (such as temporary workers) can join the health insurance system as individuals if they pay the entire contribution themselves, i.e. both the employer and employee parts. As a starting point, their contribution will be used for the pooled funds. If the arrangements are in place, such employees can simultaneously establish pooled funds, individual accounts and subsidy mechanisms for very high medical expenditures. The amount of contribution can be fixed according to the average amount of employees’ salaries.

The design of the health insurance system in different regions

Under the State Council’s principles of health insurance reform, local governments work out their own implementation plan for the employees’ basic health insurance system. Since the levels of economic development, household income, medical expenditures and drug prices vary considerably across regions, the amount of contribution paid by employers, the percentage allocated to the individual account, deductible, the share of co-payment and some other regulation of the health insurance system are different. Regarding the amount of contribution paid by employers, most regions follow the State Council’s regulation and set the amount at 6% of the total amount of the employees’ salary. In some areas the percentage is lower than 6%, as in Liuhe County, Jilin Province and Dongming County, Shandong Province; the percentage is about 2% while in Du’an County, Guangxi Province, it is 2.5%. However, in Shanghai the percentage is 12%, in Kunming it is 10% and in Beijing it is 9%. Regarding the amount allocated to the individual account, the insured employees are generally divided into several groups according to age, and percentages are set for each group. This follows the principles that retirees should have access to a higher percentage than active employees and older employees should have access to a higher percentage than younger employees. The base amount
for the calculation of the percentage is the individual employee’s average salary per month in the last year (active employees). For retirees, the base amount for the calculation is average amount of salary of local employees. The average amount of pension can also be used as the base amount for the calculation (in Shenyang).

Regarding the issue of whether retirees should themselves contribute, in general, the State Council’s regulations are followed, according to which retirees are not requested to pay a contribution. However, in some specific places, such as Guangzhou City, the employers are requested to pay the contributions not only for their active employees, but also for their retirees. The employers have to a contribution for retirees based on an amount equalling 75% of average salary of local employees. If the employers are in financial difficulty, the contribution can be made in several payments.

With regard to reimbursement or provider payment, different places use different methods. In most places, the fee-for-service (FFS) method is used. However, other methods are being tested as for example, in Shanghai where a combined method of FFS plus Global Capitation is used. The DRG method is being tested in Mu Dan Jiang and Qi Qi Ha Er cities in Hei Longjiang Province; global capitation and DRG are used in Zhenjiang, Jiangsu Province; In Changshu, Jiangsu Province, a fixed amount of reimbursement method is used with consideration of the level of the designated hospital and the diseases treated. In Hainan Province, a global capitation payment method is used, savings are encouraged and expenditures over the disbursed amount are shared. In Tianjin City, the pre-payment mechanism is used combined with FFS and DRG.

Multi-level health insurance system

The basic health insurance system is the core of the urban health security system. Together with mechanisms for mutual assistance to cover very high medical expenditures, the medical subsidy for civil servants, enterprise supplementary health insurance and social medical assistance, a multi-level health security system in China is being formed. These are described below:

Mutual assistance for very high medical expenditures

To help some seriously ill patients pay for their medical expenses exceeding the ceiling of the basic medical insurance system, some regions have worked out a policy of mutual assistance for very high medical expenditures, namely health insurance only for catastrophic expenditures. This scheme is compulsory in most regions, and voluntary in the rest of the country. The fund for this scheme comes from employers’ payments, employees’ payments or a combination. A set amount or a certain
percentage of salary can be used for the calculation of the contributions to this scheme. In most regions the actual amount paid as contribution for this scheme does not exceed 100 Yuan. In Xi’an, Nanchang and Dalian, the annual contribution payment is 60 Yuan, 50 Yuan and 30 Yuan respectively. The set amount may vary between employees and retirees, for instance in Xintai, the employers’ pay 2% of their employee’s monthly salary, while the payment for retirees is 8% of their pension. The mutual assistance fund for very high expenditures is separate from the basic health insurance system. In Beijing, Shanghai, Nanjing and Xian, this mutual assistance fund for very high medical expenditures is managed by health insurance agencies. It is entrusted to commercial insurance agencies such as the Xinhua Life Insurance Company in Tianjin, China Life Insurance Company in Zhengzhou and Pacific Life Insurance Company in Xiamen.

Enterprise supplementary medical insurance

Apart from the basic health insurance, enterprises can also establish supplementary health insurance to further relieve the burden on employees who already have basic health insurance and mutual assistance for very high medical expenditures. Under the regulations, enterprises that have paid the social insurance contributions in full can determine autonomously whether or not they want to purchase supplementary insurance. For the contributions to this supplementary health insurance, the employees’ welfare fund can be used to pay an amount that is within 4% of the employees’ total salary. The portion of the contribution that exceeds 4% can be considered as part of the enterprise production cost. This supplementary health insurance can be established by purchasing commercial health insurance or by entrusting social health insurance agencies. Some large companies operate the supplementary health insurance system by themselves.

Health care subsidy for civil servants

Under the State Council’s Regulations in Document No. 44 issued in 1998, civil servants enjoy a health subsidy in addition to the basic health insurance. In 2000, the Ministry of Finance and the Ministry of Labour and Social Security jointly issued Guidelines on a Health Care Subsidy for Civil Servants. The subsidy covers excessive medical expenses above the ceiling amount covered by the pooled funds of the basic health insurance. The subsidy also covers the medical expenditures for the services covered by the insurance but paid by individual civil servant in excess of a fixed amount. Medical expenditures for services used by persons entitled to specific services under central and provincial government regulations are also covered. In most regions, the health care subsidy for civil servants and the mutual assistance scheme for very high medical expenditures are independent of each other. That is,
when the medical expenditure exceeds the amount covered by the basic health insurance, the portion above the ceiling amount can be covered by a health care subsidy for civil servants. However, in some other regions, the mutual assistance for very high expenditures and the subsidy are inter-related so that the mutual assistance funds for very high medical expenditures take up the amount above the maximum, leaving the portion of individual payment below the ceiling amount to be covered by the health care subsidy for civil servants.

Social medical assistance

Social medical assistance is aimed at helping those who fail to join health insurance or at relieving the financial burdens that are beyond health insurance coverage for urban residents in extreme poverty. The Ministry of Labour and Social Security deals with health insurance, while the Civil Affairs Department manages social medical assistance. The social assistance fund has limited coverage and low assistance capacity as it is still in an initial stage. According to statistics, by the end of 2003 more than 30 cities across the country had established social medical assistance funds. The benefits of social medical assistance include considerable reductions or exemption from some user fees, such as registration and examination fees, general treatment charges and hospitalization fees. Social medical assistance also provides very poor persons with some support for participation in basic health insurance. The social medical assistance funds mainly come from local government budgets, the public welfare fund created by the lottery and donations. At present, the relevant departments under the State Council are working on a document to regulate the urban social medical assistance and thereby enable expansion.

Work injuries and maternity insurance

The pilot scheme for insurance to cover work injuries and diseases and maternity insurance was started in 1993. In 2003 the State Council issued Regulations on Insurance for Work Injuries, stipulating that any enterprises and private firms with salaried staff should join the system and pay the contributions for work injuries for all employees. Individuals were not liable for payment of this insurance. The contribution rates vary among different industries and even within each industry there are wide differences in the contribution brackets, according to the risk of injury and related treatment costs. This insurance covers any work related injury and occupational disease, as well as a cash allowance, and compensation for work injury induced disability. In the case of the death of a worker due to a work related injury or occupational disease, the insurance pays funeral expenses, a pension for the family and compensation for the loss of life of the worker.
By the end of 2002 the number of participants in the work injury insurance scheme had reached 44.06 million, the contribution revenue reached 3.2 billion Yuan and claims amounted to 1.99 billion Yuan with a cumulative surplus of 8.11 billion Yuan. By the end of 2003 the number of participants had increased to 45.73 million.

At present there are no clear State Council regulations on maternity insurance but pilot maternity insurance schemes have been started in some regions. In other regions, women can be reimbursed for pregnancy related expenditures from the health insurance fund. In the pilot regions, the scope of coverage is urban enterprises and their female employees. The contribution rate can be decided by the local government according to the number of persons who may have a child, the amount of subsidy of delivery and the cost of delivery related care. The contribution rate can be adjusted and the highest rate should not exceed 1% of the total amount of salary. The benefits include reimbursement for pregnancy examinations, delivery, surgery, hospitalization, drugs and family planning, surgical fees, post-natal examination and treatment and a cash maternity leave allowance calculated on the basis of the average monthly salary of the previous year. By the end of 2002, the number of insured women had reached 34.88 million, revenue from contributions reached 2.18 billion Yuan while claims amounted to 1.28 billion Yuan with a cumulative surplus of 2.97 billion Yuan. By the end of 2003 the number of insured increased to 36.48 million women.

4. Rural Health Insurance

Due to differences in the levels of economic development and dual economic social structures, different health insurance systems were adopted in urban and rural areas. After the founding of the People’s Republic of China, urban residents were essentially provided with health care free of charge or were covered by the health insurance system for workers, leaving the rural residents without coverage. The rural cooperative medical system (RCMS) was introduced for rural areas and became popular in 1960s and 1970s. This system ensured some medical assistance to rural residents but was still far from a sound health insurance system. The RCMS has experienced ups and downs till almost complete collapse with the disappearance of the planned economy.

There were several initiatives to tackle the problem of health care coverage for rural residents. In 1993, the State Council decided to re-establish the RCMS in 1993 and various pilot schemes were implemented with the support of the international development partners. Most of these pilots were set up at township level, without uniform guidelines and without agreed and sustainable financial support of government at township, county and provincial levels. There were many problems with the pilots, including contribution levels which were too low to provide
adequate benefits, rigid registration procedures such as enrolment and contribution payment only once a year and complicated reimbursement methods with long waiting periods for insured persons to be repaid after they had themselves paid for health services. Most of the pilot projects collapsed after several years, and new attempts were made by the Ministry of Health to establish new forms of social health insurance for the rural population.

In 2002 to tackle the existing problems of illness induced poverty and health care costs leading to poverty, the Chinese government again decided to establish a new rural cooperative medical system. Compared with the old system, the new RCMS design gave more emphasis to the government’s responsibilities in financial support. Both central and local governments allocated an equal share of 10 Yuan for each farmer participating in new RCMS in western and central rural areas. With the exception of the large cities, governments at all level in eastern and central areas were encouraged to provide a subsidy of 20 Yuan for each participating farmer.

Under the principle of wide implementation after successful trial, this new RCMS is to be expanded to cover all farmers by 2010. In the 220 pilot counties that have adopted the trial RCMS since 2003, more than 60 million farmers have enrolled in the systems. Moreover, to alleviate poverty among farmers and ease their financial burdens, the Ministries of Civil Affairs, Health and Finance issued Guidelines on the Implementation of Rural Medical Assistance in 2003. The guidelines are aimed at ensuring multi-channel financing mechanisms, such government allocations and voluntary donations to provide funds to enable low income farmers to participate in the new RCMS and to cover their catastrophic medical expenses as well as treatment costs for special infectious diseases under State regulations. With the aim of establishing a standard and sound rural medical assistant system by 2005, the Central Government will also provide special fund to regions with financial difficulties.

5. For-profit Commercial Health Insurance

With the development of compulsory social health insurance system, voluntary commercial health insurance was considered a good way to accelerate the development of health insurance in China. The operation of commercial health insurance companies in China goes back to 1982 when the China Life Insurance began to offer a cooperative employees’ medical insurance scheme. After more than 20 years’ development, commercial health insurance has grown in China, particularly as the implementation of the Urban Employees’ Basic Health Insurance Reform left much room for the development of commercial health insurance. The commercial insurance sector is regulated mainly by the Chinese Insurance Law issued in 1995, amended in 2002 and other related documents issued by the China Insurance Regulatory Commission (CIRC) and Ministry of Finance.
Law states that health insurance, life insurance and accident insurance are all in the category of straight life insurance; while insurance for property loss, responsibility insurance and fidelity insurance are all in the category of property insurance. No insurance agency is allowed to cover both of the insurance categories without the approval of CIRC, while property insurance companies can operate short-term life insurance and accident insurance.

According to the data available, by 2002 there were 29 life insurance companies and 8 property insurance companies providing more than 300 health insurance products. Besides the traditional products such as cash benefits and reimbursement for hospitalization charges, insurance companies have taken on new benefits such as income replacement and long-term care. The premium revenue has increased rapidly from 2.769 billion Yuan in 2000, 6.155 billion Yuan in 2001, 12.245 billion Yuan in 2002 and 24.192 billion Yuan in 2003, which is a more than an eight-fold increase within these three years. The premium revenue accounted for 2.77% of overall life insurance revenue in 2000 and the ratio increased to 4.24% in 2001, 5.38% in 2002 and 8.03% in 2003. The number of insured persons (for health care benefits) reached a record high of over 100 million in 2001, and increased to 136 million in 2002.

6. Health Insurance Reform: Progress and Achievement

The framework for health insurance reform

The major reforms in the urban areas have been underway for more than five years, since 1998. In urban areas, China has now established a multi-level health security framework, including employees' basic health insurance, mutual assistance for very high medical expenditures, a health care subsidy for civil servants, enterprise supplementary health insurance and social medical assistance. This multi-level health security system with standard regulation and socialized management is compatible with the socialist market economy, independent from individual enterprises and institutions, and plays an important role in enhancing public health, promoting enterprise reform and maintaining social stability.

Progress in the functioning of the health insurance system

According to available information, by the end of 2002, pooled funds were established in 339 prefectures and 1435 counties and cities through the Urban Employees' Basic Health Insurance systems. With regard to the number of insured persons, by the end of 2003, the number of persons insured in the Urban Employee Basic Health Insurance system reached 108.95 million, with an increase of 14.95 million over the previous year. Among those insured, 79.77 million are active employees, comprising 56% of the total active employees in pilot regions, and with an annual increase of 10.51 million over the previous year. Another 29.18 million
insured are retired workers, with an increase of 4.44 million over the last year. Some provinces and municipality achieved a high percentage of coverage, such as in Shanghai where 95% of the salaried employees now have health insurance coverage.

With regard to the revenues and expenditures of the Urban Employees Health Insurance, in 2002 the premium revenues and expenditure of the basic health insurance was 63.23 billion Yuan and 44.18 billion Yuan respectively with a yearly surplus of 19.05 billion Yuan and a cumulative surplus of 42.51 billion Yuan. The Basic Health Insurance Fund mainly comes from social pooling and also individual contributions. The surplus in pooled funds greatly affects the performance of basic health insurance. In 2002, the yearly surplus was 10.96 billion Yuan, while the cumulative surplus reached 23.51 billion Yuan. In general, the revenues and expenditures of the health insurance funds were well balanced that year. However, there were obvious inter-regional differences. In Shanghai for example, the pooled fund had a deficit of 650 million Yuan in 2002, or 8.6% of that year’s pooled fund income. In Beijing, Shandong and Hunan provinces, the yearly surplus of the pooled fund was lower than 20% of the contribution revenue, while in Shanxi, Guangdong, Hubei and Tibet the yearly surplus in the pooled fund was more than 50% of the revenue. Generally speaking, as the health insurance reform progressed, the surplus in the health insurance funds has been on a downward trend.

Improvement in access to basic health services

Compared with the traditional Free Medical Care and former Workers Insurance Care in the urban areas, (which were both enterprises-based insurance systems compatible with a planned economy), the Basic Health Insurance System is better able to ensure equity in access to health care for the insured populations. The reason is that the Employees’ Basic Health Insurance System established a social pooling mechanism to improve the protection from the financial risks caused by illness and health care expenditures, especially in cases of catastrophic illness. It effectively reduces the financial burden for the enterprises in difficulty, including small enterprises and their employees. Moreover, the contribution rate was linked to the employees’ salary level in a way that the average per capita contribution in enterprises with good economic returns contributed more than those poorly managed enterprises while all the insured persons have the same access to health care and support from the pooled funds.

Promotion of health services system reform and control of health care expenditure

By introducing the risk-sharing mechanism, all the insured persons have to pay for part of their medical expenses, which has helped to control excessive demand for
health services. The insured persons take the initiative to choose from more than one designated hospitals so as to encourage competition and improve the quality of health services as well as the attitude of the health care staff. Moreover, compared with enterprises and individual patient funds, the health insurance fund has advantages in avoiding over provision of services in hospitals, in controlling the mounting costs of services and in regulating health services. According to statistics collected from general hospitals, from 1990 to 1998 the annual average growth rates of outpatient visits, expenditure on hospitalization and drugs during hospitalization were 25%, 23.7% and 22% respectively. In 2001, these rates decreased to 9%, 5% and 4% respectively. This led to the conclusion that the implementation of the health insurance system has played a positive role in promoting health system reform and in controlling the costs of health care.

7. Health Insurance Reform: Problems and Challenges

At present, China’s health insurance system still needs to study how to solve the following main problems:

**Slow progress in health insurance system reform**

According to the regulation in the State Council’s document No. 44, the Urban Employee Basic Health Insurance System should have been established in 1999 to take the place of the original Free Medical Care and Workers Health Systems. However, some government departments and institutions, as well as some more profitable enterprises, were concerned that the scope of benefits would be lowered by joining this social insurance system. This has led to some reluctance to participate on the part of stable enterprises, while at the same time the poorly managed enterprises cannot afford to join the system. Some local governments are also concerned that health insurance reforms might create more intensified financial burdens, based on their experience with pension insurance and minimum allowances for laid-off employees living expenses.

An additional problem is the complicated design of the health insurance system which, together with other subjective and objective reasons, could lead to slow progress in the implementation of health insurance reform. By the end of 2001, nearly 20% of the counties and cities in China had not yet started the health insurance reform to replace the Free Medical care and Labour Health Insurance System, while in other pilot regions, low coverage rates of 15% to 40% were reported at the end of 2002. Moreover, the expansion of health insurance coverage has met with greater difficulties recently. Annual expansion from 2001 to 2003 was seen a downward trend, as the number of new participants in the schemes in 2001 were 34.99 million, 21.15 million in 2002 and 14.94 million in 2003 respectively.
Limited health insurance coverage

By the end of 2003, only 109 million persons, or about one fifth of the urban population, had joined the Employees' Basic Health Insurance System. That is, the new health security system still covers only a small proportion of the urban population. Some people are still covered by the old form of Free Health Care and the Workers Health Insurance. Many enterprises in difficult financial and managerial situations do not have enough capacity to pay the contributions for their employees. In addition, private enterprises have so far failed to enrol their employees in the new Urban Basic Health Insurance System. There are also several neglected groups among urban residents, such as including children and family members of the workers, students, elderly residents who are not covered as retired salaried workers and the unemployed. Such individuals are currently not covered by the new system and face financial burdens in seeking health care.

Need for improvement in health insurance management and reimbursement

At present, some regions do not have computerized information systems to simplify the health insurance procedures. Patients have to submit bills and there are considerable delays in reimbursement while there is no monitoring of the providers. Patients from small counties with lower level providers try to seek medical services at high level providers in big cities at higher cost than in their local health facilities. The health insurance agencies cannot prevent this trend and do not have effective control on health care costs. Moreover, the provider payment method has long been a disturbing problem to the health insurance operational agencies. Research findings and experience show that there is no perfect mechanism, but some careful design in provider payment should play a role in controlling negative provider behaviour. The studies of the current system so far have found that where fee-for-service is used as the payment method, there are high utilization rates of prescribed drugs and diagnostic tests using hi-tech equipment, reflecting unnecessary use. In the areas where global capitation is used to pay providers, common problems are the dumping of seriously ill patients, breaking down the inpatient services and using drugs that are not covered by the insurance to extract additional payments from the insured patients.

Inadequacy of the pooled funds and risk protection

Many countries launched health insurance system on the basis of a national pooled fund, while in China counties and prefectures are the major levels for pooling. The exceptions are the municipalities of Beijing, Shanghai and Tianjin in which pooling is at the municipal level. According to statistics, by the end of 2002 and excluding Beijing, Shanghai and Tianjin, around 1800 pooling regions had a total of almost 80
million insured persons and a pooled fund of more than 26 billion Yuan. This means an average of 40 thousand insured persons per pooling region and an annual average of 15 million Yuan as revenue from contributions per pooled region. Some under-developed pooling areas with small populations only have several thousand insured persons and their annual revenue is limited to several million Yuan. At present the health insurance system in China can hardly follow the example of other countries to establish a national pooling fund. In a country with a huge population base and inter-regional differences in economic development, such blind imitation regardless of national conditions may not encourage local agencies to control irrational medical expenditures from the pooled fund. At the same time, the risk resistance capacity at the county level is too low to enhance equality of the health insurance system across the country.

An additional problem is that some regions established more than one pooled fund. For example, Xi’an in Shaanxi Province, the health insurance systems at provincial, city and county levels established their own pooled funds. In Yancheng city there are three separate pooled funds: in Shizhi, Chengqu and Yandu, without a clear management base. Such practices impair the risk protection capacity and create unnecessary management costs in the health insurance system.

Impact of delays in the health system reform on the health insurance reform

The sky-rocketing price of prescribed drugs and the common hospital practice of compensating medical services by revenue from the sale of drugs have been the focus of the concern of the whole society over recent years. Those problems not only impair the public interests but also increase the burden on the health insurance funds. Some effective measures have been introduced to solve these problems. These include separating the accounts for health service revenue and for drug revenue, regulating the supply of drugs and introducing competitive bidding systems in drug procurement. Pilot reforms have been launched in Liuzhou, Xining and Qingdao, whereby independent retail pharmacies have been established to dispense drugs prescribed at outpatient facilities. However, the hospitals are all strongly against the above measures, as these are seen to have a negative effect on their financial interests. Since the local health department plays dual and contradictory roles of both health administrator and health provider, the problems mentioned above cannot be solved through dealing with such root causes.

A mechanism to separate the management of drug revenue and expenditures was also introduced. However, this did not work properly because almost all the balance between the two was returned to the hospitals. The competitive-bidding process was used in drug procurement, but it lacked transparency. The pilot reform on the separation of accounts for health service revenue and drug revenue has been carried out over the last two years, but so far no substantial progress was made.
Pressures due to the ageing of the population

In the first section, it was noted that China is now in a process of population ageing with a trend of significant further expansion in the future. The ageing population could lead to an imbalance in the health insurance funds by reducing the revenues and increasing the expenditures. On the one hand, an ageing population requires higher health care expenditures than a healthy young population, and a higher proportion of elderly insured persons will increase the expenditure burden on the health insurance funds. Estimations for Beijing reveal that the per capita health care expenditure on retirees is 3.5 times that of active employees. On the other hand, the current regulations state that retirees do not pay contributions towards their health insurance. The ageing population therefore induces a decrease of health insurance funds in real terms with less individual contribution. Indeed, the impact of the ageing population on the health insurance system is being shown in some regions.

Difficulties in development of the rural cooperative medical system

At present, the security level of the Rural Cooperative Medical System is low. Though it is related to the low income of farmers, the core reason is that the rural system does not have a financing mechanism that is at the same level as the urban employee’s basic medical insurance system. In pilot regions, farmers contribute 10 to 15 Yuan per year which is less than 1% of their average annual per capita income of 2622 Yuan. This means that even if the average annual per capita income is over-estimated, there is still much room for possible increases in individual contribution rates or flat rate amounts.

In 2002, the per capita expenditure on health for farmers was 103.9 Yuan. If 40 – 50% of that amount, (approximately 40 to 50 Yuan) can be used for the contribution to an RCMS fund, an acceptable cooperative health fund could be set up. At present, each farmer contributes the same flat rate amount without considering income variation. There are significant differences in the farmers’ incomes, and many poor rural households with incomes below the average would not be able to pay increased individual contribution rates. It is not considered possible to establish a progressive contribution rate based on actual income due to the lack of transparency in farmers’ earnings. Government’s financial support to the RCMS through taxation helps to motivate farmers to join and also enhance equity among the insured farmers. However, the actual national situation is that government’s financial support to the RCMS has been limited and far from adequate due to the current level of economic development, central financing capacity and the large size of the rural population.
8. Basic Ideas to Expand the Health Insurance in China

As a developing country, China is no exception in facing problems and challenges in the establishment of social health insurance. To solve the problems and meet the challenges, China has to intensify and accelerate the health insurance reform. To further improve the health insurance system, China has to focus on the following main aspects.

Completion of the financing mechanisms and solutions to the problems in the rural and elderly populations

First and foremost, government should enlarge its investment in the social health insurance system. This is needed to provide the necessary medical assistance to the retirees from poorly-run enterprises, the needy and other poor people. At present, a large proportion of the health budget goes to service providers such as hospitals and clinics. No government funds go to the demand side except for the government expenditure on civil servants and employees of state owned institutions. These practices prevent the government from meeting the requirements of public finance and hinder improvement in the efficiency of health investment. According to international experiences, health investment in many countries mainly goes into public health and the subsidization of the demand side. Therefore, the scale of health investment should be enlarged and the structure of health expenditure should be adjusted. The government should increase the investment for solving the health security problem of the poor, while enterprises and working individuals should really take responsibility for the financing of their health care through the prepayment mechanisms.

Secondly, new resources of the health insurance fund should be explored at the appropriate time. The retirees should be encouraged to make their contributions with their pension as the base for calculation. In this way, a sound health insurance fund can be established in order to meet the challenges of the ageing population. Thirdly, tax authorities are encouraged to collect social security contributions, including health insurance contributions across the country.

Strengthen the cost control mechanisms of the health insurance systems

The sustainable development of the health insurance systems in China can only be achieved by controlling the costs and increasing contribution revenue. Technically, the process of developing adequate information systems should be accelerated and a membership data bank with complete diagnostic data should be established. A mechanism for dynamic and comprehensive supervision should be developed to effectively monitor the utilization of health insurance benefits. Through appropriate
regulations, sound mechanisms for rewards, penalties and even dismissals should be established in order to manage the designated health facilities and pharmacies based on their performance. The provider payment mechanism should be improved and completed.

Adjustment of health insurance pooling mechanism at all levels

The existing health insurance pooling system at county level should be shifted to prefecture level so as to improve the capacity for risk protection. Meanwhile, besides Beijing, Shanghai and Tianjin, other provinces are encouraged to establish pooling funds at the provincial level if conditions permit. The regions without the required conditions can store some pooled funds at provincial level for further redistribution among prefectures. Moreover, the principle of localized management should be implemented and each region should have only one pooled fund.

Acceleration of health system reform

Firstly, the responsibilities of the health authorities should be clarified. The health administration cannot play the roles of an administrator and a provider simultaneously. The function of the owner of health facilities should be separated from health administration. The function of supervisor of the health service market should be further strengthened. Health administrations should actively promote health system reform. Secondly, based on the pilot reform of separation of hospital and pharmacy, the separate management of the drug revenues and expenditures should be intensified.

Large hospitals should be encouraged to link with community health facilities by encouraging their technical staff to go to community facilities in order to operate a multi-level health system. Thirdly, to optimize the use of health care resources, an inter-hospital referral system should be established to satisfy the patients’ various needs. Fourthly, the provider payment method should be improved. DRG should be actively promoted and practice of large prescription with a large number of items should be stopped. Fifthly, there should be some restructuring of the medical facility arrangements and promotion of hospital ownership reform. The development of private facility could be encouraged to improve competitive mechanisms and to form a public-private health system with public ownership as the main body.

Accelerate the establishment of rural cooperative medical system

Firstly, the management of RCMS should be transparent and should be based on law. The utilization of RCMS funds should be supervised by the rural participants. The financial management of the RCMS funds should be strengthened. Secondly, the
financing capacity of the RCMS needs to be improved. With the rapid economic development and increasing income level in rural areas, the farmers’ ability to pay for their contributions is increasing. At the same time, government at all levels should increase the amount of subsidies to the RCMS. Thirdly, organization variations to suit local conditions should be encouraged. Different ways of managing RCMS under different environment should be explored considering the local economic development and farmers’ income levels. Fourthly, the relationship between RCMS and Medical Assistance for poor farmers needs to be clarified. In general, the medical assistance should be provided under the framework of the RCMS. In the regions where the RCMS has not been established, the medical assistance system can be implemented first for the purpose of reducing the burden of high medical expenditures on farmers.

**Expand health insurance coverage from urban employees to all urban residents**

Pilot projects with integrated health insurance systems in both urban and rural areas should be promoted. The development of a better-off society (Xiaokang) demands economic and social integration in both urban and rural areas across the country by rooting out the inequalities so that basic health insurance can be extended to all Chinese citizens. Theoretical research and international experiences also show that high level economic and social development may be preconditions for the realization of such goals, and China now still has a long way to go in this area. However, universal coverage should be the goal of reform.

After the establishment of the Urban Employees Basic Health Insurance system, those with the ability to pay joined the system. Employees in private enterprises, students, family members and the unemployed should be covered, with assistance as required in order to have health insurance coverage extended from all urban employees to all urban residents. Measures then have to be taken to ensure basic health services for rural employees in urban cities. The gap between urban and rural health security levels should be narrowed in the future with the improvement in rural conditions. The pilot project of integrated health insurance systems should be implemented in selected areas in order to accumulate experiences for expansion across the whole country.
1. Background

India has experienced a mixed pattern of development in the recent past. Its performance has been impressive in many of the macroeconomic fronts like growth rate of GDP, reduction in unemployment and poverty, impressive foreign reserves, economic reforms, development of information and technology. Indicators of human development have also improved substantially over the years.

However, there is still a lot of cause for concern. The benefits of economic development have been unevenly spread across regions as well as groups, and education, health, gender issues as well as economic and non-economic deprivation continue to plague the country, and are proving to be constraints in its development. Inter-state variations in almost all the development indicators, but especially human development indicators, continue to challenge national policymaking and make generalizations difficult even today. Some of the basic indicators of development are given in Box 1.

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<th>Selected Demographic Indicators</th>
<th>Selected Economic Indicators</th>
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<tbody>
<tr>
<td>Population</td>
<td>GDP real growth rate 4.30%</td>
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<tr>
<td>Population distribution</td>
<td>GDP composition by sector:</td>
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<tr>
<td>0-14 years: 32.2%</td>
<td>Agriculture 25%</td>
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<td>15-64 years: 63%</td>
<td>Industry 25%</td>
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<td>65 years and over 4.8%</td>
<td>Services 50%</td>
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<td>Population growth</td>
<td>Birth rate 23.28 births/1,000</td>
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<td>1.47%</td>
<td>Death rate 8.49 deaths/1,000</td>
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<td>Sex ratio</td>
<td>Sex ratio 1.07 males/females</td>
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<td>Labour force by occupation:</td>
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<td></td>
<td>Agriculture 60%</td>
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<td></td>
<td>Services 23%</td>
</tr>
</tbody>
</table>
Turning now to the health sector, while the indicators like IMR and maternal mortality rates do indicate that India has made large gains in health status over the past several decades, there is much in the current scenario to cause concern, especially when these indicators are compared to those in other countries, including countries of the region. Also, India is undergoing a health transition, one feature of which is a dual burden of diseases. While communicable diseases continue to contribute to the majority of health burden, non-communicable diseases have started becoming more prevalent. The morbidity and mortality of the poor still occur largely due to preventable infections, and childhood and maternal causes continue to contribute to the major burden of disease for the poor.

In addition, the inequity in health status (as measured by infant mortality rate, under-5 mortality rate and maternal mortality) between the poor and the non-poor on the one hand, and the vulnerable categories and the general population on the other, continue to be a major issue. Many analyses indicate that the present system has serious problems with respect to access, efficiency, effectiveness and quality. The polarization of the disease burden and the continuing plight of the poor point to a level and mix of spending that seems at this point quite beyond the reach of the government. Public spending on health has been more or less stagnant at about 1 percent of GDP, which places India among the bottom 20 percent of the countries (World Bank 2001).
Health spending in India is such that curative care continues to be the major part of primary care spending, with bulk of the spending coming from private sources. Overall, private health spending accounts for more than 80 percent of all health spending. Further, nearly all the private spending in India is out-of-pocket, with very little insurance coverage, leaving a majority of Indians vulnerable to substantial economic impact from health related problems (Ellis, Alam and Gupta 2000). The middle-income households have either some form of coverage from employers or can buy insurance, and the rich have the ability to pay. The least covered or most vulnerable are the lower income and poorer households, who are left to cope with health shocks on their own (Gupta 2002).

Curative public services mostly favour the rich; about Rs. 3 (about 7 cents in US Dollars at current rates) is spent on the richest quintile for every Rs. 1 (about 2 cents) spent on the poorest 20 percent (World Bank 2001). A study (Mahal 2000) applied the tools of benefit incidence analysis to the NSS 52nd round data on health, to assess the extent to which different groups gained from publicly financed and provided services. The findings indicate that the poorest 20 percent of the population only captured about 10 percent of the total net public subsidy. The richest quintile benefited three times more than the poorest.

Other findings from the various available studies indicate that hospitalized Indians spend more than half of their total annual expenditures on health and more than 40 percent of those hospitalized borrow money or sell assets to sustain their expenditures. Those below the poverty line are much more likely to be hospitalized than others. While the poor still depend on the public sector for the majority of their health services like antenatal care, immunization, institutional deliveries and hospitalization, they access the private sector much more for outpatient care (about 80 percent). While there are numerous quality concerns of public sector services, the private services that the poor access are generally of the lowest quality. Mostly the rich access the upper end of the costly private curative care—which is provided in facilities with higher standards.

A case study based on Delhi confirms the above findings (Gupta and Dasgupta 2000), and indicate that a greater percentage of high and middle-income households use government facilities, and a greater percentage of lower-income households use private facilities. Also, the lower income households are those with least insurance coverage and they are also seeking largely allopathic as well as institutional care (rather than indigenous practitioners). There is a more than 3 times difference between expenditure in private and public facilities, and even the public facilities are not as inexpensive as one would think.
All the above findings indicate that the poor in India (a) have a higher burden of disease, (b) the poor are less likely to get hospitalized than the rich, (c) have lower access to health services, (d) access the more expensive private sector for curative care, (e) have least insurance, and (f) are more likely to fall into further poverty due to health related expenditures. Also, the public spending on health is least likely to favour the poor.

The conclusion seems to be that the national health policy of India has not been able to meet one of its main objectives: equity in health care financing and access to health care. With increasing privatization of both health services and insurance, these trends are likely to worsen in future. The seriousness of the situation has to be understood by policymakers, because if a large majority of the population is left out of the gains of development, including better and more sophisticated health care, this can only give rise to more discontent and discord.

Since health care is an essential expenditure, and is also an investment both at the individual and national level, the failure to provide access to adequate care will also lead to a less productive working population, and future higher costs of treatment and illness. While weak government financing at the central and state levels is certainly a big constraint, there is an urgent need to look at the usefulness and efficiency of the current levels of spending on health. A system which spends the majority of funds on salaries and remuneration - leaving little scope for fresh investment - needs an urgent review. There is also the need to use sharper targeting tools, so that subsidized care reaches only those who deserve it. A greater involvement of non-government organizations (NGOs) and more public-private partnerships at the local levels might overcome some of the targeting problems.

Given this background, social health insurance takes on an even greater urgency, because this is one option that will ensure a more equitable health system in the country. As will be discussed later, social health insurance in India is constrained by the fact that most of the work force is in the unorganised or informal sector – the share of organized or formal sector is only about 8 percent of the labour force in India. This feature has also been a constraint in extending other social security benefits to the population at large.

In the next section, we discuss the development of social security and insurance mechanisms in India. Section 3 discusses compulsory health insurance schemes that exist today, and in Section 4 we discuss voluntary but state sponsored/ supported health insurance mechanisms. Section 5 briefly presents the state of commercial health insurance schemes, and Section 6 presents an overview of community insurance schemes in India. Section 7, 8, 9 and 10 discuss other non-health social security and welfare schemes that exist in India, to better understand the context in which to discuss the role of health insurance. Finally, Section 11 presents a critical
analysis of the health insurance set up and proposes some recommendations that can be considered to extend social health insurance in India.


The social security programmes in India were visualized based on the Directive Principles of State Policy, which inter-alia, enjoins upon the State to strive to promote the welfare of the people by securing and protecting, a just economic and social order. With the ratification of many of the ILO Conventions, the provision of social security has taken on a more urgent dimension. Social security is based on the recognition of the fundamental social right guaranteed by law to all human beings who live from their own labour and who find themselves unable to work temporarily or permanently for reasons beyond their control. The state, as an agent of change, has to develop a system of providing protection to its labour through a legislative, as well as an administrative mechanism, so as to provide responsive, efficient, and long term assistance to its work force. A series of Acts were passed over the years to ensure greater social security to various vulnerable groups, including one major Act covering health services for the poor – the Employees State Insurance Scheme. The principal social security laws enacted centrally are the following:

- The Employees’ State Insurance Act, 1948 (ESI Act)
- The Workmen’s Compensation Act, 1923 (WC Act)
- The Employees’ Provident Funds & Miscellaneous Provisions Act, 1952 (EPF & MP Act)
- The Payment of Gratuity Act, 1972 (P.G, Act)
- The Maternity Benefit Act, 1961 (M.B. Act)
- The Minimum Wages Act 1948

In addition to these Acts, the government has been extending assistance/subsidy for both health and other requirements of indigent and vulnerable populations from time to time, and some major initiatives at both the central and state levels now exist in India. This form of assistance has taken many forms such as direct subsidy, subsidy by payment of premiums of standard insurance products and collaboration with non-government organisations to extend assistance. (Ministry of labour, 2002)

While the bulk of the governments’ efforts are on social security/welfare for those who need it most, the government has also extended health benefits to its employees in the form of social insurance through one major scheme – the Central Government Health Scheme.
There is also the significant presence of the private commercial insurance sector, both for health and non-health insurance products. This sector has shown a rapid increase in the recent past. Finally, India has seen a fairly impressive growth of community-based schemes, both health and non-health, which has happened mainly in response to the continuing needs of the population for security of all forms - economic and health.

Figure 1 gives a typology and lists all the schemes that have been studied in this analysis under the various categories. The categories considered here are health and non-health. Under health, two types of schemes have been considered – compulsory and voluntary. Similarly, the same classification has been followed under non-health schemes. Under voluntary schemes for both health and non-health products, further three-way classification has been done - state sponsored, commercial and community based. In Figure 2, the major characteristics of each of these types of schemes are listed to better understand the design and differences of each.

Figure 1. Typology of health and non-health insurance/welfare schemes in India
3. Compulsory Health Insurance Schemes

There are essentially two compulsory health insurance schemes in India. These are the Employees State Insurance Scheme and the Central Government Health Scheme.

**Employees State Insurance Scheme**

The promulgation of the Employees’ State Insurance Act, 1948 envisaged an integrated need-based social insurance scheme that would protect the interest of workers in contingencies such as sickness, maternity, temporary or permanent physical disablement, and death due to employment injury resulting in loss of wages or earning capacity. The Act is also designed to also guarantee reasonably good medical care to workers and their immediate dependants.

Following the promulgation of the ESI Act, the central government set up the ESI Corporation to administer the Scheme. The Scheme, thereafter ESIS, was first implemented at Kanpur and Delhi in February, 1952. The Act absolves the employers of their obligations under the Maternity Benefit Act, 1961 and Workmen’s...
Compensation Act 1923. The benefits provided to the employees under the Act are also in conformity with ILO conventions.

The ESI Act 1948 applies in the first instance to non-seasonal factories using power and employing ten or more persons and non-power using non-seasonal factories and establishments employing twenty or more persons. The Act contains an enabling provision under which the “Appropriate Government” is empowered to extend the provisions of the Act to other classes of establishments - industrial, commercial, agricultural or otherwise. Under these provisions, most of the state governments have extended the ESI Act to certain specific classes of establishments such as shops, hotels, restaurants, cinemas etc employing 20 or more persons.

The Act extends to the whole of India and the administration of the ESI scheme is the responsibility of an autonomous body - the ESI Corporation (ESIC). The Ministry of Labour is the concerned Ministry that oversees the operation of the corporation. The corporation is chaired by the Union Minister for Labour, and the Labour Secretary is the Vice Chairperson. The other members are from central and state governments, employers and employees organizations, medical profession and the Parliament.

The ESIS currently covers about 8,500,000 insured members, with a total of about 32.9 beneficiaries. The employers and employees contribute 4.75 percent and 1.75 percent respectively of their wages.

The regular pre-payment arrangements, with compulsory employer-employee contributions and earmarked deductions on the one hand, and the fact that this scheme has been set up as part of the social security net, makes this a typical social health insurance scheme, and the only one that fully qualifies as such in India. However, many analyses have revealed that the ESIS system suffers from numerous quality issues (Gumber 2002, Lawyers Collective Newsletter, 2003) including non-availability of drugs, waiting time and poor services.

**The Central Government Health Scheme (CGHS)**

The CGHS was started in 1954 in Delhi with the objective of providing comprehensive medical care facilities to the central government employees (active and retired) and their family dependents. Besides central government employees, the scheme also provides services to (i) members and ex-members of Parliament, (ii) judges of the Supreme Court and High Court (both sitting and retired), (iii) freedom fighters, (iv) central government pensioners, employees of semi-autonomous bodies/semi-government organizations, (v) accredited journalists and (vi) Ex-Governors and Ex-Vice Presidents of India. In addition, employees of the Accountant General of India are being provided these benefits in a few cities.
Contributions range from Rs.15 to Rs.150 per month to become a cardholder. The number of cardholders currently is 983,243 and the total number of beneficiaries is 4,327,014. It is important to remember that there is no fixed contribution from the government and the scheme is run as a benefit given to the employees. In other words, the government bears the cost of provision almost entirely, with only nominal contribution from the beneficiaries.

The health services are provided to the beneficiaries through health centres, polyclinics and government/recognized hospitals and cover out-patients facilities under all systems of medicine, emergency services in the allopathic system, free supply of necessary drugs, laboratory and radiological investigations, domiciliary visits to seriously ill patients, specialist consultations both at the health centre and hospital level.

The scheme was initially started in Delhi, and subsequently extended to 23 cities. This scheme has all the important features of SHI, except that individuals can opt out of the scheme. In reality, however, such attrition is low.

For those not covered under the CGHS, the All India Services (Medical Attendance) Rules, 1954 applies. Since this is an important rule, below it is explained in some detail, based on the information provided by the Ministry of Personnel Public Grievances and Pensions.

Under this Rule, the government defines "Contributory Health Service Scheme" as any approved scheme of free medical attendance and treatment of servants of the Government and the members of their families in return for such monthly contribution by every Servant of the Government as may, from time to time, be determined by the Government.

"Government" means in the case of a member of the Service serving in connection with the affairs of the Union, the Central Government, and in the case of a member of the Service serving in connection with the affairs of a State, the Government of that State: Provided that a member of the Service serving in connection with the affairs of a State falls ill in some other State the Government of that other State shall be deemed to be the Government for the purpose of clause

"Member of the Service" means a member of an All-India Services as defined in section 2 of the All India Services Act, 1951, (61 of 1951). It is not clear what the total number of beneficiaries covered under this scheme is, but information on the scheme needs to be considered within the health insurance scenario in India.

As in the case of ESIS, the CGHS has also been plagued by numerous quality issues and is not very popular among its beneficiaries, except for hospitalisation.
In addition to the contributory schemes mentioned above – which meet the classic definition of social health insurance - there are several health benefit schemes running for different groups of employees in the government sector. For example, railways, defense, mining and plantation workers are covered fully by health benefits offered by these organisations. Each of these benefit schemes is backed by their own health care infrastructures meant exclusively for the workers in that sector. The public sector undertakings like Oil and Natural Gas Commission and the Steel Authority of India also have their own facilities meant exclusively for their employees and their dependents.

4. Voluntary State Sponsored/Supported Health Insurance Mechanisms

The government – both at the centre, state and local – has been an active participant in many ways to support different schemes of health coverage in India. These schemes are voluntary in nature and the government subsidizes the premiums. It is again difficult to collect accurate information from every state on each such scheme. Some details on selected schemes on which information could be gathered are given below, with the caveat that it is entirely possible that more such schemes may be running at present in India.

(1) The Government of Jammu and Kashmir has offered to cover every government employee and three dependents by an Employees Group Mediclaim Policy offered by the National Insurance Company. A premium of Rs. 1400 has been fixed, and the governments of Jammu and Kashmir pay a subsidy for the first year of Rs. 700 and Rs. 350 depending on the type of employee for a sum insured of Rs. 300,000 per family unit on a floater basis.

(2) Goa is providing financial assistance for availing tertiary care. Treatment to individuals whose income is less than Rs. 150,000. Government has also enhanced the amount to the extent of Rs. 300,000 in the super specialized categories such as cancer, kidney transplant, neurosurgery and open-heart surgery including post-operative care. It is proposed to introduce a system of compulsory registration of beneficiaries with a payment of a nominal fee of Rs. 100/- per member of the family. More than one thousand beneficiaries have already received care through the scheme with benefits of up to Rs. 60,000,000 during 2002-03 and during 2003-04, Government has spent Rs. 60,000,000 up the end of December 2003 and 740 beneficiaries have availed this facility.
(3) National Maternity Benefit Scheme (NMBS) under the National Social Assistance Programme of the government. Under this, cash assistance of Rs.500 is provided to women in households with incomes below the poverty line and 19 years of age and above, up to the first two live births.

(4) Universal Health Scheme for BPL (below poverty line) population: under this scheme, explained in more detail below, the government provides a Rs. 100 per year subsidy for BPL population.

(5) Centrally sponsored Thrift Fund Scheme for handloom weavers: the member contributes 8% of wages or income and the Central and the State governments contribute 4% of wage to the Fund.

(6) Welfare Funds for Limestone & Dolomite Mine workers, Iron ore, Chrome ore & Manganese ore Mine workers, Mica Mine workers & Cine workers, Beedi workers: purchase of spectacles to mine and beedi (indigenous cigarette) workers, reservation of beds in tuberculosis hospitals, treatment and subsistence allowance in case of tuberculosis, reimbursement of expenditure upto Rs.100,000 for heart disease and kidney transplant, maternity benefits at Rs.500 per delivery to a female beedi worker for first two deliveries and assistance for family welfare. The collection is through a tax on mica export, export of iron ore, internal consumption of iron ore, manganese ore and chrome ore as well as limestone and dolomite. The welfare fund for beedi workers is being financed by at Rs.2 per thousand manufactured beedis.

(7) Mathadi Workers Boards scheme: Diagnostic services such as radiology, pathology and ultrasound and health care from 12 health centres and two hospitals. Boards contribute 2 percent of their levy and each worker contributes Rs.20 per month.

A very special case of government support is when a community insurance scheme is subsequently subsidized by government, either by subsidizing the premiums or by subsidizing other operational elements of the scheme. Below, we list two such schemes, but there may be other community insurance schemes that are also supported by government.

(1) Rag Pickers’ Insurance: this scheme started in Pune covers rag pickers with the Municipal Corporation of Pune contributing fully the premium on behalf of the rag pickers. The scheme is the Jan Arogya policy offered by New India Assurance Company.

(2) Karuna Trust community insurance scheme in Karnataka: here also the government of Karnataka has assured support in the form of payment of premiums to vulnerable groups. The product is again a tailor made
These examples indicate the states' willingness to bear part of the burden of health and related expenses in the form of either premium or contribution to a pool or waiver of fees, or burdening other operational costs.

5. **For-profit Commercial Health Insurance**

While the private health insurance market in India is still relatively untapped, there has been a significant expansion in private insurance since the Privatization Bill on the insurance sector was passed.

To give a brief background, the Insurance Regulatory and Development Bill, which was passed in the Parliament in January 2000, allowed the insurance sector to open up to private players. The Insurance Regulatory and Development Authority, IRDA, is the government agency that has been created to ensure that the insurance sector operates in a fashion that is consistent with the interest of the consumers. The General Insurance Company (GIC) was converted into India's national reinsurer from December 2000, and all the four subsidiaries working under the GIC umbrella were restructured as independent insurance companies. The Indian Parliament cleared a Bill in July, 2002 de-linking the four subsidiaries from GIC. A separate Bill has been approved by Parliament to allow brokers, cooperatives and intermediaries in the sector.

In addition to the four public sector general insurance companies and Life Insurance Corporation, India now has 13 life and 9 non-life insurers in the private commercial sector. In addition, Third Party Administrators (TPAs) have been allowed to operate in the health insurance market to facilitate cashless transactions and smooth administrative functioning of the insurance market. Health insurance premiums in India have risen from Rs.5,310 million (or USD 117 million at current rates) in 2000-01 to Rs.1,045 (about USD 231 million) during 2002-03, which includes Overseas Medical Policies (IRDA Journal 2003). This is impressive and indicates that there is probably going to be continuous growth in the health insurance market in the near future.

The major share of the health insurance market is of Mediclaim, the standardized product offered by the four public sector companies, National Insurance, New India Assurance, Oriental Insurance and United India Insurance.

The Mediclaim scheme was till recently a reimbursement policy covering hospitalization and domiciliary hospitalization for a pre-specified period. There are additional features, such as reimbursement of the costs of medical examination, a
Selected Case Studies from Asia and the Pacific

An insured person can choose a sum insured between Rs. 15,000-Rs 500,000. Mediclaim excludes care for pre-existing diseases, HIV/AIDS, dental care and pregnancy related conditions.

The private commercial insurance companies are at present only 10-15 percent of the total health insurance market. The products that they offer are similar to Mediclaim, and a few companies offer comprehensive products combining life and health insurance.

In addition to Mediclaim and the private health insurance products, another policy offered by National Insurance Company and Life Insurance Corporation (LIC) of India is the Critical Illness Policy. For example, the Critical Illness Policy offered by the National Insurance Company is an exclusive benefit policy for individuals in the age group 20-65 years. The scheme covers critical ailments, including Coronary Artery Surgery, Cancer, Renal Failure, Stroke, Multiple Sclerosis, major organ transplants like kidney, lung, pancreas and bone marrow. A similar policy, Asha Deep, is offered by LIC. Among the private sector companies also, several companies offer either stand alone or composite critical illness policies.

Finally, as mentioned above, the public sector insurance companies have introduced a Community-based Universal Health Scheme, with elements of subsidy for below-poverty-line (BPL) population. Under this scheme, premiums of Rs 1 per day per individual and Rs. 1.50 for a family of five, and Rs. 2 for a family of 7 have been fixed. This allows (a) reimbursement of medical expenses up to Rs. 30,000 towards hospitalization (b) cover for death due to accident for Rs. 25,000 and (c) compensation due to loss of earnings at the rate of Rs. 50 per day up to a maximum of 15 days.

6. Voluntary Community Based Health Insurance Schemes

Despite the myriad schemes described above, there continues to be a significant gap between the needs of the population for health cover and what actually exists by way of such cover. To fill this gap, different NGOs and community-based organizations have come forward with their own schemes, catering to a wide range of populations and their needs. In a country the size of India, it is not possible to list in a comprehensive manner all the schemes currently run by different organizations in different states. This exercise, however, is urgently needed for getting the complete picture of health coverage in India.

In this report, we have analysed 16 schemes in different parts of the country. Table 5 below indicates the salient features of these schemes.
Table 5. Salient features of selected community health insurance schemes in India

<table>
<thead>
<tr>
<th>Scheme/Characteristics</th>
<th>State of operation</th>
<th>Services covered</th>
<th>Beneficiary</th>
<th>Premium structure</th>
<th>Insurance coverage</th>
<th>Insurance company</th>
<th>Service provision by the NGO</th>
<th>Co-payment</th>
<th>Donor for the scheme</th>
</tr>
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<tbody>
<tr>
<td>AKHS, Ahmedabad</td>
<td>Gujarat</td>
<td>Registration and Consultation for any diseases any time, Yearly check up - Diabetes, Hypertension,</td>
<td>Members of Dairy cooperative</td>
<td>No direct premium, 6 paise per liter of the milk is being calculated.</td>
<td>Health</td>
<td>Yes, OPD only</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vimo SEWA, Ahmedabad</td>
<td>Gujarat</td>
<td>Hospitalization expenses with an upper limit (Additional benefits of Maternity cover, Denture and Hearing Aid at subsidized rate for Fixed Deposit members)</td>
<td>SEWA union members - Urban and Rural, their husband and children</td>
<td>Vimo SEWA has 3 schemes under the integrated package</td>
<td>Composite ICICI Lombard and National Insurance</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribhuvandas Foundation, Anand</td>
<td>Gujarat</td>
<td>Members of TF are covered for primary care and secondary care at their sub centers, hospitalization at any of the eight empanelled trust hospitals.</td>
<td>All families that are pouring milk at dairy cooperatives, irrespective of the amount of the milk.</td>
<td>Rs. 25/year/family for the membership of TF and pouring of minimum 300 liter milk/year for SPAM membership. The services of TF sub centres can availed by nonmembers at Rs. 10/year/family.</td>
<td>Health</td>
<td>Yes, OPD only</td>
<td>No</td>
<td></td>
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<tr>
<td>BAIF, Pune</td>
<td>Maharashtra</td>
<td>Hospitalisation (Inclusive of maternity extension) UP TO Rs. 5,000 Natural death Rs. 20,000 Death due to accident Rs. 50,000 Partial permanent disability Rs. 25,000 Total permanent disability Rs. 50,000 Annual health examination</td>
<td>Members of Self Help groups of BAIF, Individuals coming from a family having annual income considered as BPL or marginally above it.</td>
<td>Rs. 225 for SHG member and Rs. 260 for others. (The additional benefits like, concession at the health facilities and loan for hospitalization, can not be extended to non-SHG members)</td>
<td>Composite UIIC</td>
<td>No</td>
<td>No</td>
<td></td>
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<tr>
<td>Rag Picker's insurance scheme, Pune</td>
<td>Maharashtra</td>
<td>Hospitalisation, Standard jan Arogya policy coverage with an upper cap and life cover</td>
<td>Rag Pickers, kabadiwala, Dabbabatiwalah, Membership fees - Rs. 25 and LIC premium Rs. 25. Age below 45 - Rs. 70 46-55 - Rs. 100 56-65 - Rs. 120 66-70 Rs. 140, Paid by Municipal Corporation Family floater: Same premium for spouse and 50% for a child.</td>
<td>Composite New India assurance Co. Ltd</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Scheme/Characteristics</td>
<td>State of operation</td>
<td>Services covered</td>
<td>Beneficiary</td>
<td>Premium structure</td>
<td>Insur-ance coverage health/Composite</td>
<td>Insur-ance company</td>
<td>Service provision by the NGO</td>
<td>Co-payment</td>
<td>Donor for the scheme</td>
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<tr>
<td>CASP, Pune Maharashtra</td>
<td>Hospitalization (Up to Rs. 16000), Domiciliary treatment (Up to Rs. 4000)</td>
<td>Needy and school going children and their families</td>
<td>Rs. 330 per family of a child, parents and two siblings</td>
<td>Health</td>
<td>New India Assurance Co. Ltd.</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>Community Assisted &amp; Financed Eye Care – Pilot Project, L.V. Prasad Eye Institute, Hyderabad Andhra Pradesh</td>
<td>Complete eye examination &amp; Cataract surgical service and other secondary level eye care and minor surgical services.</td>
<td>All individuals pertaining to rural areas of selected villages in the adopted areas.</td>
<td>Rs1/person/month on yearly basis.</td>
<td>Health</td>
<td>-</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Seba Cooperative Health Society Ltd, Kolkata West Bengal</td>
<td>Seba hospital is general hospital with 36 beds (6 ICU beds), OPD, specialty clinics, pathology, X-ray, USG, ECG, Echocardiography, Dental, GP clinic, Emergency, Ambulance and domiciliary services at night.</td>
<td>Middle - High-income group of people both rural and urban - Mediclaim scheme. Also open to patient not under Mediclaim.</td>
<td>Mediclaim and group Mediclaim - prescribed premium, - One time payment depending on the age of enrollment</td>
<td>Health</td>
<td>GIC group (National)</td>
<td>Yes, OPD and Hospitalisation</td>
<td>No</td>
<td></td>
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<tr>
<td>Student health home, Kolkata West Bengal</td>
<td>Free consultation across all the specialties @ Rs. 2 per day All diagnostic tests @subsidized rate Hospital facilities: Admission charges for medical investigation Rs. 25 Adm. Charges for surgical Rs. 75 Maintenance charges per day Rs. 10</td>
<td>Students</td>
<td>Universal subscription @ Rs. 4 p/year/ student Individual membership @ Rs. 60 p.a.</td>
<td>Health</td>
<td>yes, OPD and Hospitalisation</td>
<td>Yes</td>
<td>WB government</td>
<td></td>
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</tr>
<tr>
<td>Sri Mayapur Vikas Sangha, Mayapur West Bengal</td>
<td>Standard cover - Jan Arogya policy</td>
<td>Poor marginalized women self help group members and their family members</td>
<td>Age below 45 - Rs. 70 46-55 - Rs. 100 56-65 - Rs. 120 66-70 Rs. 140, Family floater: Same premium for spouse and Rs. 50 for a child</td>
<td>Health</td>
<td>Oriental Insurance Co. Ltd.</td>
<td>No</td>
<td>No</td>
<td>UNDP</td>
<td></td>
</tr>
<tr>
<td>Scheme/Characteristics</td>
<td>State of operation</td>
<td>Services covered</td>
<td>Beneficiary</td>
<td>Premium structure</td>
<td>Insurer/coverage</td>
<td>Service provision by the NGO</td>
<td>Co-payment</td>
<td>Donor for the scheme</td>
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<tr>
<td>Surul Health cooperative</td>
<td>Karnataka</td>
<td>Insured amount for Hospitalisation Rs.2500/- per year Rs.50/- per day as wage loss Rs.50/- per day for hospital for all services – no prescriptions to be given (The public health facilities should be used. Private health services are not covered) Ambulance services and referrals (to district hospitals / state level tertiary center) included</td>
<td>Population of the T Narasipura taluk in Mysore district and Bailhongal taluk in Belgaum district, focusing mainly on BPL and SC/ST population</td>
<td>Rs. 30 per person per annum for general population in the case of SC/ST and BPL population, the premium would be fully subsidized from the project funds and the person insured would not have to pay any amount. In the case of BPL and non-SC/ST population, the premium would be subsidized to the extent of Rs. 10 from the project funds and the person insured would have to pay the balance amount</td>
<td>Health</td>
<td>National Insurance Co. Ltd</td>
<td>No</td>
<td>No</td>
<td>UNDP</td>
</tr>
<tr>
<td>Karuna Trust, Mysore</td>
<td>Karnataka</td>
<td>Surul Health cooperative</td>
<td>Surul Health cooperative</td>
<td>Surul Health cooperative</td>
<td>Surul Health cooperative</td>
<td>Surul Health cooperative</td>
<td>Surul Health cooperative</td>
<td>Surul Health cooperative</td>
<td>Surul Health cooperative</td>
</tr>
<tr>
<td>BUCCS (Buldhana Urban Co-Operative Credit Society ) Health Insurance Scheme, Buldana</td>
<td>Maharashtra</td>
<td>Accidental death of member Rs. 25,000 If member is hospitalized for more than 3 days at a time Rs. 50/- per day up to Rs. 750/- (i.e. 15 days) Hospitalization for member and family (for one illness maximum limit Rs 15,000 with internal sub limits on various expenses) Rs. 30,000</td>
<td>Rural population of Buldana district, mostly farmers</td>
<td>Individual: INRs 365/- Family of 5 (husband, wife, three children): INRs 546/- Family of 7 (husband, wife, 3 children and insured’s parents): Rs 730</td>
<td>Composite</td>
<td>United India Insurance Co. Ltd</td>
<td>No</td>
<td>No</td>
<td>Basic Health Programme, GTZ</td>
</tr>
</tbody>
</table>
Based on the analysis of these schemes, we can broadly classify them along the following lines:

1. What is the genesis of the scheme?
2. What is the entry point of beneficiaries into the insurance scheme?
3. Is it a prepayment scheme?
4. Is the payment always monetary or also in kind?
5. Integration of other non-health services with health services? Does the membership also bring with it other benefits?
6. Are the health services provided within the organization that administers the scheme or are de-linked and provided by providers not connected in any way to the prepayment organization?
7. Are there co-payments at the point of service delivery?
8. Is the insurance done by the organization itself or by a professional insurance company? In other words, are the risks borne by the organization or an insurance company?
9. Is the scheme dependent on external sources of funding for its routine operation?

The analysis revealed a rich range of variation of schemes along these lines. Health has often been not the primary objective of the NGO activity or even the community group formation, but came because of a felt need of a group that was formed for some other reason. A good example is Tribhuvandas Foundation, which could mobilize groups on the basis of dairy activities, but subsequently incorporated health financing as another activity. In other examples, like Seba Hospital in Kolkata, the hospital management saw the need for insurance in their patients seeking care at their hospital, and decided on health insurance as a response to this need. In other places, self-help groups (SHG), especially of women, were formed in response to needs of women, and often an important activity of such groups was micro credit. From this evolved a need for financing health care and examples of successful SHGs getting into health insurance are Vimo SEWA in Gujarat, Mayapur Vikas Sangha in West Bengal and BAIF in Pune.

While all the schemes surveyed are based on pre-payment ones, the mode of collection as well as the administration and other details differ. One major difference has been presence or absence of a formal insurance company in the basic design of the scheme. There were several cases of successful collaboration with mostly one of the public sector companies, and the examples include SEWA, Karuna Trust, Mayapur, West Bengal and BAIF.

Almost all the schemes were created in response to the needs of the most economically vulnerable population of the area. To that extent the enrollment had an
inherent bias towards those with lower ability to pay. This also implied the need for more flexibility in the premium and payment structure, which seems to have been one of the most important positive points that emerged from the analysis. The four public sector insurance companies have been able to change their earlier inflexible image since the privatization of the insurance sector, and are now seen as important partners helping NGOs and CBOs in formulating tailor-made schemes on health insurance in response to the needs of the vulnerable population.

However, one inherent problem of the various schemes continues to be the financial sustainability over the years. The dependence on outside funding or subsidies seems to be a real felt need, especially in areas where the size of the coverage is not too large for effective risk and income pooling. It is safe to say that the larger the pooling, the higher is the probability of self sustainability, and lower the need for dependence on outside funding. On the administrative side, the ability of some communities to mobilize enough members may be linked to success, as reflected by schemes which benefited from the formation of SHGs. If however, size is a problem, then the scheme is limited by the ability of the organizers to get the general population into the scheme, which is always a challenge. However, as mentioned before, for schemes like Student Health Home of Kolkata, size is not a problem but the paying ability of the student population is very low, implying that subsidized care will continue to strain the resources unless a fresh infusion of funds comes in from time to time.

While it is not easy to hazard a guess as to what percentage of population is covered by these various community schemes, it is clear that these are fulfilling a felt need in many of the communities in the country, and are therefore playing an important role in making health care more affordable and accessible.

More discussion on the role of CHIs will be done later under the critical analysis of the entire system of insurance in India.

7. Compulsory Non-health Social Security/Welfare Schemes

As mentioned above, there are a few major social security laws enacted in India. These details of social security provided under these Acts are given below, excluding ESI, which has already been discussed above.

The Workmen’s Compensation Act, 1923 (WC Act)

The Act provides for payment of compensation to the workers and their dependents in case of accidents (including certain occupational disease) arising out of and in the course of employment and resulting in disablement or death. This applies to railway
servants and persons employed in any such capacity as is specified in Schedule II of the Act. Schedule II includes persons employed in factories, mines, plantations, mechanically propelled vehicles, construction works and certain other hazardous occupations. Minimum rates of compensation for permanent total disablement and death have been fixed at Rs. 90,000 and Rs. 80,000 respectively. Maximum amount for death and permanent total disablement can go up to Rs. 456,000 and Rs. 548,000 respectively depending on age and wages of workmen.

The Employees’ State Insurance Act, 1948 (ESI Act)

The Employees’ Provident Funds & Miscellaneous Provisions Act, 1952 (EPF & MP Act) (Separate provident fund legislations exist for workers employed in Coal mines and tea plantations in the state of Assam and for seamen).

This Act is applicable to 180 specified industries/classes of establishments and is applicable to every establishment that is engaged in any one or more of the industries specified in the Act or any activity notified by central government in the Official Gazette, and employing 20 or more persons. Employees getting wages up to Rs. 6500 per month is required to become a member. The current membership is 26,300,000. The employers and employees contribute 12 percent each of the basic wages, dearness allowance, and retaining allowance.

The Maternity Benefit Act, 1961 (M.B. Act)

The Maternity Benefit Act, 1961 regulates employment of women in certain establishments for a certain period before and after childbirth and provides for maternity and other benefits. The Act is applicable to mines, factories, circus industry, plantation, shops and establishments employing ten or more persons, except employees covered under the Employees’ State Insurance Act, 1948. It can be extended to other establishments by the State Governments. There is no wage limit for coverage under the Act.

The Payment of Gratuity Act, 1972 (P.G. Act)

The Payment of Gratuity Act, 1972 applies to factories and other establishments employing 10 or more persons. On completion of five years service the employees are entitled to payment of gratuity of 15 days wages for every completed year of service or part thereof in excess of six months subject to the maximum of Rs.3.50 lakh. The current maximum limit is applicable from 24.9.1997. The wage ceiling for coverage under the Act was removed in 1994.
Minimum Wages Act 1948

The wage policy for the unorganised sector, secured mainly through the Minimum Wages Act, 1948, is oriented towards providing a ‘Need-based Minimum Wages’. In the unorganised sector, the wages are fixed under this Act. Both the state and the central governments are appropriate governments for fixation/revision of minimum rates of wages in the scheduled employments falling in their respective jurisdiction.

8. Voluntary State Sponsored/Assisted Non-Health Social Security/Welfare Schemes

In addition to these Acts mentioned above, the central and state governments have launched several schemes designed for different segments of the population. These schemes are voluntary in nature and the government subsidizes the premiums. Below we list the schemes that are in the nature of welfare and are linked to insurance companies:

Programmes with links to voluntary prepayment schemes

- **Janashree Bima Yojana** covers death other than by accident (Rs. 25000 is payable), death/total permanent disability due to accident (Rs 50,000 is payable), and permanent partial disability due to accident (Rs. 20,000 is payable). So far 1,1580,000 persons have been covered under the scheme. The premium under the scheme is Rs.200/- per annum per member. Fifty percent of the premium i.e. Rs.100/- will be contributed by the member and/or Nodal Agency/State Government. Balance 50 percent will be borne by the Social Security Fund. This scheme covers workers in specified industry like textiles, printing etc.

- **Krishi Shramik Suraksha Yojana 2001**: this covers death, disability and survival benefits for specific agricultural workers. The member will pay Rs. 365/- per annum, payable quarterly/half yearly/yearly. Double the amount will be contributed from the Social Security Fund.
  - **Death**: On death before age 60: i) Payment of sum assured of Rs. 20,000/- along with return of accumulated amount with interest to the nominee. ii) Payment of an additional sum assured of Rs. 30,000/- in case of death due to accident, along with return of accumulated amount with interest to the nominee.
  - **Disability**: On disability due to accident before age 60 (i) In case of total permanent disability i.e. loss of two eyes or two limbs of use or
one eye and one limb of use, Rs. 50,000/-. (ii) In case of partial permanent disability i.e. loss of one eye or one limb of use Rs. 25,000.

- **Survival Benefits:** Lump Sum Survival benefits will be provided at the end of every 10th year after entry into the scheme till the member attains 60 years of age. The lump sum amount will depend upon the accumulation in his/her account. Further, lump sum benefit will be paid only if the membership is in force.

- **Pension:** Pension will be paid to the member on reaching age 60. The amount of pension will depend upon the accumulated balance in his account and the annuity rates at that time. Further, if member has paid for a minimum period of 10 years, then at least Rs. 100/- per month pension will be payable.

- **Varishtha Pension Bima Yojana:** This provides pension during the lifetime of the pensioner in the form of a savings scheme with 9 percent interest. In the event of unfortunate demise of the pensioner, purchase price will be returned to the nominee/legal heir of the pensioner. There is also an exit option available after 15 years. Loan facility available to the extent of 75% of purchase price after 3 years.

9. **Voluntary (Private) Commercial Non-Health Insurance Schemes**

- **Mother Teresa Women & Children Policy** covers Death/Disablement arising out of accident and also during childbirth at hospital, and surgical operation such as sterilization, caesarean, hysterectomy and removal of breast due to cancer. The premiums are Rs.15 per woman per annum for the basic cover and Rs. 23 per woman per annum for both basic and additional cover provided that it occurs within 7 days from the date of operation. All sections of women in the age group of 10 - 75 years irrespective of their income, vocation or occupation can be covered in this policy.

  - For Disablement of Insured women, the sums are: permanent total disablement Rs.25,000, loss of two limb/both eyes/one limb and one eye Rs.25,000, loss of one limb/one eye Rs.12,500.

  - For death: For married women the policy provides compensation of Rs.25,000 in the event of death of husband due to accident. For unmarried women, the policy provides compensation of Rs. 25,000 in the event of death of the insured to the nominee/legal heir.
• Additional cover: Temporary Total Disablement - Rs.500- per month subject to a maximum of Rs. 1,500.

- Raja Rajeshwari Mahila Kalyan Yojna Policy: this is very similar to the Mother Teresa policy described above.
- Both the private as well as public sector undertakings offer a range of disability covers with varied characteristics.

10. Voluntary Community Based Non-health Insurance Schemes

As in the case of community health insurance, many NGOs offer a range of non-health services including livelihood activities, pension, disability, income loss etc. Many of these are offered by the NGOs offering health products or financing and are tailor made to suit the needs of the community. These are most often than not, offered in the rural area to vulnerable populations. As in the case of CHI, it is extremely difficult to estimate the size of the population covered by such schemes, but the proliferation of NGOs offering a range of services around the country is an indication of the importance of these activities in the areas they are being offered.


There are several questions that can be raised around the issue of health insurance in India.

- Is the current division among SHI, private insurance, CHI and other forms of coverage optimal?
- Are the issues around access, availability and quality of health services similar across these different kinds of insurance schemes?
- Does India have any scope to extend social health insurance given the existing status of employment and the labour force?
  - What is the percentage of current SHI coverage?
  - What can be the target coverage?
  - What are the constraints in scaling up?
The above analysis indicates that in India, unlike other countries in this region, there are numerous schemes running in different parts of the country, documentation of which is a daunting task. The variation across states is not trivial and it is very difficult to generalize on the basis of a few examples.

Table 6. Health insurance coverage in India for selected schemes

<table>
<thead>
<tr>
<th>Schemes</th>
<th>Beneficiaries (in million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Employees State Insurance Scheme (ESIS)¹</td>
<td>25.3</td>
</tr>
<tr>
<td>Central Government Health Scheme (CGHS)²</td>
<td>4.3</td>
</tr>
<tr>
<td>Railways Health Scheme</td>
<td>8</td>
</tr>
<tr>
<td>Defense employees³</td>
<td>6.6</td>
</tr>
<tr>
<td>Ex-servicemen</td>
<td>7.5</td>
</tr>
<tr>
<td>Mining and plantations (public sector)⁴</td>
<td>4</td>
</tr>
<tr>
<td>Health insurance (Public sector non-life companies)⁵</td>
<td>10</td>
</tr>
<tr>
<td>Health insurance (Private sector non-life companies)⁥</td>
<td>0.8</td>
</tr>
<tr>
<td>Health segment of Life insurance companies (Public and private sector)²</td>
<td>0.23</td>
</tr>
<tr>
<td>State sponsored schemes</td>
<td>&lt;0.5</td>
</tr>
<tr>
<td>Employer run facilities/reimbursement schemes of private sector⁸</td>
<td>6</td>
</tr>
<tr>
<td>Employer run facilities/reimbursement schemes of public sector⁹</td>
<td>&lt;8</td>
</tr>
<tr>
<td>Community health schemes</td>
<td>3</td>
</tr>
</tbody>
</table>

¹ ESIS coverage as on March 20003
² CGHS coverage figures for 2003-04
³ These figures are based on data from Director General Employment and Training, Ministry of Labour. Approximately 10 million employees work in these two sectors of the government, as of March 2002.
⁴ The number of policies for Mediclaim is about 2 million, which would yield roughly 10 million lives covered. No firm estimates of this are as yet available in India.
⁵ The total number of lives covered has been calculated based on market share of private companies in the health business (premiums), since there is no other reliable estimate.
⁶ All riders related to critical illness benefit, hospitalization benefit and medical treatment.
⁷ Estimates are not available for this; private organized sector covered about 5.4 million employees in 2002. Using a factor of 4, roughly 35 million individuals and their families can potentially be covered. ESI covers about 25 million, and a gap of 10 million remains, of which many are covered under group medical insurance. Insurance companies cover about 11 million, and of these rough data indicate that about 40% is group policies (i.e. corporate sector); this implies about 4.4 million may be covered through insurance out of these 10 million individuals. Plantation and mining workers and their families in the private sector are covered by government regulations and amount to about 4 million individuals. This gives us a gap of 1.6 million. In the column, therefore, we have put a figure of 6 million, which is under the assumption that all of these 1.6 million people may be covered and adding the 4 million plantations and mining in private sector, and rounding off.
⁸ Public sector companies employ 2 million workers; if a family size of 4 is assumed, at most 8 million workers and their dependents can be covered. However, not all PSUs offer health benefits' coverage.
As Table 6 above on coverage (in addition to free or subsidized care at government facilities) indicates, health insurance of all forms still covers only a small percentage of the population and their families.

Broadly, there is only one nation-wide scheme that has the three most important features of social health insurance - compulsory contributions, earmarked taxes based on earnings and contribution from the employers. This is, of course, in addition to the pre-payment arrangement. Thus, ESIS is the only scheme that qualifies fully as a typical SHI. However, if we relax the definition to exclude fixed employer contribution, CGHS (including those who are covered under the Medical Attendance Rule) can still qualify as a SHI, since it has the other important characteristics of SHI. These are then the two most important schemes that cover most of the states of the country under a uniform administrative structure, and together cover about twenty percent of the organized sector population, including dependents. Overall, these schemes probably cover less than 3 percent of the population, though in the absence of firm numbers, these are the best guesses. None of the other schemes that exist in the country can qualify as social health insurance, so it is safe to say that social health insurance at present covers a very small percentage of the population.

As the table indicates, other schemes for government employees cover slightly less than 32 million individuals.

Additionally, private sector and public sector undertakings (PSUs) cover their employees, with health benefits in the form of either reimbursement, or employer managed health facilities. However, it is very difficult to get any reliable estimate of these numbers. It is estimated that PSUs are probably offering coverage to about 8 million individuals. Our calculations for the private corporate sector employer-owned facilities indicate that about 6 million individuals and their families may be currently covered (including 4 million in mining and plantation).

Another way of coverage is community health insurance offered by many NGOs with or without insurance companies. It is extremely difficult to estimate the coverage by community health insurance in India. Some estimates indicate that about 5 percent of the population may be covered by health insurance, which seems too high. Our best guess is that it cannot be more than about 1 percent, of which a substantial part is already covered in the table under insurance companies. Thus, approximately about 0.3 percent of the population may be covered by CHIs run solely by NGOs.

The rest of the population has recourse to the for-profit insurance products both in the private and public sectors depending on the ability to pay. Schemes offered by for-profit insurance companies in the government and the private sector cover an additional 4 million individuals approximately. This implies that a very small
percentage of the population – less than 1 percent - is covered by commercial health
insurance offered by public sector and private sector insurance companies.

If we add all these numbers and allow for some margin of error, the coverage
still adds up to about 85 million. This is less than 10 percent of the population, and
we are left with an uncovered gap of 90 percent.

Turning to the issue of accessibility, availability and quality of health care that
each of these insurance provides, as mentioned above, ESIS has long been plagued by
quality problems. The quality of the health facilities are often considered so low by
the insured population that patients prefer visiting private facilities rather than go to
the ESI facilities. The CGHS, which entitles beneficiaries to avail some pre-specified
facilities in the government sector, also has been criticized for poor quality of care.
Together, it is often argued that the ESIS and to a lesser extent the CGHS have not
been able to meet the standards of quality health care provision, and have together
resulted in beneficiaries switching to private providers.

This is in contrast to some of the targeted schemes, like those of the railways
and defense, that have developed their own health care facilities, and which seem to
be far superior to the ESIS and CGHS facilities in terms of quality. This is also true of
the facilities in the public sector undertakings and private sector.

Finally, those who have private insurance can choose from a wide range of
facilities in the private sector.

The unevenness of quality across the different insurance schemes indicates one
major flaw in the current set up of insurance in India. A good health care system is
one that offers homogeneous and quality health care to all the population, at
reasonable price. A good health insurance system is one that is consistent with such a
health care system.

Broadly, the insurance system (outside private insurance) can be classified as
“single group – single choice”, “multiple group- single choice” and “multiple group –
multiple choice”. Here we are defining multiple group as a group that is pooled
across both income and risk categories. If the group is not pooled across either
income or risk, we are calling it single group.

The analysis indicates that ESIS – which is not pooled across income and does
not offer a choice of facility, is a “single group – single choice” product. CGHS pools
across both income and risks and also has some choice of facility and is therefore a
“multiple group - partially multiple choice” product. Finally, facilities like railways
and defense which offer health care to their employees are “multiple group – single
choice” models, because the pooling is across income categories, within the
organization.
From the point of view of insurance, the model that pools the most is good, and from the point of view of the consumer, a system that gives choice is superior. To that extent, it seems a fully “multiple group-multiple choice” system of insurance may be perceived as the best option to follow. The CGHS has choice only at the tertiary level, but not at the level of health centres and polyclinics. Also, even among the hospitals that are pre-approved, the quality is better in the private hospitals compared to the public hospitals. That is because the latter continue to cater to the less well-off which in turn results in a deteriorating quality.

What then is an optimal system of SHI to implement? A system that is truly “multiple group- multiple choice” should be able to pool across risk and income categories and give choice to consumers. The first part will ensure a feasible scheme and the last part will ensure a minimum standard of health care.

The recommendations therefore, based on the above analysis are the following:

- Ideally, extend SHI to all the workers in the organized sector: operationally, this may mean designing a product that is based on (a) prepayment (b) earmarked tax and (c) compulsory participation, and (d) employee contribution. Operationally, this may not happen and the consolidation may result only across some categories.

- From the supply of health care angle, this would also mean consolidation of the list of facilities where beneficiaries could go to avail of the services.

- Given that the health care systems managed under public organizations like the railways and defence are working well, it is unlikely that they would agree to merge with the rest of the system. Thus, a more practical suggestion at this point is to merge the central and state governments under one umbrella and extend ESIS to all employees and not merely those earning below a certain amount.

- One possible way of implementing a SHI is to tap the tax payment system, where an ear-marked SHI tax is paid with every tax return, based on earnings. Those who opt to pay the SHI tax will be entitled to a SHI card, which entitles them to services under the new unified scheme. This will ensure quality improvements, greater coverage, possible expansion of the tax paying base, and a higher incentive to join the SHI system. Those who opt out of the system can of course have recourse to private insurance and the private sector will continue to play a role as it does now. However, the role may be a more pruned one, and would cater to only those with higher than average ability to pay.
References

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8. IRDA Journal 2003
11. Manpower profile, India yearbook 2003, Institute of Applied Manpower Research 2004
1. Brief History of Health Insurance Development in Indonesia

Health care financing in Indonesia comes from the Ministry of Health budget, the Provincial and District health care budgets, the military health services budget, social health insurance corporations, private commercial health insurance, out-of-pocket payments, and foreign aid and loans. The private sector financing comes mainly from out-of-pocket payment by individuals or households in public and private health care facilities, employer coverage, and private insurance. The amount of money contributed by the private sector is not known since Indonesia does not have a reliable national health accounts system. However, recent studies indicate that the private sector contributes almost 80% of the health expenditures. According to the best estimates during the last ten years, public financing accounted only 23.7% of total health expenditure in 2000, down from about 30% five years earlier. With such a heavy dependence on private sources, and mainly as out-of-pocket health expenditures, health insurance mechanisms become viable alternatives.

The health insurance scheme for civil servants in Indonesia was first implemented in 1968. Before the establishment of the health insurance scheme, civil servants received reimbursement for their health care expenditures. Several pilot projects were undertaken by the Ministry of Health before the formal establishment of the health insurance fund (by Presidential or Government Decree). The scheme has evolved slowly but has continued to expand and to improve significantly, despite some problems and complaints by members. Currently the scheme covers comprehensive health benefits for civil servants and their families, and civil servants and military pensioners and their families.

This is the oldest and the largest formal health insurance scheme in Indonesia. The scheme applies a social health insurance mechanism and is currently administered by a state owned company, as a for profit company known as PT Asuransi Kesehatan Indonesia (ASKES, or Health Insurance Company of Indonesia). The “for profit” objective of the company is not consistent with the concept and the philosophy of social health insurance.
Through the promotion of Village Community Health Development (Pembangunan Kesehatan Masyarakat Desa), various community and voluntary initiatives of health care financing in small scale community health funds (dana sehat) have been formally introduced by the Ministry of Health since the early 1970s. Since Indonesia had never provided free health care for the population, voluntary initiatives by the community to share resources to pay for health care have evolved since the 1950s. These initiatives used various names, including such as sickness funds, health funds, cooperative health funds, (MOH, 1994a). One model was introduced with the assistance of a private foundation in Banjarnegara, Central Java. Other similar schemes followed in East Nusa Tenggara and in Bali and then in many other regions of the country. By 1994, such schemes were developed in 11,506 villages or 18.5% of the all villages in the country. The cash or in kind contributions collected by most of the funds were very small.

In addition, the community managed health care (Jaminan Pemeliharaan Kesehatan Masyarakat, JPKM), based on the health maintenance organization (HMO) model in the United States of America was also intensively encouraged by the Ministry of Health. The JPKM has been actively debated since the inception of the concept in the Health Act of 1992. The latter scheme is formal, in a way that the MOH set regulations on the benefits, premiums, and formal licensing mechanisms. The Ministry of Health (MOH) in 1999 set a vision of Healthy Indonesia 2010 by prioritizing JPKM as one of the four main elements for health sector development: healthy paradigm, professionalism, decentralization, and development of managed health care through JPKM (MOH, 1999).

Both community schemes and the JPKM have not had significant effects on fairness in health care financing and on the health status of the members. This is attributed to the provision of insignificant benefits and contributions resulting from the lack or deficiencies in the actuarial calculations.

In 1992, comprehensive Social Security programs were first introduced through the passage of the Social Security Act. The Social Security Act mandates private employers and employees to contribute a percentage of their wages to finance four basic benefits: old age, occupational injury, death, and health benefits. The health benefits differ from other benefits in which the mandatory membership is conditional upon the provision of health benefits by employers through other channels. Employers who already offer better benefits from those offered by the Social Security schemes are exempted from mandatory joining the social security scheme. The scheme is administered by PT Jamsostek, which is also defined as a for-profit state enterprise. The profit objective of the enterprise is also peculiar in the implementation of social health insurance or a social security system which is
associated with dissatisfactions and many complaints. This scheme has not attracted many participants from the private sector.

2. Evidence of Current Health Insurance Coverage

Of the 212 million of Indonesian population, roughly 20.6% of the population is now covered by some form of health insurance. Data from the socio-economic survey (Susenas) of 2001 indicates that about 7% percent of the population is covered by ASKES, the most comprehensive scheme. The second largest health insurance coverage is the health card scheme, the social safety net (SSN) program introduced by the government in response to the economic crisis in 1999. The health card program was spread through pre JPKM agencies. A relatively low proportion of the population, 5.4%, is covered under social security health insurance schemes or under the employees' benefit programs offered by employers.

The benefits of those insurance schemes are not comparable therefore one cannot assume that those 20.6% of the population is completely free from financial risks once they are suffer from a severe or catastrophic illness. Detailed discussions of each types of health insurance are provided later.

<table>
<thead>
<tr>
<th>Type of health insurance</th>
<th>% population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Askes</td>
<td>7.12%</td>
</tr>
<tr>
<td>Jamsostek</td>
<td>1.50%</td>
</tr>
<tr>
<td>Health Card, including JPKM</td>
<td>6.50%</td>
</tr>
<tr>
<td>Others</td>
<td>5.40%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>79.40%</td>
</tr>
</tbody>
</table>

Data on health insurance coverage in Indonesia are not easily available because there is no regulation mandating insurance agencies to report membership or policies to a single entity. Each institution has its annual report but annual reports published by private insurers or HMOs are difficult to compare since the format and the contents of the reports are not standard. At this time, the only source of information to assess the prevalence of insurance coverage is from the Susenas survey. The Susenas survey collect health insurance information every three years,
starting 1998. There are seven types of health insurance available: ASKES for government employees, social security (SS) or Jamsostek for some private employees, employer covered benefits (EC), health funds (HF), health card (HC) of the SSN program, JPKM, and other insurance (OI) including private for-profit commercial insurance companies. However, because the design of the survey depends heavily on the respondents answer, the results are subject to recall and information bias. As can be seen on Table 7, the prevalence of social security and JPKM coverage was higher than estimated due to an information bias. Many respondents were not aware, for example, that they actually had no health coverage from Jamsostek but they did have coverage for other social security program in that social security system. As a result, when they were asked whether they have health insurance from Jamsostek, they mistakenly reported that they do.

The same bias occurred when respondents were asked about JPKM. Because the distribution of health cards in the social safety net program was channelled through a newly established JPKM organization, the respondents reported that they have JPKM coverage, where it was actually health card coverage. The confusion between JPKM and health card was rampant during the pilot project of JPKM using the SSN fund. Because of this reason, health card and JPKM were grouped into one in Table 1.

How do we know that some respondents mistakenly reported their health coverage? The Susenas survey provides additional information about type of employment or source of main income for the households. By examining the pattern of health insurance coverage and the sector from which the household received its main income, one could safely make some assumptions on the coverage. For example, the majority of farmers would not purchase health insurance from insurance companies or be covered by Jamsostek, unless they were employees of a large company doing business in agriculture and such companies are very rare in Indonesia. As indicated in Table 8 below, respondents who work in agriculture and reported having health insurance actually had health cards through the SSN program distributed through a JPKM institution. More than 15% of those working in agriculture reported having JPKM. From the assessment of licensed institutions to sell JPKM, none of them sold their managed care products to people working in agriculture. From this assessment it can be concluded that those who reported having JPKM actually were covered by the health card scheme.

The number of people covered by the social security scheme could be obtained directly from PT Jamsostek. By 2001, PT Jamsostek reported that their health insurance covered had 1.3 million active employees, or 2.9 million members with dependents (Jamsostek, 2003).
### Table 8. Distribution of Health Insurance Coverage by Employment Sector, Susenas 2001

<table>
<thead>
<tr>
<th>Sector</th>
<th>Askes</th>
<th>SS</th>
<th>EC</th>
<th>OI</th>
<th>HF</th>
<th>HC</th>
<th>JPKM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>7.8</td>
<td>4.6</td>
<td>5.6</td>
<td>0.5</td>
<td>2.8</td>
<td>63.4</td>
<td>15.4</td>
<td>100</td>
</tr>
<tr>
<td>Mining</td>
<td>4.9</td>
<td>25.6</td>
<td>40.4</td>
<td>1.4</td>
<td>1.6</td>
<td>23.7</td>
<td>2.3</td>
<td>100</td>
</tr>
<tr>
<td>Industrial</td>
<td>4.6</td>
<td>47.0</td>
<td>26.5</td>
<td>1.5</td>
<td>1.6</td>
<td>16.6</td>
<td>2.3</td>
<td>100</td>
</tr>
<tr>
<td>Utilities</td>
<td>29.5</td>
<td>22.3</td>
<td>37.8</td>
<td>1.6</td>
<td>-</td>
<td>8.8</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>Construction</td>
<td>8.4</td>
<td>13.0</td>
<td>17.1</td>
<td>1.5</td>
<td>3.1</td>
<td>49.3</td>
<td>7.6</td>
<td>100</td>
</tr>
<tr>
<td>Automotive</td>
<td>14.3</td>
<td>17.1</td>
<td>36.7</td>
<td>3.4</td>
<td>6.6</td>
<td>20.7</td>
<td>1.2</td>
<td>100</td>
</tr>
<tr>
<td>Retail</td>
<td>25.9</td>
<td>12.2</td>
<td>15.6</td>
<td>2.4</td>
<td>3.8</td>
<td>35</td>
<td>5.2</td>
<td>100</td>
</tr>
<tr>
<td>Wholesale</td>
<td>11.8</td>
<td>25.3</td>
<td>50.3</td>
<td>6.4</td>
<td>0.4</td>
<td>2.2</td>
<td>3.5</td>
<td>100</td>
</tr>
<tr>
<td>Import-Export</td>
<td>10.3</td>
<td>39.2</td>
<td>33.2</td>
<td>5.4</td>
<td>-</td>
<td>11.9</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>Transportation</td>
<td>12.7</td>
<td>18.3</td>
<td>25.1</td>
<td>7.7</td>
<td>2.2</td>
<td>28.6</td>
<td>5.5</td>
<td>100</td>
</tr>
<tr>
<td>Financial services</td>
<td>24.7</td>
<td>27.2</td>
<td>39.0</td>
<td>6.6</td>
<td>0.8</td>
<td>1.2</td>
<td>0.5</td>
<td>100</td>
</tr>
<tr>
<td>Health and education</td>
<td>84.3</td>
<td>3.2</td>
<td>7.1</td>
<td>2.2</td>
<td>0.6</td>
<td>2.1</td>
<td>0.5</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28.1</strong></td>
<td><strong>16.6</strong></td>
<td><strong>15.0</strong></td>
<td><strong>2.1</strong></td>
<td><strong>2.0</strong></td>
<td><strong>29.0</strong></td>
<td><strong>6.3</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### Civil Servant Social Health Insurance Scheme (ASKES)

The legal bases for this scheme are Government Regulation No 69/1991, No 6/1992, No 28/2003. The scheme covers about 13.8 million members (almost 7% of the population). All civil servants and pensioners of civil servants and military personnel are mandated to contribute 2% of their basic monthly salary, regardless of their marital status. Starting 2004, the government is mandated to match the contribution 0.25%, to be increased annually to reach the matching of 2% by 2007. All members are entitled to comprehensive benefits considered medically necessary regardless of their wage levels. The benefits however differentiated into three non-medical levels of services. The highest rank of civil servants are entitled to first class room and board, the middle one are entitled to second class rooms, and the lowest rank are entitled to be hospitalized in the third class room. All other medical benefits deemed medically necessary are not discriminated by rank.

The benefits are delivered in a defined provider network; consisting of mainly public health centres and public hospitals. ASKES pay the providers using prospective payment systems: capitation, 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 can maintain solvency. In addition to administering the compulsory scheme, PT ASKES is permitted to sell commercial products to the private sector. Currently PT ASKES has contracts with over 2,500 companies covering about 1.5 million members; increased from 131,635 members in 1994. The commercial members are entitled to various levels of health benefits, arranged on managed care principles, provided by public and private health care facilities. There are five different products which vary by comprehensiveness of the benefits and non-medical benefit levels such as VIP room if a member is hospitalized or even hospital benefits in Singapore and Australia. Payments to the health care providers are negotiated on prospective bases. For each level of benefits, the premium is set and negotiated based on an underwriting assessment of the prospective groups. Premium rates are adjusted to ensure that the benefits will be adequately financed.

The increase in premiums for compulsory members has, on average, been lower than the increase in health care expenditure. This results from the fact that the government does not determine changes in wages on a regular basis. On the other hand, health care costs, especially drug prices, increase annually to compensate for inflation and exchange rates in Indonesia. To ensure that PT ASKES remains solvent, the government determines payment rates to public hospitals. These are normally below the published rates (of hospital services) determined by local governments. The differences between the published rates, applied to all citizens not covered by ASKES, may vary from 0-50% depending on the size and location of the hospitals. The price differentials often become the subject of hot debates between the hospital directors and PT Askes. The hospitals often charge the difference between the published rate and the amount paid by ASKES to the members. This leads to dissatisfaction among both hospital staff and the members.

The status of PT Askes as a state enterprise seeking profits creates more tension between the stakeholders. The implementation of social health insurance in other parts of the world is normally on a non-profit basis. Even if public hospitals are reimbursed according to cost, complaints are limited as the social insurance carriers do not take any profit to be paid as dividends. This legal status of the social insurance carrier in Indonesia carrier is now being reconsidered, with the intention of shifting the status to a non-profit state enterprise under the National Social Security Reform Bill currently debated in the Parliament.

Although in theory all members have the right to receive comprehensive health services, many ASKES beneficiaries, especially those with higher incomes, have not used their entitlements due to the perceived low quality and hassle in obtaining the benefits. Susenas data showed roughly that one third of the members who needed health services claimed their benefits. Others simply pay out of their pocket for services outside the system. However, for catastrophic medical care, such as renal dialysis and open-heart surgery, almost all members used their entitlement. About 75% of patients in the centres for renal dialysis are ASKES members in
Selected Case Studies from Asia and the Pacific

contrast to the 7% of ASKES members in the population (Thabrany, 1999). Despite some complaints and hesitancy to use benefits provided by ASKES, recent surveys indicated that 80% of the members were satisfied with the services provided in the network (Soetadji, 2002). It is conceivable that those 20% members who were not satisfied were mainly in the upper income levels.

ASKES faces several problems linked to the trend in the country to transform public hospitals into autonomous or state enterprise hospitals. The transformation is followed by price increases as the perception spreads that autonomous hospitals will no longer receive the government subsidies. The second significant problem is the perceived poor quality of health services provided in public hospitals. The third problem is that the third child and beyond and related pregnancy treatments are not covered. The fourth problem is the relative adverse selection of the scheme that covers military pensioners (when health risks are higher) who were not covered during their active duties. The last problem is the demand for decentralized management in line with the Law of Local Autonomy now being implemented in the country.

Private Employee Social Security Scheme (Jamsostek)

The legal basis for Jamsostek, or the scheme covering salaried employees in the private sector, is the Social Security Law. All employers having 10 or more employees are obliged to join Jamsostek. The Law prescribes that (i) the participation in the health insurance program is conditional; (ii) only employers are mandated to pay the premium of 3% (for singles) and 6% (for married) of wages (non-contributory scheme); (iii) the wage ceiling has remained at one million Rupiah (equivalent of US$ 120) per month since 1993, freezing revenues for SHI contributions while costs of medical care continue to rise; and (iv) The benefits are provided to the employees and family members but only up to the third child (Jamsostek, 1999).

Membership has grown very slowly from 199,000 members in 1991 to 2.9 million people (1.3 million employees) in the year 2002. Only small employers tend to enroll their employees to Jamsostek while larger employers have opted out of Jamsostek. By 2002, Jamsostek covered less than 5% of the eligible employees. On the other hand, in 2002, there were 18.8 million employees enrolled in the other three Jamsostek social security programs (Jamsostek, 2003). A national labour survey estimated that there were 56.2 million workers fully employed in the year 2000 (ILO, 2000). Data from commercial insurance companies show that in 1999, the total membership in private health insurance companies was close to 4 million people (Djaelani, 2000). In addition, there are currently 1.5 million members of PT ASKES enrolled in the private sector. The membership profile clearly indicates that many
employers are reluctant to enroll their employees in Jamsostek and reflects some inherent operational problems within Jamsostek.

The first problem is that Jamsostek lacks management capacity to organize its health care program, especially in dealing with health care providers. The second problem is related to the ceiling of salary for premium determination. The flat amount ceiling that has not been updated for ten years ago, despite devaluation and changes in salary structure. As a result, the average contribution received by Jamsostek per member has been very low (in 2000 it was only Rp 5,224) (Jamsostek, 2002). ASKES currently sells a more limited health insurance package for Rp 20,500 per person per month (ASKES, 2002). With such a low average contribution, Jamsostek cannot negotiate with high quality health care providers and therefore has lost the trust of employers. Another structural problem of Jamsostek is the limited benefit package. For example, inpatient care is limited to 60 days, including a maximum of 20 days in an intensive care unit. Renal dialysis, cancer treatment, cardiac surgery, congenital diseases, and organ transplants are not covered at all (Supriyono, 1998). These limitations further discourage employers from enrolling their workers in Jamsostek.

**Commercial Health Insurance**

The community managed health care (Jaminan Pemeliharaan Kesehatan Masyarakat- JPKM) The JPKM Health Maintenance Organization (HMO) product is classified as commercial health insurance providing in kind benefits managed by various managed care organizations. The Ministry of Health (MOH) promoted JPKM to expand memberships through the growth of JPKM bapels. Using the SSN funds, the MOH provided incentives to set up a pre bapel, as a private corporation or foundation, to be developed as licensed JPKM organizations. A simple explanation of bapels is that these are non-insurance companies selling health insurance in the form of managed care product. The managed care product becomes an insurance product because it involves risk-transfer among the members. The promotion of JPKM was based on the Health Act of 1992 which prescribes the government to encourage the development of JPKM. Ministerial decrees provide regulations regarding the licensing requirements to sell these types of health insurance. As HMOs in the United States of America (USA), the capital and other requirements for a bapel (HMOs) are different from the requirements for an insurance company. However, in the USA, the supervision of the HMOs is mainly the responsibility of state insurance authorities while in Indonesia it is fully under the MOH.

Although in theory a bapel must offer comprehensive benefits, in practice so far none of the 24 licensed bapels provide truly comprehensive benefits due to their small size, both in terms of capital and operations. The majority of licensed bapels sold combinations of managed care and traditional commercial insurance products
because the market demands such products. According to the definition of the scheme, the largest JPKM bapel is in fact PT ASKES which administers health insurance for civil servants. It is rarely acknowledged since PT ASKES is not licensed by the MOH; instead it is licensed by a government decree which has higher legal status. Of the 24 licensed bapels, only two were non-profit because the MOH decrees require for profit status. When HMO’s were first introduced in the USA, 96% of the HMOs were in fact non-profit (HIAA, 1997).

The largest JPKM pilot project in Klaten district, funded by USAID, failed due to incompatibility between the market and the concept of JPKM. The premiums were set without actuarial base and were too low and the benefits were inferior. Efforts to encourage businesses and insurance companies to sell JPKM have not been fruitful due to the conflicting concept of JPKM as a commercial insurance with the requirement to accommodate social functions. In addition, the Ministry of Health has no adequate capacity to regulate, supervise, and understand the business of health insurance. Currently, the expansion of JPKM is on hold.

For-profit commercial health insurance

Before 1992, many large private sector companies provided health benefits to their employees on voluntary basis. An Insurance Act was passed in February 1992 permitting insurance companies to sell health insurance products. In parallel, the social security laws prescribe conditional mandatory health coverage through Jamsostek. It seems that the ‘opt out’ clause in the Jamsostek law was aimed to provide opportunity to the commercial insurance companies to continue to sell health insurance to employers. The Insurance Act does not regulate any conditions of the health insurance contract. Regulation is limited to the practices of the insurance business and these companies can sell any health insurance product considered commercially viable. The main form of the health insurance products are the traditional indemnity insurance or managed care (similar to JPKM).

Both life and general insurance companies started to offer health insurance as riders or as a separate line of businesses. They had a market advantage because they had past relationships with employers in selling life or general insurance products. By 2000, insurance companies collected health insurance premiums totalling over 360 billion Rupiah (Djaelani, 2002), which was more than double the amount collected by Jamsostek. Their market performance in terms of the number of people covered and the amount of premium earned higher revenues than the JPKM bapels that did not have experience and were limited in capital. However, it is still only large employers that purchase health insurance from the private commercial insurance companies. Medium and small employers do not buy insurance and did not enroll their employees in Jamsostek. This undermines the effort to provide
health insurance for all employees. Many experts have therefore recommended that the opt out option in the SS law should be removed in order to ensure that all employers provide health insurance for their employees (Mochtar, 2002).

Micro and community health care financing schemes

Dana Sehat and other community health care financing schemes were thought to be a viable alternative after the recommendations to increase user charges of public health facilities (Gani et al. 1997) and YPKMI (1994). It was feared that higher user charges might threaten access to health services by low-income groups and the mobilization of private funds through a prepayment mechanism was perceived to be able to offset the recommendation to raise the user charges. Such initiatives have been introduced in many developing countries such as reported by Musau (1999), Atim et al (1998), and Edmond (1999). However, experience has shown that Dana Sehat failed to address the access problems due to very low benefits and very small population coverage. The Dana Sehat schemes were introduced mainly to the poor and low-income households by setting the contributions based on consensus among the households. There was no incentive for households to contribute to Dana Sehat when the household could pay health centre services for the same amount that they contributed as a premium for the health insurance fund.

A study by Thabrany and Pujianto using the National Socio-economic survey in 1998 found that only 1.87% of the populations had health cards or were members of health funds. The Susenas survey of 2001 showed that only 0.43% of the population joined a Dana Sehat. Studies by Silitupen, Iriani, and Asnah indicated that very few households paid contributions for more than two consecutive years. The studies found that drop out rates from the first year to the second year of Dana Sehat were between 60-90% annually. In addition, there was no significant improvement in access to inpatient care for the members, because most Dana Sehat did not cover these services or only provided insignificant amounts of lump sum cash when a member was hospitalized. These low levels of benefits discouraged long-term membership. It is not surprising that since the introduction of the schemes, there has been very little progress. After the SSN program for about 18 million poor families was introduced during the economic crisis, the Dana Sehat schemes across the country were halted (Azwar, 2001).

The Social Safety Net Scheme

The Social Safety Net (SSN) program was introduced to provide financial assistance to assure that the poor have access to health services. There were three different programs in the health sector:
The first program targeted high risk pregnant women by providing block grants of Rp 10,000 (about US$ 1.2 in 2004 exchange rate) per poor household per year directly to a village midwife. The midwife then could use the funds to refer high-risk pregnant mothers to a health centre or hospital for further treatment. This program increased access to hospital services for severe cases such as bleeding and complicated delivery (Hasan, 2000).

The second program was the promotion of JPKM by providing Rp 10,000 per poor family per year to pre bapels. The pre bapel retained 8% of the funds for administration and marketing JPKM products to non-poor households. It was expected that after two years the pre bapels would be able to sell JPKM products and then become self-sustained. Throughout the country, 354 pre bapels were created, the majority of which were established by civil servants or pensioners of civil servants within district health offices of each district. They had no experience on doing business of health insurance. After one year and under heavy criticism, this program was terminated. Evaluation of pre bapels revealed that the pre bapels had no potential to develop (Ekowati, 2000; Azwar, 2001).

The third program was the block grant of Rp 10,000 per poor family for health centres. The health centre could use the money to buy drugs to purchase essential drugs which were in short supply. In addition; public hospitals received some block grants for operational costs to compensate for care provided to the poor. This program did improve access for the poor. However, those who were “near poor” (not qualified for the assistance but unable to pay for expensive medical care) still face financial barriers to meet their medical needs.

The SSN program was funded from a program loan from the Asian Development Bank. The loan was terminated in 2001 and then the government continued the program by directly distributed funds which were transferred from some subsidies for gasoline or petrol, to hospitals and district health offices.

3. Strategic Purchasing

Strategic purchasing is an essential element of health insurance schemes because once a person is insured; the demand for health services may increase. A liberal benefit approach could stimulate moral hazard and higher unnecessary utilization. The trade off between insurance and moral hazard must be managed by prudent purchasing of health services, including the inclusion of preventive measures as health insurance benefits. The Indonesian health insurance schemes, from the Dana Sehat to ASKES and Jamsostek that are managed in large scale, are designed to
implement some managed care techniques to control costs and to reduce moral hazard. For example, the Jamsostek and JPKM laws specifically prescribe capitation payment. The ASKES scheme also uses the term ‘efficient purchasing’ to allow more flexible prospective payment systems. With the exception of the commercial indemnity insurance sold by insurance companies, all other schemes use managed care techniques such as: limiting benefits in pre contracted providers (closed system) and use prospective payment such as capitation, per diem, per case, or a negotiated fee schedule in fee-for-service reimbursement.

Although prospective payments and drug formularies have been used as part of the strategic purchasing approach, drugs remain the largest item of expenditures among the insurance schemes. Sulastomo (2002), for example, reported that until 2001 the ASKES scheme spent 53% of its total expenditure on drugs. ASKES has been using a drug formulary system (comprised of generic and brand names) in whereby pharmaceutical industries bid competitively for lower prices. Still, the proportion of drug expenditures of total expenditure remains high. This was due to low reimbursement levels for medical and hospital services.

4. Current Reforms
The Road to Reforms

The severe financial crisis sparked by the exchange rates problems of Indonesian currency, ignited several social riots and caused wide unemployment. Many policymakers suddenly became aware that Indonesia did not have any strong social security scheme that could prevent the economic risks of people when due to unemployment. In 1997, the contribution of the social security fund to the gross domestic product was less than 2% which provided no economic leverage to overcome financial crisis. In year 2000 and 2002, two comprehensive reviews on health insurance and health care financing were undertaken by the Center for Health Economic Studies, University of Indonesia, funded by the National Planning Board (Bappenas) and the World Health Organization. In addition, in 2001, a comprehensive social security review was conducted by the University of Indonesia, which was funded by the Coordinating Ministry of Economic Affairs. At the same time, the International Labour Organization (ILO) Jakarta also sponsored a social security review aimed at reforming Jamsostek schemes. The studies recommended social security reforms, including social health insurance.

The House of Representatives (MPR) of the Republic of Indonesia also found that social security reform must was an important part of national reform. In the year 2000, the House of Representatives amended the Indonesian constitution by adding new articles and items, including an item stating that every citizen had the
right to social security (Article 28H). The Coordinating Ministry of Social Welfare (Menko Kesra) was aware of the need to reform the Indonesian social security schemes and took action by establishing a Task Force on social security reform in 2000. The Task Force later became part of the Vice-President's secretariat in 2001. At the same time, the House of Representatives urged the President to establish National Social Security.

In 2002, the President of the Republic of Indonesia issued a Presidential Decree establishing a Task Force on National Social Security System to write an academic paper and to draft a bill on the National Social Security System. In August 2002, the efforts to reform the Indonesian social security schemes were strengthened by the amendment to the Constitution's Article 34 (item 2) stating that "the State shall establish social security for all people and empower the disadvantaged". All of the above legal reforms brought a strong impetus to the enactment of a National Social Security System.

The Task Force managed to draft the Bill on National Social Security System by the end of 2003. The Bill was then submitted to the Parliament in January 2004, which intensively discussed and refined it. The Parliament also conducted hearings with stakeholders, and consulted every item of the Bill with the government. Finally on 28 September 2004, the Parliament unanimously agreed to pass the Bill, and on 19 October 2004, President Megawati signed the law on "National Social Security System" on the last day of her tenure.

The Law covers five social security programmes: health benefits, workers' compensation, provident fund, pension scheme, and death benefit. The health benefit programme is managed and pooled nationally and financed by social health insurance and social assistance mechanisms. The goal of the health programme is to ensure universal access of health services in Indonesia and to ensure equity and fairness in health care financing. In addition—to be consistent with the goal of maximizing benefits to all citizens, the for-profit orientation of the current operations of four Social Security Agencies is changed to be not-for-profit orientation. The health benefit programme will pave the way to establish National Health Insurance using the existing two agencies (called Badan Penyelenggara Jaminan Sosial—BPJS) that have been implementing social health insurance schemes (PT Askes and PT Jamsostek). The law mandates the government to pay contribution on behalf of the poor, part of a social assistance programme, to the BPJS.

Challenges and Strategies of National Health Insurance

The new design of National Health Insurance (NHI) within the National Social Security System has taken into consideration of the fact that Indonesia is a very large country with 210 million people, scattered in about 7000 islands. The labour force
Social Health Insurance

was estimated at about 101 million people in 2004, with the distribution of 36.2% being salaried workers, 51.9% self-employed, 3.4% employers, and 8.5% family workers. The self-employed are mainly farmers, individual retailers, with very few being self-employed professionals. With only one third of labour force being in the formal sector, it is not easy to mobilize financial resources to finance health care for the entire population within a short period of time. In addition, the per capita income of Indonesians is relatively low (i.e. in 2004 it was about US$ 1 000 at the official exchange rate or about $ 2 800 in international dollars). The low per capita income significantly affects household expenditures and the ability of workers to contribute. The National Socio-economic Surveys showed that between 50%-70% of household expenditures from 1995-2000 was incurred on food.

The NHI relies heavily on contributions from employees, employers and the government. It must start by improving the coverage in the formal sectors by mandating all employers, without “opting-out” provision as practised under the previous social security law, to allow the higher-income workers to share the risk with low-income workers. There are problems in determining and collecting contributions from those who work temporarily or as self-employed or seasonal workers. Many of the temporary and seasonal workers are working without any contract binding and they are paid daily or weekly by the small and medium-scale employers. Employers often do not count them as employees. Therefore, for efficient and effective administration, these groups should first be covered through the traditional publicly-provided service, and/or by levying user charges. However, it will be a great relief if local governments set fixed user charges for an episode of care rather than setting fees for several types of service as currently being practised nationwide. Universal access through the NHI scheme must be implemented gradually in accordance with the administrative capacity of the BPJS, and the employment, social and economic conditions of the country.

Employees in low-income salaried jobs must be made to join the system. However, it should be considered cautiously whether workers earning low income should contribute half of their contribution, say 6% of salary, and whether it will affect their basic consumption significantly. If workers contribute 3% of their monthly wages, it may not affect this daily lives. However, if workers earning low wages must contribute over 15% of their wages for various social security programmes, they may suffer from difficulties in meeting their daily needs.

Although the law that would regulate the implementation of the scheme in more detail is currently being developed, it is likely that the NHI would apply the following strategies:

(1) All salaried employees and pensioners in the public and private sectors are mandated to contribute to the NHI. The contribution level shall be the
same for single and married employees to simplify administration and to strengthen the social solidarity principle. However, a salary cap should be applied. Within the first five years, the compulsory scheme must be imposed on employers with ten or more employees. The expansion of membership shall be enforced gradually to include employers with one or more employees by the tenth year of implementation.

(2) In the meantime, workers in the informal sector may join the scheme on voluntary basis during the first ten years of implementation. The level of contributions for the informal sector should be calculated and be determined on a nominal amount that varies according to the estimated average income of various types of businesses.

(3) Self-employed professionals such as physicians, lawyers, insurance brokers and insurance agents, etc. are mandated to join the NHI from the beginning. Although, they are not employers, they are licensed or at least are registered to do their business. Compliance to the NHI shall be required for renewing the licence to conduct professional services. The contribution will be calculated by the BPJS and paid directly by the professionals on a monthly basis. It is expected that the members of the compulsory scheme would expand automatically as informal employment will be reduced.

(4) The poor and marginally poor (low-income) among the non-salaried workers shall be provided with subsidized contributions by the government. The eligibility of those who will receive subsidized contribution is subject to a means test. This group can be divided into two sub-groups:

- In 2005, the government is already paying a contribution of Rp 5,000/- per poor individual (US$ 1 = Rp 9,200 in March 2005) for about 34.6 million poor, currently being enrolled to PT Askes, nation-wide. The average contribution in 2005 for existing health insurance for civil servants is about Rp 8,000/-. At the beginning, the health care benefits for the poor are less than the benefits provided for civil servants, mainly in hotel-type of services. In the end, there will be no difference on in health care benefit for those who receive subsidized contribution from those who contribute fully.

- The low-income employees in the informal economy and also those who do not pass the means test (marginally poor) will still not be able to afford to pay for expensive medical care. This group must be provided with financial assistance for health care such as for inpatient care and elective surgical procedures. However, this group
may be able to afford expenses for outpatient care. The government should ensure access to expensive health care by providing subsidized finance in public hospitals or in third-class private hospitals. However, employees should be free to join the NHI on voluntary basis at any point of time.

(5) Coordination on benefit packages with private insurance companies that offer supplemental benefits shall be developed. Workers who earn higher wages are normally not satisfied with the benefits provided by the NHI. Therefore, the law permits them to purchase supplemental insurance from the private sector. For example, the private insurance company may reimburse non-covered hotel type services in a hospital. Alternatively, those with higher incomes may pay the price difference on account of the charges paid by the NHI and charges accrued to the patient due to higher level of care, directly to the providers. However, they would not be allowed to completely opt out from the NHI.

**National Social Security Law and its elucidation**

The following paragraphs describe the health insurance part of the National Social Security Law 2004, and elucidate some of the relevant articles.

**Part Two Health Insurance**

**Article 19**

Health Insurance is organized nationally, based on the principles of social insurance and equity. Health Insurance is organized to ensure that the members receive comprehensive health benefits and protection to meet basic health needs.

The equity principle stands for equal access to health services for a given medical need without regard to the amount of contribution paid.\(^1\) The principles of social insurance cover: social solidarity (sharing) between the rich and the poor, the healthy and the unhealthy, the old and the young, and between the high-risk and low-risk individuals. It maintains the principle of compulsory/mandatory membership and no adverse selection. The contribution is set as a percentage of salary/income and is not a for-profit payment.

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\(^1\) This provision indicates that the Indonesian government is committed to establish a National Health Insurance Programme that ensures equity, efficiency, sustainability and portability of health insurance coverage.
Article 20

Members of Health Insurance Schemes are those who pay contribution or whose contribution is paid by the government. Dependents of a member are eligible for health benefits. Every member can enrol other family members to the scheme by paying additional contribution.

Dependents mean a legal wife/husband, natural children, stepchildren of a legally married, legally-adopted children, and maximum of five persons including the member. Other family members (extended family) including the fourth child and beyond, father, mother, and parents are also supposed to be covered by the Law. To enrol other family members, an employee salaried worker needs to provide a legal letter authorizing the employers to deduct additional contribution from his/her salary and pay the contribution to the Social Security Corporation as stipulated in this Law.

Article 21

Health benefits remain valid for 6 (six) months after a member is laid off. If the member as stipulated in Section (1) is still unable to find a new job and she/he is in low income status after the six month-period, his/her contribution will be paid by the government. The government pays contribution for a member who suffers from a permanent total disability and is in low-income status. Further provisions of Section 1, Section 2 and Section 3 will be stipulated by a Presidential Regulation.

Section 1: This rule allows a member who suffers from a lay-off and his/her dependents to have protection up to six months after she/he is laid off without any obligation to pay contribution.

Article 22

The health benefits cover individual services including personal health promotion and prevention, curative and rehabilitative services, and drugs and medical supplies, as medically necessary.

Members shall contribute on cost-sharing basis for certain services that potentially may incur abuses and moral hazards.

Further provisions of Section 1 and Section 2 regarding health services and cost-sharing will be stipulated by a Presidential Regulation.

Section 1: Health services in this Article include personal health promotion, immunization, family planning services, outpatient care, inpatient/hospital confinement, emergency care and other medical procedures, including haemo-dialysis and heart surgery. The services provided are of standardized quality to ensure the sustainability of the programme and the high satisfaction level of members.
The range of services will be subject to the medical needs of members that may change overtime and the financial capacity of the Social Security Corporation. These standardized services are necessary to maintain prudent spending.2

Section 2: The types of services requiring cost-sharing arrangement are services that have a tendency for moral hazard (heavily influenced by the preferences of members), for example drugs as supplement, certain diagnostic procedures, and medical procedures that are medically inappropriate.

In cost-sharing, there must be an effort to contain costs, especially in controlling the utilization of health services. Cost-sharing can involve a nominal charge for a service or a percentage of total costs of services, and be payable directly to health facilities at the point the charge for health services is incurred.

Article 23
The health benefits as stipulated in Article 22 will be provided in public or private health facilities that bind a contractual arrangement with the Social Security Corporation. In a medical emergency situation, health services as stipulated in Section 1 could be obtained in any health facility that does bind any contractual arrangement with the Social Security Corporation. If in a particular region there is no health facility that meets the criteria to fulfill the medical needs of a number of members, the Social Security Corporation shall provide other form of compensation. When a member needs hospitalization, the hospital confinement will be provided in a standardized room, along with boarding facilities. Further provisions of Section 3, and Section 4 will be stipulated by a Presidential Regulation.

Section 1: Health facilities include hospitals, private medical practices, clinics, laboratories, dispensaries and other such health facilities. A health facility is eligible to be contracted if it has a valid licence issued by a government institution responsible for the health sector.

Section 3: Any other form of compensation may be provided as cash reimbursement, as applicable to a member’s rights.

Section 4: A member who demands higher class than a standard hospital room and board may upgrade his/her class of hospital confinement by taking supplemental health insurance coverage or simply pay additional charges which is the difference between the cost of services reimbursed by the Social Security Corporation and the sum of charges resulting from upgradation of services.

2 This provision indicates that benefits to be provided to members must be equal to the benefits provided for current Askes’ members (for government employees). However, the payment system and the amount of out-of-pocket payment of the insured will be different from current Askes payment. This provision is intended to increase certainty and protection that the insured will later not have to pay catastrophic out of the pocket expenses to meet their health care needs.
Article 24

The level of payments to health facilities for a region will be determined by negotiation(s) between the Social Security Corporation and association of health facilities in the region. The Social Security Corporation shall pay health facilities for services rendered to the members no later than 15 (fifteen) days after net claims are received. The Social Security Corporation develops health delivery, quality assurance and payment systems to increase efficiency and effectiveness of the health insurance scheme.

This provision requires that the Social Security Corporation pays health facilities efficiently and effectively. The Social Security Corporation may provide a global budget to a hospital in a region to serve a number of members or to pay a fixed monthly per capita amount (capitation). The budget or capitation covers medical fees, nursing or hospital confinement, ancillary services, and medications consumed for which the hospital director has the authority to manage the use of money. By paying on all-inclusive amount, the hospital gets the flexibility to use the fund (money) as efficiently and effectively as possible.3

In developing the health care delivery system, the Social Security Corporation applies quality assurance and cost-containment systems, including the application of cost-sharing to prevent unnecessary services.

Article 25

The drugs listed in the formulary and their maximum prices, including other medical supplies which are covered, are determined by the Social Security Corporation in accordance with existing regulations. The determination of list of the drug formulary and related prices in this Article is intended to consider the dynamic of medical needs, availability, efficiency and effectiveness of drugs and consumable medical supplies.5

3 The fifteen-day limit for the SSC to pay net claims (claims that are completed with necessary documents to be processed) is to ensure a good corporate management and to ensure that health facilities will be satisfied with the payment and therefore there is no reason to provide poor services to the members. In addition, the SSC may develop various payment systems, such as per case, diagnostic-related groups, global budget, even capitation payment to hospitals and other health facilities. The various payment systems may be in different stages across regions because of differences in the feasibility and acceptability of payment systems.

4 This provision does not intend to take over the roles of the Ministry of Health in developing a health system; rather this provision allows SSC to develop health care delivery system ONLY for its members. Such delivery system can require a gate-keeper system through a family physician or a 24-hour clinic.

5 Drug expenditures have been the largest component of the Indonesian health care system. To ensure efficient and effective delivery system, the SSC must establish a list of drug formulary in which drug expenditures are covered. Drugs shall not be only generic drugs; rather all necessary or essential drugs needed to heal a patient must be in the list. However, certain brand names drugs may not be covered unless the prices of brand names drugs are competitive to be included in the list. Consumable medical supplies are all the necessary supplies such as an infusion set, prostheses and implants etc that are necessary to enable the patient to return to her/ his productive state.
Article 26
Services that are not covered by the Social Security Corporation will be further stipulated in a Presidential Regulation.

Article 27
The contribution of the Health Insurance Scheme for salaried workers is based on a percentage of salary up to a certain ceiling, gradually to be shared by the employer and the employees. The amount of contribution for non-salaried workers is a nominal amount to be determined periodically. The amount of contribution for contribution-aided beneficiaries is a nominal amount to be determined periodically. The salary ceiling as provided in Section 1’s to be determined periodically. Further provisions regarding the amount of contribution as stipulated in Section 1, Section 2 and Section 3 and the ceiling of salary as stipulated in Section 4 will be determined by a Presidential Regulation.

The meaning of “periodically” in this section is a define timeframe to review or to set new contribution level related to the development of needs.6

Article 28
Workers who have more than 5 (five) family members, and who would like to include other family members or relatives shall pay additional contributions.

Additional contributions as stated in Section 1 will be further stipulated in a Presidential Regulation.

5. Conclusions
Indonesia has been implementing pre-payment (health insurance) schemes since the 1950s, starting with community health funds. The formal health insurance scheme for civil servants was implemented in 1968. The year 1992 changed the way Indonesia provided health insurance with the passage of three laws: the Health Act (JPKM), the Social Security Law (Jamsostek) and the Insurance Law. These three laws promote the growth of commercial for-profit health insurance in Indonesia.

The Ministry of Health has been very keen to promote JPKM as the dominant form of health insurance, offered as managed care. Massive efforts to stimulate the growth of JPKM were not successful because of the incompatibility between the market and the form of health insurance being promoted. The micro financing

6 This provision ensures that an adequate contribution is available to finance the health care benefits. Therefore, the level of contributions, both in nominal amount for non-salaried workers or as a percentage of salary, must be reviewed and changed over time.
schemes have not shown any successful evidence to improve the access and quality of health services. Learning from previous experiences, the National Social Security Bill passed by the Parliament in late 2004, covering social health insurance, will pave the foundation for a national health insurance system in Indonesia. In terms of strategic purchasing, Indonesia has long been committed to adopting cost control mechanisms to prevent moral hazards, and to improve efficiency by adopting managed care techniques.

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1. Background

Geography and climate

Japan consists of four main islands: Hokkaido in the North, Kyushu in the South, Honshu, the central and main, largest island, and Shikoku, located between Honshu and Kyushu. Japan extends 3,000 kilometres from North to South and the total land area is about 378,000 square kilometres. The land is 84% mountainous and forested, with only 16% of the land area habitable and fertile. The country is located on the circum-Pacific earthquake belt and experiences about 1,500 seismic occurrences per year (mostly tremors).

Japan’s geographical diversity and North-South extent contribute to the country’s wide range of climates. In general, Japan has four well-demarcated seasons. In the North, the average temperature is below freezing in January and 22 degrees Centigrade in summer. In the South, on the other hand, the average temperature is 17 degrees Centigrade in winter and 27 degrees Centigrade in summer. The rainy season begins between mid-June to mid-July. Since the temperature is still warm during the rainy season, humidity is very high then. After the rainy season, September brings the typhoon season. Typhoons strike Japan and cause significant damages every year. From the beginning of the rainy season through the typhoon season, the precipitation is relatively high, about 160-200 mm per month.

Population and health

The population of Japan is about 127 million, with a relatively high density of 336 persons per square kilometres (much higher in the inhabited areas). Population growth rate was 0.11% in 2003. About 19.2% of the population is over 65 years old, indicating that Japan is already an aging society. Life expectancy at birth is 81.9 (78.4 for males, 85.2 for females). In addition, Healthy Life Expectancy (HALE) is 75.0 (72.3 for males, 77.7 for females). The total expenditure on health as a percentage of GDP is 6.8%.

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Politics

Japan is a constitutional monarchy. The Japanese parliament, called the Diet, consists of the House of Representatives (500 members) and the House of Councillors (252 members). The members of the Diet are elected by public election. The cabinet is headed by the Prime Minister. The current Prime Minister is Junichiro Koizumi. The cabinet also includes the ministers, who are appointed by the Prime Minister and are usually members of the Diet. The Prime Minister is elected by the Diet. There is a local administration system which consists of 47 prefectural governments and about 3000 municipal governments whose governors are elected by public election. Prefectural and municipal governors, in addition to the central government, have the power to impose taxes. In recent administrative reforms, decentralization of the central government has taken place in terms of both political power and financing.

Economy

After World War II and the wartime destruction of the economy, Japan achieved extraordinary economic growth in the latter half of the twentieth century. On the heels of experiencing two oil crises in 1973 and 1979, the Japanese yen rose to 100 yen per U.S. dollar after the Plaza Accord in 1985, a significant change from the fixed rate of 360 yen per dollar that had been in force since the 1960s. After recovering from oil shocks, Japan experienced a bubble economy from 1987 until it burst in 1991. Since then, Japan has been experiencing deflation and struggling with low economic growth. Since 1996, Japan has been in its longest recession and deflationary spiral since World War II. In 2002, the number of unemployed persons reached 3,590,000 (an increase of 190 thousand compared to the previous year) and the unemployment rate averaged 5.4%, the highest rate since World War II.

Education and religion

Education is compulsory from age six through age fifteen years (elementary school and junior high school). The literacy rate among Japanese adults is above 99%. About 95% of junior high school graduates go on to senior high school, and 30% of senior high school graduates go on to two-year colleges, four-year colleges or universities. There are two main religions, Shintoism and Buddhism, and Japanese people generally participate in or observe the festivities of both religions. Three are about 1 million Christians, which is less than 1% of the population.

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2. Development of Compulsory Health Insurance Mechanisms

Discussion of introducing social insurance began in 1897 when Gotoh Shinpei, one of the leaders of health system development, came back from his study in Germany. In spite of the discussions, social insurance was not established until 1927, although Workers’ insurance initially started in 1903 as a trial for some government employees (mine workers, railroad workers, workers in the steel industry, and selected other workers).

Compulsory Prepayment Health Insurance in Japan was developed in the following order:

- Workers’ Insurance for some government employees started in 1905 (Beginning with mine workers, then certain other government workers)
- Mandatory Workers’ Insurance started in 1927
- Community-based insurance system started in 1938
- Total population coverage by health insurance was reached in 1961
- The Elderly Insurance system started in 1983
- Long-term care insurance started in 2000

The chronological development of health insurance is shown in Figures 3 and 4 below.

Figure 3. The growth of health insurance coverage in Japan (1897-1985)
Figure 4. *Population covered by various insurance schemes in Japan (1926-1985)*

![Graph showing population covered by various insurance schemes in Japan (1926-1985)](image)

Source: Government long-term statistics

Figure 5. *The relationship between economic growth and labour unrest in Japan*

![Graph showing the relationship between economic growth and labour unrest in Japan](image)

Source: Government statistics (long term statistics)
The development of worker's insurance

The discussion for introducing social insurance system began in 1897 when Gotoh Shinpei returned to Japan after studying the situation in Germany. He introduced the German type of Workers' Insurance, which had started in Germany in 1884, to the Japanese Diet, but implementation of a mandatory insurance system for general workers in Japan came later, in 1927. However, before introducing the mandatory insurance for all workers, a trial version was implemented from 1905 for select government employees such as railroad and steel workers, and a broader workers’ insurance scheme for government employees was established in 1907.

Japanese health insurance was first introduced on a broad scale with the promulgation of the Workers’ Insurance Law of 1922. It was implemented in 1927 and constituted the very beginning of all social insurance in Japan. The system covered company employees, and included two separate insurance structures. One system was managed by central government and covered any company with more than 5 employees. The other system was society-managed, and a society was established by any company that has more than 300 employees as an insurer. Before the introduction of these systems, voluntary mutual aid associations had been established in a small number of companies, and employers’ assistance to workers for their work-related injuries and illnesses had been stipulated by the Factory Law.

The Workers’ Insurance Law was enacted to protect workers at the time that the labour movement in Japan gathered momentum in the 1910s and early 1920s. Although it faced a financial crisis shortly after its establishment in 1929 (the world depression), this Health Insurance System gradually developed as the nation’s economy grew.

3. The Development of Community-Based Health Insurance

Initial phase

When the Ministry of the Interior carried out a survey in a rural agricultural district in 1933, it showed that most families had heavy debts and that medical expenditure was the most important cause of their debts. The background of this severe situation in rural areas was the world financial panic which began with the New York Stock Market crash in 1929, and dealt a strong shock to the Japanese economy, with special impact on rural agricultural districts due to a drastic fall in the price of silk.

Compared with people in urban areas, the health conditions of the rural people were very bad and their needs for health care were very high. However, most people living in rural districts could not afford to pay for medical care when they needed it.
Even if they could afford to pay, finding a doctor in a rural district was very difficult and they would usually have to pay for travel to see a doctor. This situation created a vicious cycle for rural people’s health. The imbalances in health care resources and health indicators are shown in Figures 6 and 7. In an attempt to improve the health situation in rural agricultural districts, the government decided to introduce a Community-based Insurance system.

Prior to this initiative, Japan had a voluntary community health insurance called “Jyorei”, which dated back to 1835 and was initially based on rice contributions in villages. Before the Community-based Insurance Law was enacted, government carried out a pilot study of the experiences of Jyorei. Using the findings of that study, the Ministry of the Interior developed the basic structure of Japan’s Community-based Health Insurance.

Figure 6. The number of medical doctors in Japan by residence (cities, villages, towns), 1900-1995
Community-based Insurance was approved by the Diet of Japan in 1935, under the condition that it be open to all population groups. The system runs on the basis of cross-subsidies among population and income groups. In 1938, the Community-based Insurance law was proclaimed and implemented, in the same year in which the Ministry of Health and Welfare was established. Community-based Insurance was designed to meet the needs of the poor in under-served rural villages. As was the case in the medical societies that had preceded it and in Jyorei, membership fees varied according to the households’ income categories. The system was initially voluntary, but became compulsory later, with the move towards universal coverage.

Development phases towards achievement of universal coverage

After the introduction of the Community-based Insurance scheme in 1938, the population covered by this system increased dramatically over a short period of time. By 1943, 74.6% of the total population of Japan was participating in one kind of health insurance scheme or another. Following the introduction of Community-based Insurance in 1938, the number of income groups was minimized to simplify calculations. The budget was subsidized by the central government, as well as by local government tax revenues which had increased substantially in the late 1940s.
During the last stage of World War II, and for several years after the war, the health insurance systems stopped functioning due to the lack of resources. However, from the 1950s, employment-related health insurance again grew rapidly as the economy boomed. The Japanese industrial structure changed with the dominant primary industries giving way to newly dominant secondary and tertiary industries. With that change, the population which should be covered by Workers’ Insurance increased, and at the same time, the population which should be covered by Community-based Insurance had decreased. It can be assumed that this changing industrial structure was one of the major forces driving Japan to achieve universal coverage, as reflected in Figure 8 below.

The combination of the two forms of health insurance (Workers’ Insurance and Community-based Insurance) led coverage to reach 90% of the total population by the late 1950s. Subsequently, new legislation was enacted and implemented and in 1961, when participation in an insurance scheme became mandatory for all citizens and universal coverage was achieved.

Figure 8. Percentage of the primary industries population* engaged in Japan, France, Germany, the U.S. and the U.K. (1950-1990)

* Primary industry population: the population is engaged in agriculture, fishery and forestry.
4. Development of Health Insurance for the Elderly

Health insurance for the elderly

Specific measures regarding health and medical care for the elderly population began in 1963, when the Elderly Welfare Law was enacted. The benefit packages for health and medical care for the elderly were gradually expanded until the beginning of the 1980’s. In particular, the system for providing for medical expenditures for the elderly, which began in 1978, had a very large impact on the health of the elderly and on health systems in Japan. Under the new system, the elderly (defined then as those at least 65 years old) could receive all medical care free of charge, and their access to health care providers improved dramatically. However, some problems also appeared, such as increases in the provision of unnecessary medical care and increasing financial constraints which limited the ability to provide the increased amounts of care. Such financial constraints were particularly serious for the community-based insurance programs, because of the elderly insured population were covered by community-based schemes.

To solve those problems, the Elderly Insurance System was introduced in 1983 through implementation of the Health and Medical Service Law for the Elderly issued in 1982. The targets of Elderly Insurance are persons at least 75 years old or persons or at least 65 years old with bedridden status. In the Elderly Insurance system, the insured initially could receive medical services with no co-payment, but are now subject to a 10% co-payment (whereas the co-payment is 30% for other public health insurance beneficiaries other than very young children). The benefit package of the Elderly Insurance is also relatively broad when compared with other insurance schemes (see the table of financial arrangements).

Persons eligible for the Elderly Insurance scheme still belong to the Workers’ insurance scheme as retirees or dependents or to the Community-based Insurance. However, the funding to provide medical care to the elderly is separated from those insurance funds, which contribute to the Elderly Insurance. Contributions from the funds are based on the total number of elderly in their schemes and total expenditures for the elderly shown in past records. The Elderly Insurance is financed mainly from tax revenues (38%) and contributions from each insurance scheme (62%). Recently, this contribution from each insurance scheme has become a big burden on each insurer, and tax subsidy rates have been increasing every year. This situation has caused passionate nation-wide arguments within the health sector reform movement in Japan. (See Figure 9 and Table 10).
Development of long-term care insurance

Long-term Care Insurance is not strictly a health care insurance scheme, but rather one of the welfare schemes. However, there is a close relationship between health insurance schemes and Long-term Care Insurance, particularly with regard to the Elderly Health Insurance explained above. In 1997, the Long-term Care Insurance Law was enacted, and implementation of the scheme began after 3 years of preparation. The purpose of this insurance is to provide integrated health care services to the elderly and to reduce the costs of medical care expenditures for long-term hospital admissions of the elderly (called "socially necessary admissions"). The main function of the system is to ensure provision of nursing care services at patients’ homes by providing financial support from the pooled funds for Long-term Care Insurance. The scheme covers nursing services for those at least 65 years old and also those between 40 and 65 years of age who are in need of care or support and are members of health insurance schemes. That is, the Long-term Care Insurance enables separation of the long term nursing care costs from other medical care expenditures, which continue to be paid by the health insurance schemes.

As noted in the explanation of Elderly Insurance, the burden of health care services on each health insurance scheme has been increasing year after year because of rapid ageing of the population (Figure 10). Therefore, separating long-term care costs from medical expenditures was necessary to sustain the health insurance

* The household unit has dramatically changed from expanded family to nuclear family in Japan. In this situation, the elderly who need some support for living tends to prefer to stay in hospitals as patients for the long term. This is one of the reasons for Japan's long average lengths of stay and for the escalation of elderly health expenditures in Japan.
schemes. However, Long-term Care Insurance faced financial constraints after only a few years of implementation. How to care for the elderly by using both Elderly Insurance and Long-term Care Insurance needs more detailed discussion.

Figure 10. Population growth rate and % of population age 65 or above

The increasing elderly population has influenced the labour market in Japan, as the increasingly elderly population causes decreases in the working population. Given the need to collect contributions to support the health insurance system, a decreasing working population has created serious problems for Japan. Also, unemployment rates in Japan have increased dramatically (from 2% in 1990 to 5-6% in 2003*) because of the recession that has already lasted for more than 10 years. These are major issues to maintain contribution collection levels that will be able to provide appropriate health care services to Japan's population.

5. Compulsory Prepayment/Social Health Insurance Mechanisms

The total system

According to the World Health Report 2000 the flow of health care financing can be divided into several steps such as the collection of revenues, pooling of funds, purchasing of services, and provision of services. For revenue collection, there are four main sources, including premiums paid by the companies for workers’ social insurance, premiums paid by employees for social insurance and by households for Community-based insurance, government tax subsidies, and user charges paid by patients. All premium rates, tax subsidy rates and co-payment rates are specified in each specific insurance law, which is enacted by the National Diet.

For the pooling of funds, there are two mechanisms in Japan: mandatory social insurance and the tax-based welfare system. The social insurance system can be divided into three components, workers’ insurance, community-based insurance, and elderly insurance.

Japan has more than fifty thousand insurers, more than 9,000 hospitals and 90,000 clinics and a large numbers of doctors, dentists and pharmacists, with 13 million admissions (an average of approximately one admission for every ten persons) and 4,000 million outpatient visits (an average of 31.5 visits per person) per year at present. There are tremendously complex transactions involving extremely large numbers of claims and payments. Accurate, quick, reasonable and effective purchasing of health care requires efficient mechanisms. Two management organizations were created to deal with the tremendous numbers of transactions. One is the Social Insurance Medical Fee Payment Fund, mainly for workers’ insurance, and the other is the National Health Insurance Confederation, mainly for community-based insurance. Each has an office in every one of Japan’s 47 prefectures. The insurers make contracts with those two organizations. Through this mechanism, the insurers do not have to deal directly with the many providers, and the providers only have to deal with two offices in each prefecture. (See Figure 11 on Health Financing Flows).

Figure 11. Health Financing Flows in Japan, 2001

The payment system is mainly on a fee-for-service basis, with fixed nation-wide fee schedules and drug tariffs, except for long term care and teaching hospitals, where payment is based on fixed per diem rates. Case payment for teaching hospitals is new, begun in 2003. This case payment method is called Diagnosis Procedure Combination (DPC) a Japanese version of DRGs (Diagnosis Related Groups) and its fees are adjusted according to the severity and expected cost of treatment of diseases.

The insured persons are obliged to pay co-payment fees directly to providers when they use services. One reason that health expenditure accounts for a relatively small fraction of Japan’s GDP, in spite of a mainly fee-for-service health care system, is that a nationwide universal fee schedule is set by the Central Social Insurance Medical Council managed by the Ministry of Health, Labour and Welfare. The Central Social Insurance Medical Council consists of three groups, the provider-dominated Japan Medical Association, purchasers such as insurers, and representatives of communities, labour unions and academia. Fee schedules and drug tariffs are set by this Council every two years or when deemed necessary.

**Pooling**

Organization and mechanisms

There are two fund pooling systems, the social insurance system and the welfare assistance system. Within the social insurance system, there are three major components related to pooling of funds, including workers’ insurance, community-based insurance and elderly insurance. For workers’ insurance, the pooling of funds is carried out within three distinct groups. The first and largest is composed of 1,722 societies which have been created by some of the relatively larger companies which manage the insurance (A “society” in this sense is an insurer which has been established by a company that has more than 300 employees). Membership is currently 31 million, or about one quarter of the population of Japan. The second is the government-managed insurance system for the employees of firms with less than 20 employees, with 28.5 million members (about 30% of the total population). The third group consists of 79 mutual funds which provide insurance for specific groups of workers such as seamen and government employees, with about 11.1 million members (about 9% of the total population).

The pooling of funds for community-based insurance programs is also carried out within three groups. One is the municipality-managed insurance, including 3,235 villages, towns and cities, with 44.8 million members (35% of the total population). Separately, 166 associations (an “association” is an insurer which has been established by a professional group or trade association) manage community-based insurance schemes covering another 4.2 million members (3.3% of the population).
The fund for the Elderly and Retired is pooled at the municipalities, and payments for providing health care services for the elderly are made to health care providers through the Social Insurance Medical Fee Payment Fund or the National Health Insurance Confederation. Persons over 70 years of age or persons who are over 65 and have a chronic illness are eligible for this insurance. The elderly person legally belongs to his or her original insurance entity, Workers’ Insurance or Community-based Insurance. However, the fund for providing medical care services to the elderly is separated from those insurance funds. It is based on the contributions from Workers’ Insurance Fund and the Community-based Insurance Fund and government subsidies (from tax revenues). The total numbers of persons insured by this elderly insurance are 3.4 million in Workers’ Insurance and 12.3 million in Community-based Insurance (12.3% of total population). The coverage of the population in the various systems in 2003 is shown in Table 9.

Table 9. Organization and membership of health insurance entities in Japan, 2003

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Number of Insurers</th>
<th>Number of the Members (%)</th>
<th>Number of the Elderly (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society-managed</td>
<td>Society</td>
<td>1,722</td>
<td>31.0 (16.1)</td>
</tr>
<tr>
<td>Government-managed</td>
<td>Central Government</td>
<td>1</td>
<td>36.3 (17.2)</td>
</tr>
<tr>
<td>Mutual Aid Association</td>
<td>Mutual Aid Association</td>
<td>79</td>
<td>11.1 (5.6)</td>
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<td>Municipality</td>
<td>City, Town &amp; Village</td>
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<td>44.8</td>
</tr>
<tr>
<td>Association</td>
<td>Association</td>
<td>166</td>
<td>4.2</td>
</tr>
<tr>
<td>Retired</td>
<td>City, Town &amp; Village</td>
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<td></td>
</tr>
<tr>
<td>Elderly</td>
<td>Fund Pool</td>
<td>City, Town &amp; Village</td>
<td>3,235</td>
</tr>
</tbody>
</table>


Financial arrangements

Financial arrangements differ among Workers’, Community-based and Elderly insurance programs. The Workers’ Insurance is financed from premiums and tax subsidies. The premium rate depends on the specific insurance program, with an
average premium of about 8% of salary, shared equally by employee and employer (50% each). Tax subsidies for society-managed and other mutual insurance programs are quite small, and they receive subsidies only for fixed management costs. However, the government-managed insurance is subsidized at a rate of 13% from tax revenue. Community-based insurance revenues are based on household contributions, with premiums based on levels of income and differing among communities. Community-based insurance is subsidized by taxes, which account for about 50% of total revenue. The revenue system of the Elderly Insurance program is complex. Funds contributed by Workers’ Insurance and by Community-based Insurance programs account for 67% of total expenditures. Another 33% of their expenditures are subsidized by tax (22% from central government, 12% from prefectures and municipalities). Patients have to pay co-payments directly to providers. The co-payment rate of the Elderly Insurance is different from that of other insurance schemes. While the co-payment rate of Workers’ Insurance and Community-based Insurance is 30% of all costs of services, the co-payment rate of the Elderly Insurance is 10%. However, even though there is a difference in the rate of co-payment across schemes, there is no difference in the benefits which insured persons can receive. The different financial arrangements are shown in Table 10.

Table 10. Financial arrangements of health insurance entities in Japan, 2003

<table>
<thead>
<tr>
<th>Workers’ managed</th>
<th>Society-managed</th>
<th>9.3%</th>
<th>8%</th>
<th>? 0%</th>
<th>30% (20% for children below 3 years old)</th>
<th>¥72,300 +(medical expense – 466,000)× 1% in general</th>
<th>¥35,400 for low income persons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government-managed</td>
<td>12.3%</td>
<td>8.2%</td>
<td>13%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mutual Association managed</td>
<td>3.2%</td>
<td>8–9%</td>
<td>? 0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based</td>
<td>Municipality &amp; Association</td>
<td>14.3%</td>
<td>Household average ¥150,000 annually, adjusted by income etc.</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retired</td>
<td>5.1%</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly Fund Pool</td>
<td>34.4%</td>
<td>67% Subsidies from insurance entities</td>
<td>34% (Central Gov. 20%, Prefectures 6%, Municipalities 8%)</td>
<td>10%</td>
<td>¥40,200 (¥24,600 for low income persons)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare</td>
<td>5.4%</td>
<td>Fully covered by Tax revenues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workmen’s compensation</td>
<td>0.8%</td>
<td>Fully covered by premiums</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Almost all inpatient care, outpatient care, dental care and drugs are covered by health insurance schemes in Japan. Therefore, the insured persons can receive these services with a 30% co-payment (above 75 years old 10%, below 3 years old 20%). However, there are some exceptions. Services for health promotion, prevention of disease, and MCH are generally not covered by health insurance (Figure 12 shows the benefits in the different schemes). Section 5, Social Security Programs (2) Maternity services cover the arrangements for maternal and child services.

Figure 12. Types of insurance benefits (in the case of health insurance)

* The patient who needs high cost medical care has to pay the total cost of services at hospital, but there are upper limitations of co-payments, the patient can be reimburse excessive payments later.

** Provision of optional benefits differ from insurer. Insurers can decide the contents of the optional benefits by themselves. Usually, this depends on the financial condition of the insurer.

In addition, certain other services are not covered, although the services can be provided at the patient's own expense; they are called Specified Medical Expenses (Tokutei Ryouyouhi in Japanese). This latter group of services includes the cost for a private bed, the cost for certain specified dental materials, the special fee for reservation*, the consultation fees at hospitals with over 200 beds for a first visit**, the

* The special fee for reservation: Generally, reservation of consultation is not necessary when the patient visits a hospital. Recently, however, some hospitals which provide advanced medicine have introduced reservation systems in their out-patients consultations, because their out-patient sections are too crowded, and the long waiting times of patients were big issues. Therefore, to reduce such waiting time, reservation systems were established and hospitals now permitted to charge special fees for reservation.
fees for overtime services (outside of regular consultation hours), the costs of services provided as parts of clinical trials, the costs for medications not approved for insurance reimbursement, and certain highly advanced types of treatment (with 77 types specified).

**Purchasing**

For the management of transactions, two managerial funds were created, the Social Insurance Medical Fee Payment Fund established in 1948 and the National Health Insurance Confederation established in 1975. Insurers have contracts with those funds, with a cost of around 1 dollar per transaction. The funds receive claims and pay the providers. These funds do basic assessments of errors in the claims or possibly unreasonably high prices of the claims. Physician reviewers are employed by these funds to check those pre-selected claims. Therefore, each insurer does not have to assess each claim, a fact which contributes to keeping the transaction costs of the Japanese health insurance system low.

**Voluntary health insurance**

In Japan, there was a voluntary community health insurance called “Jyorei”, dating back to 1835, which initially was based on rice contributions for mutual assistance among villagers to fund contract medical services. We consider that this Jyorei system provided the foundation for developing what is now Community Health Insurance®. Today, however, Japan has achieved universal coverage under its public health insurance system, and this kind of voluntary prepayment health insurance scheme does not exist anymore.

6. **Social Security and Social Assistance Programmes**

In Japan, social security and social health insurance schemes and welfare schemes share the roles of protecting the population and providing services in the areas of maternity and childhood, disability and old age, and for non-economically active persons. The systems are very complicated and there are close relationships among them.

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**The consultation fees at hospitals with over 200 beds for a first visit: there is a tendency to prefer big hospitals over small hospitals and clinics in Japan. To prevent such bypassing, hospitals with over 200 beds and permitted to charge additional fee for new patients. This fee is only charged for a patient’s first visit.**

@Ogawa, Sumiko, Toshihiko Hasagawa, Guy Carrin, and Kei Kawabata, Scaling up community health insurance; Japan’s experience with the 19th century Jyorei scheme, Health Policy and Planning 18(3): 270-278, (2003).
**Elderly**

Japan has a universal pension system to provide financial support for the elderly who can thereby maintain at least a basic standard of living, even without any other income. If they become ill, the costs of health care are covered by social health insurance (Elderly Insurance for those at least 75 years old). If they have a physical handicap because of a chronic illness or advanced age, they can receive nursing care which is covered by Long Term Care Insurance with a co-payment of 10% of the overall cost. In addition, the municipalities provide many welfare services for the elderly, such as day care services, meal delivery and home visiting services, either free or for a small payment.

**Maternity**

Maternity services provided in hospitals are not covered by health insurance, in general. Therefore, mothers have to pay the costs of delivery by themselves. However, because of a cash allowance system included in the insurance schemes, after delivery mothers can receive a cash maternity allowance which more or less coincides with the usual costs of a delivery. In cases of pregnancy related illness or complications in delivery, such as toxaemia of pregnancy or Caesarean section delivery, the costs of medical services are covered by health insurance. In such cases, there is no financial burden on mothers except the 30% co-payment for the services, and the cash maternity allowance is still given. In addition, many maternal and child services are provided by municipalities as a part of their welfare systems, at no charge to the users. Japanese women generally receive both maternity services at hospitals (for which they pay in most cases) and free ante-natal services from municipalities during pregnancy.

**Tax-based welfare system**

**Livelihood protection system**

There is a livelihood protection system for non-economically active people in Japan, providing cash allowances to maintain a minimum standard of living. The percentage of persons who receive this benefit is currently about 1~2% of the whole population. For their health care expenses, the costs are paid from tax revenues. Therefore, the beneficiaries themselves do not have to pay anything for the services.

**Fully tax-funded medical services**

There are some fully tax-funded medical services, such as services for the atomic bomb survivors (with certified ailments, that is, ailments officially recognized as having stemmed from the effects of the atomic bombs), war-related injuries and
ailments among Veterans of World War II, and for hospital treatment of new infectious diseases.

**Partially tax-funded medical services**

Some specific diseases or physical conditions have features which have enormous effects on the patients' lives, both financially and in terms of their quality of life. Therefore, for persons who have one of those specific diseases or physical difficulties, parts of their medical care costs are partially covered or supported by tax revenues. The services covered include medical services for tuberculosis, mental health services, and services for persons covered by the livelihood protection system, rehabilitation services for the physically handicapped, medical aid for children with physical disabilities or potential physical disabilities. Usually, all health care services for persons with the specific diseases or conditions who meet the criteria are covered by health insurance, and the co-payments for them are covered by the tax revenues.

**Workmen’s compensation insurance**

Following passage of the Workmen’s Accident Compensation Insurance Law, the Workmen’s Accident Compensation Insurance System commenced in 1947. About 49% of Japanese workers are now covered by the system, and the total expenditures for compensating their work-related accidents and other work-related health conditions are about 250 billion Yen per year (0.8% of total National Health Expenditures in Japan). All of the expenditures are covered by the system’s premiums.

The purpose of the system is to improve the welfare of workers by providing necessary benefits for quick and fair protection when workers suffer from injury, diseases, disabilities, or death, arising from their work. At the same time, it aims to facilitate the social rehabilitation of the victims, the provide assistance to the victims and their families, as well as to ensure reasonable working conditions.

This insurance system is managed by Government, and is compulsory for all the enterprises that employ workers, except for a few enterprises in agriculture, forestry and fishery. It also does not cover seamen and a large majority of public employees. Employers in small enterprises, self-employed persons and other workers with high occupational risks may obtain coverage under the Special Member system. Employees who are sent abroad by Japanese companies may also participate in the system under the same arrangement.

**Disability**

Persons with disabilities are supported by various welfare schemes, including health insurance, long-term care insurance and other tax funded welfare systems.
Tax based welfare system

As mentioned above, there are tax funded welfare systems covering persons with disabilities and providing various services, including health care and cash benefits.

Long-term Care Insurance

See section 4.2 above on Long-term Care Insurance.

7. For-profit Commercial Health Insurance

Under Japan’s Social Insurance System, no one can opt-out from the insurance system as an individual. Therefore, there is no private insurance that provides basic coverage for individual Japanese persons. However, supplemental private health insurance to cover additional related expenditures has become popular because of the financial burden imposed by secondary costs. These include the costs of family visits to the hospital, income loss during a hospital stay, the costs of private accommodation in hospital, and payment of legally authorized user charges.

For each episode of diseases, if the patient can afford to pay, the patient can receive private health care services which are not allowed to be used or paid for under Social Insurance programs. In such cases, none of the costs of services to treat the episode of illness will be covered by the Social Insurance System to which the patient belongs. The patients have to pay the entire amount by themselves (as an out-of-pocket payment), even though some services are covered by the Social Insurance System. (Patients in Japan are not allowed to use private health care services and public health care services in one episode. Patients have to choose whether they pay for entire costs of health services or use Social Insurance System. If the patients choose to use the Social Insurance System, they can not use any health care services which are not covered by this system.) However, very recently one private insurance company started to cover this type of cost for one (single) disease episode under their private health insurance. Entire disease episode coverage is targeted to those who think that they would or might like to use special treatments which are not allowed to be used or paid for under the social health insurance programs.

Finally, Social Insurance does not pay for health services due to injuries caused by traffic accidents. Therefore, all drivers are required to have, at their own expense, an obligatory automobile accident insurance which provides coverage for the health care of victims for injuries caused by traffic accidents. Due to limitations of the required minimum insurance, most drivers opt to also purchase complementary insurance policies which provide greater coverage for traffic accident related injuries.
Private for-profit insurance for non-medical services

There are many private insurance schemes for non-medical services in Japan. These include schemes provided by both Japanese life insurance companies and foreign-owned companies. The benefit packages differ from scheme to scheme, but most include travel costs to the hospital, income guarantee during hospitalization, the costs of private beds, and the costs of medical devices which are not covered by social health insurance. The percentage of the population subscribing to such insurance is not known exactly, but has been increasing recently.

Private commercial insurance for medical services

In 1998, SECOM, a private security service company, established SECOM Insurance Service Co., Ltd. In April, 2003, when the Japanese health insurance system was revised, SECOM offered a new plan under which the insured can receive and be reimbursed for advanced care and treatment which is not yet covered by the Japanese social health insurance system. Their plan also offers a product which covers the 30% co-payment which has to be paid when social health insurance beneficiaries use health services. This is the first case in which private insurance covers the costs of medical care in Japan. Although private for-profit insurance for medical services has not been popular in Japan; it is likely to become more popular in the near future.

Car accident injury insurance

There are two types of motor vehicle insurance for traffic accident injuries in Japan, compulsory and voluntary. Every car owner in Japan has to have the compulsory insurance, which covers the cost of health care services for persons injured in traffic accidents who are not in an insured vehicle when the driver of that vehicle is found to be at fault for the accident. However, this compulsory insurance is not enough to compensate other losses caused by the accident, such as the costs of car repairs, and the cost of medical care for the car owner and for other injured persons. Therefore, it is common for vehicle owners to have compulsory and voluntary insurance policies.


Changing situation

Japan is now experiencing very rapid ageing because of success in the increase in life expectancy and the very low birth rate. Persons 65 years of age or older will constitute one fourth of the total population of Japan in 2015 and one third in 2050, meaning that Japan will be the first ultimate-aged society in the world. Not only
Japan but also other countries, both developed and developing, will sooner or later reach this ultimate-aged society. Ageing will not only cause large burdens on the volume of health care but will also need new kinds of health services as the elderly will have many types of co-morbidity requiring integration and continuity of care. Expectations are now changing and health has become one of the greatest concerns for Japanese people since the basic requirements for living have been fulfilled.

Consumer culture has also been changing to be more demanding. Particularly the Post-war baby boomers are now becoming big customers of the health care system, and they tend to insist, for example, on open discussion of their health problems and treatment. Japanese patients have only recently started to become concerned about safety and quality issues in medicine, following an incident of wrongful surgery at a highly reputable teaching hospital in 1999. (A lung removal was done to a patient who needed a Coronary Artery Bypass Graft and a CABG was done to a patient who needed lung removal. The incident created a major sensation in Japanese society.) Management of hospitals and clinics has become more competitive recently because the supplies of beds and of physicians have increased. Many new technologies which tend not to improve efficiency but do increase costs have been developed in health care.

Finally, Japan has now been suffering from its longest economic recession since World War II. Even though we will be able to recover from the recession, the rapid economic growth known in the past is not expected to return, in part because of the ultimate elderly society which will prevail in Japan as a demographically matured society.

Current issues

Coping with increasing demand

Increasing demand, due to demographic change and to the people’s rising expectations, requires the generation of new resources as well as improvement in the efficiency of the health care system. New financial sources for the elderly are essential and may cause conflict with younger generations. Some rationing of health care for the elderly may have to be considered in the near future. In Japan, equity in health care has been maintained very well up till recently. Now, however, we have to discuss the tradeoffs between efficiency and equity. Health services focused on prevention will be important to decrease the burden of disease.

Restructuring for changing the health care delivery system

Acute care of young patients is usually episodic and distinct. On the other hand, care for the elderly requires continuity, because of co-morbidity and chronic nature of
their diseases. Also, the care required varies according to the stages of the progression of the chronic diseases. Therefore delivery systems have to be centred on patients, and continuity of information is needed to provide efficient, safe and high-quality care. Clinics, hospitals and tertiary centres have to be integrated to serve the changing needs and demands of the patients. The health care system needs to be restructured following the above principles.

Improving system performance

Improving system performance is essential in terms of quality, safety and efficiency. New payment systems need to be designed which will drive improvements in those areas of health system performance. Revisions of current laws will be required.

Health sector reform and health insurance reform in Japan

Health sector reform in Japan can be classified into three stages, and health insurance related reforms are the main target areas of reform in each stage. Since almost all major health care services are covered by either Workers’ Insurance or Community-based Insurance, health insurance related reforms will have a strong impact on the entire health system in Japan.

Japan’s first health sector reform was implemented in the 1980’s. Enactment of the Health and Medical Service Law for the Elderly in 1983 abolished free medical care for the elderly, which had been available since 1972, and triggered the reform. During the 1960s and into the 1970s, health care costs increased rapidly but were absorbed by the post-war high economic growth. After the two oil shocks that came later, the increase in health care costs became a very large burden on the government. The ensuing initial reforms attempted only to control health care costs and were not sufficient to establish a sustainable system of health care and health care financing for the ultimate aged society.

With a view to conducting a more systematic health sector reform process, the second stage of reform started in the late 1990’s with two leading reform policy proposals, “Health Insurance System of the 21st Century – Directions for Radical Changes in Health Insurance and the Provision of Health Care”, proposed by the Ministry of Health and Welfare in 1997, and “National Healthcare – Guidelines for Securing Quality Health Care and Health Insurance for All”, proposed by the Medical Insurance System Reform Council of the Ruling Party, issued in 1997. Since then, those policy proposals have played a central role in discussions in preparation for the subsequent health sector reforms in Japan. The main areas of focuses in these policy proposals were changing the fee schedule, revising drug tariffs, and establishing an independent health care insurance system for the elderly, with reform of the system for
providing health care. The changes in this recent period could be considered the first comprehensive reform of Japan’s health care system and health care financing.

In recent years, a series of reform steps have been implemented, including the clarification and prioritization of the use of hospital beds, the promotion of evidence-based medicine, the introduction of a new training system for physicians, the promotion of more intensive and more effective use of information technology in the medical care and medical information systems, measures to ensure patient safety and improvements in emergency medical care services.

Figure 13. The Elderly Insurance Reform in 2003


Establishment of an independent health care insurance system for the elderly also has been proposed as a radical reform measure in addition to other changes in the Elderly Insurance system (as shown in Figure 13). The introduction of the Long-

* The new training system for doctors just has been started in April, 2004. In this new training system, every newly qualified medical doctor has to take two years of obligatory clinical training. The new obligatory training program includes not only proposed for further training in advanced medicine at teaching hospitals but also training for work in primary care and community health care in small community level hospitals.
Selection Care Insurance system in April 2000 was not enough to sufficiently reduce the financial burden that the provision of health care to the elderly places on the social health insurance system in Japan. Therefore, establishment of an independent health care insurance system for the elderly seems to be necessary, although it is still under debate because of major differences among the many stakeholders’ views and interests.

In 2001, as follow-up to the 1997 policy proposals, new policies to accelerate implementation of more integrated health sector reform were issued by the Ministry of Health, Labour and Welfare. The progress of the reform is closely related to the administrative reform of the Japanese government and particularly to the policy of deregulation of the social sector. Deregulation and a market-oriented approach are key issues in efforts to accelerate health sector reform. In terms of health insurance reform, the government of Japan intends to phase in the consolidation of all social insurance schemes. As a first step in that consolidation, the same co-payment rates have been applied in each scheme since April 2003.

A comparison of the various reform proposals is shown in Figure 14

Figure 14. Comparisons among several health insurance reform proposals

<table>
<thead>
<tr>
<th>Nippon Keidanren, National Federation of Health Insurance Societies etc. Plan</th>
<th>The Japan Medical Association Plan</th>
<th>Japan Association of City Mayors, National Association of Towns &amp; Villages, National Health Insurance Confederation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance for workers</td>
<td>Health System for elderly (above 75 years old)</td>
<td>consolidation of every insurance scheme</td>
</tr>
<tr>
<td>Retired persons</td>
<td>The people who can work will be covered by insurance scheme</td>
<td></td>
</tr>
<tr>
<td>Working generation</td>
<td>Note: medical expenditures for the elderly would be covered by tax revenues</td>
<td></td>
</tr>
<tr>
<td>Insurance for farmers, the self-employed and members of community-based insurance</td>
<td>Note: the government intends to phase in the consolidation. Introducing the same co-payments rate into each scheme implemented in 2003, as the first step of consolidation</td>
<td></td>
</tr>
<tr>
<td>Retired persons</td>
<td>Note: the source of finance are premiums, co-payments and tax revenues</td>
<td></td>
</tr>
</tbody>
</table>

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9. Conclusion

Japan can be considered to offer a rare success story in Asia in terms of good health outcomes, efficiency and equity, based on its having the world’s highest longevity, relatively low health services expenditures, and essentially 100% coverage of the population by health insurance. The reasons for these high attainments have to be examined carefully, considering not only health care factors but also social and historical factors.

The history of Japan’s development of such high population coverage by health care insurance can have useful suggestions for developing countries. Japan’s health insurance system is unique and consists of two major components, the Workers’ Health Insurance and Community-based Health Insurance. In many developing countries, the salaried sector is small and the self-employed and informal sector (including for example farmers and small shop owners) is relatively large. Insurance coverage for the self-employed and informal sector populations has always has been problematic. The process of development of Japan’s community-based insurance is of special interest to those developing countries.

Management costs for Japan’s health insurance programs are also relatively low, in spite of the large numbers of providers and insurers. Further analysis of Japan’s systems could provide lessons of interest to the rest of the world.

On the other hand, in part due to its success in many areas, Japan now faces additional challenging issues such as the increasing and changing demands for health services due to demographic and epidemiological transitions. Restructuring health care delivery systems and creating new financial resources have become essential tasks. Although health sector reform in Japan began in the 1990s, progress has been very slow because of the involvement and conflicting interests of many high powered stakeholders. Japan could be a pilot case demonstrating the development of a sustainable, efficient and reasonable health care system suitable for an ultimate aged society. However, there is no easy answer, and many experiments and trials are needed. Collaborative and comparative studies such as this study could be very important and illuminating first steps in developing new models.

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Republic of Korea
Bong-min Yang, Ph.D.

1. Background
Korea has witnessed a remarkable social change during the last four decades. The unprecedented high economic growth rates have been accompanied by industrialization, urbanization, and most conspicuously, democratization during the period of 1960s through 1990s. The country’s systems were highly centralized politically, economically, and socially until mid 1990s, and they became decentralized in 1995. The 14 regional governments now have independent constitutional status. Along with these social changes came the development of health care system, which was largely influenced by Western Medicine.

The most noticeable change in the health care system is the establishment of a national health insurance system (NHI). The Korean government quickly proceeded from its initial step to the final goal of NHI. Each stage was achieved without much political, economic, or social resistance. The expansion of health insurance coverage was a popular issue, and voters indicated a strong preference for insurance during the process of democratization.

A significant change in Korean’s health status has been brought about during the same period. Remarkable improvements in IMR (infant mortality rate) and LE (life expectancy) have been made over the last three decades. There is no question that the development of the health care system and the evolution of NHI system played a role. However, as health outcomes are affected by multiple factors such as life style, diet, income distribution, and environmental elements, it is hard to tell how much of a change in health outcome is attributable to the utilization of medical services or reliance on the health insurance system alone.

Nevertheless, the level of health status of Koreans is still behind of those of the other Asian NICs (newly industrialized countries) and the OECD average (Ramesh, 2003). Another interesting aspect of Korean health status is its distribution among social classes. Measured by the deprivation index\(^1\), an unequal distribution of health

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\(^1\) Deprivation index, measured by locality, incorporates five deprivation factors, including family density (number of family members sleeping together in one room), male unemployment rate, rate of household (HH) heads holding manual jobs, and rate of households without kitchen or bathroom or shower (Son, 2002).
status among social classes is clear and the result is consistent among different measures of social classes (Son, 2002). Better access to health care through refining the current health insurance system may well be contributing to lessening of the gap between Korea and other countries in comparison, and the clear and significant difference in health status among social classes within Korea.

**Current Korean health care system**

Figure 15 depicts the resource flows among government, consumers, corporations, and service providers. In most cases, patients are given a choice of hospitals and clinics. In 1989, some regulatory provisions were introduced governing the choice of providers under the NHI. However, most patients did not abide by the rules, and hospitals, for fear of losing revenue, did not enforce these rules. As a result, the provisions have become ineffective.

*Figure 15. Current Korean health care system*
Providers, who are mostly private, are paid by fee-for-service in return for providing services that are covered by insurance. Total expenditure is reimbursed in part by the NHIC (National Health Insurance Corporation) and the rest by patients’ out-of-pocket payments. The sources of insurance financing are contributions made by consumers, employers, and the government. The government runs the public health programs and the Medical-Aid Program through tax financing, but government’s role is relatively very weak, due to the strong presence of the private sector, in terms of total health financing.

2. Development of National Health Insurance

Evolution of the NHI

Table 11 shows the chronological development of social health insurance programs in Korea. A blueprint for the Korean health insurance system was initiated by the Health Insurance Act of December 1963, when Korea’s annual per capita GNP was still under US$100. This scheme was primarily aimed at voluntary coverage. However, little was accomplished due to limited financial resources and lack of participation. The government then implemented the first stage of its compulsory social security program for health care in July 1977, by enforcing observance of the scheme for corporations hiring 500 or more workers. In 1983, the corporate health insurance program was extended to firms hiring 16 or more employees.

Table 11. Expansion of coverage of the NHI

<table>
<thead>
<tr>
<th>Year</th>
<th>Population covered (%)</th>
<th>Coverage (Population and benefits)</th>
<th>Number of funds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NHI</td>
<td>Medical-aid program</td>
<td>Private sector workers</td>
</tr>
<tr>
<td></td>
<td>(Insured and dependants)</td>
<td></td>
<td>workers</td>
</tr>
<tr>
<td>1977</td>
<td>8.6</td>
<td>5.7</td>
<td>513</td>
</tr>
<tr>
<td>1980</td>
<td>24.2</td>
<td>5.6</td>
<td>602</td>
</tr>
<tr>
<td>1985</td>
<td>44.1</td>
<td>8.0</td>
<td>154</td>
</tr>
<tr>
<td>Year</td>
<td>Population covered (%)</td>
<td>Medical-aid program Coverage (Population and benefits)</td>
<td>Number of funds</td>
</tr>
<tr>
<td>------</td>
<td>------------------------</td>
<td>---------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>1990</td>
<td>93.9 9.2</td>
<td>Universal coverage in 1989, includes firms with over 5 workers, urban and rural self-employed.</td>
<td>154 227 1</td>
</tr>
<tr>
<td>1995</td>
<td>97.6 3.1</td>
<td>Benefits expanded to 180 days. Health examinations and high-cost technology (e.g., C.T) included.</td>
<td>145 227 1</td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td>Benefit days expanded to 365 days (since 1999). Consolidation of all funds</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Modified version of the OECD Reviews of Health Care System: Korea, OECD 2003, p. 19

A special program for civil servants and private school teachers began in January 1979. In January 1980, the scheme was extended to cover families of military personnel and pensioners. An occupational health insurance program was introduced as a voluntary scheme in December 1981 to cover groups of self-employed workers with similar occupations. In January 1988, the rural regional health insurance program was initiated for people in rural farming and fishery areas. Finally, a program to cover self-employed and unemployed populations in urban areas, termed the urban regional health insurance program, began in July 1989. Until then, this population was the group excluded from insurance benefits.

The introduction of compulsory universal health insurance transmitted different signals to different economic agents. Many Koreans now regard health (or basic health care services) as one of their basic rights. Unlike other goods or services, everyone in the population is entitled to minimum health services for survival, regardless of his wealth or social standing.

Providers can no longer enjoy unchecked autonomy as they are subject to the many constraints inherent in the system. Physician and hospital charges are contingent upon government fixed-fee schedules, and the acquisition of certain equipment and expansion or establishment of hospitals in certain areas needs the approval of the Ministry of Health and Welfare.
For the government, the transition implies enhanced financial and social obligations. Even with an economy in recession, it would be very difficult for the government to cut budgets or reduce benefits in the future, because people are accustomed to the welfare state, and would not accept such a change. On the contrary, it is more likely that the government will face an even greater burden as certain groups, such as the elderly and the handicapped, demand their fair share of the pie.

Stimuli for the establishment of NHI

It is interesting to note how successfully the Korean government proceeded from its initial step to the final goal of NHI. Politicians, especially those in the ruling Democratic Justice Party then (1977-1989) took the initiative and gradually expanded health insurance coverage. Multiple contributing factors were involved in the process of achieving NHI.

First, the fact that North Korea provided health care free of charge for all citizens, while South did not, became one of the focal issues in politics. The government of South Korea had to introduce a comparable structure that would guarantee an equitable opportunity of health care use for all social classes. Competition between the two Koreas became one of the contributing factors towards mandatory health insurance legislation in the mid-1970s.

Second, with speedy industrialization in the 1960s, people began to realize that some of their physical sufferings were not solely their own responsibility. Exercising their voting rights, people in the workplace demanded health insurance schemes which mandated employer’s premium contributions.

Third, unilateral government policies promoting economic growth during the period of 1960-76, which resulted in an unequal distribution of wealth among classes, raised social equity issues. To avoid conflicts among classes, the government had to introduce the concept of social welfare into its policy agenda. The first outcome from such changes was the introduction of a health insurance scheme. The government and the leading political party pushed the idea with the hope that it could somehow solve the inequities, the injustice, and the unnecessary burden of being sick, brought about by rapid industrialization.

Fourth, expansion of health insurance coverage was a popular political subject. As the gap in health care utilization between the insured and the uninsured widened in the early 1980s, the majority of the uninsured pressed politicians to advance the expansion of health insurance schemes. Politicians, especially the leading Democratic Justice Party then, took an initiative to start and gradually expanded health insurance coverage.

Fifth, the growing strength of the Korean economy since 1960 was another factor that made the expansion of health insurance programs feasible. With
increased GNP and per capita disposable income, not only was the government able to finance part of the expenditures of the schemes, but also people could afford paying premiums and other related expenses. For example, two sudden jumps in the rate of beneficiaries in 1988 and in 1989 were feasible because (i) people were willing to pay premiums, and (ii) the government promised it would be responsible for part of the expenses incurred.

Sixth, consumers, faced with swelling expenditures from increased health service utilization and rising medical fees, preferred to be insured than to take the risk of being uninsured. In general, there was not much disagreement amongst the public about going to a universal health care security system, though there were some debates on whether the tax-financed National Health Service system or the premium and user-fees-financed NHI was appropriate. It had been hoped that every Korean would have health insurance and the financial burden of the system would be shared fairly among social classes.

There are other elements as well that contributed to achieving universal health insurance. One is the existence of a strong public executive and the other is a "regulation-oriented" intellectual tradition. Lastly, since there was no dominating private insurance that could have blocked any reform trial, the government could easily move forward towards its goal.

Recent reform in the NHI: Consolidation of insurance funds

In February 1999, twenty two years after the introduction of first public health insurance scheme, and twelve years after the inauguration of the NHI, the Korean Parliament passed the 'National Health Insurance Act', which mandates the consolidation of all health insurance funds into a single fund. Through this Law, Korea embarked on a transition from a multiple sickness fund system to a single fund system. This transition is part of the health care reform package that the country has been pursuing during the last ten years. It is a rather big change, and one that has been supported by various social groups, including civil non-governmental organizations.

The basic philosophy underlying the consolidation of insurance funds is the solidarity principle. The proponents of the consolidation of funds argued that social cohesion among different social groups could be strengthened through having the solidarity principle in the delivery of health services. They further argued that applying the solidarity principle to health insurance scheme is an important and necessary first step towards strengthening 'social safety nets' in Korea.²

² The need for ‘social safety net’ is particularly emphasized with the rising unemployment rate these days. As one of the conditions of World Bank Loan (after the economic crisis), the Korean government agreed with the Bank to have a reasonable social safety net for the destitute, including the unemployed.
As shown in Figure 16, the transition from 373 insurance funds to a single fund involves two stages. In the first stage (Stage I), 227 Regional Insurance funds are being merged with the Civil Servant Insurance fund, thus creating a single fund which is named the ‘National Medical Insurance Corporation (NMIC)’. This process was completed by September 1998, and the NMIC was launched on October 1, 1998. In the second stage (Stage II), all Corporate Health Insurance Funds were merged into the NMIC, thus creating a nationwide single fund which covers the whole population under one umbrella. The single fund, National Health Insurance Corporation (NHIC), was launched in July 2000. The NHIC now functions as the central cortex of health insurance administration and delivery of insurance services.

Before the integration of funds in 2000, the NHI faced problems of large financial discrepancies between funds, inequitable and insufficient risk pooling among beneficiaries, and low-level economies of scale. For example, the proportion of administrative costs to total insurance expenditure was 8.5% on average in 1997.

The transition of NHI structure from a multiple fund system to a single payer system entails a substantial improvement in administrative efficiency. The total number of funds has been reduced from 389 to one (with 242 branch offices), and the number of employees working in the funds has been reduced by one-third (from 15,036 employees before consolidation to 10,716 after full integration (NHIC inside report, 2003). With this increase in fund size and the decrease in number of employees, a reduction in annual administrative costs is realized. The percentage of administrative costs out of total insurance expenditure was significantly reduced from 7.3% in 2000 to 4.4% in 2001. The new structure witnesses a good size economies of scale. The saved administration costs could be used, for example, to lower user changes for low income class or to expand insurance coverage for the currently uncovered services.

Figure 16. Two Stages in the Process of Consolidation

(Stage I) (Stage II)

Regional HI (227 funds) NMIC NHIC
CS/SE HI (1 fund)
Corporate HI (145 funds) Corporate HI
Needless to say, risk pooling has been improved a lot through the consolidation of funds. Since the whole population (farmers, business employees, and self-employed) is under one insurance scheme, risks of different population groups are now pooled and spread over the entire population.

3. The Current NHI Structure and Organization

**Administration**

By July 2000 when stage II of the consolidation was complete, the structure of the national health insurance system was as shown in Figure 17. The business of public health insurance is separated into two parts; administration and delivery of health insurance services by the NHIC, and review of claims and technology assessment by HIRA (Health Insurance Review Agency). Both are under the supervision of the Ministry of Health and Welfare in terms of operational budgets, but they are autonomous in their functions.

Major operations, such as determining the level of contributions, level of service fees, reimbursement to providers, fund management, are the responsibility of NHIC. Meanwhile HIRA takes the role of (i) reviewing the appropriateness of claims made by providers and (ii) assessing new medical technologies, including new drugs.

The role of NHIC is assisted by 161 branches that are geographically spread over the nation. The NHIC also runs a medical center, a general hospital with 650 beds, to have on-site experience in both clinical and health promotion services.

*Figure 17. Administration structure of national health insurance*

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### Diagram

- **Ministry of Health & Welfare**
- **NHIC**
- **Health Insurance Review Agency (HIRA)**
- **161 branches**
- **6 branches**
- **NHIC Medical Centre**
**Financing**

The premium collection formula for salaried employees is different from the one for the self-employed. However, an uniform formula is used for all employees, and the same is true for all self-employed. There is one uniform premium rate, 3.96% of wage in 2003, for all the salaried employees, which is shared equally between employer (government for public sector workers) and employees. The premium basis for self-employed workers is taxable income, assets, automobiles, sex, and age. Government paid 45% of insurance expenditure of the self-employed in 2002. About four percent of salary as contribution rate is one of the lowest among OECD economies, and is the reason why the service coverage is constrained so much.

**Benefit package**

The benefit package is the same for all population groups. Benefit days, that is, the number of days of medical and drug treatment covered by insurance – expanded to 180 days in 1995, and to 365 days in 1999. Population coverage expanded step by step, starting from the people with sufficient ability to pay, corporate employees, then towards the self-employed and to those in the informal labour sector.

The extent and the level of benefit coverage are determined by the government. Most of the outpatient services and high probability inpatient services are covered by health insurance. However, many of the low probability but high cost services are excluded. Exclusion of high cost services is due mostly to the limited size of the insurance fund. Most of these excluded services are new or expensive high technology related medical services (such as MRI and ultrasound diagnostic tests).

**Payment and reimbursement**

As shown in Figure 15 above, patients pay according to fee-for-service (FFS) for all services at all referral levels. FFS has been the dominant method of payment for physicians (both Western and traditional medical practice), clinical services, and pharmacists. A demonstration with case payment structure\(^3\) using Diagnostic Related Groups (DRGs) began in early 1997. That was the first time that a payment structure other than FFS has been tried in the Korean health system. However, the case payment structure is not welcomed by provider groups, unless a substantial financial incentive is attached to it. Unfortunately, it is doomed to fail. Physicians at

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\(^3\) It is a form of fixed compensation per episode which was originally developed by the US. In the US, the method is called DRG (Diagnostic Related Groupings).
hospitals are paid salaries, and occasionally they are paid bonuses based on their performance.

The fee schedule is determined through negotiation between representatives of provider groups and the Chairman of the NHIC at the end of each year. When negotiation does not produce an agreement on the level of fees in time, MOH determines the fee levels through a committee meeting. Up to 2003, negotiation between the two parties has never been successful, implying that the government determined the fee levels.

4. Social Security and Social Assistance Programmes

In addition to the health insurance schemes, there are government financed public assistance programs for medical care: Medical-Aid (i) for the destitute and (ii) for the medically indigent (see Figure 15). The first category of beneficiaries consists of individuals who are extremely poor, or those living on public facilities, such as the homeless and elderly people without supportive family members. The second category includes individuals whose income and other means falls below a specified standard. As of 2003, 97.0 percent of the population are covered by health insurance and the remaining 3.0 percent are under the public assistance Medical-Aid Program (Yearbook of Health and Social Statistics, Ministry of Health and Welfare, 2003). The benefit package of Medical-Aid is the same as the health insurance benefit package. In other words, those services that are not covered by health insurance (such as ultrasound, MRI and some special treatments) are also excluded from Medical-Aid coverage. The number of benefit days by Medical-Aid is 365 days.

As shown in Figure 15, tax-financed public health centers provide preventive services mostly, including MCH, vaccination, child health, preventive dental, health education, and health screening. Some outpatient curative services are also provided at health centers. In some rural regions, health centers provide inpatient services as well, but on a limited scale. In the 1950s, government established national hospitals for tuberculosis and for mental illness. They still exist, and the need for separate services of this kind still remains.

5. For-profit Commercial Health Insurance

There are commercial health insurance schemes in Korea. The first such a program was introduced in early 1980s, and the private health insurance market gradually expanded during the last decade (Choi, 2003). Currently, many life insurance and damage insurance companies carry private health insurance programs. In most cases, they cover only cancer-related expenses. It is because cancer treatment is usually catastrophic and is not well-covered by NHI. In this sense, one could say that private health insurance in Korea is a form of complementary health insurance, complementary to social health insurance program (SHI). There is yet a single case of private health insurance program which is a substitute for SHI.
The rate of Out-of-Pocket payment varies among cancer patients, depending upon what kind of hospital used and the class of services (single bed room, double beds room, or multiple beds room) patients receive. However, it is, on average, about half of the total treatment costs, which could be substantial for many cancer patients. Private health insurance covers this portion of total expense, i.e., the out-of-pocket payments that are not reimbursed by NHI. However, it is interesting to note that reimbursement of private cancer insurance is (i) not linked to the actual amount of out-of-pocket payment, but is a fixed amount of benefit; and (ii) is always a cash payment. In other words, in most cases, when a patient is diagnosed as a cancer patient, he/she will be reimbursed a fixed amount in cash by private insurance companies.

Over time, as shown in Table 12, in terms of total amount of reimbursement, the market for private health insurance has been growing continuously and rapidly. The rate of growth was a bit slowed down during the period of economic crisis (late 1997 to early 1998), but it soon returned to the previous high growth trend. Unfortunately, official statistics on the number of population who purchase private health insurance programs is not available. A recent report by a local newspaper estimates the number could be over 10 million (about 20% of whole population), and that the market growth rate in terms of total premiums could be over 10% in the coming years.

As the Korean society is aging rapidly, the likelihood of introducing private long term care insurance programs by commercial companies is becoming greater. When such a program is brought in, private health insurance market will be even larger, and will play an important role in protecting people's health in Korean society.

Table 12. Amount of reimbursement of private health insurance schemes

<table>
<thead>
<tr>
<th>Year</th>
<th>Current amount (1)</th>
<th>Real amount (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>505,846</td>
<td>505,846 (100)</td>
</tr>
<tr>
<td>1997</td>
<td>744,478</td>
<td>713,102 (141.0)</td>
</tr>
<tr>
<td>1998</td>
<td>1,001,201</td>
<td>891,541 (176.2)</td>
</tr>
<tr>
<td>1999</td>
<td>1,453,356</td>
<td>1,283,883 (253.8)</td>
</tr>
<tr>
<td>2000</td>
<td>2,042,419</td>
<td>1,765,271 (349.0)</td>
</tr>
</tbody>
</table>

(1) Unit: million Korean Won.
Source: Research Centre. Private Insurance Development Institute, September 2001

6. Critical Appraisal of NHI Financing Mechanism

The gradual expansion of health insurance plans, in conjunction with the growth of the private sector, has resulted in increased demand for services and higher-quality
The nationwide coverage of health insurance has contributed to increases in health service utilization and to upgrading the level of health of the people. The growing private sector imported new medical technologies aggressively and competitively, resulting in an apparent increase in the quality of health care.

Annual health insurance statistics reveal that with the expansion of health insurance, the utilization of both inpatient and outpatient services has been increasing continuously over the last two decades, and that consumers, who believe private general hospitals provide better services, prefer care at general hospitals rather than at government hospitals or clinics.

However, these changes involved costs in the form of inefficiency and inequity, which stemmed from mishandling of the evolving health system during the last three decades. As the market share of the profit-oriented private sector rose, many undesirable aspects developed in the system, over which the government has had very little control. Some issues arising after the NHI establishment include high user charges and weak public financing, commercialized health care, payment-reimbursement method, lack of a referral channel, and the financial insolvency of NHI.

**High user charges**

Insurance coverage under NHI is limited in several respects: some of the expensive services are excluded as health insurance benefits; the “special treatment charges” which are not covered by health insurance come along with services in general hospitals, and the co-payment rate is high even for services which are covered by the insurance. The result is that only about 54% of total medical expenditures are covered by NHI in Korea, and the rest are out-of-pocket payments. A share of out-of-pocket payment that is higher than 30% is seldom found in other social insurance schemes. Based on available information, the Korean out-of-pocket cost rates appear to be one of the highest in the world. This aspect raises, by nature, the issue of equity in access to health care.

**Weak public financing**

The public share of total health expenditure in 1998 was 46.2%, the lowest among OECD countries with social insurance systems. Out of the 46.2%, 12% is from government sources and the remaining 34% is from NHI. In Table 13, the Korean figures are compared to those of OECD averages. Due to the expansion of health insurance coverage, the public share in Korea has risen over the past years, but it remains far lower than the level of OECD countries. As well known, the aspect of weak public financing is just another side of the “out-of-pocket” coin. Therefore, weak public financing leads to the same equity issue as generated by high user charges.

<table>
<thead>
<tr>
<th></th>
<th>Public share (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Republic of Korea</td>
<td>-</td>
</tr>
<tr>
<td>21-country average*</td>
<td>71.8</td>
</tr>
</tbody>
</table>

* OECD average is for those 21 countries that have relatively a complete data set.
Source: OECD Health Data 2002.

Dominant private sector

Another health insurance financing issue in Korea is the dominance of the private sector in health care delivery. The private sector, which was dominant in Korea before the introduction of social health insurance, has grown with the increase in per capita income and with the expansion of health insurance coverage. The private sector in Korea includes both non-profit and for-profit health care facilities, with university teaching hospitals as a separate category. In 1999, public hospitals accounted for only 7% of all hospitals, and 20% of all general hospitals (see Table 14).

Table 14. Public and private medical facilities, 1999

<table>
<thead>
<tr>
<th>Ownership</th>
<th>General hospitals (%)</th>
<th>Health care facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospitals¹ (%)</td>
<td>Clinics¹ (%)</td>
</tr>
<tr>
<td>Public</td>
<td>20.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Private</td>
<td>58.0</td>
<td>91.9</td>
</tr>
<tr>
<td>Non-profit</td>
<td>18.0</td>
<td>61.9</td>
</tr>
<tr>
<td>Corporation</td>
<td>40.0</td>
<td>30.0</td>
</tr>
<tr>
<td>For-profit</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>University</td>
<td>21.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Total — Percent</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

¹ Excludes dental and medicine hospitals and clinics.

In 1980, three years after the first NHI program began, 53% of all beds were public (see Table 15). By the late 1990s, the share of public hospital beds had dropped to 13%, and 87% of all hospital beds were in private clinics and hospitals. Table 5 also shows that over 90% of all physicians work in the private sector, compared to nearly 50% in other Asian newly industrialized countries (NICs). The change in hospital bed ownership has been dramatic, and the trend is expected to continue at least in the near future.

The fact that the private sector is dominant in health service delivery is not in itself a problem. The real issue is that frequent conflicts arise between the public health authorities and private providers during the course of health policy
implementation. In the absence of public sector leadership in health care delivery, private providers as a group oppose any policies that could reduce the size of their pie. For example, when the “Separation Policy” (separation of drug prescription and dispensing under health insurance) was introduced in 1999, private providers fiercely opposed to the policy for fear of losing revenues. The private providers eventually went on strike four times in a six month period.

Most of the public health policies are challenged by the private provider groups, without questioning their relevance for the health of the population. To deal with this problem of conflict, the Korean government recently set a target of ‘30% public sector’ in health care delivery. The plan is to increase the share of the public sector in health service delivery to 30% by 2008.

**Table 15. Public sector’s share of total physicians and hospital beds**

<table>
<thead>
<tr>
<th>Countries</th>
<th>Physicians</th>
<th>Hospital beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1980 (%)</td>
<td>Late 1990s (%)</td>
</tr>
<tr>
<td>Hong Kong SR</td>
<td>NA</td>
<td>45</td>
</tr>
<tr>
<td>Singapore</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>NA</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Taiwan</td>
<td>31(1993)</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: Ramesh. M., Social Policy and Administration, Vol. 37, No. 4. p.369

**Lack of referral channel**

In most cases, patients are given a choice of providers; they can choose among various providers at multiple referral levels. Because there is no patient referral channel, they can go directly to the outpatient departments of general hospitals. Consequently, within the system, a “gatekeeper“ - someone who could guide the patient to a proper provider or proper level of care - is virtually unknown. Since most patients prefer to be treated in general hospitals, both the outpatient and inpatient departments in general hospitals are overcrowded. In the absence of “gatekeepers“ in the system, there is inefficiency and a lack of cost effectiveness. Simple illnesses are treated expensively; for example, common colds are often treated by internists in general hospitals and simple headaches are treated by neurosurgeons in general hospitals. Moreover, patients often seek care from both Western and traditional physicians, and sometimes also from pharmacists, for the same episode of illness. This practice increases the revenues of the providers but does not necessarily give the patients appropriate care. Here the issue is possible
high inefficiency stemming from misuse and overuse of services. Value for money is not properly pursued in Korea's health care delivery.

**Payment reimbursement method**

As shown in Figure 15, patients are charged according to a fee-for-service (FFS) payment method at all referral levels. This system leads to abuse as the FFS method provides perverse incentive for providers to cheat, and ill-informed patients are easily subject to induced demand for unnecessary services. The combination of (i) dominance of the for-profit private sector, (ii) weak public financing and high user charges, (iii) inappropriate government regulation, and (iv) FFS makes the Korean health care system expensive, inefficient, and inequitable. The above combination of market conditions also contributes to the creation of classes among people who need health care. Some hospitals are mostly populated with the affluent, while health centres are the only resort of the medically indigent poor.

**NHI financial insolvency**

In 1975, the percent of GDP spent on health care was a mere 2.8. Between 1975 and 1997, the Korean economy recorded unprecedented high growth rates. As shown in Figure 18, from 1985 through 2001, the health care share of the total economy grew from 4.0% to 6.4%, with an annual rate of increase of around 23%. The increasing share of health costs as a proportion of GDP, therefore, signifies how fast the health sector expanded during this period. It is expected that the rate will be even higher over time.

Many factors contributed to the rapid increase in the national health expenditure. A substantial part of the total cost escalation is attributable to the increase in treatment costs. Data from health insurance expenditure show that total insurance expenditure has been increased by about 24% during the period of 1990-2001. Increases in the expenditure on treatment can be explained by several factors: providers inducing more patient visits per case (supply side); more complex cases, and insured patients paying less out-of-pocket and asking for more expensive and presumably higher-quality services (demand side).

The increases in the supply of private providers, as well as the incentives created in the payment mechanisms, have caused cost increases. A natural consequence is the financial deficit of NHI. The NHI fund is currently faces a severe deficit, paying interest for borrowed money from financial markets (see Table 16). The Korean government has health authority and devising ways to tackle this as a national priority issue.
7. Conclusion

The development of Korea from an agrarian to an industrial society served as the vehicle for the establishment of NHI. As consumers approved the idea of universal
health insurance, politicians pushed forward in recognition of public demand. The growing economy helped form NHI financially and there were no influential opposing forces existed in the market economy. As far as achieving NHI is concerned, fortunately all sectors of the economy worked in a harmonized way.

However, Korea faces persistent difficulties with the delivery and performance of its health care system, despite its implementation of NHI in 1989. Inequity and inefficiency is embedded into the structure of health care delivery. Underlying this is the fact that the health care system of Korea is inflationary by choice. It is inflationary not simply because people demand more health care services, but because of the way the system is structured; it induces an expanding amount of service provision and consumption and, furthermore, of more expensive services. On the other hand, the treatment needs of the many medically indigent persons are ignored within the system. As mentioned before, background of these deficiencies lie in the structure of fee-for-service, dominance of for-profit providers, weak public financing, and inappropriate government regulation.

Nothing is more basic to any government than ensuring adequate care for the poor, the elderly, and the disabled, and yet, Korea fails to do this. While the 1980s and early 1990s saw a rapid expansion of private health care, the story of the late 1990s is likely to be one of consolidation into giant for-profit hospital chains. This trend has already been triggered by Jabul (business tycoon) hospitals such as Samsung and Hyundai Hospital. This kind of growth can only exacerbate the current problems in the health care system.

There are many aspects of our lives that are best left to market forces to determine without interference from government. Unfortunately, health concerns are not always among them. Consumer health and quality of care are neither protected nor guaranteed by pure market forces. No country has succeeded in having a sound health system by relying solely upon market forces. Some form of regulation of both the public and private health sectors is necessary, with the government and the professional associations as principal actors in the regulation.

Korea missed a good opportunity to have a sound health care system when additional resources were pumped into the system by NHI. Now with NHI fully implemented and providers adjusted to it, it may be difficult to achieve even minor reforms. But, unless basic reforms are tried, resources will be wasted, consumers will not be protected, health care expenditures will continue to rise, insurance coverage will not be expanded, and, consequently, the accessibility of essential care to low-income families will be further reduced. Without reform now, the problems will become more widespread, persistent, and intolerable in the future.
References

1. **Background**

The Lao PDR, landlocked between China, Vietnam, Cambodia, Thailand and Myanmar, is ranked number 135 out of 175 countries in the 2003 Human Development Index. The Gross Domestic Product (GDP) is US$ 331 per capita. According to the National Statistics Centre the population size was estimated to be 5.5 million in 2002. Of the total population, 80% live in rural areas and are mainly engaged in agricultural work. The rural areas are often difficult to access and largely underserved in terms of medical service and access to education. The Population growth rate is 2.8% per year. Life expectancy at birth was 59 years in the year 2000. The under-five-mortality rate is 106 deaths per 1000 live births while the maternal mortality ratio is 530 deaths per 100000 live births.\(^a\)

The population is characterized by a large percentage of persons under 20 years of age (55%) while only 5% are over 60 years.\(^b\) However, the fertility rates have been declining in recent years while life expectancy is increasing.

The 1995 census showed that the labour force was approximately 2166,000 persons. Roughly 22% of the labour force work in non-agriculture occupations: 28% as public servants (civil servants, military, police) and 72% work in the private sector and state-owned enterprises (SOE).\(^c\)

**Public health sector**

The public health sector has always been critically under-funded. In 1997-1998, 3.2% of the GDP or US$ 11.50 per capita per year was spent on the health sector. Out of this amount the government covered US$ 1.30, foreign aid covered US$ 3.50 while the households covered US$ 6.70.\(^d\) Out of pocket health expenditure can thus take

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\(^a\) Millennium Development Report Lao PDR, Final Draft 5.0, January 2004  
\(^b\) The Households of Lao PDR, Social and economic indicators, Lao Expenditure and Consumption Survey 1997/98 (LECS2), 1999  
\(^c\) Development of Social Security in Lao PDR and Future Steps up to 2005,  
\(^d\) Common Country Assessment, The Lao People’s Democratic Republic, UN, Vientiane Lao PDR, December 2000
up a large part of especially poor families’ income and lead to debt and severe poverty.

The high cost is one of the reasons for the underutilization of health services in the Lao PDR. Another reason is the low quality of services provided. The situation of public health workers is characterized by irregular payment and substandard working conditions. There are anecdotal reports of “under-the-table” payments in health institutions, but the frequency and size of this phenomenon is not documented. Another way to assure income for public health workers is to engage in private business such as running one of the 2000 pharmacies in Laos. Studies show that 64% of medical expenses are actually spent at private providers and pharmacies while only 36% are spent at the public health system.

Due to the necessity of earning extra income in private business, the number of health workers in the public clinics is frequently limited. Thus the public sector faces problems in delivering health care to the population. This affects especially the rural and poor population, which has limited access to and choice of health service providers.

2. Development of Compulsory and Voluntary Health Insurance

Compulsory prepayment mechanisms

The Lao People's Democratic Republic was established in 1975 and introduced a one party socialist government. Part of the political ideology was to secure civil servants by providing them with a wide range of social security benefits to compensate for their low income. Hence, all 80-90,000 civil servants (not including the military and the police) are members of the government-run Civil Servants Scheme.

Due to economic stagnation the government decided in 1986 to introduce the New Economic Mechanisms (NEM). Market economy principles and reforms were introduced, stimulating the private sector and decreasing the size of the public sector and the number of SOEs. As a consequence, the garment industry and the service and construction sectors in the urban areas of the country grew, which resulted in increased numbers of non-state employed people with salaried employment. In 1994 the Labour Law called for the introduction of social security systems for these employees. The government of Laos in collaboration with the International Labour Organization (ILO) therefore decided to introduce the idea of setting up a Social Security Organization (SSO) targeting this group of employees. With the promulgation of Decree 52 in 1995 the government no longer provided free

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e The study on the improvement of health and medical services in the Lao People’s
health care. It was therefore decided to include health insurance as an essential part of the benefits provided under the SSO. The main Lao players in the development of SSO were the Ministry of Labour and Social Welfare, (MoLSW) and the Ministry of Health, (MoH).

As part of the preparation to set up the SSO, the Prime Ministers Decree No 207, Decree on Social Security System for Enterprise Employees, was drafted, widely distributed and then signed in 1999. This Decree is the main legal document determining decisions taken in regard to the SSO. There are plans to revise the Decree 207 after the initial four years of operation.

In June 2001 the SSO started operating. As most workers in private and state-owned enterprises are located in the capital city of Vientiane, the initial pilot implementation was started there. The SSO targeted all state owned and private enterprises in Vientiane with more than 10 employees. The SSO has now operated for two and a half years and currently has 20349 members of whom 12556 are females (62%) and 11767 (58%) are single. So far no extension to other provinces with high numbers of workers employed in private or state-owned enterprises has been initiated. However, there are plans to introduce the system to two districts in Vientiane province.

**Voluntary prepayment mechanisms**

With the end of free health care in 1995 the vulnerability of the indigent section of the population increased, as unexpected medical expenses posed a serious threat of pushing them into deep impoverishment. While social security schemes had been introduced for salaried workers, no health insurance scheme was targeting the 80% of the population working in the informal sector, mainly engaged in agriculture. The Lao government recognized the urgent need to approach this uncovered group and in May 2000, requested assistance from the World Health Organization (WHO) to set up a voluntary community based health insurance scheme (CBHI) to target people in the informal sector. With financial support from the UN Trust Fund for Human Security and technical assistance from the World Health Organization, the development of the pilot phase of CBHI commenced in 2001.

A Health Insurance team was set up at the Department of Planning and Budgeting in the Ministry of Health. Its main task was to design the CBHI scheme, link with other health authorities, assist in the implementation of the pilot scheme, develop systems to extend to more areas, develop a monitoring and evaluation system and to evaluate the CBHI in the wider context.†

† Community Based Health Insurance, Vientiane; Work plan preparation phase, Report on Community Consultation, March 20002

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*Selected Case Studies from Asia and the Pacific*
It was decided to start the implementation of CBHI in three pilot sites in:

1. Nine villages of Sisattanak (an urban district of Vientiane Capital);
2. Nam Bak (rural district town in the northern province of Luang Prabang, and
3. Part of Champassak (rural district in the southern province of Champassak).

The CBHI started providing health care benefits in the Sisattanak site in December 2002, in Nam Bak district town in July 2003 and in the Champassak site in January 2004. Ahead of the launch, the ministerial team in collaboration with WHO experts spent one year developing the design of the scheme. This involved various studies, training, awareness campaigns, community consultations, financial calculations and the development of local management bodies, regulations and necessary forms. As the SSO was established only a couple of years earlier, lessons learned from its start-up phase were taken into account in the development of this scheme.

Currently 1426 families have enrolled in the three pilot schemes covering 8238 people.

3. Compulsory Health Insurance

As of now, there are so far two compulsory prepayment health insurance systems in place in Lao PDR. The Civil Servant Scheme (CSS) covers employees in the public sector (administration, teachers, health staff, army and police) and the Social Security Organization (SSO) covers workers in private and state-owned enterprises. Both schemes are under the management of the MoLSW.

Civil Servants Scheme (CSS)

The 15 staff at the Social Security Department at the MoLSW deal with all issues related to the Civil Servant Scheme. Since 1989, civil servants contribute to the CSS with 6% of their salary, which is deducted automatically by the Ministry of Finance every month. However, as salaries are low (average monthly salary is 200000 kip ~ US $19.2) while the range of social benefits to be covered is extensive, the financial resources of the scheme are not sufficient to cover costs. No funds have been accumulated as reserves so far. The government does not contribute to the scheme with a fixed percentage or amount. Instead the national treasury contributes according to current ability in order to provide the most necessary amount.
The Civil Servants Scheme provides multiple social benefits such as retirement pension, health care and cash benefits for disability, maternity and funerals. The eligible persons are the civil servant, the spouse and all children under 18. As for the health insurance part, the scheme aims at covering medical expenses of the insured persons. People are free to seek treatment at any clinic or hospital and there is no waiting period as they are eligible at the time they enter the civil service. Civil servants have to pay the fee for services directly to the provider and are reimbursed on submitting their claim to the local branch of the MoLSW. For civil servants living in the provinces and rural districts the process may take up to 4-5 months as claims are referred to the provincial section of the MoLSW, which again refers them to the Social Security Department at the MoLSW. Here the final decision is taken on how much to reimburse. The scheme is supposed to reimburse all claims up to 1,500,000 kip (~US$ 144). However, this is rarely practiced and decisions on the amount to reimburse are taken on a case-to-case basis.

Health insurance through CSS is characterized by a time-consuming procedure, which often results in very late and partial reimbursement. Civil servants may not even file the claims, as the process is too lengthy compared to the benefit expected. As civil servants pay the provider directly and file the claim to the MoLSW, there is no contact between the MoLSW and the providing clinics and hospitals.

A reform of the CSS has been underway for some time. However, so far no official changes have been announced or initiated to restructure the scheme. The idea of introducing a pilot project in Vientiane Capital using the capitation system has been mentioned. The long-term goal is eventually to merge the Civil Servant Scheme with the Social Security Organization.

Social Security Organization (SSO)

After a five-year preparatory phase, the SSO started collecting contributions in June 2001. The main organizations involved in the preparation were the Ministry of Labour and Social Welfare and the Ministry of Health. External assistance was provided mainly by ILO, the United Nations Development Programme (UNDP), the Belgian Technical Cooperation (BTC) and WHO. Policies were developed; Decree 207 was printed and distributed. Management structures were then determined and staff were recruited and trained. Important issues were the identification of the three providers (central hospitals), and the requirements for information systems for the health services and membership database. The necessary information system was then developed and staff in the SSO and hospitals received training on the use of the system. Studies on target enterprises and employees were undertaken, awareness
campaigns implemented in target enterprises and information on SSO and its benefits broadcast over the radio.

Although under the MoLSW, SSO is located in a separate office in Vientiane. The SSO has around 35 staff and of these, roughly 50% are civil servants appointed and employed by MoLSW while the rest are employed directly by the SSO. Changing the status of SSO staff from civil servant to SSO-employee is a step in the transformation of the SSO into an autonomous parastatal body rather than a part of the MoLSW. The supreme governing body of the SSO is the Board of Directors, which includes members from government, employers and employees (trade union). It is responsible and accountable for all activities of the SSO. A management team in charge of the daily management of activities includes one director and two deputy directors, all appointed by the MoLSW.

The administrative and managerial tasks are organized into different divisions as required (registration and contributions, claims, computer service, policy and legislation etc). In the Health Insurance Division there are sub-divisions taking care of: quality control and complaints; contracts and administration; benefit package and capitation payment; research and development and public relations. A Medical Board advises the SSO on overall health care issues. It consists the directors of the three provider hospitals, two staff from SSO and six persons from Ministry of Health and Vientiane Capital Municipal Health Department.

SSO members (employees) contribute to the fund with 4.5% of their salary (average monthly salary of SSO members is 500,000 kip ~ US$ 48). The employer contributes with an amount equivalent to 5% of the employee’s salary and transfers the total of 9.5% directly to the SSO account every month. The SSO uses 4% of the 9.5% for health insurance purposes, which include services for both work-related and non-work related illness and injuries.

That is, the SSO health insurance has health care for work injuries incorporated into a single fund. Out of the amount accruing from these contributions, 50% is used to pay the capitation rate to the provider and 50% is kept for other purposes.

Records to date show that the costs foregone by providers have been about 50% of the capitation fee paid. So far neither SSO nor the providers have developed a plan on how to invest the savings or the amount kept in reserves.

Before the scheme started operation, studies on costs of care and expected utilization levels were carried out to determine the appropriate capitation rate. Despite the recommendations based on these studies, a higher rate was chosen when implementation started. At the launch the capitation rate was 80000 kip (~ US$ 7.7) per year per member covering all eligible dependents of the worker (as one unit). In that initial stage, the coverage of dependents was limited, as explained later. In the
following year it was raised to 100000 kip (~9.6 US$). Recently the SSO has decided to change the rate to 60000 kip (~ US$ 5.8) for each worker and for each eligible dependent of the worker.

The contracts between SSO and providers are signed every half year. However, after being in operation for 2 ½ years the providers are confident that SSO would be able to fulfil its financial commitment of the contract. From 2003 the contracts will therefore only be re-negotiated once a year. The SSO pays the providers 1/12 of the annual capitation rate on a monthly basis. The fluctuation in the number of SSO members is limited and the discrepancies are calculated by SSO on a monthly basis after receiving the exact number of members and their choice of hospital. Too little or too much capitation is balanced with the provider at the next capitation transfer. If an SSO member seeks emergency treatment in a hospital different from the chosen provider, the provider will reimburse the member directly.

Although Decree 207 stipulates that all children up to 18 years of age should be covered by the scheme this has not been implemented so far. Initially children up to five years of age were covered. In the following year, coverage was extended to include the spouse and children up to five years and in the following year, to spouse and children up to 10 years. Together with the planned change of capitation rate, the scheme will from early 2004 cover children up to 18 years as intended in Decree 207.

A benefit package has been developed by SSO to clarify for providers and members which services and drugs should be provided free of charge for the members and eligible persons. If special medication which is not included in the national essential drug list is necessary for the treatment of a member, it can be covered by SSO with the appropriate request. A list of exemptions has also been developed including treatment of traffic accident related injuries.

There is a waiting period of three months before services can be utilized. However, for work-related injuries, services are covered from the date of enrolment. So far only the three central hospitals in Vientiane City have been chosen as providers. District hospitals and health centres, which usually take on the provision of primary care, have not yet been included. SSO members can change the provider hospital once a year by submitting a form to the SSO.

As stipulated in Decree 207, the membership in the SSO is mandatory for all private and state owned enterprises employing more than 10 employees. However, compliance is weak as the SSO does not have the means to enforce the enrolment of enterprises that fail to register or to fine enterprises that are late with the payments.

Laos has joined the ASSA, the ASEAN Social Security Association and will host one of its meetings in 2005. This membership provides an excellent platform for the exchange of experiences.
4. Voluntary Health Insurance Schemes

Community-Based Health Insurance (CBHI)

CBHI is so far the only voluntary pre-paid social health insurance scheme in Lao PDR. It is designed as a non-profit scheme and does not accumulate reserves beyond the current needs. However, up to 10% of contribution revenue can be used to cover operating costs and administration, mainly covering the salary of the account manager and providing incentives for collectors. The accounts manager is the only employee of the scheme and is posted at the district hospital. His/her main duties are to receive contributions from collectors and calculate and pay the capitation amounts to providers. He/she can only issue payments upon permission of the District Management Committee.

The CBHI scheme is autonomous and community-based and is managed locally by District Management Committees which are composed of:

1. Two delegates from the district governor office;
2. Three delegates from the health sector;
3. One village leader for each village covered, and
4. One representative of the Mass Organizations in the covered area.

The Committees consists of one chair (District Governor or Deputy District Governor), two deputy chairs, a secretary and members of the committee. The main functions of these district Management Committees are to collect contributions, contract hospitals, pay capitation, monitor the quality of services, promote CBHI, register new members, receive complaints and mediate between members and the hospitals, produce transparent accounting and provide information and relevant reports.

The District Management Committee is supervised by the Ministerial Management Committee, which is composed of:

- Director of the Curative Department (chair);
- District Governor of the pilot scheme (vice chair);
- Deputy Director of Dept. of Planning and Finance (vice-chair);
- Director of Municipal/Provincial Public Health Office (member), and
- Chief of Policy Division, Personnel Organization Department (member)

The main functions of these Ministerial Management Committees are to lead, supervise, monitor and control the implementation of the CBHI schemes, solve
problems proposed by the District Management Committee and report on the progress of the CBHI to the Steering Committee at MoH.

The scheme receives technical advice from the Health Insurance Division at the Ministry of Health and from health insurance experts at WHO.

The target beneficiaries of CBHI are the population engaged in the informal sector, as they have no access to any other social health insurance. Although the scheme is voluntary, only entire families can enrol. This is to limit adverse selection and provide a better risk-mix among the members. During the preparatory phase, hospital costing studies and community consultations were undertaken. This led to the determination of how much the target population was willing and able to spend on health insurance. As a result, progressive flat rate contribution amounts were developed according to family size. Large families pay higher contributions than small families or singles. However, a modest discount is given for families with many members compared to families with few members. This takes into account the findings that income per capita is lower with increasing family size. Contributions are not identical throughout the country but are adapted to each new setting considering the local socioeconomic situation.

The collectors, who are members of the local community, collect contributions on a monthly basis. The insurance card of the family is stamped upon payment and the status of the family regarding entitlement to services is thereby indicated.

The collectors deliver the contributions to the accounts manager who then updates the lists of members and calculates the capitation amount for the provider. So far CBHI has contracted district hospitals, which again have supra-contracted a central/provincial hospital for referral purposes. Capitation is split among hospitals according to a ratio agreed upon and stipulated in the contract. Members have to seek medical care at the contracted district hospital, which acts as a gatekeeper for the central hospital. If members approach the contracted central hospital directly without being referred, the scheme will not cover the health care costs. Apart from emergency cases the scheme will also not cover for health services obtained in hospitals that do not have a contract with the CBHI scheme.

Members are entitled to a comprehensive list of medical services stipulated in the CBHI regulations and including primary, secondary and tertiary care as long as it is available in the geographical target area. Drugs included in the essential drugs list are also provided without charge. It is the responsibility of contracted hospitals to have 120 of the most frequently used drugs on stock at any time and guarantee their timely replenishment. A list of conditions not covered by the CBHI has also been developed. The exemptions are rather similar to the ones from SSO.
Although there is no official linkage with any of the other compulsory pre-paid social health insurance schemes, the majority of civil servants living in the implementation areas of CBHI have decided to join CBHI although they are already covered by the civil servants scheme.

5. Social Security and Social Assistance Programmes

Civil Servant Scheme (CSS)

According to the Labour Code, civil servants are covered for the following social security cash benefits:

- **Maternity**: Women are entitled to receive full salary for 90 days from their employers or the social security fund if contributions have been fully paid. The total period should include at least 42 days after delivery.
- **Disability**: If the disability is due to an employment-related injury or illness, it is the responsibility of the employers to pay
  - Medical expenses for immediate and continued treatment;
  - Funeral grants and lump sum benefits in the event of death;
  - Full salary for up to six months, 50% of the salary from 6-18 months while the employee is being treated or is undergoing rehabilitation, and
  - Compensation to the worker in case of disability.
- **Old-age pension**: Full retirement pension is given to men aged 60 years and women aged 55 years after completion of at least 25 years of service where contributions have been fully paid. Lump sum options are available for people not eligible who cannot fulfil the above conditions.

The benefits noted above are all part of the overall benefit package of the civil servants scheme and are administered by the same department of the MOLSW. As the entire group of civil servants is part of this scheme, in theory there is good risk pooling. However, as no reserves have been accumulated in this scheme, only limited benefits can be expected. Like for health insurance benefits, the remuneration of the other social security benefits is characterized by modest and irregular payments.

Social Security Organization (SSO)

According to the Prime Minister’s Decree 207, SSO members (salaried employees in private and state-owned enterprises), are covered for the following social security cash benefits:
**Maternity:** A woman is entitled to maternity benefits if contributions to the SSO have been fully paid in nine out of the last 12 months. She will then receive 70% of the insured earnings for a maximum of three months. If she cannot resume work for medical reasons after this period, she will be entitled to sickness benefit. Insured women unable to work during pregnancy or within six months from childbirth receive the cash sickness benefit for 30 days. Thereafter, SSO pays the equivalent of 60% of the insured average salary or wages during the previous six-month period.

**Invalidity:** Invalidity benefits can only be received for persons who have contributed to the SSO for five years. After reaching retirement age, the invalidity benefit will be commuted into retirement pension. If the invalidity is employment-related, no waiting period is required. Benefits include wage compensation, claims for permanent disability, expenses to pay a caregiver and death grants and survivors' benefits.

**Old-age pension:** Insured persons are entitled to receive pension from the age of 60. In some cases persons can retire at 55 and receive pension. People are entitled to an old-age pension if they have paid contributions for a full period of five years. If contributions have been paid for less than five years, the benefit will be paid in a single lump sum. The size of the pension is calculated by taking into account pension points, average wage and a set index.

The above benefits are all part of the mandatory benefit package of the SSO. It is a system that combines risk-pooling with mutual support and is able to deliver the above-mentioned benefits due to realistic contributions and clear definition of benefits. Since the SSO has only been operating for 2 ½ years, so far only maternity and work-related disability benefits have been paid. Old-age pensions can be expected to be requested in two and a half years' time as a minimum of five years' contribution is required to be eligible for this benefit. However, as most of the SSO members are young, many years will pass before the pension expenditure will become a major part of expenditures of the SSO.

**Social assistance programme for the non-economically active and indigent populations**

Laos is one of the least developed countries. In 1997, an estimated 39% of the population had incomes below the poverty line. This indicates the need for wide social assistance. However, as public funding is limited, the needy or indigent population can only expect limited assistance from government, if at all.
While physical rehabilitation falls under the auspices of the MoH, the MoLSW is responsible for assistance to the needy population. The MoLSW provides support for orphans, the disabled – especially the victims of unexploded ordinance - with financial and technical assistance of international organizations and NGOs. However, the support is limited compared to the need and is not provided equally throughout the country. The government does not provide any old-age pension, maternity allowance or other social benefits for the indigent population.

Informal solidarity mechanisms exist as part of the Lao traditional culture. Anecdotal stories indicate that in some communities local emergency funds are set up. Funds may be collected and then distributed to people who experience sudden illness that require funds beyond their financial capacity. In case of natural disasters – mainly flooding – the MoLSW distributes food to the victims. It manages the external donor funds and collaborates with several NGOs and organizations in organizing Food for Work activities supporting both villages hit by disaster and villages with chronic food shortages. The next phase of the ILO programme in Laos will, among others, look into the issue of how to create a coherent structure for welfare activities, thus enhancing the cost benefit of the funds spent on these activities and increasing the coverage of activities.

The Decree No 52/PM on Medical Services promulgated in 1995 put an end to free medical services. Nevertheless, medical staff can exempt poor people from paying user charges for their care. A study of central and provincial hospitals showed that exemptions ranged from 0.3 % to 11.9 % of total fees. Since no official guidelines exist on whom to exempt, decisions are taken on a case-to-case basis.

Since 2002, the Hatxayfong district in Vientiane Capital has provided free health care for the poorest families as part of their poverty reduction programme. The multidisciplinary District Poverty Reduction Committee has developed a set of criteria for poverty and is responsible for the identification of beneficiaries. Cards are issued to eligible families and currently 78 persons out of the total population of about 70500 persons in Hatxayfong district are registered, mainly elderly people and families with numerous children. These families are eligible to receive free health care and drugs at the district hospital. Services are limited to the district hospital as the activities are financed solely through the drug revolving fund of this hospital. As part of the poverty reduction programme the registered people are also exempted from paying school fees and can obtain interest free loans for agricultural activities through an ILO-funded project. The Committee will also assist in finding employment for family members out of work, and mediating between the families and the local enterprises.

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Draft of Lao Hospital Costing Study, 2003, MOH, WHO
The Swiss Red Cross is planning to set up an equity fund, which will assist poor families by buying them membership in the local Community-Based Health Insurance. This will be a local initiative in Nam Bak district in Luang Prabang province, where the first pilot of the CBHI has been implemented. Hence, it will only reach a limited number of households in a limited geographical area.

6. For-profit Commercial Health Insurance

Assurances Générales du Laos (AGL), associated with the French AGF has operated in Laos since 1990 and is currently the largest private insurance company in Laos. Its head office is located in Vientiane while it has branches in all but two provinces. As for health insurance, AGL offers the following:

- Individual health insurance;
- Life insurance, which includes health insurance;
- Group health insurance, and
- Workmen’s compensation insurance

Customers are mainly private people (1 and 2) and staff of enterprises and organizations (3 and 4). Currently more than 1000 Lao citizens are covered by one of these health insurance policies.

Different options of benefits are available within the different insurance policies. The premiums are calculated taking into account the insured person's age, gender, extent of coverage and the type of work (high risk or low risk) for workmen's compensation. The insured are reimbursed by AGL upon submission of their claims, and 100% of the expenses are reimbursed. However, upper limits on the amount to be reimbursed are stipulated in each insurance policy. The maximum amounts are generally not very high. Benefits are paid regardless of whether medical treatment is received in Laos or abroad. Medical care benefit packages include room and board, hospital services, and surgery and doctors fees. Workmen's compensation insurance also provides cash compensations in case total permanent disability or death, and covers the insured workers during working hours as well as on their way to and from work. The waiting periods are of zero, three and six months duration.

A discount on premium is provided if enterprises choose group health insurance and workmen's compensation insurance. These are for example, 10% discount for a group of 21-50 persons and 20% discount for a group of 51–200.

Motor vehicle insurance (liability) is compulsory but poorly enforced in Laos. Many if not most vehicles are therefore uninsured. The current practice in case of an
accident with personal injury is that those involved in the accident have to agree on who should cover medical expenses for the injured.

Lately numerous insurance companies from neighbouring Thailand are offering commercial health insurance policies in Laos. There is no information on how many people purchase insurance from these foreign companies. However, according to AGL, the company is receiving new customers that formerly held insurance in Thai companies. They change mainly out of practical reasons as using an in-country company makes reimbursement and communications easier. Although health insurance is not widespread and is a relatively new concept for many Lao people, AGL has in recent years observed an increased interest for health insurance by the Lao middle class.

7. Critical Analysis of Health Care Financing Through Prepayment Mechanisms

Current population coverage

The overall goal and success criteria for any social health insurance scheme will be to reach universal coverage of the target group and deliver appropriate health services of high quality.

The longest running social security scheme in Laos is the government run Civil Servants Scheme. It is the only scheme covering 100% of its target group as it automatically deducts contributions from the salaries of all 80-90000 civil servants (not including the military and the police). However, although the coverage is optimal, the actual provision of health insurance benefits is low if provided at all. Civil servants may not file claims, as the procedure of doing so involves too much work and is time consuming compared to the expected reimbursement. It also seems that many civil servants have no information about the actions they need to take. The administration of the scheme is characterized by inefficient procedures and lack of clear regulations and transparency. The health insurance under the CSS is therefore not serving as the safety net that it is intended to be.

In recent years Laos has introduced additional social security schemes to provide safety nets for the population. The mandatory SSO currently has 20249 members out of a target population of 343000 (all salaried employees working in the private sector or SOEs). Although the SSO has been running for 2 ½ years, coverage is still limited. So far, only about 6% of the countrywide target population is covered and extension should be implemented in a timely manner considering the lessons learned in Vientiane Capital.
The voluntary CBHI, the youngest of the schemes is still in its pilot phase and therefore coverage cannot yet be expected to be high. At present 8238 persons are included out of about 1690000 informal sector workers and their families in the country. How to take this scheme to scale will present a major challenge. This is mainly due to the huge target group and the barriers that exist for universal coverage of this diverse group of people in the informal sector. Implementation methods for efficient expansion have yet to be agreed upon. The high-level health insurance team in the Ministry of Health cannot be expected to perform outreach activities in all districts, and decentralized CBHI training teams will most likely need to be established to implement the extension. The means of funding the substantial start-up costs is also an issue.

Assuming that the coverage by the private insurance companies is still limited, about 555000 Lao persons are currently covered by a health insurance scheme (insured persons and their eligible dependents covered by SSO+CBHI+CSS). Including only the persons covered by a well-functioning health insurance scheme the number gets much smaller and would reach about 45300 (SSO+CBHI), which means coverage of about 10% (including CSS) or 0.8% (excluding CSS) of the overall population. Although population and workforce numbers are not accurate, they still indicate the challenge that lies ahead if universal coverage is to be achieved in Laos.

**Changes in health-seeking behaviour**

Laos PDR faces a problem of underutilization of health services. This is due to many reasons, one of them being financial constraint of the users. The introduction of social health insurance has removed this financial barrier from the members as they can expect Lao standard treatment without having to worry about the availability of cash at the time of use. By introducing the capitation system it is expected that the level of irrational drug use will be reduced, as only drugs from the essential drugs list will be provided and the capitation as such discourages over-treatment. However, health-seeking behaviour is also very much determined by the proximity of the provider and the time and money needed for transportation.

The SSO is already facing the problem that members can only access the contracted central hospitals, as no district hospitals in the vicinity of their homes are included as providers. This will have an adverse effect on the treatment seeking behaviour of members and their dependents living in the outskirts of Vientiane Capital. Plans for the inclusion of districts hospitals and eventual health clinics are now being developed.

The CBHI schemes will also soon face the problem that the growing pilot areas will overlap with the target area of health centres. The insured members of the CBHI
schemes now bypass these facilities, as they are not contractual partners of the scheme. Plans are therefore being made to include health centres in CBHI contractual arrangements.

The situation at provincial hospitals is generally characterized by long waiting periods while district hospitals are underutilized as people often go directly to major hospitals. The design of the CBHI does not allow its members to seek health care at central level, as every member has to visit the district facility first. The district hospital becomes the gatekeeper, as it will refer only patients that cannot be treated at local level. This leads to primary and other relevant care being delivered by the district hospital rather than by an overqualified central or provincial hospital and should lead to a better utilization of resources.

One desired change in health-seeking behaviour which can result from the introduction of pre-payment schemes is a shift in the provision of health care from private unregulated providers (including pharmacies) towards a higher utilization of public health care facilities. It is anticipated that this will lead to delivery of health care of higher quality and more rational use of drugs.

**Service providers**

A major question concerning the expansion of the SSO and CBHI schemes is whether the health sector is prepared for expansion. As the standard of health services in general is lower in the more remote areas, it is of utmost importance to have an accreditation system in place before the schemes are extended. This system should determine whether specific hospitals and health centres are suitable as providers or not. Uncritical inclusion of sub-standard facilities would raise ethical concerns, as insured members are forced to seek treatment only at contracted facilities. The lack of appropriate provider facilities might be a major barrier for expansion especially in the remote areas.

One of the major complaints about Lao health care facilities in general concerns the quality of services. This is not solely directed against treatment as such but also concerns the basic attitudes of medical staff. Unsympathetic staff might have a greater adverse impact on treatment-seeking behaviour than expected.

**Quality of services**

It should be in the interest of a health insurance scheme to assure members that they would receive high quality health care when needed. However, so far under the SSO there have only been limited efforts to improve the quality of care. It seems that barriers to quality assurance stem from the organizational structure of the SSO. As it is still considered a department under the MoLSW, the SSO does not have an
An independent relationship with public providers. This may prevent SSO staff from critically reviewing the health care provided, as the staff would have to criticize part of their own system. Changing the SSO into a parastatal organization by changing the employment status of SSO staff from civil servants to SSO employees is therefore a step in the right direction.

Another barrier to improving the quality of services is the fact, that the members of the medical board include the directors of contracted providers. As one of the tasks of the medical board is to ensure the delivery of quality health services for SSO members, there seems to be a clear conflict of interest in the composition of the board.

The members of the SSO scheme can change the health care provider once a year. This gives them the chance to choose the provider that offers the best service. Capitation can be considered a motivating factor for hospitals to improve their quality of care by increasing the steady flow of income. However, capitation at the same time also carries the risk of under treatment. The positive impact on service delivered by contracted providers has still to be documented. So far it seems that attracting “customers” by competing on quality is not a driving force of Lao hospitals. Yet it is noted that after the initial year of SSO a considerable number of members changed from one provider to another, which might indicate changing perceptions of the quality of health care. In this regard it would be interesting to look into the main reasons for changing providers to see whether quality issues are a major cause.

It is within the mandate of the MoH to improve the quality of health services. The introduction of health insurance schemes opens new opportunities to push for service improvements. The MoH is therefore in a position to speed up the process of developing hospital standards and accreditation systems and work towards timely implementation. The MoH could also play an important role on the issue of extending the provider system to include district hospitals. As there currently might be interests discouraging the inclusion of lower levels of health care providers in the SSO and CBHI systems, directions from ministerial level might prove helpful in applying this necessary next step.

The health insurance schemes as such have an obligation to constantly upgrade their own management and administration systems to meet the demand and expectations of members. They should take into account the feedback from their members and the SSO in particular should take advantage of their findings through the complaints “hot line” and use this evidence in the development of better services.
Economic incentives

A benefit for providers contracted under health insurance schemes is that they receive a steady income of considerable size through the capitation system. However, it seems that providers so far have not developed plans on how to best use the capitation funds to improve services. So far funds are used for direct cost-recovery of the services provided to members. Large unspent funds are therefore built up under the SSO system, both at SSO level and at the provider hospitals. Figures from the fiscal year 2001/2002 show that for one of the contracted central hospitals, the income due to capitation from SSO was about 10% of the overall hospital income (out-of-pocket user charges and SSO capitation). The expenditure on SSO patients was however only about 5% of the overall expenditure. How to spend the accumulated surplus in a way that benefits the quality of services still needs to be addressed.

There seems to be a concern among members of both SSO and CBHI that “non-members” which pay at the point of service might receive better treatment than insured people. This is a relevant concern, as it is well known that providers under a capitation system might under-treat in order to keep the cost per treatment low, and thereby increase their net income accordingly. It is therefore a concern that needs to be taken seriously. A review and comparison of care provided to both insured and non-insured patients should be conducted by the schemes. A way to boost the motivation of health staff to treat SSO members could be to use a fixed amount out of the capitation fund for an equitable bonus system to all the staff involved.

Both the providers and SSO need to plan on how to use their funds to constantly maintain and improve their services. It is of utmost importance to update computer systems and reinvest in the organization to keep it up to standard. However, as the SSO is still under the MoLSW, it has to follow government rules on how to deal with recurrent costs. This collides with the actual need for improvements (for example, permission to purchase a certain amount of computers a year rather than letting it depend on the actual need).

Impact on health care financing

For purposes of cost containment, the use of the capitation provider payment method as applied by the SSO and CBHI schemes has a clear advantage compared to the fee-for-service reimbursement practised by the CSS. Capitation also supplies the contracted health facilities with a stable source of income for services, administration and improvements and provides a much more visible flow of funding into the health sector. As the members contribute to the funds of these social health insurance schemes, the assurance of proper handling of their funds is of highest importance. Using a transparent financial system will address the concerns
that members might have towards cost-effective handling of “their” money and will have a favourable impact on the compliance of members to stay in the schemes.

The CSS is planning to introduce capitation payment as a pilot in Vientiane Capital as an initial part of their reform. This will most probably improve transparency and feasibility, as the capitation payment is less burdensome to manage for the insurer and easier to implement in a context where staff and administrative skills are limited. The capitation method may create an incentive for better financial management by hospitals, as capitation needs clear information on the cost of different services delivered and the population served.

**Financial protection and poverty-reduction strategy**

The social security schemes aim at providing health care to all their beneficiaries by combining risk pooling with mutual support. Enabling people to seek health care according to their needs, and eliminating the risk of total impoverishment due to catastrophic health expenditures is in line with the Lao National Poverty Reduction Programme, which focuses on “access and quality” of health services to the entire population. However, the needs of the poorest part of the population facing the highest barriers of receiving adequate health care have not yet been addressed by either of the schemes. How to include these people who have little understanding of insurance and no financial means to enrol even with a low contribution has yet to be solved. Creating an equity fund within the CBHI would be one way to approach the problem. However, this would complicate the simple administration of the scheme, which currently needs to develop measures to increase coverage. Furthermore, if funds for the equity fund were received from the government it would endanger the status of the scheme of being totally independent and locally administered. Receiving funds from international donors would also be an option but would cause sustainability problems.

With regard to the SSO, an extension to other provinces should include equity considerations. It should be discussed whether universal contribution rates should be implemented countrywide or whether contributions should reflect the access to services. While SSO members in Vientiane Capital can access advanced services in the central hospitals, the service provided and equipment available at provincial level is less sophisticated.

**Key factors associated with success and failure**

A key factor associated with the success of CBHI is the feeling of ownership by the community, which is created mainly by having a locally known and trusted
management structure. Also the fact, that contributions are being handled in a transparent way and no funds are accumulated reduces the worries about possible fraud, thus improving the willingness to join the scheme.

Using the capitation system has proven to be a successful way of paying for services under SSO and CBHI. On the contrary, using the fee for services under the CSS has proven to be an inefficient way of paying for health services, as Laos currently is not equipped to deal with the administrative demands connected to this payment form.

For SSO and CBHI it has been of great importance to have a charismatic driving force to advocate for the schemes. Good public relations with convincing and relevant arguments are especially important with the voluntary system. However, for all schemes it is crucial to have appropriate information and communications, as level of compliance and satisfaction is closely linked with good information.

One of the forces of the CBHI is that it operates with a rather uncomplicated administrative set-up which makes expansion easier. Running the SSO however, requires strong administrative skills and well-trained staff in all areas of health insurance. This might become a barrier in the process of extension to provincial areas, as relevant managerial skills might not be available at the local level.

Although the SSO is mandatory by decree, de facto it operates as a voluntary scheme as no enforcement tools were agreed upon before the introduction of the scheme. This might over time, lead to an adverse change in the risk-mix as members with a good risk might, opt out of the scheme, while the members with the bad risk stay in.

8. Conclusions
The provision of pre-paid social health insurance is a well-known mechanism preventing the poor from catastrophic expenditure, which could lead them into deep poverty. As the Lao households are now expected to pay 58% of the per capita health expenditure there is an urgent need to provide safety nets for the part of the population that does not have the means to cope financially with severe illness.

It is therefore encouraging that two social health insurance schemes have been introduced in Laos in recent years. Initial implementation has shown that both the mandatory SSO and the voluntary CBHI can be managed in Laos and are acceptable for the Lao population. However, the level of coverage is still low. Developing feasible plans on expansion of the schemes and at the same time including the most indigent part of the population will pose an immense challenge both in term of management and funding.
For Lao PDR universal coverage cannot be expected in the near future. Too many barriers make especially the full extension of CBHI schemes unrealistic. The main barriers will be encountered in relation to the enrollment of the minority populations living mostly by subsistence agriculture in the remote mountainous areas of the country. Most probably the schemes will have to follow a natural course of evolution by expanding to areas where managerial skills, interest, facilities and demand are available. When the schemes become well established and success stories penetrate to less accessible areas of the country, it can be expected that some of the more resistant barriers will be broken down.

The future of the Civil Servant Scheme also poses questions. A merger between CSS and SSO has been discussed. However, until the CSS has undergone a reform and considerable improvements have been achieved, such a merger will not be feasible as the health insurance of the CSS de facto is not functioning.

The concept of prepaying for future potential health problems is new for most Lao people. Nevertheless, the pilot projects of CBHI have shown that the population is willing to sign up if appropriate information is conveyed to them through community consultations. The concept of risk-pooling on the other hand seems more familiar to the Lao culture where members of the extended family often form the households. Income is pooled which enables the household to keep a living standard which would not be possible if living in a nuclear family. The above conditions are important factors for the success of implementing social health insurance in the country.

The long-term national development goal of the Lao PDR is to leave the status of being a least developed country by 2020. This requires among others a strong and healthy population and workforce. One way to improve the health status of the population is to remove the barriers for adequate utilization of quality health care facilities. Social health insurances have the ability to approach some of these barriers and will therefore provide an important tool for socioeconomic development. It is furthermore in line with the government Policy for Health Development from 2001 to 2005, which wants to:

“Promote community-based health care systems, ensure full coverage and good quality of health care services to all ethnic groups, prioritize disease prevention and health promotion activities, emphasize disease treatment, combine modern and traditional medicine; promote and support the establishment of health insurance funds, develop health management systems and ensure security for the health sector”
Information Sources

1. Millennium Development Report, Draft 5.0, jointly prepared by MDG/UNDAF Theme Groups, January 2004
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Mongolia

1. Background

Mongolia is a large and landlocked country in the northern part of Central Asia, located between Russian Federation on the north and Chinese People’s Republic on the east, south and west. The total land area of 1565000 square kilometres contains only 2.4 million population (2000) or 1.4 persons per square kilometre. More than 50% of the Mongolian population is urban and lives in the capital city Ulaanbaatar and 21 Aimag (province) centres, and 20% of the population is semi-nomadic. In rural areas population density is very low, which makes health service provision quite difficult.

During the previous political regime in Mongolia a comparatively good health care infrastructure was developed, which was adjusted to the centralized economy. Health care services for the population are offered through an extensive network of government health facilities at four levels; starting from feldscher (doctor’s assistant) posts at bag (the smallest administrative unit) level to the tertiary hospitals. Due to the attempts to ensure equitable access to health services even in the most remote areas, regardless of their economic efficiency and sustainability, there was practically universal coverage and accessibility to the primary health care (PHC) services. Under the centralized planning economy, about 5% of the GDP or 8% of the Government budget was spent for the free-of-charge health services throughout the country.

Since the start of the socioeconomic transition in 1990, the health budget as a part of the Government budget has not been reduced in monetary terms, but it has decreased in real terms due to devaluation of the national monetary unit (the Mongolian Tugrig [¥] was devalued from 4.18 ¥ in 1990 to 40.00 ¥ in 1993, 750.00 ¥ in 1996 and 1200.00 ¥ in 2000 in relation to 1.00 US$), making it difficult to run the health service at the previous level. The share of government health expenditure in GDP has dramatically dropped. This has adversely influenced the overall health care system performance. At the beginning of the transition period the population growth rate was 2.5% and almost 50% of the population were children under age 18, and around 5-6% of the population were aged 60 years and over. The infant, child and maternal mortality rates were relatively high.
The basis for health policy in the 1990s was determined in 1990 when the 4th Congress of Health Workers approved the “Guidelines for the Protection of People’s Health up to 2005”, in which the introduction of health insurance was proposed. The Constitution of Mongolia, enacted in 1992, stated that health care was a state function, but citizen’s active financial involvement has been requested instead of the previous free-of-charge health system.

Therefore the government decided to gradually introduce cost-sharing mechanisms by the population into health service financing trying to keep equitable access of all population strata to basic health services. Considering these circumstances, the government developed the Citizen’s Health Insurance Act in 1993, designed to keep previous achievements in equity and access, raise new funds for the financing of health care and to create financial protection of the population during the transition period.

2. Development of Compulsory and Voluntary Prepayment Mechanisms

The idea to create new financial sources for the health sector (Health Insurance Fund: HIF) came at the end of 1980s, and led to the accumulation of information on the topic in the related departments of the Ministry of Health (MoH) and research institutions. Study teams were sent to Asian countries, including Japan, Thailand, Malaysia and South Korea, and specialized experts and consultants were invited through international organizations.

In 1991, the first National Working Group of MoH was appointed to draft the Health Insurance Law and other related legal acts. The first draft of the Law and the required other legal acts were ready at the end of 1991. Then MoH in collaboration with “Mongol Daatgal Company (MDC)” drafted the Government Resolution on the Introduction of Health Insurance in Mongolia and associated regulatory documents, and submitted these to the government.

In designing the HIF scheme, medical workers at all referral levels of the health sector and community were involved, through various kinds of discussions, workshops, seminars and scientific conferences on the topic. In addition, there were extensive surveys on health service providers and health service consumer’s attitudes and expectations of the health insurance. After all the preparatory work, at the beginning of 1992 the final draft of the Law was submitted to the Government and then submitted to the Parliament (Baga Hural). Due to time constraints before the expected new General Election, it was not discussed in the Parliament at that time.
According to the Draft Law all employed people of Mongolia shall be covered by compulsory health insurance. However, vulnerable population groups would not be obliged to contribute and all health expenditures for individuals in these groups would be financed from the state budget. Unemployed people and foreigners could join the scheme voluntarily.

After the formation of the new Parliament and the government in 1992, the first Draft Law was again considered by the new MOH and the final version entitled “Citizen’s Health Insurance Law” was submitted to the Parliament in March 1993 and approved in June 1993. According to the Law passed, all population groups of Mongolia shall be covered by the compulsory health insurance. In Mongolia that time, poverty was an unknown phenomenon. But since 1990, poverty has become a reality due to economic crises (such as growing unemployment and inflation) and the most vulnerable population affected by these transitional effects are children, retired people and some other low-income population groups. In order to protect and fully cover the population under the scheme, the Government identified seven sensitive and vulnerable groups: children under 16, mothers (and fathers) with babies under two years old, students, pensioners, invalids, herdsmen and others, who together constituted about 70% of the population. Health insurance premiums for individuals in all these groups were to be fully subsidized by the government.

The government contributions for the seven vulnerable groups were the major determinants in the financial performance of the scheme. During 1994, payment from the Government totalled 62% of all revenues (57.7% in contributions for vulnerable groups and 6.6% for employer contributions for civil servants and state-owned institutions). During the implementation period, the government planned to gradually reduce the numbers of subsidized groups, according to economic recovery. Through amendments enacted in 1995 and 1998, herdsmen (initially by 50%, then by 100%) and students were excluded from the government subsidy.

However, the percentage of people receiving government subsidy still remained high. Currently, according to official statistics, about 52% of the population is covered by government subsidy. The government policy is to further reduce the number of subsidized groups and better target resources to the people in real need.

According to a survey (K.Tungalag, 2000), 44.2% of children under 16, and 47.9% of the elderly (age of retirement) were living below the poverty line. In other words, not all people in the subsidized groups are poor, and the number of subsidized individuals could potentially be reduced by at least 30-35%.

Due to difficulties in registration and income definition, unemployed and self-employed people's enrolment was identified as voluntary. After exclusion from the government subsidy, herdsmen and students were added to this group. As the number of people in the voluntary category grew, there was an increase in moral hazard.
(enrolment in the scheme just at the time of need). Amendments to the Citizen’s Health Insurance Law (2003) were then enacted, making coverage compulsory for all population groups, excluding foreigners. In general, since the initial introduction of the Law there have been several amendments to the Citizen’s Health Insurance Law (in 1995, 1997, 1998, and 2003).

In order to reduce negative incentives from both provider and consumer sides to admit more patients to hospital or to be admitted to receive health care benefits, a prospective case payment method rather than retrospective per day payment was introduced, in addition to co-payments for inpatient services. According to the last amendment to the Law enacted in 2003, these benefits were expanded to include the current outpatient primary health care, secondary and tertiary services.

The HIF has had a dramatic impact on funding for the health sector. In 1994, the first year of operation, health insurance funding accounted for 41.5% of the health sector funding.

3. Compulsory Social Health Insurance Mechanisms
Organizational and institutional arrangements
The management of the HIF was entrusted at first to MDC, a state-owned commercial insurance company. In 1996 the management of the fund was transferred to the State Social Insurance General Office (SSIGO). The main reasons for this transfer were considerations for savings of operational costs of activities, especially premium collection.

Today, health insurance is part of the broader social insurance scheme, which is under the responsibility of the Ministry of Social Welfare and Labour (MSWL). A Health Insurance Sub-council (HISC) has been created under the National Social Insurance Council (NSIC) nominated by the Parliament. This body operates by Law under HISC, and is chaired by the State Secretary of the Ministry of Health. Its primary role is to supervise the fund’s utilization and spending; to develop regulations and guidelines to address implementation problems and to set health insurance policy. There are also 22 sub-councils at the aimag (provincial) and the capital city level.

The SSIGO is responsible for the management of the overall social insurance scheme through its Health Insurance Department (See Figure 19). The SSIGO has 30 branches in 22 aimags and eight districts of Ulaanbaatar. In each branch, there is a director and 8 – 10 staff members, of whom two are responsible for health insurance. There is also an SSIGO representative in each soum (district), often called social inspector. In total about 1300 officers are involved in the administration of SSIGO. Administration costs are officially set at 2% of the total health insurance fund.
Currently, the health insurance scheme is characterized by individual coverage, which means that only the contributor is entitled to benefits covered by the health insurance scheme. According to the Citizen’s Health Insurance Law all citizens of Mongolia shall be insured compulsorily, in 11 categories. These are:

3.2 Coverage and Premium Collection

1. Employees of economic enterprises and organizations;
2. Owners of economic enterprises and sole proprietors;
3. Children under 16 years of age (18 if schoolchildren);
4. Students;
5. Citizens who have no income except pension;
6. Mothers with children under two years of age (under three if they are twins);
(7) Persons on regular military service;
(8) Herdsmen;
(9) Citizens, as stated in the Article 12 of the Law on Social Welfare;
(10) Persons serving a prison sentence, and
(11) Other citizens not mentioned in Articles 1 to 10;

The health insurance contributions for the various population categories are different. The amount of monthly premium contributed by insured persons belonging to the first category listed above is a percentage of their monthly salary and/or similar income. This percentage, which cannot exceed 6%, is determined by the government annually. Employees and contracted cattle breeders pay a half of the insurance premium (3%) while the remaining half is shouldered by their employers.

A financial plan for premium collection from registered companies is set up each year. Each month the accountants of enterprises and government institutions transfer contributions to the HIF account at the SSIGO, based on the list of employees and their salaries. An inspector from the SSIGO verifies whether the premium amounts to be transferred are correct. There is a penalty in case of late payment of premiums (0.3% per day).

Sole proprietors and owners of economic enterprises are responsible for premium contribution and the premium amount determined by the NSIC on the basis of the income declaration filed with the Tax Administration.

Currently, self-employed herdsmen and students (categories 4 and 8) are required to pay a flat rate premium of 500 tugreks per month. During the initial year of implementation of the Law, the government paid the entire premium for these two categories of beneficiaries at a monthly rate of 160 tugreks. Due to difficulties in registration and premium collection of unemployed and self-employed people and students, the premium collection is the responsibility of local governors and administrators of colleges and universities.

The premium for insured persons belonging to categories 3, 5, 6, 7 and 9 (fully subsidized-vulnerable groups) from the above list is a flat amount per person per month, and is borne entirely by the government. The current premium amount is 300 tugreks (proposed to be 500 tugreks in 2005 by the HISC). Initially, the premium amount was 160 tugrek in 1994, and was raised to 200 tugrek in 1995. Premiums for subsidized groups are determined annually by the NSIC based on the HISC’s proposal. The government transfers the premium to the HIF account monthly, based on the number of vulnerable people covered at each local administration.

According to the last amendment of the Law, the unit of membership can be a family, which means that the head of the household can contribute for all family
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members (spouse and children up to age 18 years). However, this amendment has not yet been fully implemented.

3.3 Benefit Types and Payment Arrangements

With Service Providers

Since its creation, the health insurance scheme has mainly focused on the coverage of inpatient care.

The benefits included under the Health Insurance Scheme are as follows:

(1) Inpatient services for illnesses and injuries that are not covered under the free medical aid programme of the Government,

(2) Outpatient treatment for minor illnesses or injuries, and

(3) Fifty per cent of the cost of outpatient prescribed drugs included in the List of Essential Drugs approved by the MoH. The prescription must come from family doctors.

The following medical services or supplies are not covered by insurance:

(1) Cosmetic services and surgery;

(2) Prosthetic devices;

(3) Additional services requested by the insured;

(4) Drugs purchased from pharmacies (except as described above), and

(5) Other services (defined) paid by the government.

According to the Law, the entitlement to benefits has a cash limitation of how much an insured person can use (as expenditure) during any year. The amount is determined annually by the HISC and the current limitation is 400000.00 tugreks.

According to amendments to the Law enacted in 2002, and applied since 1 January, 2003 outpatient and Family Group Practice (FGP) services are included under the scheme.

3.4 Provider payment

The payment system for hospitals is based upon a classification of medical institutions into three referral levels. Initially, the payment of hospitals was essentially based on fixed rates per patient-day. This stimulated hospitals to fill their beds, but not to produce high quality care. In 1998 the payment method was changed to “prospective” payment. Currently, inpatient care delivered by hospitals is paid for by the HIF on a case-by-case. At the beginning of the year, the Hospital and the Health Insurance
Office agree on an annual number of admissions based on number of beds and determined amount of money which will have to be paid for the year. Payments have to be made prospectively every month. This case payment method does not depend on the relative complexity of cases. As stated above, it is dependent only on the type of hospital. In 1998, a co-payment for inpatient services was introduced. The co-payment is 10% of the case payment irrespective of the hospital type. In 2003 a different percentage was applied according to the referral level of the hospital, and the co-payment now ranges from 5 to 15%. At the primary level of inpatient care, the patient pays 5% of the case payment, at the secondary level 10%, and at tertiary level, 15%. However, the co-payment has not solved the problem of excess in-patient admissions.

Outpatient service payment

Initially, outpatient services at secondary and the tertiary hospitals paid for 25% of total visits according to a fixed amount per visit, which caused an increase in the number of outpatient visits. Since January, 2004 outpatient services at the secondary and tertiary level hospitals are paid per visit according to a fixed amount, but should not be exceed 10-15% of inpatient care expenditure depending on referral levels. The limitation of the 10 – 15 percentage is calculated based on the expenditure share of outpatient facilities to hospital expenditure.

Payment of primary health care by Family General Practitioners (FGP)

Until January, 2003 FGPs were financed from the state budget according to a per capita basis, according to age groups and poverty percentages in each group. In other words, 10 population groups with different per capita rates were identified. According to the amendments to the Citizen’s Health Insurance Law, from 1 January, 2004, financing of FGPs is partly (40% from state budget, 60% from the HIF) transferred to the scheme, but the payment method has not been changed. Due to the lack of regulatory mechanisms and difficulties in registration and identification of the 10 population groups, the different per capita rates were in fact not used. In October 2003, regulatory documents were developed by the HISC and approved by the NSIC and related ministries. According to the document, the number of population groups was decreased from 10 to 2 (just poor and non poor). The per capita rate is increased and differentiated for the poor and non-poor population groups according to health needs, and introduces fixed poverty percentages differentiated according to the location (the percentage is higher in gher (suburban) areas with a high percentage of poor households). In other words, to fulfil the government’s Poverty Reduction Strategy, financial resources (budget, HIF) for PHC services are targeted to the poorest vulnerable population groups.

Capitation payments are made automatically to providers (FGPs), on the basis of the number of insured population registered with each FGP. The amount is
determined on a yearly basis, and paid to providers prospectively by monthly instalments.

Payment of pharmacies

Insured persons can get most drugs on the Essential Drug List partly funded (50-70%) by HIF, if prescribed by FGPs. For this purpose, a prescription stating the insurance certificate number and the doctor’s code has to be presented to accredited and defined pharmacies. The pharmacy sends the list of prescriptions dispensed to the insured to SSIGO for control and reimbursement. This involves a lot of administrative work, without direct profit to the pharmacist. There also are complaints about late payments by the health insurance office to pharmacists. Therefore, pharmacists show little enthusiasm for the sale of essential drugs.

4. Voluntary Health Insurance Schemes

There are two main types of voluntary prepayment schemes in Mongolia: private health insurance and the Revolving Drug Fund. Private health insurance plays a limited role and will be described in the section below.

The Community and Health Project (CHP) was started in 1994 by the MoH in cooperation with UNICEF and supported by a grant from the Nippon Foundation. The project aimed to address the problem of the lack of essential drugs in rural areas (soums) by establishing the Revolving Drugs Fund (RDF). Initially, the project was piloted in six aimags, with two soums in each aimag. The project coverage expanded further so that by 2003, the project covered 221 soums in 13 aimags to sustain PHC services through the active participation of the community.

The project was established by combining seed drug capital from donors through UNICEF and community contributions in cash or in kind at the start of the project. As the community participation was voluntary, the amount and type of contribution were not defined.

The RDF capital therefore consists of both donor funds and community contributions. At the soum level the RDF is managed by a pharmacist and assistant or dispenser hired by the soum Governor. The project itself is managed by the CHP/RDF committee typically composed of the soum Governor, pharmacist, the soum hospital chief, an accountant from the soum Governor’s office, and a community representative. There is also a supervisory committee composed of three members headed by the head of the local parliament.

The CHP/RDF purchases drugs from qualified suppliers and sells drugs to outpatient consumers and to the hospital. It manages the drug funds and allocates
profits from the sale of such funds to pay for operating costs and other expenditures related to health of community, such as funds for hospital facilities or the repair of such facilities or occasional community health activities. The operation of RDFs is not linked in any way to the health insurance system.

5. Social Security Programmes

With the passage of the Citizen’s Health Insurance Law in 1993, a package of Social Insurance Laws in 1994 and the Social Welfare Law in 1995, a new process was started to establish a completely new social security system in Mongolia. These laws created two parallel sets of social security programmes. One set operates on the principle of social insurance, under which benefits are financed by contributions of employers and employees and are available only to persons who have previously made contributions. The other set consists of social assistance programmes that are financed from the state budget and provide benefits to persons with the greatest social needs.

**Social insurance** covers five major programmes:
- Pension (old-age) Insurance,
- Employment Injury and Occupational Disease Insurance,
- Unemployment Insurance,
- Benefit Insurance (cash sickness and maternity benefits and funeral grants),
- Health Insurance.

Social insurance funds, with the exception of the Pension Fund, operate on the basis of the pay-as-you-go principle.

**Pension insurance** is the largest of the programmes. It provides monthly cash benefits to insured workers who have retired or become disabled and to the survivors of insured workers who have died.

**Employment injury and occupational disease insurance** provides cash benefits and covers rehabilitation expenses for work-related injury or diseases.

**Sickness benefits and maternity benefits** (short-term benefits). Workers must have contributed for 3 months to be eligible for cash sickness benefits and for 12 months to be eligible for maternity benefits. Benefit amounts depend on the worker’s earnings level and, for sickness benefits, on the total number of years that the worker has contributed to the system.
Unemployment insurance benefits are available to workers who have contributed for at least 2 years in total and for the 9 months prior to becoming unemployed.

Social welfare: The social welfare scheme offers in-kind services and cash benefits to the most vulnerable population groups. These services and benefits include:

- In-kind services including residential facilities for the elderly, disabled people as well as services for the poor, homeless people such as feeding and bathing;

- Discounts to the elderly, disabled and other groups to reduce the costs of housing, health care, wheelchairs, and hearing aids. There are 9 types of discounts and services provided for the elderly. Some of them are related to the health care costs. For example, subsidized prices for care in a sanatorium and transport for the elderly, honored people, war veterans, and those elderly with incomes below the minimum living standard; lump-sum benefit for prosthesis for elderly people; transport cost for treatment in Ulaanbaatar (the capital city) for those elderly living 1,000 km or more away.

- Monetary benefits from the Social Assistance Fund, including short-term benefits for pregnancy and delivery, child care, multi-children families, support for adopting orphans and infant care, benefits for twins or triplets, funeral grants for the elderly single persons, and long term pensions for those not eligible for the social insurance pensions.

Residential care in the social welfare system is provided by the national and local nursing homes. National and local nursing homes administer the resources allocated for nursing care directly from the state and local budget, provide shelter, food, clothes and medicine to the residents, and carry out activities involved in care, treatment and rehabilitation.

6. Private Commercial Health Insurance

Private health insurance is another alternative for people who can afford to pay the premiums and would like to get health security or supplementary insurance for benefits which are not covered by the social health insurance system.

According to the Citizen's Health Insurance Law, health insurance in Mongolia has compulsory and voluntary forms. The compulsory health insurance is provided only by the SSIGO, while the voluntary and reinsurance activities can be provided by insurance organizations with all types of ownership.
Since 2000, there are several private commercial insurance companies operating in Mongolia. The health insurance business in Mongolia is comparatively new and there are few companies acting in the field. The main companies are MDC, Ar'd daatgal, Nomin daatgal, and Erel daatgal.

**Erel daatgal**: On a voluntary basis, citizens can be insured against all types of health risks. Coverage is individual, and the health of the insured person has to be assessed. The minimum amount of health value has to be not less than minimum wage level multiplied by six (40,000 tugreks x 6 = 240,000). The premium amount has to be calculated individually according to the calculation formula. For example: 4% x 240,000 tugreks (health value) means a premium of 9,600 tugreks. The calculation percentages range from 4 to 6, and depend on where the insured person works and the relative risks in that employment, while the amount of health value is based on the agreement between the insurance company and the individual insurer. The amount of health value cannot be less than 240,000 tugreks. Contributions are made once per year. In case of illness and injury, an insured person receives a cash reimbursement, which is calculated according to a defined formula.

**Nomin daatgal**: This voluntary private health insurance covers benefits excluded from the Social Health Insurance scheme (including treatment abroad), but only in case of acute diseases. Coverage is individual. Annual premiums range from US$ 4000 to US$ 12000 and provide 50% to 100% reimbursement of treatment costs, depending on the premium amount.

Other private insurance companies mainly provide cash reimbursement in case of acute illness and injury.

7. **Critical Analysis of Health Care Financing Through Prepayment**

The following points summarize the current system:

The top priority of the health insurance programme is to achieve and maintain universal coverage for all citizens. Due to the strong start in enrolling nearly the entire population, this goal is achievable within the current programme structure. In addition, according to the last amendment to the Citizen’s Health Insurance Law, there is compulsory enrolment for all population groups in Mongolia. Although health insurance coverage is compulsory; the percentage of real coverage of the population is going down. The data in Table 16 show that HIF coverage has decreased from 95.4% to 77.6%. In addition, there are many problems in registration and information systems. The reduction in coverage and weak registration and
information systems cause serious problems in the financing of PHC providers, especially the FGPs.

There are no official statistics at all for the comparison of health status among insured and non-insured separately. According to a survey (K.Tungalag, 2000) around 65% of the uninsured were poor people. Diseases are not equally distributed among different population categories (poor, non-poor). The self-reported prevalence rates of all chronic diseases among the population are 1112.6 per 10000 population. The most frequently reported diseases are noncommunicable chronic conditions: 998.0 per 10000 population, and the lowest rate is reported among very poor individuals (603.1) while the highest is among the non-poor upper income individuals (1566.3). The next most frequently reported chronic diseases are tuberculosis (30.5); epilepsy (26.6), and malnutrition (11.2). Among the poor, the self-reported prevalence of tuberculosis (43.7), malnutrition (39.3), and epilepsy (56.8) are much higher than the average for all population groups.

Table 16. Health expenditure and health care financing in 1990-2002

<table>
<thead>
<tr>
<th>Years</th>
<th>Health expenditure by contribution (%)</th>
<th></th>
<th>Health expenditure share</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government contribution</td>
<td>HIF contribution</td>
<td>Other contribution</td>
</tr>
<tr>
<td>1990</td>
<td>100.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1991</td>
<td>100.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1992</td>
<td>100.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1993</td>
<td>100.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1994</td>
<td>53.6</td>
<td>41.5</td>
<td>4.9</td>
</tr>
<tr>
<td>1995</td>
<td>53.1</td>
<td>44.2</td>
<td>2.7</td>
</tr>
<tr>
<td>1996</td>
<td>58.6</td>
<td>37.8</td>
<td>3.5</td>
</tr>
<tr>
<td>1997</td>
<td>59.8</td>
<td>30.9</td>
<td>4.4</td>
</tr>
<tr>
<td>1998</td>
<td>47.0</td>
<td>42.3</td>
<td>3.0</td>
</tr>
<tr>
<td>1999</td>
<td>54.6</td>
<td>31.8</td>
<td>3.8</td>
</tr>
<tr>
<td>2000</td>
<td>64.3</td>
<td>28.7</td>
<td>7.1</td>
</tr>
<tr>
<td>2001</td>
<td>67.6</td>
<td>26.0</td>
<td>6.4</td>
</tr>
<tr>
<td>2002</td>
<td>64.1</td>
<td>28.5</td>
<td>7.4</td>
</tr>
</tbody>
</table>
Ideally, the health financing system has to reinforce the health policies of the government. Within the health insurance system, the payment mechanisms should also be designed to provide economic incentives and disincentives for hospitals and doctors to respond to national priorities for the health sector.

The current payment mechanism is a flat rate paid per case of hospital care. It provides an incentive for increased hospital admissions. That is, the amount actually paid for services is determined by the rate multiplied by the number of admissions. These systems have an incentive for providers to increase the number of admissions in order to increase revenues (see Table 17 below).

**Table 17. Coverage structure by population groups (% to total population)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidized groups</td>
<td>54.1</td>
<td>54.2</td>
<td>54.2</td>
<td>51.8</td>
</tr>
<tr>
<td>Workers</td>
<td>20.6</td>
<td>16.0</td>
<td>13.8</td>
<td>12.4</td>
</tr>
<tr>
<td>Others</td>
<td>20.8</td>
<td>14.8</td>
<td>12.7</td>
<td>13.4</td>
</tr>
<tr>
<td>Total coverage</td>
<td>95.4</td>
<td>85.0</td>
<td>80.7</td>
<td>77.6</td>
</tr>
<tr>
<td>Not covered</td>
<td>4.6</td>
<td>15.0</td>
<td>19.3</td>
<td>22.4</td>
</tr>
<tr>
<td>Total population</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The most important and the most difficult part of any health care financing schemes relates to the quality assurance programme. The scheme provides for a certain number of programmes to assure the quality of care, by licensing and accreditation systems under the Health Law, and by medical inspection under the Citizen’s Health Insurance Law. However, these programmes are newly established, and need better regulations and management. Since 2000, hospitals are obliged to establish their own quality assurance committees. The contracts between the Insurance Office and health care providers also contain some quality of care indicators. But all these measures are not enough. In order to better control the quality of services, it is considered that a purchasing focal point should be established in the scheme.

In order to follow the government poverty reduction strategy and assure equity in access to PHC, provider payment mechanism of FGPs on a risk (poverty) adjusted capitation basis was introduced. The payment of PHC services is designed to allocate financial resources where there are more poor people or people in need.
The main goal of the scheme is to protect the vulnerable population groups and provide equity in access to basic health services. Contributions of people who are unable to pay (vulnerable groups) are paid directly by the government; any introduction of co-payments has been avoided for vulnerable groups. There is a high rate of social admissions to hospital, especially in winter time.

In spite of these conditions, equity in access to inpatient services has not been achieved. According to a survey (K. Tungalag, 2000) poor people use the service less than rich people. For example, the utilization rate of tertiary services by the poor was 2.5 times lower than for rich people. The main factors influencing the use of these services were co-payments and informal payments.

Co-payments were introduced in order to influence patients' behaviour regarding hospital admissions. In consideration of equity, children and retired (vulnerable groups) persons were exempt from paying co-payments. However, for the other population groups with low incomes, co-payments served as a restricting mechanism.

The utilization of hospitals by level is shown in Table 18 below.

Table 18. Number of admissions and the referral structure

<table>
<thead>
<tr>
<th>Referral level</th>
<th>2000</th>
<th>2001</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary hospitals</td>
<td>57 777</td>
<td>61 527</td>
<td>64 942</td>
</tr>
<tr>
<td>Secondary level hospitals</td>
<td>15 1341</td>
<td>1 48 832</td>
<td>1 51 17 5</td>
</tr>
<tr>
<td>(aimag, district)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary level hospitals</td>
<td>8 7961</td>
<td>1 19 321</td>
<td>1 35 000</td>
</tr>
<tr>
<td>(Soum)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private hospitals</td>
<td>20419</td>
<td>27560</td>
<td>37815</td>
</tr>
<tr>
<td>Others</td>
<td>16943</td>
<td>48435</td>
<td>1861</td>
</tr>
<tr>
<td>Total</td>
<td>33441</td>
<td>405745</td>
<td>390793</td>
</tr>
</tbody>
</table>

Success factors

The key factors associated with success are the following:

- The feasibility of collecting contributions easily from a large part (almost 80%) of the entire population;
- High percentages of fully subsidized groups;
- Comparatively low administration cost (2% of the fund);
Comparatively good health care infrastructure, and
An appropriate payment mechanism for PHC providers (FGPs).

Failure factors
Several factors associated with failure may be summarized.

- **Decline in coverage**: Due to weak management, the proportion of Mongolians covered by the scheme declined from 95.4% in 1998 to 77.6% in 2003. The influencing factors were government policy to reduce subsidized groups in premium payment, and changes in the market workforce structure. Since 1995, the government has reduced state responsibility for premiums for some vulnerable groups, and herders and students have been excluded from the government subsidy. Other reasons for the decline in coverage are the growing size of the informal sector and increasing unemployment. The sizes of the informal sector and unemployment rates have not decreased over the last 10 to 15 years.

- **Lack of a purchasing focal point**: The success of operation of a separate insurance fund critically depends on rapid development of its purchasing focal point. Since the creation of the scheme, in practice there has been no purchasing focal point. The functions were managed by the HIF through allocations to aimags and provider payment mechanisms.

- **Management defects**: The scheme has been characterized by an inappropriate management structure and management and planning capacity of Health Insurance Department of SSIGO. The registration and information system to support better management are still weak, and the scheme's staff lack technical expertise and practical experience.

- **Inappropriate payment mechanism**, which causes inefficiencies and waste.

Considering the failure factors noted above, improvement will be needed in the future in the organization and management of the scheme. It will also be necessary to strengthen the real purchasing function, modernize the provider payment mechanism and increase population coverage.

8. **Conclusion**

In summary, despite the many problems that the Mongolian social health insurance scheme faces at present, it is important to recognize its achievements. It has achieved a relatively high coverage, and has reached a situation in which it has contributed nearly one third of the financing for the health sector during the last 10 years. HIF is
one of the main financial sources for the health sector of Mongolia, and plays an important role in achieving the country’s socioeconomic goals, especially those in the poverty reduction strategy.

One of the major achievements of the scheme is coverage of PHC and outpatient services. The PHC programme under the scheme is especially designed to protect poor population groups and improve equity in access to basic health services.

In order to secure better protection of poor people and improve equity in access to the secondary and tertiary levels of health care, there is a need to choose appropriate provider payment mechanism of both out and inpatient services. The current co-payment policy should also be reconsidered, as it unfairly penalizes low income people and the sick.

One of the attractive features of the scheme is universal population coverage. However, due to weak management, and lack of sensitivity to the changing workforce structure, the trend has been towards a reduction in coverage, which threatens the financial sustainability of PHC.

A Health insurance scheme needs strong management. It needs to have a strong organization, with clear competence over the financial revenue and expenditure aspects, as well as a purchasing function which allows improvement in the quality of services.
1. Background

The long-run performance of the Philippine economy is characterized by slow and uneven economic growth compared to countries in the South-East and East Asian regions. Analysis shows that such relatively poor performance was due to the combined effect of policies associated with less openness to trade, a lower government saving rate, and weaker institutional quality (Sachs, et al 1998).

Philippines experienced a severe economic crisis in the mid-1980s from which it still has to be completely recovered. The current per capita GDP is still lower than the per capita GDP in 1981. Poverty rates remained high at 35% of all families in 2000. Whatever declines there have been since 1988 occurred only in urban areas. Rural poverty remained at 46% from 1988 to 2000.

Coupled with the slow economic growth is the slow structural transformation of the economy. The proportion of labour force in industry has remained stagnant at around 10% since the 1970s. The decline in the share of labour force in agriculture was absorbed in the services sector, often in unskilled and low paying categories, e.g. personal services.

In the meantime the population continued to grow rapidly compared to other countries in the Region. The growth rate remained at around 2.3% in the 1980s and 1990s. South Korea, Thailand, and Indonesia, which like Philippines had high growth rates in the 1960s and 1970s, succeeded in reducing their rates to 0.9%, 1.0%, and 1.3% respectively in the 1990s (UNESCAP 2000). The 2000 census counted 76.5 million people, more than double the number in 1970. In 2004, the population is estimated at 83 million.

The slow economic growth, high poverty rates and continued rapid population growth affected progress in several human development indicators. Fertility and infant and child mortality remained high compared to neighbouring countries. Differentials in health outcomes (infant and child morbidity and fertility) and health care utilization (contraceptive use and maternal care) remain wide. For example, data from the 1998 National Demographic and Health Survey revealed that infant and child mortality among the poorest asset quintile were more than twice the level of the richest quintile.
The poorest quintile had a fertility rate of 6.5 children per woman compared to only 2.1 children per woman for the richest group. The poorest group had less access to trained medical personnel than the richest group in terms of maternal care (prenatal and delivery attendance). Because of high fertility and less access to maternal care, the maternal mortality rate is much higher in Philippines (170) compared to the countries in the Region with the exception of Indonesia. Thailand’s maternal mortality ratio is 44, for South Korea it is 20, while that for Singapore is 6.

Slow economic growth and high poverty rates constrain expenditures by the government and households on needed health care. The slow structural transformation of the economy makes it harder to expand coverage of social insurance schemes beyond the formal employed sector. The continued rapid population growth makes progress in improving health and other human development indicators more difficult. While rapid economic progress and slower population growth will provide the foundations for sustained improvements in health and other human development indicators, there is a need to adopt innovations in resource mobilization and allocation in the social sectors that will maximize the impact of limited resources.

2. Development of Compulsory and Voluntary Health Insurance

The different ways in which health care expenditures are financed are reflected in the National Health Accounts. By 2001, 38% of total health spending was financed by national and local government through tax revenues while household out-of-pocket payments financed 43% of total expenditures. These might be considered the traditional source of expenditures. Over the years, however, other sources of financing were developed to help ensure that the growing population would have financial access to needed health care services from both public and private sectors.*

To help the population have financial access to higher quality health care, Philippines launched in 1969 a compulsory health insurance scheme known as the Medicare Programme. The Programme was implemented in 1972 after the creation of the Philippine Medicare Commission, which oversaw the health insurance scheme. The scheme was designed to start with the employed sector, but was aimed to eventually achieve universal coverage. Insurance benefits were limited only to

*The Philippine health care system is characterized by a large private sector (compared to some countries in the Region). About half of total hospital beds in the country are private. There are numerous private physicians’ offices and diagnostic centres especially in urban areas. In the rural areas, private practitioners include traditional births attendants and traditional healers. In the private sector, patients have to pay for their care.
inpatient care. The premium was equally shared by both employee and employer equal to 2.5% of the employees’ salary base.

The Programme was implemented (premium collection and benefit reimbursement) by the Government Service Insurance System (GSIS) for government employees and by the Social Security System (SSS) for private employees. In 1975, both GSIS and SSS also implemented the Employees’ Compensation (EC) programme, which is designed to provide public and private sector employees and their dependents with income and other benefits in the event of a work-connected injury, sickness, disability or death. The benefits come in the form of cash in the case of disability or death, medical and related services for injury and sickness, and rehabilitation services in case of permanent disability.

Data from the 1991-1994 National Health Accounts show health insurance (both Medicare and the health component of EC programme remained a small contributor to total health care financing in spite of twenty years in existence. This finding spurred the Department of Health and Congress to consider a new legislation designed to expand the role of social health insurance in making health care affordable to the people.

In 1995, Congress passed the National Health Insurance Act (Republic Act 7875), which instituted a National health Insurance Programme (NHIP) and established the Philippine Health Insurance Corporation (PhilHealth) to administer the Programme. PhilHealth also assumed the responsibility of administering the former Medicare programme for government employees managed by the Government Service Insurance System (GSIS) and private sector employees managed by the Social Security System (SSS). The NHIP aims to achieve universal coverage by 2010.

In addition to social health insurance, coverage is also provided by a number of private insurance companies providing health benefits. In 2000, there were 156 private insurance companies authorized by the Insurance Commission to transact business in the country: 114 non-life and 42 life insurance companies. The indemnity health industry is growing very slowly in terms of people covered as well as in share in total health care financing. The 1990s saw the emergence of HMOs in Philippines.

These are mainly investor-based HMOs directed at the employed sector and are profit-oriented. The HMO benefit package commonly offers preventive health care, inpatient and outpatient services, and emergency care. The fee charged for membership depends on the degree of actuarial risk, the type of room, the frequency of payment, the number of persons covered, and the supplemental benefits (Gamboa, et al. 1994). At present there are about 21 investor-based HMOs listed as operating in Philippines (www.Rxpinoy.com). The HMOs' share in health care
financing rose from 1.3% in 1992 to 5.7% in 2001. In contrast, private health insurance share declined from 2.8% in 1992 to 1.3% in 2001.

Another source of financing for health care are the private employers who provide health benefits voluntarily or as required by law or collective bargaining agreements. Apart from NHIP (and formerly Medicare) and EC, the Labour Code prescribes a minimum set of medical, dental, and occupational safety obligations for employers. The requirements vary, depending on the hazards in the work place and on the number of workers employed.

At the lower end of the scale, the Labour Code requires that first-aid treatment must be available within the premises. Larger companies on the other hand must provide a company clinic with a full-time doctor, nurse, and dentist. Collective bargaining agreements (CBA) also specify the medical benefits that companies must provide their employees and the employees’ dependents. The estimate of the share of employer-based plans and private enterprise expenditures based on Labour Code requirements expenditures was placed at around 5% of total health care expenditures from 1992 to 2001.

Another form of health financing is community-level health insurance. There are many community-level health insurance initiatives at the grass-roots level. However, estimates of their contribution to total health care financing is not known, partly because of the difficulty in obtaining systematic and standard financial information from these institutions.

In sum, by 2001 as revealed by the 2001 NHA, these other financing mechanisms, namely social health insurance, private insurance and HMOs, employer-based and enterprise-provided health benefits, contributed 19.7% of total spending. Social health insurance contributed 7.8% in 2001, up from 6.0% in 1992. HMOs and private insurance contributed 7.0% in 2001, up from 4.1% in 1992, mainly on account of the growth of HMOs. The remainder was contributed by private enterprises either voluntarily for their employees or as required by the Labour Code.

3. **Compulsory Health Insurance**

**Medicare Programme**

The Medicare programme is a compulsory health insurance scheme established by Republic Act 6111 in August 1969 and implemented on 1 January, 1972, with the creation of the Philippine Medical Care Commission (PMCC). The PMCC, as a government agency, is supervised administratively by the DoH.

Medicare was implemented in two stages. Programme I, which initially covered only public and private sector employees and their dependents, now
includes retirees and the self-employed. Programme II was intended for the informal sector but its implementation has been set back by financial and administrative difficulties. PMCC formulates policies and coordinates the implementation of Programme I. The SSS serves the needs of private sector employees, while the GSIS attends to state employees.

By 1990, Medicare covered 23.5 million Filipinos (38% of the total population). About 16.8 million were under SSS and 6.7 million under GSIS. Medicare provided only inpatient benefits. The employee and employer share equally in the premium contribution to Medicare, at 2.5% of the salary base credit. Medicare support values or the portion of hospitalization expenses paid for by Medicare have fallen short of the targeted 70%. Between 1970 and 1989, they averaged from 32% to a peak of 49% in 1989. This decline in support value is believed to be partly responsible for the spurt of HMOs (to be discussed later in this report) as employers attempt to provide health benefits to workers to supplement existing Medicare coverage (Gamboa, et al. 1994)

National Health Insurance Programme

In 1995, Congress passed the National Health Insurance Act (Republic Act 7875), which instituted a National health Insurance Programme (NHIP) and established the Philippine Health Insurance Corporation (PhilHealth) to administer the Programme. PhilHealth assumed the responsibility of administering the former Medicare programme for government and private sector employees, with the programme’s transfer from the Government Service Insurance System (Oct. 1997) and Social Security System (April 1998).

Coverage

The NHIP covers the following:

- Employed members - all those employed in the government and private sector;
- Individually paying members - self-employed, Overseas Filipino Workers, professionals in private practice (doctors, lawyers, dentists, etc.);
- Non-paying members - members entitled to lifetime coverage that include retiree and pensioners of the GSIS and SSS prior to the implementation of the NHI Act of 1995, and those who have reached the age of retirement and have paid at least 120 monthly contributions, and
Indigent members – members classified as indigent under the NHIP who are entitled to subsidized premium. Target members of the Programme are those belonging to the lowest 25% of the population.

Also covered under the NHIP without additional premium are the legitimate spouse of the member who himself/herself is not a member in any of the above categories, and the children (legitimate, illegitimate, adopted and step-child) below 21 years old, unmarried and unemployed.

In 2002, some 8.71 million members or approximately 43.56 million beneficiaries were covered by the National Health Insurance Programme (NHIP). This figure is about 53% of the entire population. Of the 43.56 million beneficiaries, 45% or 19.57 million come from the private sector, 23% or 10.19 million from the government sector and 16% or 6.75 million are individually-paying members.

Some 14% or 6.30 million are enrolled under the Sponsored (formerly indigent) Programme and close to 2% or 730,495 are retirees or non-paying members. By July 2003, the sponsored programme membership rose to 149,321 families or 7,466,060 beneficiaries were covered under the programme.

Benefits

Effective December 1999, PhilHealth has a unified benefit package for all members. This package of benefits with the corresponding ceiling in pesos according to hospital category is shown in Table 19. It should be noted, however, that providers are

---

* A single period of confinement refers to a series of confinements / procedures for the same illness with the interval between such confinements not exceeding 90 calendar days within the calendar year. A member shall only be entitled for the remainder of the benefit ceilings set by the Corporation for that period for drugs and medicines, X-rays, laboratories, and others.

The following types of illnesses are distinguished: catastrophic, intensive and ordinary. Catastrophic illness refers to (a) illnesses or injuries such as but not limited to cancer cases with metastasis and/or requiring chemotherapy or radiation therapy, meningitis, encephalitis, cirrhosis of the liver (child’s C), myocardial infarction, cerebrovascular attack, rheumatic heart disease grade III, renal failure, other conditions requiring dialysis or transplant, other conditions with massive hemorrhage, shock of any cause; and (b) surgical procedure or multiple surgical procedures done in one sitting with a total Relative Unit Value of 20 and above such as but not limited to coronary angioplasty, coronary bypass, open heart surgery, or neurosurgery.

Intensive illness/procedure refers to (a) all confinements requiring services in an intensive care unit such as respiratory and monitoring support, cardiac/haemodynamic monitoring and maintenance; (b) other similar serious illnesses or injuries such as but not limited to cancer, pneumonia, moderately or far advanced pulmonary tuberculosis including its complications, cardiovascular attack, disease of the heart, chronic obstructive pulmonary disease, liver disease, typhoid fever, fever grade III, H-fever, kidney disease, sepsis, diarrhea with severe dehydration, hepatitis B, dengue haemorrhagic, or severe injuries; and (c) surgical procedure or multiple surgical procedures done in one sitting with a total Relative Unit Value of 8 but not exceeding 19.99. Ordinary illness refers to illnesses or injuries other than those included in the above enumeration. (PhilHealth, 2000: Revised Implementing Rules and Regulation, July 2000).
allowed to bill the patients for cost above the benefit ceilings. The support value defined as the amount per cent of total cost of confinement that is reimbursed by health insurance typically declines as the cost of health care goes up.

For the Sponsored Programme, in addition to the above benefits (called Phase I), PhilHealth introduced additional benefits (Phase II), which entitled members with the following services from accredited Rural Health Units or Health Centres: free primary consultation with the physician; and free laboratory examinations for complete blood count, chest X-ray, stool exam urinalysis and sputum microscopy for TB suspects.

Recently, new health care packages were also introduced. This included PhilHealth benefits up to the second normal delivery and tuberculosis treatment using the Directly Observed Treatment Short Course (DOTS). During the SARS scare in 2003, PhilHealth designed a package worth P100000 for health care workers who might contract the disease, while entitling members and their dependents to a similar package worth P50000. Renal dialysis in free-standing clinics can also be reimbursed now.

**Table 19. United Benefits for all Members and Dependents under the National Health Insurance Programme**

<table>
<thead>
<tr>
<th>Room and Board</th>
<th>Hospital Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Not exceeding 45 days for each member &amp; another 45 days to be shared by his dependents</td>
<td>200</td>
</tr>
</tbody>
</table>

**Drugs And Medicines**

<table>
<thead>
<tr>
<th>Per single period of confinement</th>
<th>Hospital Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Ordinary</td>
<td>Primary</td>
</tr>
<tr>
<td>b) Intensive</td>
<td>350</td>
</tr>
<tr>
<td>c) Catastrophic</td>
<td>700</td>
</tr>
</tbody>
</table>

**X-Ray, Lab, etc.**

<table>
<thead>
<tr>
<th>Per single period of confinement</th>
<th>Hospital Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Ordinary</td>
<td>Primary</td>
</tr>
<tr>
<td>b) Intensive</td>
<td>350</td>
</tr>
<tr>
<td>c) Catastrophic</td>
<td>700</td>
</tr>
</tbody>
</table>

**Professional Fees**

<table>
<thead>
<tr>
<th>Per single period of confinement shall not exceed:</th>
<th>Hospital Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ordinary</td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td>600</td>
</tr>
<tr>
<td>Specialist</td>
<td>1,500</td>
</tr>
</tbody>
</table>
Social Health Insurance

Hospital Category

<table>
<thead>
<tr>
<th></th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Intensive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td>900</td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td>Specialist</td>
<td>1,500</td>
<td>1,500</td>
<td>1,500</td>
</tr>
<tr>
<td>c. Catastrophic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td>900</td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td>Specialist</td>
<td>1,500</td>
<td>1,500</td>
<td>2,500</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. RVU of 30 and below</td>
<td>385</td>
<td>670</td>
<td>1,060</td>
</tr>
<tr>
<td>b. RVU of 31 to 80</td>
<td>0</td>
<td>1,140</td>
<td>1,350</td>
</tr>
<tr>
<td>c. RVU of 81 and above</td>
<td>0</td>
<td>2,160</td>
<td>3,490</td>
</tr>
</tbody>
</table>

Surgeon: Maximum of 16,000
Anesthesiologist: Maximum of 5,000

Compensable Outpatient Services: Chemotherapy, Radiotherapy, Cataract Extraction, Hemodialysis, Minor surgical procedures done in an operating room complex

Surgical Family Planning

<table>
<thead>
<tr>
<th>Service</th>
<th>900</th>
<th>900</th>
<th>900</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>1,125</td>
<td>1,125</td>
<td>1,125</td>
</tr>
</tbody>
</table>

Source: PhilHealth

Premium Contribution

Employed Sector

Effective 1 January, 2004, the minimum Salary Base (SB) was revised from Php 3000 to Php 4000 and the maximum SB was revised from Php 10000 to Php 15000. The contribution schedule is now as follows:

<table>
<thead>
<tr>
<th>Monthly Salary Bracket</th>
<th>Monthly Salary Range</th>
<th>Salary Base (SB)</th>
<th>Total Monthly Contributions</th>
<th>Personal Share (PS=SBx1.25%)</th>
<th>Employer Share (ES=PS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4999.99 and Below</td>
<td>4000.00</td>
<td>100.00</td>
<td>50.00</td>
<td>50.00</td>
</tr>
<tr>
<td>2</td>
<td>5000.00 to 5999.99</td>
<td>5000.00</td>
<td>125.00</td>
<td>62.50</td>
<td>62.50</td>
</tr>
<tr>
<td>3</td>
<td>6000.00 to 6999.99</td>
<td>6000.00</td>
<td>150.00</td>
<td>75.00</td>
<td>75.00</td>
</tr>
</tbody>
</table>

Table 20: Contribution Structure in the Employed Sector
<table>
<thead>
<tr>
<th>Monthly Salary Bracket</th>
<th>Monthly Salary Range</th>
<th>Salary Base (SB)</th>
<th>Total Monthly Contributions</th>
<th>Personal Share (PS=SBx1.25%)</th>
<th>Employer Share (ES=PS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>7000.00 to 7999.99</td>
<td>7000.00</td>
<td>175.00</td>
<td>87.50</td>
<td>87.50</td>
</tr>
<tr>
<td>5</td>
<td>8000.00 to 8999.99</td>
<td>8000.00</td>
<td>200.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>6</td>
<td>9000.00 to 9999.99</td>
<td>9000.00</td>
<td>225.00</td>
<td>112.50</td>
<td>112.50</td>
</tr>
<tr>
<td>7</td>
<td>10000.00 to 10999.99</td>
<td>10000.00</td>
<td>250.00</td>
<td>125.00</td>
<td>125.00</td>
</tr>
<tr>
<td>8</td>
<td>11000.00 to 11999.99</td>
<td>11000.00</td>
<td>275.00</td>
<td>137.50</td>
<td>137.50</td>
</tr>
<tr>
<td>9</td>
<td>12000.00 to 12,999.99</td>
<td>12000.00</td>
<td>300.00</td>
<td>150.00</td>
<td>150.00</td>
</tr>
<tr>
<td>10</td>
<td>13000.00 to 13999.99</td>
<td>13000.00</td>
<td>325.00</td>
<td>162.50</td>
<td>162.50</td>
</tr>
<tr>
<td>11</td>
<td>14000.00 to 14999.99</td>
<td>14000.00</td>
<td>350.00</td>
<td>175.00</td>
<td>175.00</td>
</tr>
<tr>
<td>12</td>
<td>15000.00 and up</td>
<td>15000.00</td>
<td>375.00</td>
<td>187.50</td>
<td>187.50</td>
</tr>
</tbody>
</table>

Source: PhilHealth

Individually Paying Programme (IPP)

Premium contribution for the IPP including all existing self-employed, voluntary, and overseas worker members of SSS is fixed at Php100 per month. This can be paid on a quarterly, semi-annual or annual basis. According to PhilHealth, the premium contribution is fixed generally because there is no regular monthly compensation for which to base the contribution upon. Furthermore, the IPP is made under a voluntary scheme and majority of the target clientele of the programme falls under the less privileged sectors.

Sponsored Programme

The LGU and National Government through PhilHealth share the premium payments for the indigents to be enrolled. Other government agencies and officials as well as private entities may also participate in the Programme by paying the LGU premium counterpart. Donations to the Programme are fully deductible from...
taxable income. The discounted premium is Php 1200, which entitles the indigent household one year of coverage. The premium is discounted in accordance with the income classification of the Local Government Unit where the indigent enrollees reside. The premium discount is then paid for by the National Government. The table below presents the schedule of premium contributions to the sponsored programme.

**Table 21. Schedule of LGU Premium Contributions**

<table>
<thead>
<tr>
<th>LGU Income Classification</th>
<th>Year</th>
<th>% Discount</th>
<th>% Premium Payment</th>
<th>Annual Premium</th>
<th>Monthly Premium</th>
<th>Per Capita*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st to 3rd</td>
<td>1st onward</td>
<td>50%</td>
<td>50%</td>
<td>P 594.00</td>
<td>P 49.50</td>
<td>P 9.90</td>
</tr>
<tr>
<td>4th to 6th</td>
<td>1st and 2nd</td>
<td>90%</td>
<td>10%</td>
<td>P 118.80</td>
<td>P 9.90</td>
<td>P 1.98</td>
</tr>
<tr>
<td></td>
<td>3rd</td>
<td>80%</td>
<td>20%</td>
<td>P 237.60</td>
<td>P 19.80</td>
<td>P 3.96</td>
</tr>
<tr>
<td></td>
<td>4th</td>
<td>70%</td>
<td>30%</td>
<td>P 356.40</td>
<td>P 29.70</td>
<td>P 5.94</td>
</tr>
<tr>
<td></td>
<td>5th</td>
<td>60%</td>
<td>40%</td>
<td>P 475.20</td>
<td>P 39.60</td>
<td>P 7.92</td>
</tr>
<tr>
<td></td>
<td>6th onward</td>
<td>50%</td>
<td>50%</td>
<td>P 594.00</td>
<td>P 9.50</td>
<td>P 9.90</td>
</tr>
</tbody>
</table>

* Paid by the National Government
** Monthly premium per person for an average family size of five members
*** Reckoned from the date the Memorandum of Agreement with PhilHealth is signed

Source: PhilHealth

Heath Care Providers

As of May 2004, there are 1520 accredited health care facilities equivalent to nine out of 10 DOH-licensed hospitals. There are to date 16204 accredited health care professionals, 40% of which are concentrated in the NCR. PhilHealth also has 178 RHUs compared to just 33 accredited RHUs in June 2001, making the Outpatient Diagnostic Package available to more indigent beneficiaries.

3. **Voluntary Health Insurance Schemes**

Although information is incomplete and unsystematic, there exists a number of community-based health financing schemes designed to address problems related to inadequate or unaffordable services. These schemes take various forms, from single-purpose programmes to multi-purpose programmes that address both health and other socioeconomic concerns of the community. The schemes involve direct provision of health care goods and services, the setting-up of health financing*

*An amendment to the National Health Insurance Act is being discussed in Congress that would peg the share of LGU according to their income classification irrespective of how long they occupy such classification.*
schemes, and activities that simply enhance or expand the capacity of the existing health care delivery system.

In the early 1990s, many of these schemes were identified through innovative information gathering contests sponsored by the DoH and the German Agency for Technical Cooperation (GTZ) in 1990 and 1993 as part of the Health Management Information System (HAMIS) project.* Both contests promised cash awards and public recognition as incentives. Any public or private organization which participated in the planning, delivering, and assessing of health care could enter including: self-help groups, city health offices, rural health units, private hospitals, government hospitals, HMOs, health insurance companies, local government, city councils, outreach projects, cooperatives, trade unions, community organizations, charitable foundations, neighbourhood associations, barangay associations and nongovernmental organizations. Contestants were judged on the basis of effectiveness (outcomes from delivery of health care), efficiency (better management of resources for health), and equity (improved access to health care for the poor) (Schwefel and Pons, 1993). In 1990, 102 projects joined the contest and 52 became HAMIS awardees. In 1993, 153 projects joined the contest and 68 became awardees.

An analysis of the information that contestants provided about their objectives, organization, and activities uncovered a number of interesting insights into the operation of these various schemes (Herrin et al. 1996). First, unmet health care needs in a community were defined to result from under-provision or underutilization of health services. Under-provision occurs when there are not enough local health care providers in the community and transport to the nearest facilities is difficult. Underutilization may occur when sections of the community (i) cannot afford to pay for health care; (ii) do not know that health care is available (and affordable), and (iii) do not recognize health conditions that require medical attention. Numerous community health programmes and projects have been developed that attempt to address one or a combination of these problems.

Secondly, the approaches used to overcome under-provision or underutilization were varied and can be classified into the following four: (i) Direct provision of personal and public health care services; (ii) Establishment of health insurance and other health financing schemes; (iii) Assistance to existing health providers and other programmes for the purpose of expanding, improving and sustaining service provision (e.g. training, construction of facilities); and (iv) Information, education and communication (IEC) campaigns on health and health-related concerns. Examples of these initiatives are shown in Table 22 below.

---

* The description that follows is summarized from Herrin, et al. (1996).

Selected Case Studies from Asia and the Pacific
Table 22. Examples of Community-based Initiatives in Health Care Delivery and Financing

<table>
<thead>
<tr>
<th>Causes of Unmet Health Care Needs</th>
<th>Under-provision of health care</th>
<th>Underutilization of Health Care</th>
<th>Due to geography or lack of transportation</th>
<th>Due to general lack of providers</th>
<th>Due to lack of financial resources</th>
<th>Due to lack of knowledge and information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Mobile Surgery</td>
<td>5. Community Participation in the TB Control Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Establishment of insurance and other financing schemes for health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assistance to existing providers and other provider programmes for the expansion and improvement of service provision</strong></td>
<td>3. Rehabilitation of the Sta. Fe Rural Health Unit</td>
<td>6. City Health Office Linkage with NGO, industrial organizations to augment personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Federated Primary Health Care in Surigao</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Purok Health Databoard</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pure IEC for health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16. &quot;Gabey sa Kalusugan&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17. Child-to-Child Health Education Programme</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18. Stop AIDS Campaign</td>
<td></td>
</tr>
</tbody>
</table>

Source: Herrin et al. (1996)

Of the various initiatives identified, close to 90% directly provided health care services; about 5% established some form of health insurance fund; about 50% undertook activities for the enhancement and improvement of service provision in existing facilities, and nearly 85% had IEC components.
Thirdly, community health projects were implemented and managed by various types of institutions. Nearly 60% are being run by religious, civic and other non-governmental organizations including religious orders, local churches, cooperatives, people’s organizations, professional and corporate associations and charitable foundations. Government and private hospitals, clinics and lying-in centres manage about 15 percent of projects; while RHUs and BHS centers manage another 12 percent. The remaining projects are being run by other local and national government agencies, schools and cooperatives.

Finally, funding sources of projects varied to include: (i) foreign donors including USAID, UNICEF and GTZ; (ii) the Philippine government, both local and national; (iii) local donations in the form of cash, kind or labour from private individuals, industry, religious and civic organizations; (iv) fund-raising activities including benefit dances, bingo socials, cockfights, lotteries; (v) earnings from entrepreneurial activities such as cooperative stores, drugstores, manufacture and sale of various products; (vi) fees for services rendered (e.g. medical consultation fees, training fees); (vii) membership fees including insurance premiums; (viii) loans, and (ix) others including earnings from trust funds and other assets and funds left over from previous years’ operations. Eighty percent of projects have two or more sources of funds. About 70% receive funds from local donations. Thirty to 35 percent use funds from government, membership fees and fund-raising activities. Twenty to 25 per cent receive funds from entrepreneurial activities and foreign donors. Only 5 to 10 percent use loans and funds collected as service fees.

Unfortunately, there has been no systematic effort to follow up the activities of all of the HAMIS winners. Available information from informal sources suggests that some of them still do exist and are doing well such as the Federated Primary Health Care in Surigao, the Lucena Diabetic Patients Association. A national federation of HAMIS winners was formed in 1993 to serve as a link among the winners. Although the national network has not been active in recent years, the Luzon network has been active and has held annual conventions. It is also learned that there are plans by the leaders of the different networks to activate the national network.*

More recently, DoH and PhilHealth with the support of GTZ through the Social Health Insurance Networking and Empowerment (SHINE) project has identified and worked closely with community-based initiatives (referred to as community-based health care organization (CBHCO). Of the 66 community-based health care schemes identified, 35 were recently surveyed to obtained more information (Flavier, et al. 2004). The study finds that these CBHCOs are located in both urban and rural areas. They perform varied roles including health care service

* Communication with Ms. Fe Remotique of GTZ, Philippine Office.
providers, administrative intermediaries with strong information, education, and communication activities, and health care financing.

Benefit packages vary and are difficult to classify but in the case of health care financing schemes, they include outpatient and inpatient drugs, surgery, room and board, professional fees, diagnostics and laboratory, dental and cash benefits. They generally complement those offered by the NHIP. Contribution structures also vary (and are again difficult to classify) but typically much lower than PhilHealth premium (about 29% of PhilHealth’s annual premium). Membership varies from low to upper-middle-income groups that include both the formal and informal sectors. One problem about CBHCOs as a group is that the membership base is not stable, and hence revenues at times may be too low to cover catastrophic or simultaneous claims. Social reinsurance, therefore, has been suggested.

5. Social Security Programmes

Government Service Insurance System (GSIS)

The GSIS, created by the Commonwealth Act No. 186 passed on 14 November 14, 1936 is mandated to provide and administer the following social security benefits for government employees: compulsory life insurance, optional life insurance, retirement benefits, disability benefits for work-related contingencies and death benefits.

The GSIS covers all government workers irrespective of their employment status, except employees who have separate retirement schemes under special laws such as members of the Judiciary and Constitutional Commissions; contractual employees who have no employee-employer relationship with their agencies, and uniformed members of the Armed Forces of Philippines and the Philippine National Police, including the Bureau of Jail Management and Penology and the Bureau of Fire Protection.

The GSIS membership in its social security package is the estimated at 1.4 million employees of the Philippine Government. In addition, the GSIS also services the members’ dependents and beneficiaries, the retirees and pensioners, and the survivors of the deceased members or pensioners.

Social Security System (SSS)

In 1954 the Social Security Act (Republic Act 1161) was passed that provided for a social security system for wage earners and low-salaried employees. With some
amendments to the law, the Act was finally implemented in 1957 covering the employed segment of the labour force in the private sector. The Social Security System (SSS) administers social security protection to workers in the private sector. Like the GSIS, the SSS provides a range of social security benefits that include retirement, death, disability, maternity, and sickness benefits. It also provides medical rehabilitation services and funeral grants. It also administers the Employees' Compensation (EC) Programme for private employees. (Prior to its transfer to PhilHealth, SSS also administered the Medicare Programme for private employees.)

Self-employed farmers and fishermen were included in the programme in 1992 while workers in the informal sector earning at least Php 1000 a month such as ambulant vendors and watch-your-car boys, were covered in 1995. In 1993, household helpers earning at least Php 1000 were included in the compulsory coverage of employees.

On 1 May, 1997, the Social Security Act of 1997 (Republic Act 8282) aimed to strengthen the SSS was passed. The Act amended the Republic Act 1161, providing for better benefit packages, expansion of coverage, flexibility in investments, stiffer penalties for violators of the law, conditions to apply or waive penalties of delinquent employers and the establishment of a voluntary provident fund for members.

In June 2003, SSS had a total of 25.1 million members, which represented around 72.5% of the country's total 34.6 million labour force. The SSS membership comprises employees (19.8 million) and self-employed and voluntary members (4.6 million). Included in the self-employed/voluntary members are farmers and fishermen, Overseas Filipino Workers, and non-working spouses.

**Employees' Compensation Commission (ECC)**

The Employee's Compensation Programme (ECP) is designed to provide public and private sector employees and their dependents with income and other benefits in the event of a work-connected injury, sickness, disability or death. It was created under Presidential Decree 626 and became effective on January 1975. It provides a comprehensive benefit package consisting of preventive occupational safety and health aspects, curative or medical and compensatory grant, and rehabilitation of occupational disabled workers.

There are three agencies involved in the implementation of the Employees Compensation Programme. These are the Employees' Compensation Commission (ECC), which sets policies of the ECP and to review appealed cases from the GSIS and the SSS, the administering agencies of the ECP.
Covered under the ECP are: (i) all public sector employees including those of government-owned or corporations and local government units; (ii) all employees in the private sector covered by the SSS; and (iii) Filipino Seamen compulsorily covered under the SSS. Land-based contract workers are only subject to coverage under the ECP if their employer, natural or juridical, is engaged in any trade, industry or business undertakings in Philippines.

Under the ECP the following are compensated: work-connected injury or accident; work-connected sickness; and any disability or death resulting from any work-connected accident or work-connected sickness. The compensation which a claimant may receive is in the following forms: cash-income benefit for disability or death; medical and related services for injury or sickness; and rehabilitation services (in addition to monthly cash income benefit) for permanent disability. An injury is compensable if it was sustained due to an accident arising out of and in the course of employment. Similarly any sickness that is listed by the ECC as an “occupational disease“ is compensable. Finally, a disability is compensable if it is caused by a work-connected injury or sickness.

**Employer-Provided health benefits**

Employers provide health benefits voluntarily or as required by law or collective bargaining agreements. Apart from Medicare and ECC, the Labour Code prescribes a minimum set of medical, dental, and occupational safety obligations for employers. The requirements vary, depending on the hazards in the work place and on the number of workers employed. At the lower end of the scale, first-aid treatment must be available within the premises. Larger companies on the other hand must provide a company clinic with a full-time doctor, nurse, and dentist. CBA also specify the medical benefits that companies must provide their employees and the employees’ dependents.

**6. For-profit Commercial Health Insurance and HMOs**

**Commercial Indemnity Health Insurance**

In 1988, there were 102 companies involved in health and accident insurance in the country. The indemnity health industry is growing very slowly in terms of people covered. Because of the generally low income of the majority of the population and the low profits in health insurance as a product line, the life insurance companies studied in 1994 foresaw no dramatic growth for commercial indemnity health insurance. Besides, at that time hospital cash plans, which involve lower administrative costs, were being marketed more aggressively by these companies.
There was also a growing clamour from labour unions for a comprehensive HMO type of health benefit package. (Gamboa, et al., 1993).

**Health Maintenance Organizations (HMO)**

The 1990s saw the emergence of HMOs in Philippines. These were mainly investor-based HMOs directed at the employed sector and were profit-oriented. Their growth was partly in response to employers' need to supplement the social health insurance benefits, whose support value had declined due to increasing health care costs, and partly due to the clamour by labour unions for such health benefit package.

The HMO benefit package typically offers preventive health care, inpatient and outpatient services, and emergency care. Pre-existing conditions are excluded. The fee charged for membership depends on the degree of actuarial risk, the type of room, the frequency of payment, the number of persons covered, and the supplemental benefits (Gamboa, et al., 1993). At present there are about 21 investor-based HMOs listed as operating in Philippines (www.Rxpinoy.com). The HMOs share in health care financing rose from 1.3% in 1992 to 5.7% in 2001. In contrast, private health insurance share declined from 2.8% in 1992 to 1.3% in 2001.

According to Gamboa, et al. (1993), doctors are either paid regular salaries or accredited and compensated on a fee-for-service basis, at rates negotiated by the HMO with individual doctors. Salaried physicians serve at HMO-owned clinics. Enrollees requiring diagnostic procedures or treatment that are not available in-house are referred to other clinics or hospitals or to accredited physicians. HMOs accredit clinics in strategic locations and in places where there are no HMO-owned facilities.

7. **Critical Analysis of Health Care Financing**

Data from the National Health Accounts shown in Table 23 allow us to get a bird-eye view of the health financing system in its entirety. The data show that by far the largest single source of financing is still the households, contributing 43% of total health expenditures in 2001. Households in turn finance these expenditures, especially large and unanticipated expenditures, in a variety of ways – from savings, contributions from extended family, borrowings, sale of assets, and from reduction in current consumption or human capital formation in children such as nutrition and basic education. Lower-income groups are likely to bear a disproportionate burden of these expenditures.

<table>
<thead>
<tr>
<th>Source of funds</th>
<th>Percent share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>35.2</td>
</tr>
<tr>
<td>National</td>
<td>30.8</td>
</tr>
<tr>
<td>Local</td>
<td>4.4</td>
</tr>
<tr>
<td>Social Insurance</td>
<td>6.0</td>
</tr>
<tr>
<td>PhilHealth</td>
<td>5.7</td>
</tr>
<tr>
<td>Employees compensation</td>
<td>0.3</td>
</tr>
<tr>
<td>Private sources</td>
<td>58.9</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>49.6</td>
</tr>
<tr>
<td>Private insurance</td>
<td>2.8</td>
</tr>
<tr>
<td>HMOS</td>
<td>1.3</td>
</tr>
<tr>
<td>Employer-based plans</td>
<td>4.2</td>
</tr>
<tr>
<td>Private schools</td>
<td>1.0</td>
</tr>
<tr>
<td>All sources</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As a last resort, government expenditures, financed from taxation, provide households protection from risk of catastrophic health care expenditures. However, the ability of government to finance health expenditures has been limited due to slow economic growth and low government savings rate. Risk protection then has to be provided by other means. The Philippines embarked upon social insurance programmes much earlier than such countries as South Korea and Thailand, yet while South Korea achieved universal coverage in the 1990s, the Philippines social health insurance programme is barely covering half of the population. The growth of private schemes such as HMOs and community-based schemes, while indicating innovativeness in responding to financing needs, also indicate the inadequacy of government-sponsored or formal schemes. As mentioned earlier, part of the difficulty in expanding social insurance is the low incomes of households in view of continued high poverty rates and due to the slow structural transformation of the economy leaving a large portion of the labour force in hard-to-reach agricultural and informal service sectors.
With the devolution of health care services to the local government units (LGUs) in 1992, much of health care delivery and financing became the responsibility of LGUs. With this responsibility came additional resources from the national government in the form of increased share in internal revenues, referred to as the internal revenue allocation (IRA) to LGUs. While there remains the concern about the mismatch between the IRA shares and the cost of devolved health functions and the fact the IRA is given as block grants, which LGUs can choose to spend among competing local expenditures other than health, LGUs on the whole have been responsive to delivering quality health care and financing such investments. One aspect which many LGUs have responded to is the financing of premium subsidies for the Indigent Programme of PhilHealth. The growth of coverage of indigents has been particularly rapid in the last few years. However, there is still much further to go in view of the slow decline in poverty rates and the fact that LGUs with large numbers of the poor are also the ones with limited financial capacity to subsidize their premium.

While efforts are being made to expand health insurance coverage of the population, there are issues that need to be addressed to ensure that risk protection is adequate without unnecessarily raising the total cost of health care. These issues arise from the fact that health insurance can affect health utilization patterns and therefore overall costs. While it is expected that health care utilization increases with insurance as financial barriers are reduced, the type of health care that is sought can be influenced by the package of benefits that the insurance provides. Simulation analysis has demonstrated that hospitals are likely to be preferred over clinics as health providers, if insurance pays only for inpatient services, and that insurance has a tendency to induce individuals to substitute less expensive services (clinic care) with more costly services (hospital care). Furthermore, within hospital-based services, insurance shifts individual preference from public to private facilities. All these behavioural changes are likely to raise the financing requirements of the health sector. (Solon et al. 1995)

In addition to providing risk protection to the poor, the expansion of health insurance had the additional beneficial effect of assuring minimum quality of services for both insured and non-insured. This came about from the accreditation requirements that PhilHealth imposes on those wishing to participate in the NHIP. With the inclusion of outpatient care in Rural Health Units (RHU) as health insurance benefits for the Indigent Programme, efforts to improve the quality of health care in RHUs (through, for example, the Sentrong Sigla programme) was accelerated because of the need of RHUs to be accredited in order to participate in the insurance programme.

A health sector reform programme has been under way since 2000 that involves the coordinated implementation of a number of inter-dependent
interventions including health insurance coverage expansion, development of local health systems, upgrading regulatory capacity, restructuring hospitals, and strengthening public health care activities. The success in engendering the synergistic impacts of these reforms is expected to have profound influence on the future structure of health care financing and the quality of health services.

References


Singapore

Kai Hong Phua

1. Background
Singapore is a city-state with a total population of over 4.2 million resident nationals living in a highly urbanized and planned living environment. It has inherited a strong British-type National Health Service system with the dominant role of the government in the public provision of health services, which is financed mainly by central taxation. Over the past 25 years, the government has actively embarked on a systematic series of health sector reforms to restructure the health care delivery system and to diversify the sources of financing.

Health Care Philosophy
The health-care philosophy of Singapore emphasizes the building of a healthy population through preventive health-care programmes and the promotion of healthy living. Singaporeans are encouraged through the public health education programmes to adopt a healthy lifestyle and be responsible for their own health. The government ensures that good quality and affordable basic medical services are available to all Singaporeans through the provision of heavily subsidized medical services at public hospitals and government polyclinics. All private practitioners, hospitals, clinics, laboratories and nursing homes are required to maintain a high standard of medical services through licensing and regulation by the Ministry of Health.

To promote personal responsibility, Singaporeans are required to save under the Medisave scheme, for their medical expenses, especially during old age. This is to avoid over-reliance on state welfare. Under the scheme, every employee sets aside 6-8% of monthly income into a personal Medisave account and the savings may be used to pay for hospitalization expenses and health insurance premiums incurred by the employee and family. This system is intended to encourage individuals to stay healthy and minimize the use of unnecessary medical care by sharing costs and co-payments.

To promote these ideals, the government has a philosophy that emphasizes building a healthy population through disease prevention and the promotion of
healthy living. Individuals are encouraged to take responsibility for their own health by saving for their own expected medical expenses. To reinforce this sense of personal responsibility, the health care system is designed to gradually build upon three health-care financing programmes that help people pay for medical expenses: Medisave, Medishield and Medifund. These three programmes are intended to create a largely self-funded health care system that requires people to first look to personal and family resources for health care, relying on the government only after their own resources are depleted.

The principle of co-payment by the patient for medical care at the time of consumption was adopted in the public system to discourage unnecessary utilization. For those who choose to seek medical care in public hospitals, their hospitalization expenses are subsidized between 20-80% by the government. Lower subsidy is given to those who prefer the creature comforts and more luxurious services in the higher-class wards. The indigent can apply for partial or full remission of their hospitalization bills at public hospitals. There is universal coverage as no Singaporean is ever denied access into the health-care system and use of emergency services, or ever turned away by hospitals.

2. Development of Compulsory and Voluntary Prepayment/Health Insurance Mechanisms

In 1981, the government officially embarked on a plan to restructure the health care system in Singapore, principally through the introduction of an alternative method of financing as part of the existing Central Provident Fund (CPF) concept of compulsory savings. The idea of using CPF savings for medical care had been mooted much earlier in the 1970s when the government was looking at various options to finance old age security and the increasing costs of public services. It was not until the appointment of a new Minister for Health in 1981 that the policy to shift away from the old tax-based financing system took shape in the form of a major exercise in national health planning.

The National Health Plan

In June 1981, the Ministry of Health held many discussions with many stakeholders in both public and private sectors, and the National University of Singapore to gather ideas on how to develop further the health care system in Singapore. Further research and data collection were conducted, including the review of alternative health care systems in developed countries. The Members of Parliament were also consulted in February 1982 to consider their viewpoints. In March 1982, the Minister for Health announced in Parliament the proposed Medisave Scheme and its
underlying philosophy, which was followed by extensive press publicity. Throughout the following year, more dialogue sessions were held with grassroots and community leaders from the Citizens Consultative Committees, representative employers' federations, trade unions and health-related associations.

The National Health Plan (NHP) was revealed in February 1983 to introduce the Medisave scheme as a compulsory savings plan for medical coverage. The NHP was intended to change the direction of the Singapore system, and avoid the pitfalls and problems of over-generous welfare systems elsewhere. The declared objectives of the NHP were to secure a healthy, fit and productive population through active disease prevention and promotion of healthy lifestyles, and to improve cost-efficiency in the health care system. It was also justified on the grounds of meeting the growing demand of a rapidly ageing population for higher quality health care. The rationale for the NHP was that Singapore's health care system must "stand the test of time as the demand for hospital care will go up while the anticipated tax revenue may be expected to go down in relative terms".

The solution thus lay in a personal savings scheme like Medisave, with the philosophy to reward the individual for staying well. The scheme would also detach the quality of the health care system from the vagaries of economic growth, as past financing was heavily dependent on taxation or budgetary allocation. These objectives were also consistent with preserving the traditional values of self-reliance and strong family ties, which would be promoted as the primary social support for care of the sick and aged, embodied in the two axioms of "saving for a rainy day" and "charity begins at home". The Medisave account in the CPF finally evolved, which allowed withdrawals to pay for expensive medical costs, within certain limits, of account-holders and immediate family members. It was conceived that this additional source of funds could ease the pain of increasing costs for the individual and family.

A Blue Paper on the National Health Plan was released in February 1983, which was widely publicized through the mass media. Feedback from the public was actively solicited while there was follow-up by the media covering issues related to health care financing and delivery. Parliament then debated the National Health Plan in August 1983 before it (i) approved in principle the Medisave Scheme which would enable Singaporeans to set aside their own savings to meet future hospitalization expenses; and (ii) recommended that there be periodic reviews in the implementation of the scheme and that adjustments be made when experience showed this to be desirable.

From then until April 1984, the scheme was given mass media coverage to explain how it would work in practice. Printed informational material was widely distributed and public talks were held in community centres, hospitals and companies to provide information to as large a population as possible. The
Medisave Scheme was eventually implemented in all government hospitals from 1 April, 1984.

Before the scheme was expanded to include approved private hospitals from 1 January 1986 onwards, it was first introduced as a pilot project involving the new National University Hospital (run by an autonomous quasi-government company) from June 1985. The scale of charges and Medisave withdrawals here were equivalent to those in government hospitals. Withdrawal rates however, were subjected to a ‘per day maximum’ for hospital charges and a maximum rate for major groups of surgical procedures. The same limits were then applied to the private hospitals.

Since the scheme started, several modifications have been made to it based on the experience acquired. Initially, account-holders were only permitted to use their Medisave accounts to pay for the full charges of hospital stay in lower-priced wards and only a partial component for the more expensive rooms. This was gradually extended to cover almost all categories of hospital charges, but subjected to maximum daily limits. In addition, Medisave accounts that are used for payment of higher-priced medical treatment would not be allowed to be overdrawn.

Population policies

The Committee on the Problems of the Aged was convened by the government in 1983 to recommend measures to prevent, ameliorate or deal with problems of the ageing population, and its report set out a national policy covering aspects of employment, financial security, health and recreational needs, social services and institutional care, and family relations. Measures implemented at that time were reinforced by the Report of the Advisory Council on the Aged in 1989, which recommended the development of community-based programmes for maintenance of good health, prevention of disease, and rehabilitation and social support for the elderly.

These measures were implemented in a manner consistent with the National Health Plan and the Medisave Scheme, which in turn recognised that savings through the CPF were to form the backbone of viable financing of increasingly expensive health care of the elderly in Singapore over the longer term. Singapore has thus approached the financing of cost-effective health care for an expanding elderly population and more sustainable methods of financing care within the framework of its overall old age security system. The official policy of enlarging the scope of mandatory savings to cover other areas is consistent with the social objectives of providing old age security. Since health care needs and expenses are expected to rise dramatically with ageing, mechanisms to protect the elderly against expected medical costs were the first additions to be built into the CPF scheme.
In the Singapore context, financing health care through pay-as-you-go taxation or out-of-pocket payments was considered to be inadequate to pay for good quality health care and prior savings therefore had to be enforced to meet the anticipated rising costs of medical care. These considerations formed the underlying basis for the National Health Plan of Singapore formulated in 1983. In addition to promoting personal responsibility for maintaining good health, the Plan has aimed to build up financial resources so as to create the means to pay for medical care during illness, especially in old age.

Integration of Medical Savings and Social Health Insurance

Singapore’s current health care financing reforms developed in three stages: Medisave, the savings component of the system, was introduced in 1984. Medisave represents a form of compulsory saving. Because the contribution is based on wages, the very old and the very young frequently do not have Medisave accounts. However, Medisave funds now support over 80% of inpatient expenditures since these can be used to pay the medical bills of family members.

Medisave funds are never adequate to cover all or most high-cost health expenditures, so there would be significant demand for health insurance. Medishield was introduced as a catastrophic insurance plan in 1990. Medishield premiums are automatically deducted from the Medisave, unless account-holders request otherwise. To reach the threshold for catastrophic coverage, it is usually necessary to have had a very long hospital stay or one of several costly, ongoing outpatient treatments such as day surgery or chemotherapy for cancer. Various supplementary Medishield Plus and voluntary private medical insurance schemes were also allowed in 1994, to offer different levels of coverage, based on deductible or excess per policy year, claim limits per policy year, and claim limits per lifetime.

Medifund, a third financing component, was established by government endowment in 1993 to support health care for the poor and indigent. Government budget surpluses are used to fund additional contributions to Medifund. Requests for financial assistance are considered on a case-by-case basis with preference to “low-wage Medisave/ Medishield contributors and elderly persons whose accounts are not adequate to cover expenses.”

Singapore’s experience represents a natural experiment in the development of medical savings. While costs and demand continue to rise in Singapore, it is widely believed that unnecessary expenditures for inpatient care have been reduced without dramatic limits on physicians’ incomes or the availability of newer high-technology treatment. However, it is important to emphasise that Singapore uses a fairly narrow definition of services eligible for medical savings expenditures (e.g. excluding most outpatient care), has a fixed fee schedule for medical services, and does not have comprehensive insurance. But universal access to public health-care is
guaranteed through a system of targeted subsidies and subventions from tax-based sources, as well as a last-resort Medifund endowment for the indigent. It does not use medical savings as the sole mechanism for financing care, nor does it treat medical savings as a single solution to all health policy problems.

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<th>Chronology of Health Care Financing Development in Singapore</th>
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**Social Health Insurance**
3. Compulsory Prepayment/Social Health Insurance Mechanisms

Compulsory prepayment and social health insurance mechanisms in Singapore consist of the 3-M schemes of Medisave, MediShield and Medifund.

Medisave

Medisave is the compulsory medical savings scheme linked to the Central Provident Fund (CPF) accounts, and all employed people must contribute to a Medisave account up to the age of 55, with a minimum sum to be retained for health care in old age. Employees and employers contribute a total of 30-40% of the employee’s wages to the CPF, which serves as a national social security and pension fund based on savings. From this fund, equal contributions from the employer and employee amounting to 6% of wages are deposited into the employee’s Medisave account until age 34. The percentage deposited increases to 7% between ages 35 and 44, rising to 8% at age 45 and continues until retirement or until the ceiling is reached. For self-employed individuals who earn more than US$ 6000 per year, the Medisave contribution rate is 5% of an estimated “net trade income”, which is paid annually during the statutory renewal of trade licences.

As of 2005, the maximum monthly contribution is S$ 300 for employees below 35 years of age, S$ 350 for those between 35 and 44 years old, and S$ 400 for those 45 years and above. For self-employed persons, the maximum monthly contribution is S$ 300, based on a maximum monthly income of S$ 6000. There is a maximum limit on the Medisave balance, currently maintained at S$ 30000 and which is regularly adjusted for inflation. After this maximum account balance has been reached, additional funds in Medisave are transferred automatically to the owner’s normal account in the CPF.

Medisave savings earn interest at the prevailing CPF rate which is based on the current average inter-bank interest rates. The earned interest is also retained in the Medisave account and all Medisave and CPF savings are tax deductible. Upon the death of an account-holder, the Medisave balance along with the CPF account will be paid in cash to the bequeathed nominee, and will be free of estate duty. For those who have not nominated a beneficiary, Medisave balances will be channelled to the Public Trustees to be distributed to family members according to the law.

Medisave accounts can also be pooled to pay for medical expenses of immediate family members, including spouses, children, parents and grandparents who do not have their own accounts. The use of Medisave for extended family
members such as siblings, in-laws, uncles/aunts and nephews/nieces may be allowed on a case-by-case basis if the patient is hospitalized in a subsidized ward of public hospitals.

Medisave is currently subject to a withdrawal limit of S$ 300 per day for inpatient stays, which includes a maximum of S$ 50 for the doctor’s daily attendance fees and S$ 150 for day surgery. In addition, there is a fixed limit ranging from S$ 150 to S$ 5000 for different categories of surgical procedures within a table of operations. For psychiatric treatment in long-stay institutions and chronic care in community hospitals, the use of Medisave is subject to a withdrawal limit of S$ 150 per day and a maximum of S$ 3000 per year. For approved outpatient treatment which may be expensive, Medisave can be used within certain limits, for procedures such as assisted conception, chemotherapy, radiotherapy, renal dialysis, and antiretroviral treatment, etc.

Medishield

Medishield is a low-cost medical insurance scheme to help CPF members and their dependents to meet the high costs for serious and prolonged illness. It is designed to be a supplementary back-up to Medisave that provides catastrophic illness insurance with premiums payable from Medisave accounts. It has a voluntary opt-out feature for those who have other health insurance coverage or who cannot even afford the relatively low premiums. Medisave account holders can also use their Medisave to pay the premiums for their dependents to join Medishield. The premiums are risk-rated according to age and range from S$12 per year for those aged below 30 to S$96 for the 61-65 age-group, and rising from $132 to $390 for those aged 66-70 to 80 years, when coverage stops.

Medishield will cover the hospitalization expenses for most catastrophic illnesses, such as intensive care, surgical operations and implants, kidney dialysis, chemotherapy and radiotherapy for cancer treatment. Medishield will not pay for treatment of pre-existing illnesses, congenital illnesses, cosmetic surgery, labour delivery charges, mental illness including personality disorders, drug addiction, alcoholism, and overseas treatment.

Medishield will cover 80 % of the total claimable amount above a deductible of S$500 for patients in subsidized wards of public hospitals, and above a deductible of S$1000 for those in the higher class wards. Medishield is subject to a claim limit of S$120 per day for inpatient stay and S$100-$600 for surgical operations. There are also claim limits of S$15,000 a year and S$50,000 for a lifetime. The deductibles and co-insurance payments of 20% can be paid out of Medisave or by cash.
**Medifund**

Medifund is a financial assistance scheme to help needy patients pay for their medical care. It is an endowment fund set up as a safety net for the poor and indigent who are without family support or do not have adequate Medisave or Medishield coverage. The fund is built up during periods of high economic growth so as to relieve the dependency on traditional sources of charity and taxation as the primary means of financing social welfare for the poor. Only the interest income from the principal will be used in order to keep the endowment fund sustainable.

Medifund grants are provided in all approved public hospitals and government medical institutions to help Singaporeans pay their medical bills. Every approved hospital and medical institution will have its Hospital Medifund Committee to consider and approve applications, and decide on the quantum of assistance according to recommended guidelines. Applications are submitted by patients through a Social Medical Worker who would conduct an interview equivalent to a means test. Committee members comprise largely of people who are actively involved in community social work and would be able to adopt a fair and flexible approach in their assessments.

The amount of assistance from Medifund depends on individual circumstances, taking into account the conditions of the patient and family, and the bill size incurred. To encourage a greater sense of personal responsibility, Medifund provides greater support to those who have contributed regularly to Medisave and covered by Medishield, but despite these, have run into financial difficulties. It will give priority to elderly patients with no Medisave or Medishield coverage, and without family support.

**4. Social Security and Social Assistance Programmes**

Financing care for the ageing population has surfaced as a critical issue in Singapore, as the rapid ageing of the population is expected to intensify the demand for expenditure on health care and long-term care, making it necessary to plan for appropriate and cost-effective services so that the organization and financing of care can be integrated with arrangements for income support to guard against the pressures of increasing costs. This section presents an account of the integrated approach in which Singapore’s policies are directed towards achieving this objective.

The core measure for tackling ageing in Singapore is the Central Provident Fund (CPF) which was set up in 1955 as a universal, compulsory saving scheme to provide income support for the working population when they retired. Subsequent provisions for health care have been integrated into the CPF, and together these
measures set the context in which arrangements for long-term care are now being developed. A Public Assistance scheme is administered by the Ministry of Community Development to provide a minimum income for the destitute, frail and disabled elderly who have no income from their CPF account and no family support. While the issues of population ageing faced by Singapore have much in common with other rapidly ageing countries of the Region, the initial solutions devised by way of the CPF and further elaborations building on that foundation have set in train a system that is in many ways unique to Singapore.

It is now more than 20 years since the Singapore government began to recognize the impact an ageing population would have on society. In line with its philosophy of long-term planning and with some considerable foresight, the government set up an Inter-Ministerial Population Committee in 1984. This was to be the first of a series of inter-ministerial committees that have examined issues of ageing over the ensuing years. In 1988, the National Advisory Council on the Aged was formed to undertake a comprehensive review of the status of population ageing in Singapore. One of its key recommendations was that a National Council on Ageing should be set up with the character and authority of a statutory board to effectively plan and coordinate policies and programmes for older persons. Other proposals included:

- Raising the retirement age from 55 to 60 as continued employment would provide a sense of worth, dignity and financial independence to older persons;
- Readjusting the seniority-based wage system to remove disincentives to employ more older people;
- Expanding and strengthening public education programmes on the older persons and ageing so that positive attitudes towards older persons could be inculcated;
- Making land available for voluntary organizations to set up homes for older persons and lengthening the term of leases for these homes, to address the scarcity and high cost of land in Singapore;
- Studying the feasibility of providing health and medical services for the frail older persons living in their own homes, and
- Increasing the dependency tax rebate for families who look after older persons.

A number of these initiatives have been acted on to support family care for the elderly and so give expression to the government’s philosophy of maintaining family support. Measures taken include provision of financial incentives linked to...
CPF contributions and preferential treatment in allocation of housing and housing loans, closely integrated with the wider housing and income security policies that are particular to Singapore. These measures are reported to have increased the proportion of elderly living with family from 81% to 86% in 1995. This 5% shift is more impressive when seen as a relative decline among the 19% of the elderly who were not previously living with their children as it indicates a change in living arrangements for one in four of this group. Allowing for the proportion of the elderly who have no children, family living arrangements are evidently being sustained.

To meet further challenges, the 1990s witnessed the development and implementation of three milestone policies. A significant piece of legislation, the Maintenance of Parents Act, was introduced in 1994 after extensive deliberation by various community groups and a Parliamentary Select Committee. The policy aims to prevent the neglect of elderly parents and provide for action when problems arise, and public endorsement for this policy that imposes a legal obligation on children to maintain their parents is again quite particular to Singapore. In 1996, amendments to the Women’s Charter provided channels for elderly parents to exercise legal action if they were victims of physical, mental or psychological abuse. An enlightened policy covering medical care of the terminally ill was also put in place in 1996. Under the Advanced Medical Directive Act, persons who have been medically certified to be brain dead, can now under their earlier directives be relieved of medical life support. This policy is seen as reducing unnecessary suffering for both the terminally ill older persons and their families. However, the present take-up rate is rather low and it is not expected to play a significant role in the immediate future.

Beyond these specific initiatives, a national policy on ageing in Singapore has taken shape after a number of policy reviews. Two characteristics in the policy formulation process have been noted. First, the various committees have the benefit of representation from various sectors and so receive diverse inputs from government ministries and agencies, providers, professional and community organizations, leading to decisions that are very likely to be implementable. Historically, cross-sector representation has worked well in the local context and it is a standard feature in the Singapore’s government problem-solving approach. Second, the committees were given wide publicity, and public awareness on the issues of ageing was heightened especially when controversial recommendations were proposed. The enhanced discussion of policy changes by the public has seen an increasing emphasis on social care of older persons. The Inter-Ministerial Committee on the Ageing Population, formed in 1998, has also revisited many of the recommendations of earlier Committees on ageing matters and has proposed a more
coordinated and comprehensive plan to deal with challenging issues of Singapore's ageing population in the 21\(^{st}\) century.

**Funding principles**

Achieving coordinated and comprehensive planning of long-term care in Singapore requires that a number of key features of other health and social policy areas are also applied to this field. Thus, the principle of co-payment is being applied in long-term care as far as possible, as it applies in health and social services for the general population. The individual consumer and his or her family are expected to share a portion of the charges while the government subsidizes the rest. This principle applies to the Medisave scheme, and it also demonstrates that joint responsibility lies with the family unit, as savings can be used to meet the cost of ageing parents’ hospitalization and long-term care as well as for the individual’s own expenses.

Access to publicly-funded health and community care services for the elderly, such as home nursing, day care and rehabilitation, is restricted by a variety of eligibility tests. A sliding scale of charges based on household income is imposed for these services and only recipients of the Public Assistance programmes are entitled to free medical service at the government polyclinics. All other Singaporeans above age 60 are however entitled to a subsidy of 50% of the fees charged at these polyclinics. This principle of a sliding scale of means-tested fees will be further refined and extended to all long-term care services in the future.

**Financing Long-Term Care**

There is presently no comprehensive system for financing long-term care in Singapore, and financing currently draws on:

- Direct payments from older individuals and their families;
- Community assistance to voluntary welfare organizations which secure up to 50% or more of their recurrent expenditure from fund raising;
- Government funding through grants-in-aid to voluntary welfare organizations, providing up to 90% of capital funding and up to 50% of recurrent funding based on government cost norms and 75% for Public Assistance cases, and
- Extensions to Medisave to provide limited coverage for selected forms of non-acute care as noted above.

While the norm is to keep elderly members as long as possible in their own homes, a number of problems have become evident in recent years. Although there
is little statistical information on the types and quality of informal care provided to the elderly in their own homes, it is not inconceivable that most of the care is rendered by untrained relatives and maids. Lower-income families who cannot afford household help would be hard-pressed to provide good quality care to their elderly members. The increasing costs of care without access to subsidies except for those receiving Public Assistance could also create pressures on middle income families, and the all-or-nothing situation with regard to access to subsidized nursing home care has only recently been addressed with the introduction of means testing that gives those with some income access to part subsidies rather than none.

Second, due to the lack of long-term care alternatives and the limited financial assistance available, there can be perverse incentives to hospitalize since the current 3-M financing system only covers hospitalization. The present hospital subsidy system may also explain the longer lengths of stay in the lower class wards as lower-income patients and their working class families cannot afford the direct or indirect costs of alternative care at home. Since subsidies for home medical care and home nursing care are limited to the poor and indigent, there still exist currently perverse incentives to admit elderly to nursing homes when they could possibly otherwise be served more cost-effectively in their own homes.

The present bias in funding to nursing homes is likely to increase. Capital grants to voluntary welfare homes have increased in recent years, along with rising operating expenditure. These capital grants carry future commitments to operating costs that will have to be met by a mix of government funding, increased fundraising and fees. Notwithstanding the commitment to support families in providing care for their elderly, the third problem is that there has been no comprehensive funding for community care services and long-term care in the recent past.

Recent Initiatives and future options

Several recent initiatives have been taken in Singapore, based on recommendations of the IMC, which extend provisions for long-term care within the wider framework of the CPF and the 3M scheme and which maintain the role of government as a partner with families and voluntary welfare organizations.

Recent policy announcements have promised more government matching grants-in-aid for voluntary welfare organizations to work with grass-roots organizations through the Community Development Councils. Many of these new funding mechanisms are directed at the local government infrastructural development to cater for the needs of ageing constituencies. The deliberations of the IMC have focused public attention on the financing issues regarding the provision of long-term care. Other recommendations included a review of capital funding for voluntary welfare organizations to build step-down care facilities, a means test to
channel government subsidy for step-down care to those patients most in need of financial help, and government subsidies to support home medical care and home nursing services.

Two initiatives were taken in early 2000. First, an Elder Care Fund was set up under the Medical and Elderly Care Endowment Schemes Act to finance the future operating subsidies of voluntary welfare organizations. Initial capital injections of $500 million through 2000 are to be built up to a target of $2.5 billion by 2010. Second, means-testing has been introduced in voluntary nursing homes with a sliding scale of subsidies from 25% to 75%, taking account of household size and income. Prior to this, other forms of community care have not been means-tested, in contrast to the medical and health services, which provide discounts for elderly patients or waivers for those on Public Assistance.

A second round of initiatives was announced in January 2001, when a number of recommendations that had been made by the IMC, through the Working Group on Health Care, were endorsed by the government. Principal among these is the move to restructure funding of voluntary welfare organizations in a way that provides incentives for them to raise more funds and to cover an increased volume of patients, including more fee-paying clients, and to improve the quality of care quite substantially so as to attract the higher-income clients. Under the previous arrangements, grants to voluntary welfare organizations were capped or reduced once the voluntary welfare organizations raised excess funds. These arrangements not only provided little incentive to raise funds, but could in fact penalise voluntary welfare organizations which did raise additional funds.

At present, government funding for 90% of capital costs does not differentiate between the types of residential care, such as quality of amenities and level of comfort in the physical environment. The recommendation to fund on a “cost per bed” basis also does not take into consideration special requirements and needs of different services to be provided. Government funding for recurrent costs also does not differentiate specifically the case-mix of patients, like age, gender, severity of disease and complicated conditions. Recently policies have been formulated to target the limited government subsidies to those in greatest need. Furthermore, there policies now have refined subventions to balance the affordability of patients and their families with means-tested user charges.

Beyond the initiatives that were recently supported by the government, the IMC also recommended the establishment of additional financing for long-term care, renamed as “step-down care”. The proposals included an insurance scheme to help individuals and their families defray the high costs of step-down care required by those elderly with very severe functional disabilities. The IMC thus concluded that the best option for financing would be along the lines of the Medishield scheme.
Like the Medishield scheme, a long-term care insurance scheme would be based on an opting-out approach, and have the features of deductibles and co-insurance to discourage over-consumption and over-servicing. There is concern that the number and proportion of those who have opted out of Medishield could be repeated in any long-term care insurance scheme established on a voluntary basis. Of greater concern is the large number of young people who have opted out of Medishield, despite the relatively cheaper premiums that are already adjusted to their lower risk-ratings. It will become increasingly unfair for those remaining in the smaller pool to have to bear the burden of carrying the risks of the elderly, especially if those who have opted out and have not contributed earlier are allowed to opt in later without any penalties.

Indeed this was the case when the Eldershield scheme for severe disability insurance was launched in 2002. Despite massive publicity and public debates, the scheme experienced almost 40% opt-out rates, leading to a classic case of adverse selection inherent in most private health insurance markets. These were due to various reasons:

- The scheme was privatized to be managed by two large private insurance agencies which were allowed to act as alternative carriers, and was perceived to be profit oriented and commercial rather than social insurance schemes
- The premiums were substantial relative to the benefits to be paid out, thus conveying the impression that the scheme does not over give little value for money, and
- Many of those who opted out were from the higher-income and younger age-groups for whom the benefits were considered meagre in relation to the relative risks of needing long-term care.

Currently, there is an on-going review of the 3-M system and existing optional health insurance products like the fledgling Eldershield scheme for severe disability insurance and various Medishield Plus schemes in the market for catastrophic illness, with the objectives to fill in the gaps and enhance coverage. Early policy announcements point to the need for compulsory enrolment and greater enhancement of benefits through strengthening the insurance components of the 3-M financing mechanisms.

5. For-profit Commercial Health Insurance

Private health insurance does not play a major role in Singapore as it is estimated to contribute less than 5% of total health expenditure. Private insurance companies
offer competitive medical insurance plans to complement the government’s Medishield and Medishield Plus schemes.

Medisave can be used to pay for premiums of approved plans which must also include similar features like co-payments and high deductibles for catastrophic illnesses that are consistent with social objectives to reduce moral hazard. Private health insurance plans with enhanced medical benefits are usually provided as perks within a total benefits package to expatriate staff and senior management. Many multinational and large companies in Singapore also purchase private medical plans, including managed care plans for their employees and dependents. Such company medical benefits are common and are treated as wage costs and business expenses that are tax exempt, up to a cap of 2% of overall remuneration. The benefits vary according to the entitlement and wage package offered to staff.

Except for catastrophic illness and dread disease products, the local insurance industry has not ventured into newer areas beyond the traditional group and individual medical indemnity plans. While the for profit insurance companies are naturally cautious about underwriting newer and unknown products, the National Trade Union Cooperative’s insurance company, NTUC Income, is more supportive of many national and socially beneficial schemes like managed care, severe disability and long-term care insurance for trade union members.

NTUC Income has pioneered the introduction of managed care since 1992, but this has not grown much due to lack of support from unionists and employees. This is despite the government’s indirect support by allowing Medisave to be used to pay for the premiums in the NTUC Income schemes, which are non-profit cooperative plans. In 2000, there were about 10 managed care organizations in Singapore, with the largest, NTUC Income having only about 22000 members.

NTUC Income together with the largest local insurance carrier, Great Eastern Life, also tendered successfully to manage the privatized Eldershield scheme for the severe disability insurance scheme introduced in 2002. However, the opt-out rates were extremely high at about 40 %, even though Medisave could be used to pay for the relatively high premiums, while the proposed payouts were generally not considered to be attractive enough.

In the provision of long-term care, private operators are not present in greater numbers because of the lack of financial incentives and problems in obtaining suitable premises mainly due to prohibitive land and rental costs. There are also difficulties in recruiting staff and high labour costs for specialized and trained personnel. Private nursing homes either cater to the very rich by charging high fees for superior facilities or provide very basic or poor quality care to the lower-income patients in order to retain higher profits.
Recently, it was announced that the private insurance industry would be invited to play a bigger role to provide enhanced coverage to the Medishield and Eldershield schemes. Several alternative proposals have been submitted by competing groups to the Ministry of Health. The details of the financing proposals are currently under consideration for a complementary public-private participation to enhance health insurance in Singapore.

6. Critical Analysis of Health Care Financing Through Prepayment and Health Insurance Arrangements

The actual implementation of the Medisave Scheme, though formulated and coordinated by the Ministry of Health, required the active participation of many sectors of the population, including the medical and related professions, academicians, politicians, community and grass-roots leaders, employers and employees, and the mass media alike. It took over two years of thorough public debate of the issues involved, for the dissemination of vital information and to gather feedback from all levels of the community. This exemplifies the importance of bottom-up planning and community participation in the wide acceptance and successful administration of any innovative public programme.

The 3M financing system covers expensive hospitalization and limited outpatient procedures, including selected non-acute care in community hospitals which provide post acute and rehabilitative care, and hospices. At present, most types of long-term care are excluded. Medisave withdrawals are limited to a maximum of $300 per day of hospital stay and according to the type of operations performed. These ceilings have not been adjusted despite several revisions in hospital fees. Due to the fixed limits which have not been adjusted for inflation, increasingly larger amounts of expenses for medical care have to be paid out-of-pocket, which would have detrimental effects on lower-income individuals and families affected during the recent economic downturn when unemployment rates rose. This could explain the recent dramatic shift in the preference for admissions into lower-priced wards in the heavily subsidized public hospitals.

Policy review

Following the implementation of Medisave and Medishield, along with the teething problems concerning the major restructuring of the public hospital system, a Review Committee on National Health Policies chaired by the Minister of State for Health was appointed in April 1991 to review the policy directions for the country. It presented the first part of its report in October 1991, emphasizing health promotion and disease prevention as the basic philosophy to Singapore’s healthcare policies.
In its main report presented in February 1992, it recommended priority areas for action and measures for improving health-care while controlling costs and quality. Suggestions were made on manpower planning, medical specialization and training and ensuring professional standards and quality of care. The main thrust of the recommendations was on health-care financing, to define the role of government in financing health-care and managing health-care cost.

The government accepted in principle the recommendations of the Review Committee and a Ministerial Committee on Health Policies headed by the Deputy Prime Minister, eventually finalized the courses of action to be implemented. In a parliamentary White Paper on Affordable Health Care presented in October 1993, it set out the government’s philosophy and approach to controlling health care costs, in order to keep basic health care affordable to all Singaporeans. Among the plethora of cost-containment measures that were recommended were defining a good basic medical package; controlling the supply of doctors and hospital beds, and regulating subvented public hospitals through revenue caps and subsidies.

The government has therefore introduced revenue caps on corporatized hospitals to prevent them from generating excessive profits through inducing demand without the need to remain cost-effective. It is establishing limits on average charges per patient day and will adjust them annually. Hospitals that exceed the limits will have their government subsidies cut by that amount, while hospitals with a budget surplus will keep the additional funds.

The current average bill sizes from all public hospitals for up to 70 of the most common diagnostic conditions are listed on the Ministry of Health website. Following its implementation in 2003, dramatic adjustments were made to moderate price differences among outliers. Plans are being considered to introduce a more refined subvention system to adjust for case-mix based on diagnostic conditions.

Historically, the rate structure of public hospitals may have indirectly influenced rates in private hospitals under the assumption that the public would be price-sensitive to the incremental cost differences between the two. The government has also threatened in the past, to impose more direct cost constraints on private hospitals and doctors, especially for “balance-billing” where providers charge substantially more than the limits set in various public financing schemes. However, there are inherent difficulties in its implementation unless the payment system and fee schedule are standardized and adjusted for different risks and severity of disease conditions, and is complicated by the absence of a case-mix classification of patients related to diagnostic groups. This problem is currently being addressed with the implementation of a modified DRG system based on a global budget similar to that of the Australian model.
Adverse selection

Another outstanding issue inherent in the design of Medishield concerns voluntary opting-out in the scheme. This feature was to allow an element of choice for those who may have alternative coverage or those who may not be able to afford premiums that are risk-rated according to age. This is regressive to the older age-groups but the poor elderly who are uninsured for catastrophic illnesses can still fall back on the Medifund as a last resort. A Cost Review Committee in 1996 was concerned that one in four older Singaporeans over the age of 60 had opted out of the scheme. As this group was more likely to require health care, the Cost Review Committee noted that such a high rate of opting-out was undesirable.

This problem of adverse selection could potentially grow bigger in the future unless there is a greater degree of compulsion for enrollment, and acceptable rating of community risks that are actuarially fair to all age segments of the population. This issue and related problems of the current gaps in health care financing and social health insurance is currently being examined by a committee within the Ministry of Health, which is expected to finalize its recommendations for implementation in 2005.

Coverage

The current system of subsidies provides access to affordable health care for the elderly in the lower-and middle-income groups. In public hospitals, the subsidies range from 20% to 80% of the fees charged, depending on the ward class. In the government polyclinics, elderly patients pay only nominal fees with about 75% subsidy. It is expected that future generations of the elderly population will have built-up enough Medisave savings and that the majority who will also have Medishield coverage will have sufficient financial resources to meet the cost of acute care. Those who do not have enough Medisave funds, Medishield coverage or family support, will rely on Medifund and other forms of financial assistance or charity.

Medisave can be used to pay for hospital expenses of immediate family members, in line with the concept that the basic social and economic unit of the society is the family, and that caring for the welfare of ill and aged members of society is to remain first and foremost, a family responsibility. The aim is to preserve certain desirable values such as filial piety, and thereby serve to enhance the stability of an essential societal structure amidst rapid changes. Only where there are genuine difficulties in the case of the entire family being unable to meet the medical expenses of its sick and elderly does the state step in to subsidize costs from public taxes.
The 1995 National Survey of Senior Citizens in Singapore has shown that Medisave has become the most important provision relied upon by seniors aged 55 and above to finance their health care. More than half (55%) depended on their children’s Medisave to pay for their medical expenses while 18% depended on their own Medisave and 2% on their spouse’s Medisave. Medisave funds accounted for nearly 75% of the health care financing provisions of seniors, with the older groups relying on their children’s Medisave more than their own. Further, two thirds of older women depended on their children’s Medisave compared to 44% of men. As older men were likely to have accumulated more in their Medisave account over their working life, 30% of men were self-reliant for financing their health care, but only 7% of women. Less than 10% of seniors had not made any financial provisions for health care, either because of low income or unemployment or limited capacity to accumulate Medisave or personal savings, or because they felt that they could rely on their children to pay their medical bills if required.

Resource mobilization

A high priority on the health reform agenda is mobilizing enough resources to finance efficient and equitable provision of health care for increasing demand. This is likely to require an increasing diversification of financing instruments so as to develop a broad and sustainable revenue base to cope with rising health care costs. Singapore has diversified into extrabudgetary financing but in a radically different direction with the introduction in 1984 of an important new instrument based on mandatory medical savings accounts. Are medical savings an effective financing tool to mobilize resources for sustainable health spending by Singaporeans for their old age?

In the longer term, the role of medical savings accounts is destined to rise considerably in Singapore. Today the proportion of all health expenditures financed by Medisave disbursements is only 8% but the total amount of assets accumulated in members’ savings accounts is already equivalent to four year’s worth of Singapore’s national health expenditure. The total balance stood at S$ 22.7 billion as reported in the Ministry of Health Annual Report of 2001, and there were more than 2.71 million accounts, thus giving an average of about S$ 8300 in each account. This would constitute a substantial nest-egg for the future aged population and other contingencies when the economy is expected to slow down while welfare consumption would continue to go up.

There are several reasons for this impressive mobilization of financial resources:
When Medisave was launched in 1984, there was an initial transfer of CPF special accounts amounting to S$ 2180 million earmarked for medical savings;
The interest earned from savings was more than the annual withdrawal rates as the payouts were limited by strict rules for withdrawals, and
Due to rapid economic growth rates, extensive payroll contributions could be collected from an expanding formal labour sector.

To date, Singapore has sought to balance supply and demand in the health sector by deliberate manpower and facilities planning, and by mobilizing individual savings through the Medisave scheme within the CPF, despite contribution rates being reduced owing to the recent economic downturn. It is not clear whether demand has been rationed implicitly through constraining consumer purchasing power as there were parallel co-payments, price and other supply-side controls at the same time.

Efficiency

However over the years after its introduction, some initial income effects were observed by the dramatic shift in demand from the older government hospitals to the restructured and private hospitals, and a discernible upgrading from the lower to the higher-priced wards. This phenomenon was corrected by the introduction of mandatory pre-admission financial counselling to advise patients to make appropriate choices regarding the type of ward class and medical services.

Few countries explicitly target costly financial risks in the design of their social insurance programmes. In exception, Singapore's Medisave scheme generally excludes coverage of inexpensive outpatient services (which are financed through other sources like taxation, employment benefits and out-of-pocket payments) so that Medisave balances are reserved to pay for infrequent but high-cost inpatient care. However, because they depend 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 programmes based on cross-sectional risk-pooling that is designed to finance the extreme catastrophic tail of the risk distribution.

Government policies on cost-sharing to help control moral hazard and contain costs in social insurance programmes vary greatly. Health financing policy in Singapore combines non-trivial co-insurance rates with explicit targeting of costly risks. On average about 60% of hospitalization costs in public hospitals are subsidized by the government. The residual 40% charged to patients is covered between Medisave and out-of-pocket payments. Thus patients feel a double bite of
individual responsibility - not only in the form of 20% co-insurance paid out of their Medisave account, but also another 20% paid directly out of pocket. Claims for back-up Medishield coverage of catastrophic expenses are subject to 20% co-insurance on top of a high annual deductible.

**Equity**

The total amount of subsidized care in Singapore is approximately equivalent to about a third of the total health care expenditure, or 1% of GDP. A key component of the government’s policy is a tiered structure of subsidies based on the setting in which care is delivered and the amenities provided with it. In the public hospitals, the different classes of wards receive varying degrees of subsidy, while private hospitals are unsubsidized. A major change following the review was to ensure that subsidies are targeted by appropriate channelling of patients into the appropriate ward classes according to their ability to pay, which is roughly determined by their Medisave account balances as a form of means-test.

In principle, individuals are free to choose their level of ward accommodation based on their preference. Financial counselling is provided at the time of admission into the public hospitals when patients are advised that it is their responsibility to choose a ward class they can afford and to cover their expenses through a combination of Medisave, Medishield or other sources of personal funds. If required, patients can draw on their spouse’s, children’s or parents’ Medisave accounts with the necessary consent.

Class A wards have no subsidy and compete with private hospitals, offering private rooms with such amenities as air-conditioning, television and attached bathrooms, in addition to the government’s list of basic services. Care delivered in the remaining four wards - B1, B2+, B2 and C - is supported by varying levels of government allowances. For example, the subsidy level in a class B1 ward is 20% of the total charges. Patients are responsible for the remaining 80%, which may be covered by Medisave, Medishield and/or personal resources. The fraction paid directly by the government increases incrementally, reaching 80% for class C, with the patient responsible for the remainder. As the subsidies increase, the amenities decrease. B1 wards have four beds to a room; B2 patients do not have choice of physicians; class C wards are generally open wards. In addition, Medishield pays a greater fraction of hospital charges for poorer patients and those who elect to receive their inpatient care in subsidized hospital settings.

Reforming pricing policy for publicly-provided services is likely to be an important instrument to improve equity in the incidence of public spending. Out-of-pocket costs facing users of publicly provided health services are often non-trivial, especially for hospital inpatient care, and can be a barrier to access by the poor.
Improving access may require selective price reductions, compensated by increased subsidies from the budget. Implementing this strategy calls for a pricing policy that consciously differentiates prices by the income class of users. In this way, public subsidies can be better targeted instead of being distributed indiscriminately. One targeting mechanism is through self-selection by charging lower prices for services more likely to be used by the poor. Alternatively subsidies can be targeted directly by means-testing individual users. Singapore's policies demonstrate both of these approaches to promoting equity.

Budget subsidies continue to play a major back-up role in financing hospital inpatient care and are targeted to poorer users by self-selection using public sector pricing policy. Explicit price discrimination is built around four different classes of hospital wards in public sector hospitals ranging in ascending order of comfort from Classes C, through B2 and B1 to A. The subsidy ratios are highly differentiated, ranging from 80% hospital costs in the lowest Class C, to 70% in Class B2, 20% in Class B1 to 0% in Class A. Public hospitals provide financial counselling to help patients and their family members select an affordable ward class. These differential subsidies are intended to help equalize the affordability of the class-specific prices relative to the income levels of patients who select them.

As a last resort, patients unable to pay their subsidized hospital bills can apply for a means-tested grant from their Hospital Medifund Committee. This safety net is targeted directly at households in the lower one-third of the income distribution. One problem of the three-tiered approach is that some segments of the population which are currently not covered by the Medisave and Medishield schemes may also not qualify for Medifund which has very stringent eligibility conditions. These individuals have to depend on other forms of financial assistance. Thus during the recent economic downturn, fees were reduced in public hospitals and eligibility criteria for Medifund were liberalized. A recent policy to implement means-testing on a wider scale for patients in public hospitals along with more generous subsidies and coverage, is currently under-way.

Overall assessment

A significant factor contributing to the health sector reforms in Singapore hinges on the local population's traditional cultural values to be self-reliant and to have high saving rates. Savings approaches for health care financing require sufficient funds attached to individuals or households to pay for some or all health-care consumption. Although illness and the need for health care occur unexpectedly, the demand for health care is not purely a matter of chance.

The time, place, and type of health care that a person may need in the future is largely unknown, but a healthy young person can anticipate that chronic disease
will become much more likely when he or she grows old. The changing needs for health care over the course of a life imply that health care may be funded, at least in part, by savings.

Thus savings approaches to financing health care have an important advantage. If people pay for health care with their own savings rather than insurance coverage, it should be possible to avoid the moral hazard that is typical of indemnity insurance. Savings alone will be insufficient to fund all health care for many people, since few people will be able to save enough to pay for the care needed to treat the most expensive illnesses.

People would under-save for health care whenever they have inadequate insurance and if they can obtain care for free, also called free-riding. Furthermore, low-income men and women may be unable to save very much money during their working years for any purpose, including savings for health care that they would need in old age. Therefore, there has been little interest in adopting pure savings approaches to health care financing on a wider scale. Instead, most savings approaches also incorporate some form of high deductible or high excess catastrophic insurance as well.

Singapore has the first and most developed system of prepaid medical savings which are integrated into social health insurance. The mix of financing mechanisms is supported by a range of government initiatives to improve efficiency in the public and private sectors of the health care system and to ensure equitable access to necessary medical care regardless of income.

There is continuing debate over the effects of medical savings on total health care spending and on health care cost inflation. Singapore has enjoyed a lower rate of growth in health care spending than other East Asian countries and spends a lower percentage of GNP on health care than other countries with comparable levels of economic and health system development. There is also general belief that the judicious mix of taxation, savings and insurance systems have indeed contributed to more effective health care spending by reducing wasteful and unnecessary spending.

7. Conclusions

The Singaporean system has shifted away from a model of tax-based and national health service, to a mixed system that has retained the dominant role of the public sector in providing essential medical services through a combination of taxation and savings, with limited insurance only for catastrophic illness. It is purposely designed to move away from the comprehensive and overly generous insurance models that may be unsustainable.
The declared objectives are different from those of other models having universal coverage, by limiting insurance only for “insurable” expenditure (i.e. high-cost events of low probability and not low-cost events of high probability for which other types of financing would be more efficient and effective). It is important to note that the government still maintains heavily subsidized public health services for most preventive and primary health care, in addition to a dominant share of public hospitals for basic health needs. Thus, the role of the state to support the truly needy from public funding, while average individuals and families are expected to contribute towards greater cost-sharing of increasingly expensive health care, so as to encourage shared responsibilities and a more sustainable health-care system.

Many countries have adopted pay-as-you-go social security and health insurance schemes, which without reform will be unaffordable and unsustainable against the fastest population ageing rates in the world. Their growth rates will inevitably slow down and yet they have to maintain higher spending with shrinking tax bases. Considering that health care needs are expected to be greater in old age, the proactive policies of the Singapore government have assumed that the same requirements be met for health care financing as for old age social security systems.

The three basic functions of redistribution, savings and insurance have been applied for financing health care as for old age security. Even though the relative risks and uncertainties may be different for health care needs, a similar mix of financing methods has been utilized to offer more protection while promoting growth in a rapidly ageing population. These considerations have formed the basis for the existing integrated systems of old age security and health care financing in Singapore, which are fully-funded savings schemes that could avoid the inter-generational transfer problems of pay-as-you-go systems financed from taxation.

Bibliography


Thailand

Viroj Tangcharoensathien, Phusit Prakongsai, Walaiporn Patcharanarumol, Chitpranee Vasavid, and Kanjana Tisayaticom

1. Background

Thailand, a lower middle-income country in South-East Asia, has gradually achieved a remarkable Human Development Index (HDI) since 1985. The global HDI rank of Thailand in the 2003 Human Development Report was 74 and the index in 2001 was 0.768 (UNDP 2003). The HDI gradually increased from 0.612 in 1975, to 0.650 in 1980, to 0.673 in 1985, to 0.705 in 1990 and finally to 0.739 in 1995 (UNDP2003). The increase in GDP per capita and life expectancy were two crucial factors affecting the increase in Thai HDI.

In 2002, the population size was 62 million, with a life expectancy at birth of 69.9 years and total fertility rate of 2.1 (average during the period of 1995-2000). Economic performance was remarkable especially during the early 1990s, but the 1997 financial crisis brought down economic performance for a few years, until recently in 2002 several indicators reflected a return to economic recovery. The GDP per capita was US$ 6400 in 2001, with a growth rate of 3.0% (average for 1990-2001). However, income was not equally distributed, and the ratio of richest to poorest deciles indicated a gap of 13.4 or the ratio of the richest to poorest 20 percentiles indicated a gap of 8.3 in 2000, while the Gini index was 43.2.

The education profile in Thailand is remarkable, with an adult literacy rate in 2001 of 95.7%. Public expenditure on education from 1998 to 2000 was 5.4% of GNP, the total government education expenditure was 20%, of which primary education got 36% share, secondary 27.1% and tertiary 24.1% of all educational levels (average for 1998-2000).

In 2001, the health profile indicated an IMR of 24 and an U5MR of 28 per 1,000 live births, while average MMR from 1985 to 2001 was 44 per 100000 live births. Immunization achieved a very high coverage rate due to strong and extensive geographical coverage of the health care infrastructure. This is reflected in several indicators such as, one-year-olds fully immunized against measles reached 94%, births attended by skilled health staff was 95% (average for 1995-99) and the ratio of physicians per 100000 population was 24 (1990-99).

In 2000, the total health expenditure per capita was US$ 237 PPP, whereby the public share was 2.1% of GDP and private share was 1.6% of GDP.
The study on Burden of Diseases indicates that HIV/AIDS, stroke and traffic injuries are among the first three leading causes of deaths among men (Table 24). The top three among women are HIV/AIDS, stroke, and diabetes. The ten most common diseases claim 66% and 52% of total life years lost among men and women respectively. Similarly, those common diseases also claim 52% and 45% of total Disability Adjusted Life Years (DALY) loss among men and women, of which more than half is preventable by risk reduction, notably HIV/AIDS, traffic injuries, tobacco-related diseases and primary liver cancer. In 1999, People Living with HIV/AIDS among adult age group 15-49 years was 2.15% and HIV among children between ages 0-14 years was 13900. (UNDP2003)

Table 24: Top ten conditions contributing to DALY loss by sex, Thailand 1999

<table>
<thead>
<tr>
<th>Rank</th>
<th>Men</th>
<th>DALY</th>
<th>Women</th>
<th>Both Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Traffic accidents</td>
<td>6 WUNH</td>
<td>7UDIIIF DFLGHOW</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>/VDHIDQFU</td>
<td>'LDEHMHV</td>
<td>6 WUNH</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>/RZ ELUWZHUKW</td>
<td>'HSUHMAWO</td>
<td>/VDHIDQFU</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>'LDEHMHV</td>
<td>7UDIIIF WDFLGDQ</td>
<td>/RZ ELUWZHUKW</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>HP SK\ VHP D &amp; 2.3'</td>
<td>2 WDFUQUDW</td>
<td>&amp;2.3 ' HP SK\ VHP D</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>VRCHHP LFKHJUV GLHVDH</td>
<td>/VDHIDQFU</td>
<td>VRCHHP LF KHUDWVDH</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>'UXI KQUP ZQGKHDQGQF VH</td>
<td>&amp;2.3' HP SK\ VHP D</td>
<td>'HP HQMO</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>+FP IFLHDGWAYIZBOFH</td>
<td>CQHP ID'S</td>
<td>'HSUHMAWO</td>
<td></td>
</tr>
<tr>
<td>52%</td>
<td>45%</td>
<td>47%</td>
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</tbody>
</table>


2. Evolution of Health Insurance and Social Welfare

Since the early 1970s, successive governments had started to promote a “piecemeal targeting approach” for health insurance and social protection to its citizens (Tangcharoensathien et al. 2004-forthcoming). These included the Free Medical Care Scheme for the Poor or the Low-Income Card and the Civil Servant Medical Benefit Scheme (CSMBS), the Social Security Scheme (SSS), the Workmen Compensation Scheme (WCS), the Voluntary Health Card Scheme (VHS), and for-profit private health insurance.
In early 1975, the government initiated a specific medical welfare scheme to cover the poor or low-income households. This scheme provided tax-financed public health services for poor households with earnings below the national poverty line. Cards enabling free of charge health services (termed "free cards") were issued through means testing, whereby the community was involved in identifying the poor. Despite community involvement, local prejudice and nepotism were difficult to avoid. Several assessments indicated the scheme covered some non-poor and inadequately targeted the real poor (Kongsawat 2000; Pannarunothai 2002). In 1994, this scheme for poor households had expanded to cover more targeted population groups, namely the elderly (aged over 60 years), children under 12 years old and all disabled people. Due to inadequate public health care financing, public hospitals were allowed to collect user charges from those who were not free-card holders and cross-subsidization among health insurance schemes was observed. However, inadequate financing for the Free Medical Care scheme led to inequitable health service provision in terms of quality of care for the poor.

Government employees and their dependants (spouse and children under 18 years old and elderly parents) were the first group in the country to be covered by a worker benefit scheme. The Civil Servant Medical Benefit Scheme (CSMBS) was introduced in 1980, essentially a fringe benefit. This is a tax-financed, non-contributory scheme, to serve as a medical welfare scheme for government employees whose salaries are generally lower than those in the private sector. The scheme applies a fee-for-service reimbursement model for provider payment. As a result of this model and a very weak capacity of the scheme management to reject over-charging and fraudulent claims, rapid increase in expenditure of the scheme has been observed (Tangcharoensathien et al. 2002).

A mandatory prepayment Workmen Compensation Scheme (WCS) was developed before the Social Security Scheme (SSS). The WCS first launched in 1972, was an employer liability scheme for work-related injuries, illness, disability and death. The Workmen Compensation Act replaced the previous law of 1994 and transferred responsibility for WCS to the Social Security Office. Both the WCS and SSS cover only private sector employees, while dependants (spouse and children) are not covered. Similar to the CSMBS, fee-for-service basis is the payment model for health care providers in the WCS; inefficient health service provision has been experienced under this payment model.

The SSS launched in 1990 is a tripartite payroll-tax financed scheme, which covers health care for non-work-related illness and injuries, and maternity and cash allowances for disability, old age and death. The scheme started with coverage of employees in enterprises with more than 20 workers. It was gradually extended to cover more than 10, more than five and finally more than one worker in April 2003.
As the vast majority of the Thai population are engaged in the informal sector, social health insurance did not play a significant role in coverage expansion to the whole population to achieve universal coverage. The scheme has not yet improved performance in extending coverage to the informal sector and regulatory capacity to enforce quality of care (Mills et al. 2000) is still weak. The absence of a mandate to achieve universal coverage towards social health insurance is the major reason why the SSS has been reluctant to expand the coverage of beneficiaries' spouses and dependants. Moreover, the merging of other populations or schemes into the SSO is hampered by arguments among SSS beneficiaries, health policy-makers, and health sector reformists regarding differences in the source of finance, patterns of contributions, the benefit package and payment methods to health care providers.

A voluntary public insurance scheme or the voluntary Health Card Scheme was initiated by the Ministry of Public Health to cover the non-poor and the uninsured in 1983. It was first started as a community financing scheme in pilot areas and later scaled up at the national level. In 1994, the scheme evolved into a public-subsidized voluntary health insurance scheme, where 50% was financed by a household voluntary contribution and the rest was supported by the government budget. The scheme suffered from adverse selection where the healthy opted out, while the sick and chronically ill opted in. As a result, the scheme was not financially viable (Srithamrongsawat 2002), particularly at the time of economic crisis.

Voluntary private commercial health insurance covers a small fraction of the population, and mainly those who are better off and demand private health care services. It applies risk-adjusted premiums collected annually, and applies fee-for-service reimbursement with various levels of co-payment. Most health services are purchased from private-for-profit hospitals (Pitayarangsarit S et al. 2002).

Despite efforts to extend coverage by different players in Thailand, by the end of 2001, there were still 15 million Thais without coverage. Under the current government led by Prime Minister Thaksin Shinnawat, Thailand achieved universal coverage (except some areas in Metropolitan Bangkok) in October 2001, through a merger of the medical welfare scheme for the poor, the elderly, children, and the voluntary Health Card Scheme. These and other uninsured populations were covered under a new financing scheme, termed the “30 Bahts” or the Universal Coverage (UC) scheme. This is financed by general tax revenue, using a contract capitation model for provider payment and cost sharing by patients of 30 bahts when care is provided. (Towse et al. 2004).

As a result of this reform, in 2004, there are three major public health care financing schemes providing health coverage for the entire population. These are:
The CSMBS, which covers public sector employees and their dependants (parents, spouses and children) approximately 5.7 million beneficiaries,

The SSS, a mandatory pre-payment scheme protecting private sector employees approximately 7.2 million beneficiaries against non-work-related illness, and injuries and maternity.

The UC scheme covers the rest of population, approximately 47 million.

Despite the achievement of universal coverage, 3.2 million or around 5% of the total population were still not covered in April 2003. A sub-group analysis reveals that 34% of those without any coverage live in Bangkok and a half of them are in the fourth and the fifth income quintiles (the rich and the richest). In rural areas, the proportion of the population without coverage and identified as poor is higher than that in the urban areas (Vasavid et al. 2004).

Table 25 demonstrates the gradual increase in population coverage by type of financing in 1991, 1996, 2001 and 2003.


<table>
<thead>
<tr>
<th>Type of Financing</th>
<th>2001</th>
<th>2003</th>
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<tbody>
<tr>
<td>6 FKHP H</td>
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<td>74.7</td>
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<td>9 ROICMWHI + HDOIK &amp; DUG</td>
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<td>0</td>
</tr>
<tr>
<td>8 QOXUHG</td>
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<td>5.1</td>
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<td>P 3 RSXOMRQ</td>
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</tbody>
</table>


Note: Data start in 1991, the first year available under the Social Security System

Having described the evolution of health insurance expansion in the previous section, this section describes and analyzes four prepayment health care financing schemes in Thailand in order to draw lessons on their success and failure as well as the determining factors. Literature reviews and secondary data analysis of existing documents will be employed for the analysis. These four schemes are:

- Social Health Insurance, a mandatory scheme for the formal sector employee for non-work-related illnesses,
Voluntary Health Card, a voluntary prepayment health insurance scheme which was transformed to public subsidized voluntary health insurance,

Workmen Compensation Scheme, a mandatory scheme for work-related injuries and illness of the formal sector employees, and

Private voluntary health insurance.

3. Compulsory Prepayment/Social Health Insurance Mechanisms

The first Social Security Act was promulgated in 1954, based on the tripartite contribution concept. However, political issues and the economic climate prevented this law from being implemented (Walee-Ittikul S 2002).

In 1974, a Workmen’s Compensation Scheme, as a form of employer liability scheme was initiated to cover salaried employees for work-related injuries, illness, disability and deaths. The scheme took several years to cover the whole country in a phased manner.

When political and societal acceptance of social insurance reached its peak, the 1990 Social Security Act was promulgated by the Parliament. The Social Security Scheme (SSS) was fully implemented in April 1991. Health care was included as a benefit with the objectives of reducing inequities in access to health services among different population groups and providing financial protection against health service expenditure to all salaried employees in the private sector. Originally, the scheme covered employees or enterprises with 20 or more workers, but it was later extended to cover enterprises with 10, five and finally one or more workers in 1990, 1994, and 2002, respectively.

The benefits of SSS can be classified into two types: health care and cash benefits, which cover income-replacement during illness, maternity, disability (covering absence from work) and old age as well as child allowances and funeral grant. The health care branch, which is the area dealt with here, is therefore one branch of all the benefits provided by the Social Security Scheme. It covers illnesses and injuries that are not related to work (which were already covered by WCS). Unfortunately, the health care benefits were not extended to dependents (spouse or children) of the employed workers. The only exception is the provision of maternity care for spouses of male workers.

The milestones in the progress in social health insurance and social security for formal sector private employees can be summarized as follows (Tangcharoensathien et al. 2004- forthcoming):
1954: The first Social Security Act was promulgated, but was not enforced, and the SSS was not established,

1974: The Workmen’s Compensation Scheme was established to suppress a Labour Union demand for social security,

1990: The Social Security Act was again promulgated, as a mandatory scheme for private sector enterprises with more than 20 employees and the SSS was established as the administrative agency,

1994: SSS Coverage was extended to enterprises with more than 10 employees,

2001: SSS Coverage was extended to enterprises with more than five employees,

2002: SSS Coverage was extended to employers with more than one employee.

The Social Security Scheme is a mandatory tripartite contributory scheme, which is financed by an equal payroll tax paid by the employee, the employer and the government. Various qualifying periods for benefit entitlement are enforced and a period of continued entitlement to health for employees who leave their salaried employment is also granted.

According to recommendations by the International Labour Organization (ILO) consultants during the design of the scheme in 1982 (several years prior to promulgation of the Law in 1990), the contribution rate was calculated based on a limited benefit package, namely only hospitalization, while ambulatory services were excluded. The design in the 1982 proposal was for a fee-for-service reimbursement, similar to the provider payment method in the Workmen's Compensation Scheme.

However, during the drafting of the Social Security Act in 1990, the recommendations of ILO providing technical assistance towards the implementation of the new Social Security Act and political pressure led to the expansion of the benefit package to include ambulatory care without a change in the level of contributions. The capitation provider payment model was also recommended by ILO and included in the regulations of the Social Security System. The decision was supported by the negative experience with fee-for-service payment in the Workmen’s Compensation Fund and the expectation of lower administrative costs of the capitation model (Tangcharoensathien et al. 1991).

Under this capitation contract model, there is no co-payment at point of service. This model offers considerable potential for achieving efficiency by combining consumer-led competition, the development of suitable incentives to
health-care providers who command scarce health-care resources (capitation sends signal towards rational investigation and prescriptions) and formal contracts between the Social Security Office and providers (Tangcharoensathien et al., 1999a). Several OECD member countries have been observed to follow a similar provider payment model.

A single rate capitation was applied to cover ambulatory and inpatient services. Capitation was calculated based on a target service utilization rate per person per year and the unit cost of services for ambulatory and admission services with an additional amount as an incentive towards accepting the provider payment method. Unit cost covers only operating costs of health services (staff and other non-staff operating expenditure). Public and private health-care providers were invited to provide services to registered workers on a competitive basis. The same capitation fee is applied to all contractor hospitals, both public and private. An initial annual capitation amount was set at 700 bahts (US$ 28) and in 1991 (Tangcharoensathien et al. 1991), the capitation rate was modestly increased to an annual amount of 1100 bahts per capita. In 2002, an extra amount of 150 bahts per beneficiary with a reported chronic illness was added.

The benefit package is quite comprehensive, covering a wide range of personal health care services, ambulatory care, hospitalization, dental care, and maternity services. High cost care was reimbursed outside the capitation contract in order to ensure adequacy of services. Recently, access to haemodialysis for end-stage renal failure has also been provided. However, a small exclusion list, for example, cosmetic services and infertility treatments have been excluded from the benefit package.

Since the strength of the Social Security Scheme lies in its capacity for cost-containment, the cost-quality trade-off has subsequently become a significant problem, especially when employees did not exercise their right to choose the provider with which they were registered in the initial years (Mills et al. 2000). However, employees are entitled to change their registered contractor hospitals on an annual basis. Changes in the number and proportion between public and private health care providers participating in the Social Security Scheme from 1991 to 2004 are shown in Table 26. The number and proportion of health care provider selection of SSS beneficiaries are also demonstrated in Table 27. It is worth noting that health care provider selection was limited only in the first year, when employers selected the provider hospital.

* Calculation based on three ambulatory visits and 0.5 hospitalization days per capita per year, and average costs of 150 bahts per outpatient visit and 600 bahts per hospital day (Tangcharoensathien & Walloe-Ittikul, 1991).
Table 26. Public and private health care providers participating in the Social Health Insurance Scheme during 1991-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of health care providers</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>1991</td>
<td>119</td>
<td>18</td>
</tr>
<tr>
<td>1992</td>
<td>118</td>
<td>27</td>
</tr>
<tr>
<td>1993</td>
<td>119</td>
<td>37</td>
</tr>
<tr>
<td>1994</td>
<td>122</td>
<td>55</td>
</tr>
<tr>
<td>1995</td>
<td>126</td>
<td>63</td>
</tr>
<tr>
<td>1996</td>
<td>126</td>
<td>72</td>
</tr>
<tr>
<td>1997</td>
<td>127</td>
<td>70</td>
</tr>
<tr>
<td>1998</td>
<td>127</td>
<td>78</td>
</tr>
<tr>
<td>1999</td>
<td>128</td>
<td>103</td>
</tr>
<tr>
<td>2000</td>
<td>130</td>
<td>116</td>
</tr>
<tr>
<td>2001</td>
<td>133</td>
<td>129</td>
</tr>
<tr>
<td>2002</td>
<td>136</td>
<td>132</td>
</tr>
<tr>
<td>2003</td>
<td>137</td>
<td>132</td>
</tr>
<tr>
<td>2004</td>
<td>144</td>
<td>134</td>
</tr>
</tbody>
</table>

Source: Social Security Office, 2004

Table 27: Beneficiary selection of public and private health care providers during 1991-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of health care provider selection</th>
<th>Proportion of selection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>1991</td>
<td>2,256,502</td>
<td>468,541</td>
</tr>
<tr>
<td>1992</td>
<td>1,552,579</td>
<td>991,210</td>
</tr>
<tr>
<td>1993</td>
<td>1,487,500</td>
<td>1,506,394</td>
</tr>
<tr>
<td>1994</td>
<td>1,614,617</td>
<td>2,012,174</td>
</tr>
<tr>
<td>1995</td>
<td>1,805,596</td>
<td>2,169,182</td>
</tr>
</tbody>
</table>
Entitlement to social health insurance is linked to employment status but continues for three months after employment termination. The issue of loss of entitlement became evident during the economic crisis in mid-1997. Through a special ruling, entitlement to health care and the other short-term benefits (such as maternity benefits) under the social security system were extended for one year after termination of employment. A large number of salaried employees were affected by the huge amount of dismissals in order to save many firms from being closed down.

The inability of the SSS to expand its coverage becomes the main obstacle to achieving universal coverage, even among formal sector private employees. There is provision for voluntary affiliation under Article 39 of the Social Security Act allowing for persons who were previously covered to continue to contribute on their own behalf and maintain participation in the scheme. This also applies to retired salaried employees who receive pensions from the SSS.

### 4. Voluntary Health Insurance

In 1983, before the establishment of the SSS, the Ministry of Public Health (MoPH) launched a voluntary pre-payment scheme, namely the Voluntary Health Card...
Selected Case Studies from Asia and the Pacific

Scheme (VHS) as a response to the “Health for All” policy. The objectives of this scheme were to ensure equitable access to health services and to protect against financial hardship due to expensive medical treatments for those who were working in the informal sector, for example, farmers, street vendors, private car drivers, and were not eligible for the low-income card. After the implementation of the SSS, individuals who were not covered by the Social Security Scheme, CSMBS, and the Medical Welfare Scheme (MWS) were the target groups of VHS. During two decades of implementation, the scheme was adjusted many times due to unclear policies on national health insurance and health welfare as well as changes in the responsible administrators (Srithamrongsawat 2002).

The development of VHS can be classified into five phases (see Table 28). In the first phase, it was aimed to complement the activities of mother and child primary health care (MCH) and provide access to basic essential treatment. First a low-priced prepaid health card was piloted for eight months in seven provinces. After an assessment, the MOPH with technical and financial assistance from GTZ, set the target for the second phase to expand the voluntary health card to at least one sub-district in each province in 1985, to all districts of each province in 1986, and then to all sub-districts at the end of 1987. To support the primary health care policy, funds were arranged at the community level as a revolving fund and they were provided as a loan for health card members to build latrines, and were later collected back to pay health facilities at the end of the year.

In the third phase, at least 70% of households enrolled were initially identified by the MOPH. The target was later reduced to 30% due to the top-down policy to expand the scheme to cover all sub-districts. Two types of cards, the MCH card and the family card for curative care, were provided. The utilization of health services was capped at eight illness episodes per card with a ceiling of 2000 bahts per episode.

In the fourth phase started from 1994, the principle of VHS was expanded to national public-subsidized voluntary health insurance. Moreover, objectives of the funds were changed to providing health security to beneficiaries and to achieving universal coverage. The government started providing a subsidy in the form of an annual matching fund, which was similar to the principle of the social security scheme. The scheme was managed like a revolving fund with a reinsurance policy aiming to distribute financial risk of high cost medical services at the central level. Only family card was offered to the beneficiaries with neither limitation of health service utilization nor a ceiling of health service expense.
Table 28: Main characteristics of the Voluntary Health Card Scheme

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conceptual framework</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCH and FP (Community financing)</td>
<td>Primary health care (Community financing)</td>
<td>Primary health care and voluntary health insurance, Voluntary health insurance.</td>
<td>Public-subsidized voluntary health insurance.</td>
<td></td>
</tr>
<tr>
<td><strong>Policy objectives</strong></td>
<td>To support PHC.</td>
<td>To provide health security.</td>
<td>To provide health security.</td>
<td>To provide health security.</td>
</tr>
<tr>
<td>To achieve target in MCH and FP</td>
<td>To improve referral system.</td>
<td>To support primary health care.</td>
<td>To achieve nearly universal coverage.</td>
<td>To achieve nearly universal coverage.</td>
</tr>
<tr>
<td>To improve referral system</td>
<td>To integrate health services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To change the role of health care providers to be health Facilitators.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To downsize ambulatory services of tertiary care hospitals.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target population</strong></td>
<td>At least one sub-district in all provinces, and two villages in each sub-district.</td>
<td>All provinces covering all districts in each province and 30% of total population.</td>
<td>All provinces. Sub-groups of population with no health benefit coverage who may suffer from health care expenditure.</td>
<td>All provinces Sub-groups of population with no health benefit coverage who may suffer from health care expenditure.</td>
</tr>
<tr>
<td>18 villages in 7 provinces</td>
<td>Reducing from 70% to 30% of villagers.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Social Health Insurance
When Thailand went into economic recession in 1997, the scheme became financially unsustainable. The reduction of household income shifted the pattern of people’s health seeking behaviour from private to public health sector providers. This led to a remarkable increase in demand for the cards. Therefore, the government decided to increase the matching fund from 500 to 1000 bahts per card instead of increasing the card’s price but limited the annual sale of cards to three million cards. In this regard, the scheme was inevitably geared to be a social assistance or welfare-oriented concept rather than an insurance-oriented one. The lessons drawn from the VHS can be summarized as follows:

- Public voluntary prepaid health insurance was successful in providing health insurance coverage to the population in rural areas. It also ensured equitable access to health services when needed and protected households from getting in debt from expensive medical treatments.

- Expansion of the public health insurance scheme to cover those in urban areas especially Bangkok was very difficult. The number of problems and complications tended to grow instead of coverage.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Card prices</strong>&lt;br&gt;200 bahts for medical treatments &amp; MCH&lt;br&gt;100 bahts for medical treatments only&lt;br&gt;100 bahts for MCH</td>
<td><strong>Card prices</strong>&lt;br&gt;• 200 bahts for Family card&lt;br&gt;• 100 bahts for MCH</td>
<td><strong>Card prices</strong>&lt;br&gt;• 300 bahts for family card&lt;br&gt;• 200 bahts for individual card&lt;br&gt;• 100 bahts for MCH</td>
<td><strong>Card prices</strong>&lt;br&gt;• Family card only&lt;br&gt;• 1000 bahts; equally matched by the government and cardholders</td>
<td><strong>Card prices</strong>&lt;br&gt;• Family card only&lt;br&gt;• 1500 bahts 2/3 from the government and 1/3 from cardholders.</td>
</tr>
<tr>
<td><strong>Limitations of utilization</strong>&lt;br&gt;Not established</td>
<td><strong>Limitations of utilization</strong>&lt;br&gt;• Not more than eight illness episodes per card and capped to 2000 bahts per episode</td>
<td><strong>Limitations of utilization</strong>&lt;br&gt;• Not more than six illness episodes per card and capped to 2000 bahts per episode</td>
<td><strong>Limitations of utilization</strong>&lt;br&gt;• No limits of utilization and capping. Including MCH Reinsurance polity for high cost care and cross-boundary utilization.</td>
<td><strong>Limitations of utilization</strong>&lt;br&gt;• No limits of utilization and capping. Including MCH Reinsurance polity for high cost care and portable cards.</td>
</tr>
</tbody>
</table>

Source: Adapted from Srithamrongsawat, 2002

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In order to achieve universal coverage, a compulsory health insurance is the most appropriate method, rather than a tax-based welfare scheme or voluntary social health insurance.

Public voluntary health insurance scheme can be considered as an additional tool during the transitional period when universal coverage is still not feasible or achievable.

5. Social Security - Workmens' Compensation Scheme

The WCS was set up according to Decree Number 103 which was formally announced by the Revolution Party on 16 March 1972. After more than two decades of implementation, the 1994 Workmen's Compensation Act replaced the Revolution Party's Decree on June 1994 due to the out-of-date details of the Decree and the establishment of the Social Security Office. The purpose of the new Act was to replace individual employer liability and to provide a prompt and equitable protection against injury, disease, disability or death resulting from employment through the pooled risk of all private sector employers. The employees are entitled to benefits consisting of medical and rehabilitation services and cash benefits including compensation and monthly indemnity. In case of death due to work-related injuries and illness, a funeral grant is paid to survivors.

Contributions to the WCF are mandatory and solely paid by employers on an annual basis. The contributions are assessed on total wages of employees multiplied by the contribution rate, according to the type of business. The contribution rate varies from 0.2-1.0% of wages based on risk rating of establishment type classified by industrial classification. The rate is used for the first four years of contribution. In the fifth year, this basic rate of contribution may increase or decrease depending upon the accident record of the enterprise. This is called experience rating. Higher accident records and higher claims from the fund result in a higher experience rate and thus the basic rate in the fifth year may be adjusted in line with the increasing trend of compensation from the Fund, as shown in Table 29. In addition:

- Firms whose loss ratio is less than 10% are granted a 70% reduction in the basic rate.
- Firms whose loss ratio is 60-70% are not granted a reduction rate or are penalized by an increase in the basic rate.
- Firms whose loss ratio is 150% are penalized with an increase in the rate, to 200% of the basic rate.
Table 29. Loss ratio and experience rate

<table>
<thead>
<tr>
<th>Loss ratio</th>
<th>Experience rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10%</td>
<td>30% of basic rate</td>
</tr>
<tr>
<td>10.01-20%</td>
<td>40% of basic rate</td>
</tr>
<tr>
<td>20.01-30%</td>
<td>50% of basic rate</td>
</tr>
<tr>
<td>30.01-40%</td>
<td>60% of basic rate</td>
</tr>
<tr>
<td>40.01-50%</td>
<td>70% of basic rate</td>
</tr>
<tr>
<td>50.01-60%</td>
<td>80% of basic rate</td>
</tr>
<tr>
<td>60.01-70%</td>
<td>same basic rate</td>
</tr>
<tr>
<td>70.01-80%</td>
<td>110% of basic rate</td>
</tr>
<tr>
<td>80.01-90%</td>
<td>120% of basic rate</td>
</tr>
<tr>
<td>90.01-100%</td>
<td>130% of basic rate</td>
</tr>
<tr>
<td>100.01-110%</td>
<td>140% of basic rate</td>
</tr>
<tr>
<td>110.01-120%</td>
<td>150% of basic rate</td>
</tr>
<tr>
<td>120.01-130%</td>
<td>160% of basic rate</td>
</tr>
<tr>
<td>130.01-140%</td>
<td>170% of basic rate</td>
</tr>
<tr>
<td>140.01-150%</td>
<td>180% of basic rate</td>
</tr>
<tr>
<td>150.01% -</td>
<td>200% of basic rate</td>
</tr>
</tbody>
</table>

Source: Workmen’s Compensation Office

Although the scheme is mandatory and most establishments in Thailand with one or more employees must pay contributions to the WCF, some enterprises are exempted from the law. Employers who are peddlers or stall shop owners, and fisheries are exempted from the scheme. However, in case of a work injury, the employees in these establishments, though not covered by the Fund, have to notify the WCF. The WCF officer can then issue an ordinance to enforce the employers to pay compensation to the employees according to their rights.

The employers have to submit the WCF Registration Form within 30 days as from the date when the establishments have one or more employees. The WCF collects contributions from the employer annually. In the first year, employers have to pay contributions as from the date when the establishments had one or more employees. For the next year, the employers have to pay contributions by January. Contributions are calculated in advance at the beginning of the year.

Contributions may not be directly linked to the real wage during the year because employers may reduce or increase the number of employees or adjust
wages. Therefore in February of each year, the WCF requests the employers to notify the total real wage of the former year to the WCF Office. As a result, the WCF can compare the contribution with the amount collected at the beginning of last year. The WCF has to return any surplus back to the employers or collect the deficit by the end of March each year.

Employees are eligible to receive benefits from the fund as soon as their employers register with the Fund and within 30 days from the date when the establishments have one or more employees. When employees suffer from work injuries or illness, they can receive compensatory benefits, which consist of medical expense, monthly indemnity, rehabilitation expenses and a funeral grant. Work injuries include physical or mental injuries or death suffered by an employee as a result of work or in the course of protecting the interest of the employer or according to the orders of the employer. Occupational diseases mean illness suffered by an employee as the result of a work related cause or diseases incidental to the nature or the conditions of work.

Medical expenditures can be reimbursed as necessary up to an amount of 35000 bahts per claim. If medical expenditure exceeds 35000 bahts, the employees can be reimbursed up to an amount not exceeding 50000 bahts according to the rule. If doctors allow the employees to be absent from work due to work-related illness work for more than three consecutive days, employees will receive reimbursement for medical expenditure and income replacement at the rate of 60% of the monthly wages up to a period not exceeding one year. In the case of loss of organs, employees will receive reimbursement for medical expenses, income replacement at the rate of 60% of the monthly wages where the employee is unable to work and compensation at the rate of 60% of the monthly wages in case of loss of certain organs of the body for a period not exceeding 10 years.

In case employees need rehabilitation services, they can receive the following:
- Reimbursement for medical and vocational rehabilitation expenses for amounts not exceeding 20000 bahts, and
- Reimbursement for surgical expenses for amounts not exceeding 20000 bahts.

In case of permanent total disability, the employees receive reimbursement for medical expenses and compensation of 60 % of the monthly wages for a period not exceeding 15 years. In case of death or disappearance of employees during their work duties, the survivors receive funeral expenses at the amount of one hundred times of the highest rate of the minimum daily wages and compensation at 60% of
the monthly wages for eight years. A ceiling for compensation under the WCF has been applied. The amount of compensation in case of absence from work due to loss of organ, disability, death or disappearance must not be less than 2000 bahts and should not exceed 9000 bahts per month. To obtain reimbursement of medical expenses, the patient can bring the receipt of the medical expense and reimbursement is made by the WCF within 90 days from the date of payment for services. If employees receive medical treatment from hospitals with agreements with the WCF, the hospitals collect payment directly from the WCF.

WCS performance analysis 1993-2002

Table 30 describes the performance of the WCS. Figure 20 demonstrates the progress of the WCS in terms of number of employers registered and employees covered in 1993-2002. The rapid increase of employers registered in 2002 was due to the extension of coverage of enterprises with more than one employee. The scheme now piggy-backs onto the SSS registration. Figure 21 describes trends in contribution and compensation of the WCF. After 1998, contributions collected outpaced compensation paid by the Fund, and resulted in significant surplus. This is a result of significant reduction in claim rate per 1000 employees as indicated in Figure 22, from 47 claims per 1000 in 1993 to 29 in 2002, and due to the reduction in amount of compensation per claim.

Table 30. WCS performance, 1993-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>Employer</th>
<th>Contribution (million Baht)</th>
<th>Employee covered</th>
<th>Injuries claims</th>
<th>Compensation (million Baht)</th>
<th>Compensation per claim</th>
<th>Claims Per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>34,772</td>
<td>921</td>
<td>3,355,805</td>
<td>156,548</td>
<td>927</td>
<td>5,918</td>
<td>47</td>
</tr>
<tr>
<td>1994</td>
<td>41,690</td>
<td>1,126</td>
<td>4,248,414</td>
<td>186,053</td>
<td>1,169</td>
<td>6,285</td>
<td>44</td>
</tr>
<tr>
<td>1995</td>
<td>49,860</td>
<td>1,398</td>
<td>4,903,736</td>
<td>216,335</td>
<td>1,370</td>
<td>6,333</td>
<td>44</td>
</tr>
<tr>
<td>1996</td>
<td>58,129</td>
<td>1,838</td>
<td>5,425,422</td>
<td>245,616</td>
<td>1,610</td>
<td>6,553</td>
<td>45</td>
</tr>
<tr>
<td>1997</td>
<td>61,533</td>
<td>2,235</td>
<td>5,825,821</td>
<td>230,376</td>
<td>1,986</td>
<td>8,623</td>
<td>40</td>
</tr>
<tr>
<td>1998</td>
<td>64,423</td>
<td>1,733</td>
<td>5,145,835</td>
<td>186,498</td>
<td>1,630</td>
<td>8,739</td>
<td>36</td>
</tr>
<tr>
<td>1999</td>
<td>69,946</td>
<td>1,631</td>
<td>5,321,872</td>
<td>171,997</td>
<td>1,404</td>
<td>8,165</td>
<td>32</td>
</tr>
<tr>
<td>2000</td>
<td>74,617</td>
<td>1,673</td>
<td>5,417,041</td>
<td>179,566</td>
<td>1,257</td>
<td>6,999</td>
<td>33</td>
</tr>
<tr>
<td>2001</td>
<td>79,235</td>
<td>1,765</td>
<td>5,544,436</td>
<td>189,621</td>
<td>1,277</td>
<td>6,732</td>
<td>34</td>
</tr>
<tr>
<td>2002</td>
<td>253,363</td>
<td>1,992</td>
<td>6,541,105</td>
<td>190,979</td>
<td>1,220</td>
<td>6,389</td>
<td>29</td>
</tr>
</tbody>
</table>

Source: WCS Office, 2004
Figure 20. Registered employer and employee coverage

No of employer and employee covered by WCS

<table>
<thead>
<tr>
<th>Year</th>
<th>Employer</th>
<th>Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>50,000</td>
<td>1,000</td>
</tr>
<tr>
<td>1994</td>
<td>100,000</td>
<td>2,000</td>
</tr>
<tr>
<td>1995</td>
<td>150,000</td>
<td>3,000</td>
</tr>
<tr>
<td>1996</td>
<td>200,000</td>
<td>4,000</td>
</tr>
<tr>
<td>1997</td>
<td>250,000</td>
<td>5,000</td>
</tr>
<tr>
<td>1998</td>
<td>300,000</td>
<td>6,000</td>
</tr>
</tbody>
</table>

Figure 22. WCS financing situation, contribution and compensation, 1993-2002

Contribution and compensation, WCS 1993-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>Contribution (Million Baht)</th>
<th>Compensation (Million Baht)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>921</td>
<td>927</td>
</tr>
<tr>
<td>1994</td>
<td>1,126</td>
<td>1,169</td>
</tr>
<tr>
<td>1995</td>
<td>1,370</td>
<td>1,398</td>
</tr>
<tr>
<td>1996</td>
<td>1,610</td>
<td>1,838</td>
</tr>
<tr>
<td>1997</td>
<td>2,235</td>
<td>1,733</td>
</tr>
<tr>
<td>1998</td>
<td>1,986</td>
<td>1,631</td>
</tr>
<tr>
<td>1999</td>
<td>1,765</td>
<td>1,673</td>
</tr>
<tr>
<td>2000</td>
<td>1,404</td>
<td>1,257</td>
</tr>
<tr>
<td>2001</td>
<td>1,220</td>
<td>1,277</td>
</tr>
<tr>
<td>2002</td>
<td>1,220</td>
<td>1,765</td>
</tr>
</tbody>
</table>
6. For-profit Commercial Health Insurance

Private commercial insurance has been available in Thailand since 1929 to cover mostly the better-off population (Tangcharoensathien et al. 2002). There are two major types of private health insurance companies: those providing health insurance as part of life insurance policies, and companies providing health insurance alone. Both types also provide individual and group insurance policies (Pitayarangsarit S et al. 2002, Surasiengsang S 2004). Private insurance companies are regulated by the Department of Insurance of the Ministry of Commerce. Membership is voluntary, and prior physical examination, and exclusion of existing conditions and the elderly, are common practices. The membership of health insurance policy is renewed annually.

The population coverage by voluntary insurance in 2004 is estimated at five million persons, or 8% out 63 million Thais (Surasiengsang 2004). However, the 2003 Health and Welfare Survey (NSO 2003) indicated a lower coverage of 1.1 million (2% of total population) by private insurance. Estimates from Surasiengsang tend to be more reliable due to the accuracy and completeness of data sources. There is a trend towards increasing coverage by private commercial insurance, especially during good economic growth. With the sign of recovery from the 1997 economic crisis seen in 2003, a consistent increase in premium collection was observed, as shown in Table 31.
### Table 31 Performance of private commercial insurance, 1998-2002.

<table>
<thead>
<tr>
<th>Year</th>
<th>Premium receipt, x  bahts</th>
<th>Reimbursement of claims, x1000 bahts</th>
<th>Loss ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life + health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>7,094,819</td>
<td>91%</td>
<td>3,662,346</td>
</tr>
<tr>
<td>1999</td>
<td>7,380,125</td>
<td>90%</td>
<td>3,454,637</td>
</tr>
<tr>
<td>2000</td>
<td>9,283,048</td>
<td>91%</td>
<td>3,315,905</td>
</tr>
<tr>
<td>2001</td>
<td>9,578,912</td>
<td>91%</td>
<td>3,612,208</td>
</tr>
<tr>
<td>2002</td>
<td>10,558,611</td>
<td>91%</td>
<td>3,949,976</td>
</tr>
<tr>
<td></td>
<td>Health Insurance alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>708,082</td>
<td>9%</td>
<td>518,316</td>
</tr>
<tr>
<td>1999</td>
<td>790,603</td>
<td>10%</td>
<td>596,115</td>
</tr>
<tr>
<td>2000</td>
<td>872,817</td>
<td>9%</td>
<td>610,972</td>
</tr>
<tr>
<td>2001</td>
<td>895,955</td>
<td>9%</td>
<td>614,625</td>
</tr>
<tr>
<td>2002</td>
<td>1,027,257</td>
<td>9%</td>
<td>708,499</td>
</tr>
<tr>
<td></td>
<td>Both plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>7,802,901</td>
<td>100%</td>
<td>4,180,662</td>
</tr>
<tr>
<td>1999</td>
<td>8,170,728</td>
<td>100%</td>
<td>4,050,751</td>
</tr>
<tr>
<td>2000</td>
<td>10,155,865</td>
<td>100%</td>
<td>3,926,877</td>
</tr>
<tr>
<td>2001</td>
<td>10,474,867</td>
<td>100%</td>
<td>4,226,833</td>
</tr>
<tr>
<td>2002</td>
<td>11,585,868</td>
<td>100%</td>
<td>4,658,476</td>
</tr>
</tbody>
</table>

Source: Ministry of Commerce

The financing of private insurance is solely based on voluntary annual premium contribution, with a risk-and-age adjusted indemnity insurance. Annual premium rates vary considerably, and range from a several hundred bahts per person for group insurance (1 USD = 40 bahts in 2004) to several thousand bahts per person, depending on the benefits covered. In 2002, the total insurance premium
receipts amounted to 11.6 billion bahts of which 91% came from life plus health insurance, and 9% from health insurance policies alone.

The analysis of the private commercial insurance market shows that the three largest private insurance companies that provide life plus health insurance have 85% of the total market share. One of the companies providing only health insurance had more than half of the market share (Surasiengsang 2004) of that product. This indicates a considerable market concentration. The analysis indicates higher market share (91% of total premium collected) and lower loss ratio (42%) among life plus health insurance policies. Companies providing only health insurance with a share of only 9% of total premiums collected had a higher average loss ratio at 71%, while the national average loss ratio was only 44%. In other words, the life plus health insurance companies had a higher profit margin than the others, as seen in Figure 23.

Figure 23.: Loss ratio comparison between life plus health and health alone, 1998-2002

A typical private health insurance policy would cover only inpatient admission services and ambulatory care for injuries from accidents and injuries. The inpatient benefit package generally covers the following:

- Room and board, and nursing charges per inpatient day
- Other treatment costs
- Surgical fees
- Operation theatre fees
- Anaesthetist’s fees
Ambulatory services for accident injury and emergency services
Laboratory and radiological diagnosis
Doctor’s fees in hospitals

Several varieties of benefit package are provided, depending on the level of premium. These may include a co-payment per ambulatory visit or inpatient admission by the patients, a lump sum payment for each episode of illness (plus co-payment if beyond the lump sum), cash compensation for income loss during admission or convalescent period differ among private health insurance arrangements. In some cases, rehabilitation services and travelling costs may be included in the benefit package.

However, some illnesses and services are commonly excluded from the benefit package. These are:

Suicide
Injuries resulting from war, civil strife or strikes, and injuries to members participating in army, police and volunteer activities in wars or conflicts.
Injuries from nuclear accidents and radiation
Injuries related to travel in non-civil aviation services
Treatment for conditions existing prior to the start of the policy
Physical check-ups either during admission or ambulatory services

The most common mode of payment to health care providers is fee-for-service reimbursement. It is increasingly common that certified hospitals bill the insurance companies directly. Hospitals need to seek prior authorization for inpatient treatment insured persons as for any high cost intervention from the insurance companies.

Problems encountered in private commercial insurance relate to the fee-for-service payment method, in which the insured, the insurance brokers and the health care providers may not be concerned with controlling costs. Health care providers have incentives to over-investigate and over-prescribe. Once insured, there is some risk of individuals using health services excessively (moral hazard). This prompts insurance companies to introduce tighter control, utilization reviews and medical audit. A network of certified private hospitals has been recommended for insured persons which allows direct billing from these hospitals to insurance companies. To minimize the costs of inpatient admissions, an outreach ambulatory clinic at the workplace is a promising intervention for specific working populations covered by group policies.
7. Critical Analysis of Prepayment/Social Health Insurance Mechanisms

The analysis above shows that mandatory and voluntary social health insurance schemes cover only a small proportion of the population in the formal private sector, especially as the SSS covers only individual workers and not family members, while public sector employees are covered by the non-contributory CSMBS. Private commercial insurance covers only the better-off who can afford to pay high annual premiums.

In the Thai context, where formal sector employment is still small, mandatory and voluntary prepayment schemes still have serious limitations in expanding coverage to the whole population. While there is no politically conducive environment, social health insurance still seems to have weak support. At a time when there was no political support for full blown universal coverage through social health insurance, an effort to initiate work-related injuries and illnesses compensation through WCS was legitimate and gained support from policy-makers. The implementation of the WCS resulted in human capacity development to manage the health insurance fund and served as a solid platform for later implementation through the SSO. However, the configuration of WCS-fee-for-service reimbursement with ceiling model led to over-charging, abuse and fraudulent claims, especially when the regulatory function of the WCS was weak. For this reason, health insurance under the SSO did not follow the WCS model and initiated the capitation contract model. Subsequent evaluation of the capitation payment model indicated cost-containment capacity with a decent quality of care.

Furthermore, after the promulgation of the Social Security Act and beginning of the provision of health care benefits, an initial capitation rate of 700 bahts was proposed and accepted by the providers. Subsequent updates of the capitation rates were supported by calculations conducted by local researchers.

The MoPH hospitals were the major contractor hospitals for the SSS health insurance during the first few years of its implementation. Without strong support by the MoPH hospitals, it was impossible to implement social health insurance. Not all private hospitals were interested in contracts with the SSO in the first year but the number of participating private hospitals grew in subsequent years when evidence indicated very low utilization rates among the insured and allowed for a very high profit margin.

Eleven years after the implementation of social health insurance through the SSO (1990-2001), the Universal Coverage (UC) scheme was launched. The UC scheme has adopted the SSO capitation contract model financed by general tax revenue. In a
developing country like Thailand where formal sector employment is still small, it is
difficult to apply mandatory health insurance to extend coverage to the entire
population. A proper mix of health care financing sources for UC is needed through,
for example, contributions from the formal sector employment and general taxation
for the rest of population.

8. Conclusions

It is not only the source of health care finance that is important for the extension of
health insurance coverage, but also the method according to which health care
providers are paid. Social health insurance in other countries where a fee-for-service
reimbursement model is the major mode of payment to health care providers (such
as Philippines, The Republic of Korea and Taiwan) is facing difficulties of cost
escalation and inefficiency. In addition, beneficiaries in such countries tend to
shoulder a high level of co-payment.

From the Thai experience, it can be concluded that private commercial health
insurance has limitations in extending health insurance coverage, as they only
provide this choice to the wealthier population. This is not a policy goal if a country
needs to extend coverage to the whole population.

On a voluntary basis, private commercial health insurance has a
supplementary role to play for services not covered by the benefit packages offered
in public schemes (such as the SSO and CSMBS). However, private insurance
companies still provide the whole package, thereby duplicating most of the benefits
covered, and requiring a full premium. By law, the SSO does not allow members
with private commercial insurance policies to opt out. This indicates a closer policy
attention to regulate the private insurance market.

It is not clear why the SSO has not put more serious effort in expanding health
insurance coverage to the employees' dependents, while there were good
opportunities and adequate resources to do so. Repeated recommendations have
also been made by ILO consultants regarding the technical and financial feasibility
of such extension.

We need to reiterate the recommendations made to the SSS to extend the
coverage beyond the workers to cover their spouses and children as well. This
would minimize the government's fiscal burden in supporting the current universal
coverage scheme that should be covered by social health insurance through the SSO.
References

1. Department of Insurance. Annual report of the Department of Insurance, several years. Ministry of Commerce.


Viet Nam

Afsar Akal and Nguyen Kim Phuong

1. Background
Viet Nam, since its establishment in 1945, has pursued with socialist models in economic and social development. Basic social services such as health care and education were free till 1986. From 1986, along with the disintegration of the former communist world, the country has embarked upon an economic reform programme known as “doi moi” which has transformed the system from a centrally planned one to a market-oriented one. Private economic sector emerged and it has profoundly affected social sectors, including health. One of the most challenging issues in the health sector today is finding alternative health financing mechanisms which can meet the growing health needs of the population as the economy grows at a faster pace.

Prior to 1986, the health care system focused on primary health care, health education and disease prevention. With a considerably low income base to begin with after a long war and post-war reconstruction period, Viet Nam achieved significantly good health indicators, in comparison with other countries of the same income level. During the last ten years, Viet Nam has achieved a significant reduction in its population growth rate with an annual average of only 1.7%. The population was 77.6 million in 2000, and is estimated to be 81.2 million in 2003. While the unemployment rate in urban areas was 6.4% in 2000, 6.3% in 2001, and reduced to 6.0% in 2002, the national average including rural areas hovers above 10%. People living below international poverty line* accounted for 16.4% of the total population in 1998 and this internationally comparable poverty rate is expected to decline to 10.6% by 2004. Living standards in mountainous areas and among the ethnic groups are still very low. The rate of unused working time of labour in rural areas is much higher than the urban unemployment rate as a result of low investment in rural areas. More than one million youths enter the labour force each year but there has been a lack of job opportunities, caused by the reduction in growth rates of production and business.

* Source: World Bank, East Asia and Pacific Region (2003); measured in constant 1993 prices of purchasing power parity (PPP) dollars, population living below one PPP-dollar per day.
On the health-financing front, national health expenditures in the past have been financed by central and local government general revenue. However, along with the collapse of the local collective economic system, the government faced severe fiscal pressures, which resulted in under-funding of the health sector in large. There was a drastic cut in the government budget for health care during the 1980s. In order to cure and sustain the system, the government allowed health care facilities to apply cost recovery methods. Introduction of user fees at public facilities was timed with the introduction of health insurance pilots for the formal sector. The shift from fully public subsidized system to a mixture of budgetary support and additional funding from user fees and social insurance has led to the flourishing private provision of health care in Viet Nam. Private practice among the public sector employed health staff has become more acceptable by the populace, in an effort to let providers gain additional income complementary to their officially low salaries financed by the state budget.

There is growing recognition among policy-makers that user charges in health care seriously jeopardize the equity in access to health care. Furthermore, user charge collections became an engine for the escalation of health care prices, distorting the quality of care, worsening professional ethics, placing financial burdens on many families and putting a barrier for the poor to access these services.

At the same time, the policy-makers have been put under pressure to mobilize more resources for health care. There is growing recognition that government is no longer able to pay for all of health care needs of the nation. With the economic reform programme, the concept of “socialization of health care” has been introduced with the notion that both government and citizens should join in efforts to financially contribute for health care.

The recent socioeconomic developments will expectedly challenge the government’s efforts to institutionalize social insurance mechanisms in the country for the first quarter of this century. The rural and informal sector still accounts for a sizeable share of the total economy, and setting functional social safety nets while integrating the informal sector into the broad social insurance system will occupy significant policy debate time in the foreseeable future.

2. Development of Health Insurance Mechanisms

In the late 1980s, social health insurance was put on the policy table for discussion as a means to mobilize more resources for health care and replace direct user charges. Social health insurance was also considered as a means to promote social solidarity, by pooling the contributions together to share the risks among the members. The policy option was discussed in detail and experimentation with social health insurance first began piloting in a few provinces in Viet Nam during the early nineties, initially covering government employees. In 1992, compulsory health
insurance was introduced countrywide with the issuance of the first government decree on health insurance (Decree 299) and with the establishment of health insurance offices in all provinces and with the Central Office in Hanoi. Since then, social health insurance has grown steadily, covering mainly civil servants and employees of the state-owned enterprises, including those who retired and have made meritorious services to their country, and in part private enterprise workers, students and the eligible poor.

After almost ten years of implementation, members of national health insurance schemes are largely concentrated within the formal salaried workers and school students. Viet Nam is still largely an agricultural country with the majority of population residing in rural areas and not yet covered by health insurance. It is a challenge now for Viet Nam to expand the coverage to the rural population. Development of appropriate voluntary health insurance schemes is now being piloted in different provinces as a first step in the route to achieve universal coverage in health insurance.

**Health insurance schemes**

Currently, the following three social health insurance schemes are operating:

- **Compulsory Insurance Scheme:** covering active and retired salaried workers in the public sector, private sector with over 10 employees and social benefit recipients such as meritorious persons or war invalids;
- **Voluntary Insurance Scheme:** for students, farmers, informal sector and private sector with less than 10 employees, and
- **Health Insurance for the Poor:** covering low-income earners, residents of communes facing difficult socioeconomic conditions and ethnic minorities living in rural, remote and mountainous areas.

**Administration of health insurance**

Social health insurance is administered by the Viet Nam Social Security Agency (VSS) and Provincial Management Boards for Health Care Fund for the Poor (HCFP). VSS with its Head Office in Hanoi and with 64 provincial/regional and more than 500 district offices, provides benefits for about 11.6 million people excluding the poor scheme members or 15.7 million including the poor (2003—See Figure 24). Provincial HCFP Management Boards administer benefits for a targeted 14.6 million people of which more than four million have been issued free health insurance cards through VSS. The two administrations combined are aiming to provide benefits to more than 30% of the total Viet Nam population within a few years. The administration of social health insurance, which used to be under MoH,
Social Health Insurance was shifted to VSS in January 2003, which administers benefits for long-term pension, disability, occupational health, maternity and labour accidents.

**Figure 24. Health Insurance Coverage by Viet Nam Social Security Agency**

**Social Health Insurance Coverage**  
**VSS Administered Schemes 1993-2002**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Insured</th>
<th>% Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>0.5</td>
<td>5%</td>
</tr>
<tr>
<td>1994</td>
<td>1.0</td>
<td>10%</td>
</tr>
<tr>
<td>1995</td>
<td>2.0</td>
<td>13%</td>
</tr>
<tr>
<td>1996</td>
<td>3.0</td>
<td>16%</td>
</tr>
<tr>
<td>1997</td>
<td>4.0</td>
<td>19%</td>
</tr>
<tr>
<td>1998</td>
<td>5.0</td>
<td>20%</td>
</tr>
<tr>
<td>1999</td>
<td>6.0</td>
<td>20%</td>
</tr>
<tr>
<td>2000</td>
<td>6.5</td>
<td>20%</td>
</tr>
<tr>
<td>2001</td>
<td>7.0</td>
<td>20%</td>
</tr>
<tr>
<td>2002</td>
<td>7.5</td>
<td>20%</td>
</tr>
<tr>
<td>2003</td>
<td>8.0</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Government regulations and main events in health insurance development**

Health insurance has not yet been adopted as law. The highest order regulatory document applicable today is the Health Insurance Decree/58 enacted in 1998, which replaced the first Decree/299 of 1992. Preparatory work has begun to include health insurance as a chapter in the Draft Social Security Law.

Various parts of the health insurance decree have been annulled by subsequent regulations. Table 32 below contains the title, date of issuance and historical significance of each regulation related to health insurance.

In practice, after a law is passed the President issues a decree proclaiming the law to bring it into force and the relevant ministry issues a circular to provide guidance on how to implement the decree of the government. The process for the creation of these legislative instruments, while simpler than ordinances and laws, has reportedly led to situations where the subsidiary legislations are in conflict with the law they seek to implement. In response the policy environment in this area became highly dynamic. MoH, MoF, MOLISA, Prime Minister’s Office and National Assembly are actively debating policy improvements and issuing new changes.
Table 32. Chronology of Main Health Insurance Regulations and Law Amendments

<table>
<thead>
<tr>
<th>Reference and Title of Regulation</th>
<th>Date of Issue</th>
<th>Historical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime Ministerial Decision 45-Introduction of Cost Recovery and Social Insurance</td>
<td>24 April 1989</td>
<td>Government introduces user fees at public facilities and allows piloting of social health insurance and setting up of humanitarian funds for the poor to generate additional funding for health care. Health care is officially no longer free in Viet Nam.</td>
</tr>
<tr>
<td>Decree 299-Health Insurance Regulations</td>
<td>15 August 1992</td>
<td>Nationwide implementation of social health insurance is decreed in Viet Nam.</td>
</tr>
<tr>
<td>Decree 95 and revision of, by Decree 33-Schedule of Fees at Government owned Hospitals and Clinics</td>
<td>27 August 1994 Revised 23 May 1995</td>
<td>Cost recovery at public facilities is embodied in a higher order regulatory document. Increased user charges, which are currently applicable.</td>
</tr>
<tr>
<td>MoH and MoET Inter Ministerial Circular 14-Student Health Insurance Scheme</td>
<td>19 September 1994</td>
<td>Voluntary Health Insurance for a large segment of the population (students) is introduced.</td>
</tr>
<tr>
<td>MoH MoLISA Inter Ministerial Circular 14-Exemptions Policy</td>
<td>1995</td>
<td>Some groups of people (the poor, meritorious persons, children under age six etc) are exempted from paying official user fees.</td>
</tr>
<tr>
<td>MoH and MoET Inter- Ministerial Circular 40-Voluntary Student Health Insurance</td>
<td>19 July 1998</td>
<td>Amended first school health insurance circular by expanding benefits, increasing premiums and modifying reserve rules.</td>
</tr>
<tr>
<td>Inter-Ministerial Circular 05/1999-Free Health Insurance Cards for the Poor</td>
<td>29 January 1999</td>
<td>Fee exemption policy is replaced with special allocations (mainly from provincial Hunger Eradication and Poverty Reduction Programmes). Government brings the poor under social insurance with premium-backed funding.</td>
</tr>
<tr>
<td>Decree 63-Health Insurance for the Dependents of Armed Forces</td>
<td>18 June 2002</td>
<td>First instance of compulsory health insurance coverage extended to the dependents.</td>
</tr>
<tr>
<td>Reference and Title of Regulation</td>
<td>Date of Issue</td>
<td>Historical Significance</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| Prime Ministerial Decision 139-Health Care Fund for The Poor and subsequent Circular 14 on Implementation Guidelines | 15 October 2002  
16 December 2002 | Special provincial allocations for funding for the poor scheme is replaced with Central Government funding. Government increases the premium, decentralizes the administration of health insurance by setting up provincial management boards independent of VSS and stops reserve build-up. |
| Decree 100-Prescribing the functions, tasks, powers and organizational structure of Viet Nam Social Security Agency | 6 December 2002 | Health insurance portfolio is moved out of MoH and handed over to VSS to unify social insurance administration. MoH retains policy control over health insurance. |
| Prime Ministerial Decision 02-Stipulating the Financial Management Regulations of Viet Nam Social Security | 2 January 2003 | All social security is now administered under a single “fund holder” made up of various “component funds or risk pools” each to be monitored separately. |
| Ordinance 07 of National Assembly on Private Medical and Pharmaceutical Practice | January 2003 | National Assembly endorses more stringent regulations for private provision of health. Private providers can contract with VSS and other insurers. The regulation aims to enforce private medical practitioners not to engage in the provision and sale of pharmaceutical drugs. |
| MoH/MoF Inter Ministerial Circular 77-Voluntary Health Insurance and subsequent Circular 3631 on Implementation Guidelines | 5 August 2003 | Voluntary insurance is now available to a larger population with a broader benefit package under a regulatory framework. Alternative payment methods can be used in provider contracts for this scheme only. Introduced “community enrolment thresholds” to eliminate adverse selection. Waiting periods and caps on some benefits introduced for the first time. |
| MoLISA Circular 24 Health Insurance for the Elderly (Above 90) | 6 November 2003 | Extension of health insurance to old people using the model applied for scheme for the poor. Another instance of fee exemption being replaced by premium-backed health insurance. |
Figure 25 below shows growth of health insurance coverage during the past decade and major historical events and regulatory changes introduced by the government in order to increase health insurance coverage.

Figure 25. **Historical events in social health insurance coverage**

### 3. Compulsory Health Insurance Schemes

**Scheme Summary**

<table>
<thead>
<tr>
<th>Administering Agency</th>
<th>Viet Nam Social Security Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation Type/Date</td>
<td>Decree-58/1998</td>
</tr>
<tr>
<td>Target Group</td>
<td>Formal sector-active and retired salaried workers in the public sector (civil servants and state-owned enterprise employees), private sector with over 10 employees and social benefit recipients such as meritorious persons or war invalids.</td>
</tr>
<tr>
<td>Dependent coverage</td>
<td>Dependent family members are excluded except for military personnel.</td>
</tr>
<tr>
<td>Administering Agency</td>
<td>Viet Nam Social Security Agency</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Contribution basis and Premiums</td>
<td>Percentage of salary or earnings including allowances-3% payroll tax shared between employer (2%) and employee (1%) excluding old age pensioners and social security beneficiaries whose contributions are paid by the state (3%) of base pension and national minimum wage respectively.</td>
</tr>
<tr>
<td>Benefits</td>
<td>Primary, in-patient and outpatient services and benefit paid drugs. Exclusions apply.</td>
</tr>
<tr>
<td>Co-payments</td>
<td>20% of official user fee from active employed category. Pensioners and social security beneficiaries exempted. Approximately 50% co-payments apply for high-tech diagnostic/treatment services and disposable medical supplies for all beneficiaries. Safety-net of six times minimum wage, above which all costs are covered by the scheme.</td>
</tr>
<tr>
<td>Service provision</td>
<td>Free choice of provider at district hospital level and below. Patient needs to follow referral lines.</td>
</tr>
<tr>
<td>Provider payment methods</td>
<td>Capped fee for service. Providers receive capitation-based quarterly advances.</td>
</tr>
<tr>
<td>Reserves/Risk Pooling</td>
<td>Reserve carry-overs allowed. Nationally, the risk pooled with voluntary scheme.</td>
</tr>
</tbody>
</table>

Compulsory health insurance covers active and retired salaried workers in the public sector (civil servants and state owned enterprise employees), private sector with over 10 employees and social benefit recipients such as meritorious persons or war invalids. Currently dependents of insured are not covered by compulsory insurance except for the armed forces*. All elderly persons above age 90 are covered by government-funded health insurance either through the formal VSS pension scheme or by MOLISA (Circular 24).

* Approximately 400,000 dependents became eligible following this regulatory change representing 7% of total compulsory insured persons.
Benefits

The general framework for the health insurance benefit package is based on three criteria:

- Whether separate government funding exists for particular health interventions;
- Whether there is a fee exemption policy for the type of benefits demanded by a target group, and
- Whether another insurance scheme covers a benefit (i.e. employment injury or traffic accidents).

Services that are funded by the government under a vertical programme (i.e. vaccinations, TB, leprosy, malaria etc.) or services, which are likely to be demanded by a target group under an exemption policy (congenital malformations and diseases), are generally speaking not covered by health insurance (See Table 33). Hospital stays and diagnostic services are covered by insurance but certain items such as disposable medical supplies, high-technology diagnostic services and treatments and benefit-paid drugs are specifically outlined in separate MoH regulatory decisions.

Co-payments

Individuals in the meritorious category and pensioners are not required to pay co-payments. Active contributors (employed persons) are required to pay 20% co-payment based on the schedule of hospital fees. Co-payments for disposable medical supplies and high-technology diagnostic and treatment services are generally 50% of the charge and regulated separately.

Choice of provider

Generally speaking, members have free choice of provider although this has limited applicability in practice, especially in rural areas. All members are required to nominate a primary-level provider, which is often a district-level hospital, which can be changed every quarter. Rural people are generally required to be registered with the provider located within the administrative jurisdiction even though some members may well be closer to a provider in a neighbouring district. Members can obtain health services from Commune Health Stations (CHS) if there are sufficient members residing in the area and the District Health Centre (DHC) has an agreement with the CHS.
**Table 33. Broad Health Insurance Benefit Package of VSS-Administered Schemes**

<table>
<thead>
<tr>
<th>Benefit Inclusions</th>
<th>Benefit Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary health care</td>
<td>• Treatment for leprosy, psychiatric treatments (schizophrenia), epilepsy</td>
</tr>
<tr>
<td>- Personal hygiene, nutritional, environmental health and prevention activities</td>
<td>• Medicines used for tuberculosis, malaria, rabies prevention and treatment</td>
</tr>
<tr>
<td>- Health check-up</td>
<td>• Family planning services</td>
</tr>
<tr>
<td>- First aid and emergency care</td>
<td></td>
</tr>
<tr>
<td>• Health care provider level</td>
<td>• Fees for HIV/AIDS tests, gonorrhoea and syphilis, diagnosis and treatment</td>
</tr>
<tr>
<td>- Insured members can choose health care provider at district-level to register and will be referred to higher level when necessary.</td>
<td>• Preventive medicine, vaccinations, sanatorium, regular check-up, health examination for recruitment</td>
</tr>
<tr>
<td>- If health care is given in consistence with the regulations at district, provincial and central levels: the health insurance fund will pay 80% of the fees, the other 20% will be paid by the insured person.</td>
<td>• Aesthetic orthopaedics and plastic surgery, glasses, hearing aid, false limbs, false teeth, false eyes, artificial joints, crystalline lens and heart valve, prosthetics</td>
</tr>
<tr>
<td>- If patient’s total out-of-pocket payments for the 20% co-payment amount exceed the amounts set in the current applicable regulations for a given year, VSS will cover the cost difference.</td>
<td>• Rehabilitative treatment out of the list established by the Ministry of Health</td>
</tr>
<tr>
<td>- Members visiting providers where they are not registered for first level of contact or making discretionary choices for medical practitioner or medicines have to pay all the fees. Health insurance agencies will consider and reimburse costs in accordance with the currently applicable regulations on fees.</td>
<td>• Congenital diseases and birth defects</td>
</tr>
<tr>
<td>- In emergency cases, people with health insurance cards will be given health service and treatment at any health care provider and enjoy all health insurance benefits regardless of variations in technical levels or different administrative boundaries.</td>
<td>• Occupational diseases</td>
</tr>
<tr>
<td></td>
<td>• Labour accidents</td>
</tr>
<tr>
<td></td>
<td>• Road accidents including after effects from road accidents</td>
</tr>
<tr>
<td></td>
<td>• War accidents and calamities</td>
</tr>
</tbody>
</table>
Benefit Inclusions

- Health service given under the doctor's instructions:
  - Examination, tests, X-rays, functional investigation for diagnosis and treatment
  - Provision of medicines within the list established by the Ministry of Health, blood and fluid transfusion using the common materials, health equipments for health care
  - Surgeries and operations
  - Use of patient beds
- For maternity: health insurance agencies will pay the fees according to the currently applicable regulations.
  - Death allowance per case at applicable rate set out in regulations.

Benefit Exclusions

- Suicides, intentionally caused injuries, drug addiction, law violations
- Early pregnancy tests and diagnosis, infertility treatment
- Costs of transporting the patients, meals during treatment period

Members can also obtain services from private providers albeit with partial reimbursement even in the absence of a contract between VSS and the private provider. The health insurance benefit for private consultations is often lower than the actual charge commensurate with the level of fee that would be payable to the equivalent public level provider.

Insured members can obtain health services from any provider in their own provinces or outside in accident and emergency cases but they are normally required to make the payments to the providers themselves and then seek reimbursement once they return to the jurisdiction where they are registered. If the case is referred to a tertiary hospital outside the province of usual residence, in most cases the member needs to pay only the co-payment amount.

**Fund management and risk pooling**

Since the take-over of health insurance by VSS, allocation for health insurance reserves and administration is abolished. All compulsory health insurance premium income is used for paying health care benefits. From each month's social insurance fund income, VSS advances benefits to members and all carry-overs (revenue minus expenditure) are invested in bank deposits and government bonds.
Compulsory and voluntary schemes are now combined under a single risk pool. VSS can carry reserves for compulsory and voluntary health insurance schemes. Reserve carry-overs for health insurance for the poor are disallowed.

**Administrative expenses**

Insurance administration is for card printing and distribution, paying agent commissions, for IEC-Information Education and Communication campaigns and for conducting regular inspections at enterprise level (for premium payment compliance) and health care provider level (to detect fraud).

Funding of administration is sourced from total revenue of social insurance fund, which includes all social insurance contingencies. Administrative expenses cannot exceed 4% of the estimated value of social insurance premium revenue in a year.

**Contracting and provider payments**

Government administered health insurance is generally conducted through contracts with public providers. Private hospital contracting has been piloted on a small scale. The National Assembly Ordinance 10 on private medical practice allows VSS to sign contracts with private providers. Contracting between VSS and a health care provider is normally done for providers who operate as a separate legal entity. In effect, these are limited to provincial, central and district-level hospitals. Commune health stations and inter-commune polyclinics can provide services to insured members under the supervision of DHC and receive payment from the DHC.

Every quarter, VSS transfers a fixed percentage of premium income to each of the contracted health providers based on the number of registered members. This advanced “capitation-based” budget is approximately 70% of the health insurance premium for the quarter and covers all primary, outpatient and inpatient care services (See Table 34). The advance is for supporting health care services until all health services provided to insured persons are reconciled against itemized bills. The payment method is hence “fee-for-service with budget capping/ceilings” in order to safeguard the fund.

The hospital fees are based on a government Decree (95/ Revision Decree 33), which applies to public-owned and operated hospitals and clinics. The regulation is more than eight years old and the fees have not been adjusted since their official introduction. Providers on the other hand have taken initiative in moving the fees upwards within the range applicable in this regulation as well as introducing discretionary fees for advanced diagnostic and treatment services.
Due to more flexibility allowed for drug and disposable medical supplies prices, which are more or less determined by market forces, most provider income in the past has been highly dependent on movement in prices of pharmaceutical and medical supplies and volume of prescriptions given to patients who are willing to pay.

**Table 34:. Compulsory Scheme Fund Allocation, Quarterly Advance Calculation and Final Settlement Methods**

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Allocation Ratio</th>
<th>Quarterly Advance Calculation Method</th>
<th>Final Settlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care</td>
<td>5%</td>
<td>Fixed % of premium income (70%)</td>
<td>Capped</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>45%</td>
<td></td>
<td>Capped-Intra-Provider Adjusted*</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>50%</td>
<td>Historical average cost for each clinical department adjusted by price index</td>
<td>Un-capped</td>
</tr>
</tbody>
</table>

* Expenses for patients referred to other hospitals are deducted from the payment of members’ principal registered provider.

**Safety nets**

Safety nets provide financial protection for members who suffer catastrophic health expenditure and apply to persons who are required to pay co-payments. For compulsory members who pay co-payments (active employed), annual co-payments exceeding six times the minimum salary per month is set as a safety-net threshold above which all benefit-payable health expenses of the member are covered by VSS.

There are two complexities in the current safety net rules. The threshold only covers services where 20% co-payments apply. In other words, 50% co-payment applied to disposable medical supplies and high-technology diagnostic and treatment services are excluded from the calculation amount as they are not defined in the fee schedule of hospital bed-day charge or outpatient consultation fee as defined by the health insurance decree.

**Reimbursement**

Insured persons can be directly reimbursed by health insurance under the following circumstances:
Member receives services not from his/her principal registered care provider such as in the case of accident and emergencies.

- Member is outside his/her residential province.
- Member receives services from a private provider.
- Member has paid co-payments in excess of the safety-net thresholds.

The payment amount for the private service would be based on the fee schedule applicable to the principal registered public care provider with a provision to allow a benefits up to 20% more than the public provider’s fee.

4. **Voluntary Health Insurance Schemes**

Voluntary health insurance in Viet Nam is a VSS-administered pre-payment scheme being experimented as an interim mechanism for reaching universal health insurance. The target population segments are the dependents of individuals covered by the compulsorily insured, the self-employed and informal sector workers and their dependents. Unlike compulsory insurance premiums, which are a fixed percentage of salary or other forms of income, voluntary health insurance premiums are defined as flat-amount contributions and paid in full by the households. Definition of young age family dependents exclude children under six years of age as they are exempted to pay user fees at publicly-owned health facilities.

Circular 77 issued in August 2003 (See Table 32) regulates voluntary health insurance, which has expanded health insurance benefit package and brought them more or less in line with the compulsory scheme. People can join VSS-administered voluntary health insurance from three channels:

- Schools
- Administrative Units (i.e. commune, village, hamlet, ward)
- Associations/Mass Organizations (i.e. Women’s Union, Farmers’ Union, Youth Union, Fatherland Front etc.)

**Scheme Summary**

<table>
<thead>
<tr>
<th>Administering Agency</th>
<th>Viet Nam Social Security Agency in close cooperation with community administrative units, mass organizations and schools.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation Type/Date</td>
<td>Circular 77/2003.</td>
</tr>
<tr>
<td>Target Group</td>
<td>Informal sector, rural/agricultural workers and students</td>
</tr>
<tr>
<td>Dependent coverage</td>
<td>All family members except currently insured by the compulsory scheme. Optionally fee-exempt children under age six can register.</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Contribution basis and Premiums</td>
<td>Flat amount with discounts for additional members. Separate for urban and rural members. Lower premiums apply for students.</td>
</tr>
<tr>
<td>Benefits</td>
<td>Primary, inpatient and outpatient services and benefit-paid drugs. Exclusions apply. Benefit caps apply. Waiting periods apply.</td>
</tr>
<tr>
<td>Co-payments</td>
<td>20% of official user fee. Approximately 50% co-payments apply for high-tech diagnostic/treatment services and disposable medical supplies. Safety net of 1.5 million dong, above which all costs are covered by the scheme.</td>
</tr>
<tr>
<td>Service Provision</td>
<td>Free choice of provider at district hospital level and below. Patient needs to follow referral lines.</td>
</tr>
<tr>
<td>Provider payment methods</td>
<td>Capped fee for service. Capitation-based contracts are allowed subject to agreement with the provider.</td>
</tr>
<tr>
<td>Reserves/Risk Pooling</td>
<td>Reserve carry-overs allowed. Nationally, the risk pooled with compulsory scheme.</td>
</tr>
</tbody>
</table>

Commissions, which are a type of administrative expense is payable to the community agencies undertaking health insurance enrolment campaigns. The latter two channels have been created by the new regulation to mobilize the community. The involvement of community organizations and administrative units is to enrol all family members except currently-insured persons under compulsory insurance or children under 6. Family enrolment is functional only if families join through mass organizations or through an administrative unit. The school channel, as before, does not enrol parents of students.

Community enrolment thresholds have been introduced in order to overcome adverse selection. Accordingly voluntary health insurance is offered to the public only if a community channel can warrant a minimum percentage of enrolment among target people before VSS processes membership applications (See Table 35).
Table 35. Community Enrolment Thresholds for Voluntary Health Insurance

<table>
<thead>
<tr>
<th>Enrolment Channel</th>
<th>Community Enrolment Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local administrative units (commune,</td>
<td>Minimum 20% of total households residing.</td>
</tr>
<tr>
<td>hamlet or ward)</td>
<td></td>
</tr>
<tr>
<td>Associations (Women’s Union,</td>
<td>Minimum 40% of total members of an association excluding compulsorily</td>
</tr>
<tr>
<td>Farmer’s Union, Youth Union etc)</td>
<td>insured.</td>
</tr>
<tr>
<td>Pupils, students (Schools)</td>
<td>Minimum 30% of students at school.</td>
</tr>
</tbody>
</table>

**Premiums:** Voluntary health insurance premiums are defined as flat amounts per person where a discount of 5% is incrementally applicable for each additional member.

Table 36. Voluntary Health Insurance Premiums

<table>
<thead>
<tr>
<th>Areas (VND)</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local administrative units (commune,</td>
<td>80000-140000</td>
<td>60000-100000</td>
</tr>
<tr>
<td>60000-140000</td>
<td>60000-100000</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>80000-140000</td>
<td>60000-100000</td>
</tr>
<tr>
<td>Rural</td>
<td>35000-70000</td>
<td>25000-50000</td>
</tr>
</tbody>
</table>

Each local jurisdiction can choose an affordable premium amount established within these bounds (see Table 5), which can only be increased by VSS if the government increases official hospital charges. All hospital fee increases and subsequent raise in premium need to be endorsed by the MoF.

A family of five in a rural area where the authority sets the base premium at 60000 would be paying 270000 dong per year calculated as 60000+57000+54000+51000+48000 with the 5% discount of 3,000 dong incrementally applied for each additional member. A complicating factor exists for students. If the local school is offering health insurance, a family would pay a lower premium and

\* A temporary threshold of 15% applies for the 2003/04 school year during the transitional period since the new regulation came into effect.
the family premium calculation above would exclude school-enrolled family members. If there is no school health insurance on offer, which is often the case in rural localities, family members attending school would only receive the incremental 5% premium discount.

As a rule, members can pay their premiums every six months (semi-annual). However, this does not mean the collection cycle is year round every month, where each member can join anytime and pay their premiums six months after their joining date. The premium collection cycles are timed to be around harvest times and need to be completed within a month. Those who do not join at the collection time are generally excluded until the next collection cycle arrives. Each member needs to join for at least six months for VSS to print the insurance card validity period.

There is no guaranteed minimum government subsidy for voluntary health insurance members. The Circular leaves it open for community organizations (unions and associations) to use their working budgets to subsidize premiums of their members who need financial assistance.

**Benefits, co-payments and benefit caps:** The benefit package of the voluntary health insurance scheme is similar to the compulsory scheme (for actively employed persons who are required to pay co-payments of 20%). Voluntary insurance regulation has introduced a 20000 dong threshold per service below which no co-payments are required in order to simplify insurance administration. Accordingly, low-cost services such as primary level care and essential drugs below this threshold are available free of charge to voluntary members.

Unlike the compulsory scheme, voluntary health insurance has benefit caps for high cost surgical and medical interventions. Accordingly, VSS pays up to 10 million dong per person for heart surgery and 12 million dong for kidney transplants. Vaccinations for rabies/animal bites are also capped at 300000 dong per person per year.

**Provider contracting and payment methods:** Provider contracting and payment methods for voluntary insurance is no different than the compulsory scheme although capitation payment method is allowed, provided that the provider agrees to perform services to all registered voluntary members under this arrangement.

The voluntary health insurance circular is a lower-level document than a government decree. Therefore fee-for-service method established by Decree 95/ Decree 33 (see Table 32) applies to all compulsory and poor scheme members administered by VSS. This creates possibilities for duplicate payment methods in a jurisdiction for different classes of health insurance members.
5. Health Insurance for the Poor

**Scheme Summary**

<table>
<thead>
<tr>
<th>Administering Agency</th>
<th>Provincial HCFP Management Boards in close cooperation with Viet Nam Social Security Agency.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation Type/Date</td>
<td>Prime Ministerial Decision 139/2002.</td>
</tr>
<tr>
<td>Target Group</td>
<td>Low –income persons, populations living in rural, remote and mountainous provinces under difficult conditions, ethnic minorities.</td>
</tr>
<tr>
<td>Dependent coverage</td>
<td>All family members except fee-exempt children under age six.</td>
</tr>
<tr>
<td>Contribution basis and Premiums</td>
<td>Flat-amount 70000 dong per person per year shared 75% (52500 dong) by Central Government and 25% (17500 dong) by domestic and international donors.</td>
</tr>
<tr>
<td>Benefits</td>
<td>Primary, in-patient and outpatient services and benefit paid drugs. Exclusions apply.</td>
</tr>
<tr>
<td>Co-payments</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Service Provision</td>
<td>Free choice of provider at district hospital level and below. Patient needs to follow referral lines.</td>
</tr>
<tr>
<td>Provider payment methods</td>
<td>Capped fee for service and capitation-based quarterly advances.</td>
</tr>
<tr>
<td>Reserves/Risk Pooling</td>
<td>Reserve carry-overs not allowed. Provincially risk-pooled.</td>
</tr>
</tbody>
</table>

The Health Care Fund for the Poor (HCFP) is an insurance mechanism set up for a designated group of people by the decision of the Prime Minister. The decision has consolidated a number of regulations that exempted certain groups of beneficiaries from paying hospital fees in the past.

HCFP works on the basis of a per capita allocation of 70000 dong where the government funds a minimum of 75% and the remaining 25% is sourced from international and domestic donors. The fund is administered by Provincial Management Boards. They can either decide to purchase health insurance cards from VSS for a fixed price of 50000 dong per card or reimburse health expenses of eligible members. Alternatively, care providers who provide services to exempted beneficiaries could also be reimbursed by these boards.
The fund needs to be spent for providing health benefits and its administration only, therefore fund roll-overs (reserve accumulation) are not allowed.

**Target groups, main beneficiaries**

- The rural poor with an income of less than 80,000 dong per month in remote and mountainous areas and 100,000 dong in other rural settings.
- The urban poor with an income of less than 150,000 dong per month provided that they have legal residence status. This excludes unregistered migrant poor.
- All residents of designated rural, remote and mountainous areas and ethnic minorities living in the communes of these designated areas, regardless of income level.

Membership is family based, except the under-six-years-old children who are exempted.

**Policy implications**

HCFP has the following policy implications:

- Increasing government’s funding for health care;
- Decentralization of health insurance administration;
- Fragmentation of risk pools, and
- Changing the flow of funds from provincial special allocations such as Hunger Eradication and Poverty Reduction Programme funding to Central Government’s consolidated budget.

Previously, a free health insurance card for the poor scheme was administered through VSS, with provincial governments purchasing cards on behalf of the poor, at 30,000 dong per card (Circular 05/1999) from the VHI. The present amount of 70,000 to a large extent dealt with the problem of inadequate funds to cover the health care costs of the poor. There was no formal arrangement for central budget to provide funding for provinces and hence, poor provinces relied on special budgets that were allocated broadly under the Hunger Eradication and Poverty Reduction Program of MoLISA. The few provinces that are self-sufficient in terms of local tax and other revenue sources could make the necessary allocations while the remaining provinces suffered from budget constraints. Due to lack of funding, the target of four million cards was not achieved and total distribution was reported to be around 1.6 million by 2002. By the end of 2003, VSS reported approximately four million cards purchased by 31 Provincial HCFP Boards, and accounting for 28% of total
The directing of government subsidies from the Central Government has established greater equity in funding. The likely impact of this policy change is expected to increase public funding for health care (including tax-funded and VSS-administered social insurance/prepayment schemes) by 12%.

**Risk pool**: The HCFP mechanism has created two separate health insurance risk pools for administration by VSS and Provincial Boards as per capita financing is 70000 dong whereby the insurance card cost is 50000 dong (See Table 37). Regardless of which agency administers the benefits, the fund is further fragmented at provincial level. Each provincial pool is separate: the deficit in the pool of one provincial HCFP fund is not subsidized by the surplus of another. If a Provincial HCFP board decides not to purchase health insurance cards from VSS, the HCFP pool operates as a single risk pool for that province alone.

The VSS health insurance risk pool is made up of compulsory and voluntary schemes, as two component funds are risk-pooled nationally. Revenue from HCFP premiums is not pooled nationally and is separately accounted for by the VSS.

**Table 37. Main Features of HCFP and Pooling Arrangements**

<table>
<thead>
<tr>
<th>Health care fund for the poor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Features</strong></td>
</tr>
<tr>
<td>Target Population: million persons</td>
</tr>
<tr>
<td>Per capita Allocation dong</td>
</tr>
<tr>
<td>Central Government Contribution Billion dong</td>
</tr>
<tr>
<td>in USD millions</td>
</tr>
<tr>
<td>Local Government and Donor/Other Contributions Billion Dong</td>
</tr>
<tr>
<td>in USD millions</td>
</tr>
<tr>
<td>Total estimated expenditure per year Billion dong</td>
</tr>
<tr>
<td>in USD millions</td>
</tr>
<tr>
<td><strong>Pooling Arrangements</strong></td>
</tr>
<tr>
<td>Insurance card price dong</td>
</tr>
<tr>
<td>Health Insurance Pool-VSS (maximum) Billion dong</td>
</tr>
<tr>
<td>in USD millions</td>
</tr>
</tbody>
</table>
### Selected Case Studies from Asia and the Pacific

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<table>
<thead>
<tr>
<th>Provincial Pool (Government Guaranteed minimum) Billion dong</th>
<th>36.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>in USD millions</td>
<td>$ 2.37</td>
</tr>
<tr>
<td>Provincial Pool (Minimum if all local/donor contribution is collected) Billion dong</td>
<td>292</td>
</tr>
<tr>
<td>in USD millions</td>
<td>$ 18.96</td>
</tr>
</tbody>
</table>

**Note:** Calculations are based on full coverage of 14.6 million target population. The sharing of the funding pool depends on provincial level arrangements. Cards could either be purchased from Viet Nam Social Security or members receive direct reimbursement for their Health expenses. Alternatively care providers can get reimbursed from the Provincial Management Boards of HCFP.

It should be noted that, provincial-level fragmentation currently serves its purpose based on the current situation in Viet Nam whereby administrative capacity is a major constraint.

**Provider payments:** Providers can receive funding from VSS or from the Provincial HCFP Boards. The VSS channel operates if the Provincial HCFP Board purchases health insurance cards from VSS. Payments to these providers are based on VSS’s current policies and practices applied to compulsory and voluntary scheme members.

If the Provincial HCFP Board chooses the direct reimbursement method to the providers, the Board needs to make quarterly advances to providers according to the rules stipulated by Circular 14 on HCFP implementation guidelines. Accordingly, a capitation-based payment of 10,000 dong per member needs to be allocated for commune-level health services. This amount would normally be forwarded to the District Health Centre (DHC), which supervises the activities of Commune Health Stations (CHS) in their locality. In return, the DHC needs to purchase drugs and supplies and distribute them to CHS in their area.

For district and provincial-level hospital in-patient and out-patient services, the Provincial HCFP Boards need to make a budgetary estimate for services to be rendered to the poor and forward 70% of this amount to each of the district and provincial hospitals every quarter. The advance would then be reconciled against actual expenses whereby the shortfall would be covered by the fund and the surplus adjusted (netted-off) in the following quarter’s advance.

Central-level hospitals would not be paid in advance as some of them are located outside provincial borders and they also receive tertiary referrals (cross-border patients). These facilities are required to provide services free of charge to eligible members, which then would be submitted to each of the Provincial HCFP Boards where these members reside for reimbursement.
Providers may also receive funding for patients who have been issued with exemption letters by the local authorities for persons who have not been pre-qualified as eligible beneficiaries. In these cases, the provider needs to submit total expenses based on the hospital fee schedule for approval by the Provincial HCFP Board. As a board member provincial VSS offices may qualify whether the expenses are benefit-payable as defined in the benefit package. Payment to the provider would be subject to approval and availability of funds.

Regulations require all health care benefits covered by the HCFP to be in line with the VSS benefit package (See Table 33). However, items such as disposable medical supplies and high-technology diagnostic and curative services are subject to different co-payment regulations, which eligible HCFP members may have to incur despite regulatory requirement that no fees would be collected from these members. If discretionary fee collection policies are applied to eligible members, these persons may still contact Provincial HCFP Boards and seek reimbursement.

6. Social Security Programmes

From a regulatory point of view, social insurance is a legal benefit to protect employees. It uses contributions of employers, employees and financial support of the government in order to provide material benefits to the insured persons and their families in case of reduction or loss of income caused by sickness, employment injury, occupational disease, maternity, unemployment, as well as retirement (old age pension) and survivor benefits.

Before 2003, all these five social insurance contingencies were administered by VSI (Viet Nam Social Insurance Agency) and health insurance was administered by VHI (Viet Nam Health Insurance Agency), which used to be under the administration of MoH. Since January 2003, the two agencies have been merged and health insurance has been added as the sixth contingent for social insurance programme of the country. The newly merged organization now called VSS (Viet Nam Social Security Agency) is directly under the Prime Minister.

There are two forms of social insurance schemes: compulsory and voluntary operating in Viet Nam. The coverage of the compulsory insurance includes all workers who have been working for three or more months at the publicly or privately-owned enterprises, which employ ten or more workers and at public service organizations and agencies stipulated by state for performing administrative functions.
**Table 38. Payroll contributions for Social Insurance**

<table>
<thead>
<tr>
<th>Percentage of Salary and Allowances</th>
<th>Employer</th>
<th>Employee</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Diseases and Labour</td>
<td>15%</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Accidents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Old Age and Survivor Benefits and</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Death Allowance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Insurance</td>
<td>2%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>17%</td>
<td>6%</td>
<td>23%</td>
</tr>
</tbody>
</table>

The voluntary system applies to workers who are normally engaged in tasks which have a duration of less than three months, in seasonal or occasional jobs in the informal sector, in enterprises that employ less than ten workers, self-employed, small business and handicraft workers. Because of administrative complications, only health insurance contingency of the social security programme is operating on a voluntary basis at the moment. As noted before, this scheme is predominantly made up of students who do not need the other social insurance contingencies.

The contribution rate of social insurance premiums is 23% of the total salary fund where the employer pays 17% and the employee pays 6% of his/her salary to the compulsory social and health insurance schemes (See Table 38). The five social insurance contingencies collect 20% of payroll of which 15% is paid by the employer and 5% by the employee. The health insurance contingency is 3% and shared as 2% employer and 1% employee. Employees only contribute for pension and death allowance (5%) and health (1%).

**Sickness benefits**: Sickness benefit is a cash-benefit paid when an employee is suffering from an illness or disease, which prevents him/her from continuing to work. The number of days a sickness benefit is payable are proportional to the number of years of contributions. For a contributory period of 15 years or under, the sickness benefit is 30 days in a year, from 15 to 30 years of contributory period, the benefit is 40 days and for 30 years or more, it is 50 days in a year. These benefit-paid days are 10 days higher for each contributory period for those working in heavy or hazardous occupations or jobs.
The amount of sickness benefit is 75% of the salary, which is used as the basis to set the payment of social insurance premiums. An employee who suffers from a disease, which requires long treatment under funded programmes of the MoH (such as tuberculosis, mental illness, epilepsy, cancer, leprosy etc) is entitled to a cash sickness benefit for a maximum of 180 days in a year, irrespective of the time for which he/she has paid social insurance premiums. A person is also entitled to sickness benefit if he or she has to take leave from work to look after a sick child.

**Maternity benefits:** Maternity benefit is designed to ensure that working women can support themselves and their baby before and after birth, and to protect the health of the mother and the child. The maternity benefit is a cash benefit including days of absence both before and after the delivery of the child and is set at 100% of the monthly salary.

**Employment injury and occupational disease benefits:** Employment injury and occupational disease benefits are paid to workers suffering an employment injury or occupational disease and are designed to compensate the worker for loss of earnings and working capacity. The employer is liable to pay all medical expenses as the health insurance benefit package excludes occupational diseases as well as paying the salary for the victim during the period of his/her hospitalization and treatment.

The employment injury benefit paid by social insurance depends on the degree of working disability and contains two components, a one-time benefit for injuries that caused working disability of 5% to 30% and a one-time benefit plus a monthly allowance for working disability of 31% or higher. The allowance is calculated as a percentage of minimum salary (40% to 1.6 times) and is proportional to the degree of disability.

**Survivors' benefit:** The survivors' benefit or death allowance is designed to provide support to the dependents of the worker. The funeral benefit is designed to cover reasonable burial expenses for the insured person and is equivalent to eight times the minimum wage. The amount of monthly survivors' benefit for each relative (up to four beneficiaries) is equal to 40% of the monthly minimum wage. The benefit is raised to 70% of minimum wage for survivors who have no other income or direct support from another relative. If the survivors have stable income and are not young age dependents in school, then they are entitled to a lump sum death allowance instead of a monthly survivors' benefit. The lump sum amount is based on number of years of contributions and capped at 12 times the average monthly wage of contributor.

**Old-age pension benefits:** Old-age pension is designed to assist workers to maintain a reasonable standard of living when they are no longer able to work due to old age. The retirement age is 60 for men and 55 for women and having paid
social insurance contributions for 20 years or more. There are many special rules for individual circumstances such as disability or working in hazardous conditions when these broad measures are applied.

The amount of monthly pension is based on the age of the employee, the number of years covered by social insurance premiums and the average of the monthly salaries, which have been used as the basis for computing the level of his/her social insurance premiums. The lowest pension is at least equal to the minimum wage and the maximum is equal to 75% of the average of the monthly salaries (i.e. these are lower and upper replacement rates). The pensioners are also entitled to health insurance benefits paid by the social insurance fund.

**Operational linkages (Affiliation of social insurance with health insurance and risk pooling):** The main advantage of social insurance administration is the unified management of all social insurance schemes under the VSS umbrella. This allows better compliance monitoring as well as better social insurance fund management. Each social insurance contingency is risk-pooled separately but the investment decisions for the protection of social insurance fund are done in a unified fashion. The merger has also eliminated inter-agency transfers between VHI and VSI and simplified administration. At the moment there are intra-fund transfers between social insurance and health insurance for beneficiaries whose health insurance contributions are funded out of social insurance fund such as pensioners and workers who are temporarily away from work for sickness, employment injury or maternity.

The merger has also strengthened pooling of 64 provincial-level social insurance funds under a single centrally monitored fund. There has been no instance for a need to cross-subsidize between social insurance contingencies so far. Within compulsory and voluntary health insurance schemes however, the latter scheme often experienced a deficit among non-school health insurance members, undermining not only the viability of the fund but the continuity of the scheme's offering to the general public. Cross subsidization between compulsory health and voluntary health insurance is allowed as all pilot voluntary health insurance schemes have been unified under a regulatory framework applicable across the country.

VSS also administers health insurance benefits for the poor whose cards are purchased by provincial HCFP Boards. The premium income from cards, (purchased at 50000 dong per member), is pooled separately by the VSS as the regulation issued by the Prime Minister (Decision 139) does not allow reserve carry-overs for this scheme. Therefore, the surplus funds from health expenses of HCFP members need to be remitted back to the provincial boards by the VSS and if expenditure exceeds premium income, each provincial deficit has to be funded by
the provincial HCFP Boards. The compulsory and voluntary health insurance premiums therefore do not cross-subsidize HCFP members.

7. **For-profit Commercial Health Insurance**

Private insurance is available from some commercial insurance companies. Individual accounts and premiums which are risk-rated, are calculated based on age, health status, type of job, number of years working at the organization and other individual characteristics. Each individual has also to pay an administrative fee to the commercial insurance company and there is no government protection for private insurance.

There is some evidence that around five million students are insured by Bao Viet, a government-owned, for-profit general insurance company under MoF. However little is known about the nature of benefits (health, life, general insurance or motor vehicle accident insurance etc). Also some foreign-owned general insurance companies and finance houses offer health insurance to high-income earning persons.

The national health accounts data of 2000 indicate that despite low population coverage, private health insurance has accounted for about 11% of total provider revenue, rivaling social health insurance, which accounts for 10% (see Figure 25).

*Figure 25. Public Provider Revenue by Source*

![Public Hospital and Clinic Revenue by Source-2000](source: WHO/MOH National Health Accounts Study-2003)
Table 39: Private Health Insurance Expenditure in Viet Nam

<table>
<thead>
<tr>
<th>Private Insurance-Funded Health Expenditure-2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Private Insurance-Funded Health Expenditure Million Dong</td>
</tr>
<tr>
<td>% of Provider Revenue from Private Insurance Agencies</td>
</tr>
<tr>
<td>% of Total Health Expenditure funded By Private Health Insurance</td>
</tr>
<tr>
<td>% of Recurrent* Health Expenditure from Private Insurance</td>
</tr>
</tbody>
</table>

* Excluding Capital/Infrastructure Spending

Private insurance includes treatment expenses of persons involved in motor vehicle accidents, which is excluded from the benefit package of all VSS-administered schemes. Private health insurance accounts for about 3% of total and 3.4% of recurrent health spending (See Table 39).

8. Critical analysis of Health Care Financing in Viet Nam

Insurance coverage

In order to understand the role of social insurance in health financing in Viet Nam, we first take a close look at the big picture: the segments of the population, which have financial access to health services under various health insurance schemes or exemption mechanisms and those that do not. As at the end of 2003, there were estimated to be about 26.2 million people out of 81.2 million having some formal type of social health insurance (see Figure 26) representing 32% of the population. This leaves 55 million uninsured persons with limited (via user-fee exemption mechanisms) or no financial access to health services.

The broad population structure is made up of 27.3 million young age and 6.3 million old age and disabled dependents looked after by a workforce of 47.5 million people. Among the young age dependents some 9.3 million under the age of six have been exempted from paying hospital fees or user charges at publicly-owned health facilities. Due to failure of exemption mechanisms in general, this group (12% of the total population) is currently at the centre of policy debate. The remaining 18 million young age dependents are students of which 4.4 million (25% of target) are insured by the voluntary scheme administered by VSS. The coverage rate of students is higher in urban areas than rural.

Out of 6.3 million old age and disabled dependents, 2.7 million are insured under compulsory health insurance scheme administered by VSS made up of 1.6 million pensioners and 1.1 million under meritorious category. This represents altogether some 44% of this population segment.

Out of the total 47.5 million workforce only about 39.2 million are estimated to be economically active or employed. Some 8.2 million people, including adolescents who are not attending school, are economically inactive, unemployed or underemployed.
Figure 26. **Insured and Uninsured Population Segments**

- **Target HCFP Insured**: 14.6 mil. (18% of Total Pop, 38% of Narrow)

- **Total Population-2003**: 81.2 mil.

- **Young Age Dependents**: 27.3 mil.
- **Under 6 year olds**: 9.3 mil.
- **Students**: 18 mil.

- **Workforce**: 47.5 mil.
  - **Economically Active Employed**: 39.2 mil.
  - **Inactive/Unemployed or Underemployed**: 8.2 mil.

- **Old age/Disabled Dependents**: 6.3 mil.

- **Compulsory Insured**
  - **Public Sector**: 3.58 mil. (90%)
  - **Private Sector**: 0.78 mil. (9%)
  - **Total**: 4.3 mil. (36%)

- **Formal Sector**: 12.3 mil.
- **Informal Sector**: 27 mil.

- **Voluntary Insured**: 4.4 mil. (25%)
- **Voluntary Insured**: 88 thous. (0.3%)

- **Pre-Qualified Uninsured for HCFP Cover**
  - **Broad Definition**: 69.6 mil.
  - **Narrow Definition**: 36.7 mil.

- **VSS Administered**
  - **Card Purchase Method**: 4 mil.

- **HCFP Board Administered**
  - **Direct Reimbursement Method**: 10.6 mil.
Among the 39.2 million active employed persons, some 12.3 million people belong to the formal sector out of which 3.58 million in the public and 780 thousand in the private sectors have compulsory health insurance. These two contributory classes represent the highest percentage among compulsorily insured. The coverage rates in the public and private sectors are 90% (considerably high) and 9% (very low) respectively. The overall insurance coverage among formal sector employed is 36%.

The informal sector, comprising 27 million employed in the household-run economic activities predominantly in the agricultural/farming sectors, represents the largest segment of the population that is uninsured. As at 2003, only 88 thousand non-students were estimated as insured by voluntary insurance schemes administered by the VSS. This however is a result of a major fall in membership from as high as 676 thousand people in 1995 during the height of voluntary insurance expansion initiatives. Policy makers have tackled this issue and a new voluntary health insurance regulation was passed in the second half of 2003 in order to win back the numbers that were lost over the years. The means of implementing this regulation and its perceived success rate in coverage and benefits occupies significant debate time in national forums.

The Health Care Fund for the Poor (HCFP) was introduced in late 2002 to provide health insurance to the poor and vulnerable. Before this fund was established, some 1.6 million poor were issued free health insurance cards funded by the government and administered by the VSS. The target number of people for the HCFP scheme was established as 14.6 million for 2003.

The combined compulsory and voluntary insurance scheme coverage was 11.6 million by the end of 2003 leaving 69.6 million people broadly defined as uninsured. When the exempted categories (children under 6), formal-sector employed who would normally be covered under the compulsory scheme or else have sufficient income, and the uninsured students who would normally be insured under the voluntary scheme are excluded, a narrow target of 38.7 million can be established for eligible people who can benefit from the HCFP. As at the end of 2003, four million persons had received health insurance cards from the VSS, which was purchased out of HCFP. The remaining 10.6 million people, generally speaking, were eligible for direct reimbursement from the management boards that administer this fund. Reportedly some 3.6 million insurance claims were lodged for the scheme administrators’ consideration and reimbursement during 2003. This preliminary figure indicates that if all of the target population had in fact been insured, some 34% of the insurance method recipients would have benefited from this fund while the remainder may not have required health care services during 2003.

**Health-seeking behaviour of insured persons**

Service utilization rates of compulsorily insured persons are considerably higher compared to other social insurance scheme members (See Figures 26 and 27). Hospital admission rates of this group have levelled around 17% for more than half
a decade. This figure is comparable to health-seeking behaviour of the highest income quintile in Viet Nam (and many of the developed world) regardless of their insurance status.

Figure 26. Hospitalization Ratios of Insured Persons

Figure 27. Medical Rate of Use of Insured Persons
The low rate of use among poor scheme members directly replicates health-seeking behaviour of the lowest two income-quintiles in Viet Nam regardless of insurance status. A number of factors are at play: indirect costs (transport, meals, cost of accompanying relatives) and opportunity costs (loss of time away from work or income generation activity) have been major deterrents for poor people’s health-seeking behaviour. Secondly, the incapacity to make under-the-table payments or high official fees for services, part covered or excluded by the health insurance benefit package, have reportedly resulted with negative attitudes among health care workers for delivering care to the poor. Members are often not well-informed about the benefits they are eligible for or too old to travel to the providers which are better equipped or funded. The administrative procedures for insured members while seeking care are often cumbersome. This rather bleak picture may change after the introduction of the HCFP, which is not reflected in these trend patterns.

**Health spending**

Share of public funding (tax and social insurance and excluding external sources) for health care has declined from 30% to 25% between 1998-2000 (See Table 40) while both total and per capita spending in international dollars have risen for both public and private.

**Table 40. Public and Private Health Expenditure in Viet Nam**

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health Expenditure-Mill. VND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Funded</td>
<td>5344675</td>
<td>5741581</td>
<td>5921603</td>
</tr>
<tr>
<td>Private Funded</td>
<td>12504563</td>
<td>13768448</td>
<td>17367751</td>
</tr>
<tr>
<td>Total</td>
<td>17849238</td>
<td>19510029</td>
<td>23289353</td>
</tr>
<tr>
<td>In USD-Billions</td>
<td>1.28</td>
<td>1.39</td>
<td>1.63</td>
</tr>
<tr>
<td>Per capita Health Expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in VND</td>
<td>236551</td>
<td>254711</td>
<td>299984</td>
</tr>
<tr>
<td>in USD</td>
<td>16.92</td>
<td>18.19</td>
<td>21.01</td>
</tr>
<tr>
<td>of which -Public</td>
<td>5.07</td>
<td>5.35</td>
<td>5.34</td>
</tr>
<tr>
<td>-Private</td>
<td>11.85</td>
<td>12.84</td>
<td>15.67</td>
</tr>
<tr>
<td>Share in %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Funded</td>
<td>30%</td>
<td>29%</td>
<td>25%</td>
</tr>
<tr>
<td>Private Funded</td>
<td>70%</td>
<td>71%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Source: WHO/MOH National Health Accounts Study-2003
The national income spent on health rose above 5% in 2000 (See Figure 28) and is estimated to have levelled between 5-6% of GDP during 2001-2004 after factoring in the impact of unofficial payments, which are excluded from 1998-2000 national health accounts study. While this level is moderately high within the Region, the total spending of $1.6 billion or per capita of $21 in international dollars is quite low due to the low-income base of the country.

More than 80% of total private funding for health care is sourced from household out-of-pocket payments (See Table 41). This trend has been consistent throughout years where households account around or more than 60% of total health spending in Viet Nam.

**Table 41. Household and Social Insurance-Funded Health Expenditure**

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Household-Funded</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total-Mill. VND</td>
<td>10778739</td>
<td>11350576</td>
<td>14611106</td>
</tr>
<tr>
<td>% of Total Private</td>
<td>86%</td>
<td>82%</td>
<td>84%</td>
</tr>
<tr>
<td>% of Total Health Exp’re</td>
<td>60%</td>
<td>58%</td>
<td>63%</td>
</tr>
<tr>
<td><strong>Social Health Insurance Funded</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total-Mill. VND</td>
<td>672319</td>
<td>603532</td>
<td>722138</td>
</tr>
<tr>
<td>% of Total Public</td>
<td>12.58%</td>
<td>10.51%</td>
<td>12.19%</td>
</tr>
<tr>
<td>% of Total Health Exp’re</td>
<td>3.77%</td>
<td>3.09%</td>
<td>3.10%</td>
</tr>
</tbody>
</table>

Source: WHO/MoH National Health Accounts Study-2003
Government budgets allocated for health mainly through supply-side subsidies account for 22% of total health spending. (See Figure 29). Other private sources including external aid at 9% of total health spending is more than total social and private insurance funding for health care combined (See Table 42).

Figure 29. Components of Total Health Expenditure

Table 42. Total Health Expenditure in 1998-2000 and % share by primary sources

<table>
<thead>
<tr>
<th>Total health Expenditure Mill. VND</th>
<th>1998</th>
<th>%</th>
<th>1999</th>
<th>%</th>
<th>2000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Budget</td>
<td>4,672,356</td>
<td>26.18%</td>
<td>5,138,049</td>
<td>26.34%</td>
<td>5,199,465</td>
<td>22.33%</td>
</tr>
<tr>
<td>Social Insurance</td>
<td>672,319</td>
<td>3.77%</td>
<td>603,532</td>
<td>3.09%</td>
<td>722,138</td>
<td>3.10%</td>
</tr>
<tr>
<td>Private-Households</td>
<td>10,778,739</td>
<td>60.39%</td>
<td>11,350,576</td>
<td>58.18%</td>
<td>14,611,106</td>
<td>62.74%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>413,963</td>
<td>2.32%</td>
<td>484,645</td>
<td>2.48%</td>
<td>695,872</td>
<td>2.99%</td>
</tr>
<tr>
<td>Other Private, External Aid</td>
<td>1,311,861</td>
<td>7.35%</td>
<td>1,933,227</td>
<td>9.91%</td>
<td>2,060,773</td>
<td>8.85%</td>
</tr>
<tr>
<td>Total</td>
<td>17,849,238</td>
<td>100.00%</td>
<td>19,510,029</td>
<td>100.00%</td>
<td>23,289,353</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Source: WHO/MoH National Health Accounts Study-2003
Role of social insurance in total health spending

The social insurance funded health expenditure measured before the introduction of HCFP in 2002 accounted for about 12% of total public funded and 3% of total health spending in the country (See Tables 41 and 42 respectively). Despite 16% population coverage throughout this period, the role of social health insurance in total health spending is still fairly small. The government as an employer of civil servants and SOE employees and payer of social insurance contributions of most pensioners and meritorious persons (via transfer payments), indirectly contributes for the bulk of social health insurance funding.

The VSS-administered social health insurance revenue and expenditure in nominal terms have constantly risen during the past decade (See Figure 30), as more members are covered and formal sector salaries grew both in real and nominal terms. The national minimum wage rise from 210000 VND per month to 290000 VND has resulted from a considerable increase in compulsory scheme revenue especially after the second half of 2002.

Figure 30. Social Health Insurance Revenue, Expenditure and Reserves
The average contribution per member in international dollars has also increased over the years (see Figure 31). The compulsory scheme contributions per person have levelled above $10.50 and are seven times higher compared to voluntary or poor scheme contributions. The average contribution per member has levelled around $6 during the past few years.

Figure 32. Health insurance reserves and servicing ratios
During the past decade, national health insurance expenditure has consistently been lesser than annual premium income with a high of 89% in 1997 and averaging 75-80% during the past few years (see Figure 32). This has made room for a sizeable reserve build-up equivalent to 21 months of average insurance benefit outlays as at the end of 2002.

During the 1996-1998 period, 20 mainly urban and large-provinces overspent their health insurance revenue. The revised health insurance decree (58/1998) has introduced firm measures to ration expenditure. Co-payments, national reserve pooling and capped-fee for service payment method, were introduced and more stringent inspections on providers began to be conducted. While these targeted measures were successful in rationing insurance expenditure and building up reserves, these policy changes have resulted with general dissatisfaction among both health care providers and members.

Current policy measures are aiming to increase benefit payouts while increasing population coverage. While the poor scheme is no longer risk-pooled together with compulsory and voluntary scheme, the central government funding has brought significant equity although it is yet early to make firm conclusions on the actual impact of HCFP on service access.

The current low level of voluntary premiums and separate risk-pooling before the merger of health and other social insurance schemes have resulted in lesser population coverage among non-students. The new voluntary scheme with higher level of contributions and risk pooling with compulsory scheme together with the fact that the target is exclusive of the lowest income quintile (after the introduction of HCFP), may render more equitable contributions and service access among members.

9. Conclusions
Viet Nam is continually putting more equitable and pro-poor health financing policies in place. The achievements to date can be summarized as follows:

- The exemptions policy is gradually being replaced with premium-backed social health insurance.
- The introduction of HCFP has created a safety net for the lowest income quintile. This initiative is expected to increase total health insurance coverage to more than 30% of the population by 2004-2005.
- There are positive indications that the government’s funding for health care through increased demand-side subsidies such as HCFP initiative
will account for a higher percentage of total health expenditure coming from public sources instead of private out-of-pocket payments.

- Voluntary insurance schemes are unified and gradually being introduced to the largest segment of the uninsured population (rural/informal sector).
- Policy considerations are being debated for including dependents starting with the young-aged.
- The benefit packages of different institutional insurance schemes have been harmonized, and the breadth of health insurance benefits has improved.

While sufficient attempts have been made to increase population coverage, the amount of complexity in the administration of health insurance is largely ignored. It is also likely that greater equity in access to and the provision of benefits would be gained by simplification. Insured members need to value the benefits they get from health insurance. “Quality of health care” is one dimension and “quality of health insurance services” is another. “Quality of care” may improve once targeted government funding reaches the providers and VSS becomes a dominant source of finance for providers. Providers however need to be adequately rewarded in a timely manner.

The current policy climate in Viet Nam is to continue running three institutional insurance mechanisms for those covered by the compulsory, voluntary and scheme for the poor. The government may scale down membership of the poor scheme (reduce HCFP target population from 14.6 million) as poverty is gradually reduced in the country. Currently, there is currently limited policy support to make health insurance compulsory for all people. Although 2010 may be a difficult target to reach universal coverage as originally planned by the ninth Communist Party Congress, significant steps are continually being made which warrant acknowledgement.
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Roy Harvey has had long experience in health research, policy and management; first as statistician and actuary for the national health insurance programme and later as a project leader and consultant on World Bank and AusAID health finance reform projects in East European countries, such as Romania, Bulgaria, Slovenia and in South-East Asia countries such as Indonesia, Malaysia, the Philippines, and in China and Papua New Guinea. He has developed and conducted Health Sector Reform training programmes for World Bank staff. He is working at the Centre for Health Service Development at the University of Wollongong, on research and consultancies on health financing and health service delivery issues.

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