SOCIAL HEALTH INSURANCE

A Guidebook for Planning

Charles Normand and Axel Weber
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— Charles Normand

— Axel Weber
SECTION I

HOW TO USE THE GUIDEBOOK
Introduction

This guidebook is designed to be used by countries that are considering the introduction of social health insurance financing for health care, as a replacement for or to supplement existing funding. The first social health insurance system was established in Germany over 100 years ago. Since then, other approaches to financing universal health care have developed, such as tax-financed national health care systems. Over time, systems have changed and developed in their attempts to: a) improve the health status of the population (by guaranteeing access to health care); b) provide high-quality and appropriate care; and c) maintain the sustainability and affordability of care through cost containment.

A close look at the range of different systems of health service financing reveals that there are advantages and disadvantages with all financing methods. Nevertheless, depending on a country’s specific circumstances, some methods may be more appropriate than others.

The focus of this guidebook is on one particular health financing approach — social health insurance. It aims to lead policy makers and programme planners through the process of evaluating the usefulness and feasibility of social health insurance, in the context of existing political, sociocultural and economic circumstances. It also provides detailed planning advice for the design of a social health insurance system, and it offers insight into the process of improving the chances for a successful implementation. As a planning tool, this guidebook will be useful in all countries where alternative health care financing mechanisms are contemplated.

This guide cannot and does not aim to discuss the determination of specific health policy goals or the problems of measuring health status and the impact and efficiency of health interventions. Although this guide stresses the importance of clearly defined national health policy goals, it clearly limits itself to the analysis of the advantages and disadvantages of one particular financing and organizational option for the delivery of health care.

Preparing and planning for social health insurance

Social health insurance can only be successfully introduced if the conditions are suitable. It must make a contribution to the achievement of health policy goals, notably the improvement of health status, and it must serve to improve both funding for health services and access to care for the population. Social health insurance must clearly be viewed as a policy tool, rather than an end in itself. This means that the goals of health policy must be clear, so that the new funding arrangements can be seen to help to meet them. The first chapter in section II of this guidebook therefore covers the process of identifying health policy objectives, and the constraints on achieving those objectives.

If social health insurance is introduced into a country without careful consideration of the objectives and without proper preparation, it will fail. Efforts and resources will be wasted, and it may be more difficult or even impossible to introduce the system successfully at a later stage. The rest of section II focuses on determining if social health insurance is desirable, in the context of health policy objectives, and feasible, in the context of existing constraints. The
section also provides guidance for countries that need to lay the groundwork for the eventual introduction of social health insurance. Section II is thus concerned with the "decision phase": whether or not to proceed with the development of a social health insurance plan.

Figure 1 depicts the sequence of steps outlined in section II. The figure is not intended to represent the only possible sequence of thought and preparation, nor does it provide an exhaustive list of issues that must be considered. Rather, the figure is intended to highlight the importance of ensuring that relevant issues have been considered before resources are devoted to design and further planning. A country should only move on to the actual design of a social health insurance system if it can successfully progress through the steps in the figure.

**FIGURE 1
DECISION PHASE**

**IDENTIFICATION OF HEALTH POLICY OBJECTIVES**

**IDENTIFICATION OF CONSTRAINTS**

**IS SOCIAL HEALTH INSURANCE DESIRABLE?**
- EQUITY CONSIDERATIONS
- IMPACT ON HEALTH SECTOR
- STAKEHOLDERS' INTERESTS
- HISTORY, CULTURE, SOCIETAL VALUES

**IS SOCIAL HEALTH INSURANCE FEASIBLE?**
- NATIONAL ADMINISTRATIVE CAPACITIES
- EARNINGS, TAXATION AND CONTRIBUTION BASE
- LABOUR MARKET STRUCTURE
- EXISTING HEALTH CARE INFRASTRUCTURE

**PROCEED WITH THE DESIGN AND PLANNING PHASE**

If a decision is taken to proceed with the introduction of social health insurance, the next step is the detailed design of the system. Section III provides an overview of some fundamental issues related to design. The section illustrates that a country's history, culture and existing political and economic systems must be considered in the design process. The overall theme of section III is that a social health insurance system should be designed to suit the particular needs and circumstances of an individual country, and not simply imported from abroad.

Section IV continues the design process, with an emphasis on the individual components of a social health insurance system. Decisions have to be made on the population to be covered, how access to services is to be organized, how services are to be provided, how providers are to be paid, how costs are to be controlled and how the system should be managed. These are important and time-consuming tasks, and require attention at an early stage.
Finally, section V looks at experiences with social health insurance in several countries. The country examples provide insight into how varying circumstances can lead to the development of alternative forms of social health insurance financing. Section V also emphasizes the importance of ensuring that social health insurance will be acceptable to those who will use it. Advice is provided on how to build consensus and support for the new system.

Sections III, IV and V are thus concerned with the "design and planning phase" of a social health insurance system. Figure 2 illustrates the steps involved in the design process, beginning with a clear specification of health policy objectives. It is critical that the process of design is compatible with a country's explicit health policy goals.

**FIGURE 2**

**DESIGN AND PLANNING PHASE**

- CLEAR SPECIFICATION OF HEALTH POLICY OBJECTIVES
  - PRELIMINARY DESIGN ISSUES
    - ESTABLISHING LIAISON
    - ENSURING FUNDING
    - CONSIDERATIONS OF EQUITY
    - CHOICE OF SYSTEM TYPE
  - DESIGN OF SYSTEM COMPONENTS
    - POPULATION COVERAGE
    - BENEFIT PACKAGE
    - ORGANIZATION OF HEALTH SERVICES
    - PROVIDER PAYMENT MECHANISM
    - COST ESTIMATION AND CONTROL
    - FINANCING
    - ADMINISTRATION AND MANAGEMENT
  - BUILDING CONSENSUS AND GAINING SUPPORT

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5
ANALYSING THE ECONOMIC AND POLICY ENVIRONMENT
Chapter 1

HEALTH POLICY CONSIDERATIONS

1.1 Health policy and market failure

Experience in all countries that have comprehensive health services shows that problems in the health sector cannot be addressed without some level of government involvement. Simple market solutions, as are common in other sectors of the economy, do not work well in the health sector owing to a number of types of market failure.

Market failure is the term used by economists to describe circumstances in which there are constraints on the smooth operation of the market. Constraints may take the form of regulations or rules — which can, in principle, be removed — or can flow from the nature of the goods or services provided. It is generally agreed that, in the event of market failure, government needs to develop structures and policies to counter its effects.

In the case of health services, the major sources of market failure are the monopoly power of providers, ignorance and uncertainty among consumers and an element of externality. In order to protect the public, and ensure a basic level of competence, health care professionals are licensed. There are constraints on entry into the professions, there is a structure of ethical principles within which professionals must operate, and there are rules governing access to care. This means that the health care professions exercise monopoly power. It is one of the tasks of health policy to ensure that this power does not work against the interests of the patient.

In addition to the power exercised by professionals, there are often other types of monopoly power in health care. Many services yield economies of scale, and there is often only one provider in a particular area who can provide care efficiently. This is called a “natural monopoly”.

However, a more important source of market failure is ignorance and uncertainty among consumers. For any one person, it is very uncertain whether or when there will be a need to use health services. This is combined with an asymmetry of knowledge about illness and health care between patients and health care professionals. Health care professionals act both as advisers, telling the patient what services are appropriate, and as providers of those services. This asymmetry of information further reinforces the monopoly power of professionals.

When uncertainty and ignorance about the need for health care is combined with the high cost of specific types of care, market failures often result. Market failures can be exacerbated when the needs for health care are greater in poorer sections of the community. Experience suggests that, under these conditions, the insurance market fails to work fully, and that some element of regulation will be needed.
Thus, government must have a health policy in order to counter market failure. Possible health policy goals are discussed below. Social health insurance and other health financing mechanisms should be judged in terms of their potential to contribute to the achievement of health policy goals.

1.2 Health policy problems and objectives

The ultimate goals of health policy in most countries are long life and good health for the population. The health policy objectives intended to achieve these goals are normally expressed in terms of measures to protect the population from avoidable disease and provide efficient health services for those who will benefit most from them. There are additional objectives regarding the quality of the service, such as choice, appropriate facilities and equipment and other factors that affect the quality of the experience of being a patient.

Many important influences on health are outside the control of health services, such as those relating to the environment, lifestyle and occupation, as well as socioeconomic and genetic influences. Health policy may therefore be properly seen as the policy of a government, rather than a single ministry.

Health policy goals, as defined in terms of life expectancy and health status, can be hard to monitor. The effects of interventions are often seen only after a long time, and it can be difficult to assign any given effect to a particular intervention. It is therefore normal to use additional criteria for judging the appropriateness of health policy and the extent to which policy goals have been met. These will include the proportion of the population which is covered for basic health services, the range and availability of services, indicators of service quality and indicators of the health of the population.

Although health policy goals have been described in terms of achieving the maximum impact on the health of the population, there are other characteristics which are valued by the population and which may, therefore, be adopted as objectives by politicians. Two such objectives are security and social protection. Even though it may be demonstrated that there is little chance of a person needing access to a particular service, there may still be a great desire in the population for it to be available. This is most likely to happen when the services in question help to save life. Some demand for services that have little impact on policy goals is induced by providers with an interest in particular types of treatment and care.

In most countries, people who can afford it are allowed to purchase privately whatever health services they wish, regardless of the priority that some of those services might otherwise attract. It is important to give thought to the way in which these services relate to the government's health policy. If a treatment would have been provided as a priority anyway, supplementary purchases will help to meet policy goals; they should therefore be encouraged and may be subsidized. But low-priority services, which do little or nothing to meet policy goals, should not receive government assistance or encouragement, any more than other goods and services do.
1.3 Constraints on meeting health policy goals

If government resources are scarce, it is very important to ensure that they are not devoted to subsidizing care that can be shown to have relatively little effect on the main goals of health policy. It should be remembered that government subsidies are often provided through other government departments, in the form of exemption from import duties, subsidies for the training of staff and economic development funding.

When considering the contribution of social health insurance, the question is whether it can provide additional, secure funding for the provision of services that help to meet health policy goals. In other words, health insurance that supplies only low-priority services should be treated like any other consumption, enjoying no particular support or encouragement from government. It is important to consider any mechanisms for the financing and provision of health services in terms of the extent to which they help to meet policy goals; there is therefore a need for a clear statement of policy at an early stage. The success of a health policy should be judged not only by the volume, but also by the mix and distribution of services.

The health policy adopted by a government depends on the economic, historical, cultural, institutional and political environment, the country's stage of development, and other government policy objectives. Familiarity with a set of institutions may be one reason to continue with them, even if they would never be introduced in that form if a new system were being set up.

1.4 Health policy and the level of health care spending

Social insurance can help to meet health policy goals if these require additional funding which is not, or not easily, available from other sources, or if it leads to better use of existing spending on health. Additional spending is only justified if it yields greater benefits than spending on other goods or services. Health insurance funding may help to ensure that the wishes of the population for higher spending on health services are met.

However, although there is considerable public pressure for higher spending on health services, it does not necessarily lead to great gains in terms of the main health policy goals of longer life and better health. Some demand is induced by suppliers of care and by those who have an interest in the sale of pharmaceuticals and medical technology, and there is often little evidence that these should be priorities. It is clear that many countries (including many industrialized countries) have overinvested in medical technology which does little to achieve health policy goals.

A comparison of different countries suggests that the priority given to health services rises as a country becomes richer. Poorer countries typically spend around 3-4% of national income on health services, whereas the usual figure for richer countries is 8-10%. There is no intrinsic reason why higher levels of spending should not occur in poorer countries, but other priorities are often seen as more pressing, such as development of the basic infrastructure, including housing, water supply and communications. It is well known that these developments in themselves have an important impact on health, and in many countries they will have much more impact on health policy goals than the
development of curative health services. A relatively lower priority for health services in poorer countries is therefore logical in terms of health policy. In a growing economy, the resources available for health services are likely to be increasing, and the priority of health services is also likely to increase.

In many countries with health services funded by and/or provided by the state, there is great inefficiency in the health sector. A social insurance mechanism may help in several ways. Firstly, the greater explicitness and visibility of spending on health services can lead to greater accountability in expenditure. Secondly, employers and employee representatives have incentives to monitor spending. Thirdly, the introduction of contracts for the supply of services, and the greater autonomy of service providers (if this has not already been achieved) can provide mechanisms for monitoring the efficiency and appropriateness of spending.

Social health insurance can be a useful mechanism for channelling resources into high-priority use and improving the efficiency of service provision. In assessing the appropriateness of social health insurance, several questions should be asked:

(1) Should spending on health services have a higher priority than at present? If so, can the country afford a higher level of expenditure on health services?

(2) Is the development of health services restricted by the lack of mechanisms to channel resources into health, rather than the affordability of health services?

(3) Is the growth of the economy sufficient to allow significant development of health services?

(4) Would a change to social health insurance, with its greater visibility of resources for health services, lead to more efficient use of the existing spending?

If the existing level of spending on health care is near the limit of what can be afforded in the current state of the economy, then social health insurance is unlikely to offer any useful benefits compared with existing arrangements. If the answer to the other questions is "no", then no further consideration of social health insurance is appropriate at this stage.

Social health insurance may have a useful role at a later stage in a country's development, even if it may be presently inappropriate. Some of the measures discussed in chapter 3 are relevant for countries that wish to prepare for the eventual adoption of a social health insurance scheme.
Chapter 2

THE DESIRABILITY AND FEASIBILITY OF SOCIAL HEALTH INSURANCE

2.1 Introduction

There are four main categories of funding for health services:

- government finance raised through taxes
- social insurance
- private actuarial insurance
- direct payment for services by patients.

With the exception of the last, these systems all provide an element of insurance (risk pooling or risk sharing). Services are provided free or below cost price on the basis of rights derived from past contributions. There is therefore an element of protection from the risk of ill-health.

As well as insurance, systems of health financing may provide an element of mutual support. Those at higher risk and those on lower incomes are supported in part by people with high incomes and low risk. Given the correlation in all countries between low income and high risk of ill-health, there is a case for providing this support.

This chapter defines a number of different systems for health service financing and provision. It then discusses the basic advantages and disadvantages of social health insurance.

2.2 Definitions

Government tax-funded systems pay for health services out of general government revenue. There may also be some special health taxes, e.g., on health-damaging goods or activities. Decisions about the overall funding of services are made as part of the overall planning of government expenditure.

Social insurance systems pay for health services through contributions to a health fund. The most common basis for contributions is the payroll, with contributions from both employer and employee. Contributions are based on ability to pay, and access to services depends on need. The health fund (or funds) is usually independent of government, but works within a tight framework of regulations. It is normal under social insurance for entitlements to services to be listed in detail, and for contribution rates to be set at a level intended to ensure that these entitlements can be met.

Private actuarial insurance is based on risk. People pay premiums based on the expected average cost of providing services for them. People who are in high-risk groups pay more, and those with low risks pay less. Services covered by
the insurance may vary between different companies and different insured persons. The basis is exactly the same as for insurance on a car or house.

Direct payment by patients involves neither insurance nor mutual support. Patients are charged according to a set tariff for the services they use.

2.3 Advantages and disadvantages of social health insurance

Social health insurance is thus one method of financing health services, as either the main or a supplementary funding mechanism. A more detailed discussion of its advantages and disadvantages is provided later in this chapter. However, it is worth considering more generally the circumstances in which this system can help a country to meet its health policy goals. The main reasons for choosing social insurance financing are the following:

- it can provide a stable source of revenue for services
- the flow of funds into the health sector is visible
- it can help to establish patients’ rights as customers of the health care providers
- it combines risk pooling with mutual support, by allocating services according to need and distributing financial burdens according to the ability to pay
- it can operate in pursuance of government health policy goals, but it can maintain a degree of independence from government
- it can be associated with efficient provision of health services.

The main disadvantages of social insurance financing are:

- high administrative costs
- problems of cost containment
- problems of ensuring coverage for workers in agriculture and the informal sector.

2.4 Health service provision

Chapter 2.2 described four systems for funding health services. There is also a choice of types of provider of health services, and a choice of relationship with the funding organizations. Providers can be owned by government, private non-profit-making or private profit-making organizations.

Funding organizations may be allowed to own providers of care, or may contract with independent providers for the supply of services. It is possible to mix private ownership of facilities with tax or social insurance funding, or to fund public service provision through private financing mechanisms. In other words, there is no need for funding and service provision to be owned by the same sector; it is feasible to have combined organizations for both funding and provision, or a separation of funders and providers. Most countries have a mixture of systems for financing health services, but there is normally one source of funds which plays the largest part in giving most people access to most of their care.
2.5 The role of government

Governments must be active in setting health policy goals, devising frameworks for the funding and provision of services, and ensuring that there are mechanisms to monitor the achievement of policy goals. This is because market failure creates a need for a clear set of policy goals and ways of achieving them. It is important to distinguish this from direct funding and provision of care by government, which is optional and normally depends on the availability of non-government mechanisms and institutions.

2.6 Who wants social health insurance?

Before embarking on a serious analysis of the desirability and feasibility of social health insurance, it is useful to consider the sources of pressure for its implementation. For example, in the countries of central and eastern Europe (and indeed many other parts of the world) the low level of resources for health care as compared with western Europe, the low salaries for health care professionals and the poor quality of many health care facilities combine to create a demand for higher levels of funding, especially among health care professionals. Much of the argument has been driven by the desire of health care staff to improve their incomes. There is a risk that any additional funding will provide higher incomes for staff without any significant increase in the volume or quality of care. Although it is desirable in the long run that there should be a well paid and highly motivated body of health care professionals, it is unlikely that this is the highest priority for additional funding.

2.7 History, culture, values and traditions

Social health insurance is always introduced against a background of existing attitudes and traditions in the provision of health services. For example, where health services have been provided free at the point of use (although paid for through taxation) there may be resistance to changing to a system where payment is more visible. In some countries, a system of unofficial payments to physicians has become established (indeed, they sometimes represent more than half a physician’s income) and insurance may only be acceptable if these payments can be eliminated. Insurance brings with it a different relationship between physician and patient (a customer/service-provider relationship), which may conflict with tradition.

Social health insurance is based on mutual support and involves a transfer of resources from relatively richer and healthier people to relatively poorer and sicker people. It works best when there is a consensus among the population that mutual support is a good thing. If there is no such consensus, it will be difficult to promote acceptance of the scheme.

The question that must be answered is:

- do historical or cultural conditions allow for the introduction of social health insurance at present?
Although these factors are unlikely to represent a long-term constraint on the introduction of social health insurance, it is advisable to consider them at an early stage.

2.8 Levels and sources of funding for health services

Resources for the provision of health care are limited by the level of the country's income. Further limitations may come from a failure to mobilize resources for health. Social health insurance may provide a mechanism for making resources available but it does not, in itself, make it possible for a country to afford health care. It is therefore important to consider the ability of the country to afford health services, and to assess the potential of social health insurance to mobilize extra resources.

A gap between the resources a country can afford to devote to health services and the funds which can be mobilized through tax and private insurance can be due to several factors. Political constraints on tax funding (sometimes imposed from outside) can limit the state budget for health. Market failure in the supply of private insurance leaves cover incomplete, especially among poorer people and those who need treatment and care for chronic conditions. However, for some groups in the population, social health insurance can mobilize resources: some people are willing and able to pay for additional protection, but have difficulty obtaining appropriate cover from private or government sources.

In countries where the funding of health services is constrained by the low income of the country and the relatively low national priority of health services, the introduction of social health insurance will be of no value in mobilizing resources.

2.9 Equity

Introducing social health insurance can improve access for some groups in the population and may widen coverage by bringing additional resources into the health sector. Funds released by moving part of the population from a government-funded to a social-insurance-funded system of care can allow other priority services to be developed. For example, freed up resources can be used to improve the provision of services to population subgroups not covered by social health insurance.

However, there are certain risks. Safeguards have to be built into the system to ensure that improving access for one part of the population does not at the same time worsen access for others. This situation could occur if government health care workers responsible for serving the uncovered part of the population are increasingly called upon to provide services for covered groups. As another example, if the insurance scheme is designed primarily to provide coverage for people with stable, formal-sector employment (and relatively high incomes), this could result in improved access for a group with relatively low morbidity and low health service needs; if resources are limited, coverage for populations with greater needs could be reduced.
2.10 Feasibility of social health insurance

Besides assessing the affordability of services and the potential role of insurance, it is important to look at the feasibility of social health insurance. Among other things, it is necessary to identify the administrative needs of an insurance system and decide whether they can be met. Insurance arrangements tend to be more complex (and often more expensive to administer) than tax funding, and certainly require considerable administrative skills.

The following subsections deal with two issues which may affect the feasibility of social health insurance.

2.10.1 Payroll deductions

Social health insurance is normally provided through a system of payroll contributions to a health fund. It is typical (although not essential) for the total contribution to be calculated as a percentage of income. This amount is normally split between employer and employee: for example, if the total social health insurance contribution for a worker is 12% of the wage, this may be made up by contributions of 8% from the employer and 4% from the employee.

The distinction between employee and employer contributions may not be important. For the employer, the decision to employ a worker depends on the overall cost of wages and other payroll costs. For the employee, the main areas of interest are take-home pay and other benefits. If contributions to the insurance fund are tax-free, there is little analytical difference between employer and employee contributions, although there may be important psychological differences. One reason for having employer contributions is that they encourage employers to seek cost containment, since the employer benefits from any savings in resources.

One important question is whether payroll contributions are the best source of funds for health care. In most countries, the payroll is already a major source of taxation—income tax, pension contributions, unemployment insurance and sometimes insurance against loss of earnings due to ill-health. If the deduction rate is already high (i.e., the proportion of total payroll costs taken out in compulsory deductions is high) then it is not advisable to use this source for additional deductions. The effect of further payroll charges is likely to be to discourage employers from retaining or taking on staff, with the consequence of higher unemployment. Before embarking on a further analysis of the potential role of social health insurance, it is worth asking two questions:

(1) What is the current level of deductions from the payroll, and is it advisable to impose further charges?

(2) What is the current level of unemployment, and is it advisable to risk introducing a measure that may increase it further?

If the answer to these questions is "no", then there is no point in considering social health insurance further at this stage, although it may become feasible if part of the burden of taxation and contributions can be moved to another base.
2.10.2 Labour market structure

There is a trend in most countries for the proportion of the population in formal employment to fall and for more people to be self-employed. The income of self-employed people is difficult to assess for at least three reasons:

- incomes tend to be variable, depending on the amount of work available or, in the case of agriculture, on crop yields, prices of produce, etc.
- personal and business income can be confused, so that it is genuinely difficult to know whether a cost is incurred by the business or the individual
- since it is difficult to assess the income of self-employed people, and because incomes tend to be taxed, there are strong incentives for people to understate their income.

Social insurance for health is funded by a percentage deduction from incomes (or salaries), and this depends on there being an agreed measure of income. Social health insurance therefore works best in the context of a relatively large formal sector, with a large proportion of the population working as employees, so that there is little scope for doubt about their incomes.

Although it is difficult to assess contributions for any self-employed person, there are particular problems with people working in agriculture. Farmers have the additional problem that incomes are very uneven over the year. A large proportion of their income may be realized in a few weeks (i.e., at harvest time) and so they will have real difficulty in paying regular weekly or monthly contributions.

Of course it is possible to operate social health insurance for self-employed people, and there are many examples of ingenious ways of assessing the level of contributions. If incomes are consistently understated, it is possible to charge a higher rate for self-employed people, or to insist on a higher level of co-payments.

The important consideration is that it is more difficult and more expensive to operate under these conditions. If the informal sector is large, there is likely to be little scope for introducing social health insurance.

Analysis of the structure of the labour market leads to an important question:

- is the formal sector large relative to the informal sector, and will it be possible and cheap to collect health fund contributions?

If the answer to this question is "no", then it is unlikely that a system of social health insurance covering the whole population is feasible at this stage as the main source of revenue for health services. However, it may have a part to play for some groups in the population, as a first step towards a more comprehensive system.
2.11 Social health insurance and national infrastructure

The aim of health policy should be to improve the health of the population by means of preventive and curative interventions. Funding should be used primarily for providing services and not for financing the administration of the system. It is also important to ensure that the new organizations will be able to operate effectively. This means that there must be some basic infrastructure, such as a body of educated personnel who can be trained to manage the health funds, a system of laws within which the insurance laws can operate, systems for assessing incomes for the purposes of payroll deductions, and procedures for collecting other payroll contributions.

Social health insurance requires some additional administrative arrangements for collecting contributions and providing access to care, and it can only be effectively developed if these arrangements can be put in place. The overall level of education within the country can be important in this respect. Adequate standards of literacy and numeracy in the general population may be important to the extent that self-assessment is an element in the determination of insurance contributions. Thus education in general, as well as the educational level of the administrative staff, can be significant.

Some countries have an established system for collecting income tax through payroll deductions. Under these conditions, it may be possible to introduce social health insurance contributions using the same basic procedures, but paying the money into different funds. This can simplify the operation of social health insurance and reduce costs.

The above comments are meant to be examples only. However, it is important to assess the overall availability of the infrastructure needed to support social health insurance. Specifically, it is worth asking three questions:

1. Is there a core of well educated administrators who could be trained to operate a social health insurance system?

2. Is there a framework of law and enforcement procedures to support a social health insurance law?

3. Do existing administrative structures and procedures offer mechanisms for collecting contributions?

If the answer to the above questions is “no”, social health insurance is unlikely to be feasible at this stage.
2.12 Social health insurance and health care infrastructure

Health insurance gives the insured population an entitlement to health services. It is therefore important to ensure that the health infrastructure exists to provide those services and that there is some incentive to comply with the insurance. It is important that an individual should have better access to care if he/she pays the contributions due and obtains insurance. This is true even if the insurance is compulsory, since it helps to ensure that contributions are paid.

In principle, insurance does not require a system of hospital-based secondary and tertiary health services, although such provision is typically popular with the population, and thus with the insured population. The important thing is to ensure that the health services to which insured people are entitled can be delivered.

When social health insurance is introduced, it is often difficult to offer advantages to members in the form of better access to care. Most countries have a system of access to some emergency care, regardless of ability to pay or insurance status. There is considerable disquiet when people in serious medical need are refused treatment because of their inability to pay or lack of insurance. There is therefore a potential conflict between the desire to protect the population, regardless of people's insurance status, and the need for insurance to offer significant advantages to the insured population. This problem is particularly severe when insurance is proposed in a country with an existing system of state-funded, free or heavily subsidized health services (however poor these services may be). People will question the advantages and resist the introduction of additional and highly visible insurance contributions unless they bring demonstrable additional benefits.

Several mechanisms can be used to resolve these difficulties. It is sometimes possible to give immediate access to emergency care for everyone who needs it, and to recover the money later from those who can afford to pay. Alternatively, the incentive to be a member may be better access to non-emergency care.

Before embarking on the detailed planning of an insurance system, two questions should be asked:

(1) Does the health service infrastructure exist to provide the services to which insured people are entitled?

(2) Will the scheme be able to offer significant advantages to members without denying access to emergency care to the rest of the population?

If the answer to the above questions is "no", then social health insurance is unlikely to succeed under current conditions.
2.13 To proceed or not to proceed with social health insurance

Depending on the conditions in the country, three decisions are possible. If conditions are favourable, the government may decide to start setting up the necessary institutions, legal framework and procedures for social health insurance. If conditions are not suitable, then the choice is between taking steps to overcome the constraints (see chapter 3) or deciding not to proceed with health insurance at this stage.

A decision not to proceed is often sensible. If conditions are unsuitable, introducing social health insurance can lead to higher costs of care, inefficient allocation of health care resources, inequitable provision and dissatisfied patients. It can also make it more difficult to realize the potential advantages of social health insurance in the future.

The questions in the previous sections aim to define the minimum conditions under which social health insurance is likely to be successful. If it is not possible to prepare the country, or a specific sector of the country, to meet these conditions, it is better not to proceed.
Chapter 3
PREPARING FOR SOCIAL HEALTH INSURANCE

3.1 Removing obstacles

This chapter reviews the measures that might be taken to prepare a country for the introduction of social health insurance. Many of the problems considered were introduced in chapter 2.

If the problem is the poor performance of the national economy, it may be necessary to wait until policies to produce growth and development have led to a higher income per capita, and thus to the possibility of devoting a higher proportion of the country’s resources to health care. No detailed consideration is given here to policies for growth and development.

3.2 Social health insurance and the tax/benefit system

If social health insurance is to be funded by a charge on the payroll, then it is important to consider the effect this can have on the overall level of deductions. One approach is to reduce payroll deductions for income tax, pensions, unemployment insurance and other income-maintenance policies. This can be difficult if social health insurance is being introduced for only part of the population. It is possible, although complicated, to allow members of insurance schemes to opt out of the national health funding system, effectively lowering their payroll deductions. Arrangements of this sort are used in some countries in the provision of retirement pensions, where people contributing to approved private schemes may be allowed to opt out of state pension contributions and benefits.

One way of achieving this is to have a transitional stage in which the insurance fund is an earmarked part of the income tax, so that the introduction of social health insurance simply takes the process one stage further. This approach avoids the problem of people appearing to pay more but gaining no additional access to care. In time, it may be possible to increase the level of contributions for social health insurance in line with developments in the entitlement to services.

3.3 Employment and the labour market

When people move from formal employment to self-employment, it becomes more difficult to measure income, and the tax base can be eroded. If there is a policy of deriving government revenue from income tax, and if the aim is to have a progressive tax system, it is important to develop mechanisms to assess incomes and to collect income tax. This process of assessment can be used to assess other types of liability for insurance, charges and contributions. Although social health insurance may not in itself justify the development of a
framework for assessing incomes, it is an additional argument for such a development.

People often move to self-employment because it gives them tax advantages. There is no logical reason why government should encourage such a change, and it may be worth examining the tax structure to ensure that it does not contain inappropriate incentives.

In any case, in preparation for the introduction of social health insurance it is important to assemble information on all the deductions and charges on the payroll. Government departments often develop policies without taking full account of the policies of other departments, and the combined effects may cause problems. If social health insurance is to be based on payroll payments, it may be necessary to move some revenue-raising to another base, such as sales or property taxes. This will be particularly important where unemployment is a serious problem and particular care must be taken to avoid discouraging employers from taking on staff.

If the suggestion is to set up a social health insurance scheme covering occupational groups with a high proportion of self-employed people (e.g., farmers) then it is important to consider which type of contribution base will work best. It is possible to raise a levy on goods sold at auction, or accept payment in surplus produce rather than a regular financial contribution. It may take some time to find a suitable mechanism for raising charges on this type of group.

3.4 Preparing the administrative infrastructure

Two types of preparation are needed to ensure a suitable administrative infrastructure — training staff and setting up structures and procedures. The skills needed to administer a system of social health insurance are different from those used in other types of health service management and financing. Staff need to be equipped to manage the collection of contributions, support the process of identifying entitlements, arrange for access to the services to which members are entitled, and monitor the quality and appropriateness of care.

Training staff to establish and manage the social health insurance system can take several years, and some of the work needs to be done before the new arrangements are established. Many countries make the mistake of trying to develop social health insurance without the necessary skills.

3.5 Preparing the health services

One objective of social health insurance is to improve access to health services. Early action may be needed to ensure that the services to which insured people are entitled are available, and in places where they can easily gain access to them.

Development of health services can be done directly, with government building the facilities, training the staff and buying the equipment, or indirectly, with government encouraging health services development by private and nongovernmental bodies. It is important to remember that, even in countries where all health services are supplied by private-sector organizations, there is a need for
at least some element of government control over the pattern of services and facilities. Providers will only invest in buildings and equipment on a large scale if they see a reasonable chance of winning contracts. There are very long lead times between the initial decision to proceed with building or training programmes and the eventual provision of services, so that the government is likely to be involved in providing guarantees or incentives.

Especially if the health sector is unprepared for an expansion in the demand for services, additional funds can simply inflate the price of health services without improving access. This does nothing to meet health policy objectives. To avoid this problem, it is usually necessary to develop a plan for health services that remain funded by other mechanisms.

The need to contain costs has led most countries to place some limits on the development of health care facilities. However, the main need for government involvement is the time which elapses between the initial planning of new services and facilities and their completion.
DESIGNING SOCIAL HEALTH INSURANCE: PRELIMINARY ISSUES
Chapter 4

BASIC QUESTIONS RELATED TO DESIGN

4.1 Introduction

Section II of this guidebook is concerned with the critical decision of whether or not to proceed with the development of social health insurance. In Section III it is assumed that, after a careful analysis of conditions in the country, the decision has been made to proceed to the design and planning stage. This is not an irrevocable decision; if serious problems arise, the development of the system may still be delayed or abandoned.

Figure 2 in section I suggests the stages to be followed in the detailed design of social health insurance. Once social health insurance has been established as a valid option, policy objectives must be clearly specified, so that they can be taken into account in the design of the system. The next stage is to develop detailed system components and mechanisms; this is described in section IV. Section V deals with the lessons to be learned from the experiences of other countries and ways of building consensus and gaining support for social health insurance.

4.2 Developing health policy

The government's objective in the design of health policy should be to achieve long life and good health for the population. Ensuring access to appropriate and effective health services is one way of achieving this.

Before plans for social health insurance are developed in detail, health policy goals and targets should be clearly stated. The insurance plans must be compatible with policy goals.

Policy goals must be stated at the level of overall objectives (e.g., long life and good health) and in terms of targets associated with these goals (e.g., access to effective and efficient services, equity, etc.). For the purposes of policy development, it is better to avoid going into too much detail about how these goals and targets are to be achieved.

4.3 Choice and diversity in health service provision

Although it is possible to allow social health insurance organizations to be responsible for the provision of health care, there are reasons for discouraging this. It is likely that the introduction of social health insurance will lead to greater diversity in the provision of health services. Health funds can usually choose to contract with government, private non-profit-making or private profit-making providers. The growth of choice and diversity in the provision of health services can lead to more efficiently provided health care and improved quality of care.
4.4 Liaison with government departments and programmes

The development of social health insurance, whether mandatory or voluntary, and whether it covers the whole population or only certain groups, will affect other areas of health policy, the feasibility of other taxes and charges, and other government objectives. If social health insurance is to be successful, these effects must be anticipated and taken into account in planning the system.

It is important to consider the overall burden of taxes and charges, and to avoid excessive dependence on a single source of funds. There is therefore a need for liaison between the health funds and the government departments and agencies that levy taxes or charges. This liaison must be permanent, since insurance contributions and other taxes and charges are regularly reviewed. A mechanism for exchanging information and preventing unilateral action by any of these agencies will therefore be required.

There are other government objectives which may be influenced by the introduction of insurance. For example, economic development requires a flexible and mobile labour force, and government may be reluctant to introduce rigidities into the labour market. The objective of controlling inflation will be undermined if insurance leads to a rise in health care costs. In addition, balance-of-payments objectives can be adversely affected by imports of medical equipment and drugs.

Government objectives to promote economic development through increased capital investment can also interfere with health policy objectives. Policies exempting capital goods from import duties, for example, can lead to inappropriate purchases of expensive and low-priority medical technology. The result is that government resources may be devoted to activities that unintentionally undermine government health policy. Clearly, liaison must be maintained with the government departments responsible for economic policy and development.

A potential problem arising from a growing diversity of health care provision (see chapter 4.3 above) is its implications for health personnel. There is normally little incentive for the private sector to be involved in the cost of training and professional development if it can recruit staff easily from public hospitals. This can mean that providers are not competing on equal terms, since public hospitals bear the cost and disruption of training. On the other hand, teaching hospitals (which are often government-owned) may gain an unfair advantage from employing the most prestigious staff.

There is a growing realization that ways must be found to guarantee equal treatment for all health care providers as far as training costs are concerned, and to ensure that high-priority services are not starved of skilled health professionals. Training of health professionals is very expensive, and it is important to ensure that enough staff are trained to meet the needs of all the providers that contribute to health policy goals.

It is also important to consider that the health fund(s) will need qualified staff in order to function properly. The skills needed will be in actuarial sciences, epidemiology, health economics and other health sciences. Some people with these skills may already be working in government departments, but further training is likely to be necessary. The need to coordinate training policies with
the requirements of the health fund and with government health policy objectives implies that there must be close cooperation with ministries of education throughout the social health insurance planning process.

4.5 Funding services not covered by insurance

Social health insurance works best for the coverage of curative care in both primary and secondary care settings, because people enjoy the benefits of being guaranteed access to treatment in the event of illness. It is more difficult, however, to fund prevention and health promotion through insurance.

The relative priorities given to the expansion of primary health care, to improvements in secondary care, or to disease prevention and health promotion will depend on the existing characteristics of the health services, the patterns of disease and the available options for improving health. If the highest priority is to expand primary health care coverage among scattered rural populations, with an emphasis on basic care and health promotion, it is unlikely that social health insurance will help to achieve this: the transfer of skilled health professionals to the curative services covered by insurance may even hinder it. If the highest priority is health promotion—programmes to encourage people to give up smoking, for example—then social health insurance is probably irrelevant. A mixture of government funding, with fees and co-payments by patients, and innovative forms of community financing are likely to be more useful for the expansion of preventive and health promotion services.

4.6 Equity

Social health insurance is often introduced in order to supplement other systems of health service financing, at least initially. As coverage expands, it may become the largest or even the universal method of funding basic health care. If the scheme is the first stage of a longer-term policy development, then it may be acceptable to have a period in which equity objectives are not met. However, if the health insurance will never cover more than a small part of the population, then this may cause resentment among those who are refused membership. A population's desire for access to health services comes from comparison with similar populations within and outside the country. Providing services for one group can seem like depriving another.

It is worth considering the option of introducing social health insurance to cover the whole population, but with "deemed" (credited) contributions for those who cannot or do not pay for themselves. Once the necessary structures and procedures are in place, deemed contributions can be replaced by real ones. A universal system of social health insurance will normally retain deemed contributions for specific groups, such as unemployed or retired people.

Equity considerations have influenced thinking about access to health care for many years. If health insurance releases government resources to develop services for people not covered by the scheme, and thus raises standards for the people worst off, greater inequality may be acceptable, but a limited scheme which reduces access for some groups may be very unpopular, which can reduce its chances of successful implementation.
4.7 What sort of health insurance should be chosen?

The emphasis of this guidebook is that social health insurance should be designed to serve health policy. As discussed in the sections above, it is also important to consider health insurance in the context of other government policies. These concerns will play a role in the decisions about the actual structure of the social health insurance scheme. In this respect, there are several fundamental choices to be made, some of which depend on the prevailing social and political culture as well as on health policy.

An important question is whether the scheme should be mandatory or voluntary for the target population. As the subsequent parts of this guide make clear, there are many advantages in mandatory systems, which improve risk pooling and avoid some incentives to "hitch a free ride". Also, it is difficult to use a voluntary system to meet health policy goals. However, there is a political cost in terms of the acceptability of the scheme to the population.

Another issue concerns the ownership and organization of the health fund. A critical decision to be made here is whether to set up a single fund or several funds. The arguments for having a single fund are simple — administrative costs are reduced, the system is easier to monitor, it can offset the monopoly power of physicians and other providers, and the incentives for selecting only good risks are removed. With a single fund, it is possible to ensure greater equity of access to services. The disadvantages of having only one health fund are that subscribers have no choice of insurer — which thus eliminates the possibility of competition — and a single fund can become ungainly, difficult to manage and overly bureaucratic.

Even if there are multiple health funds, it is difficult to achieve genuine competition between them. In Germany, for example, there are many funds but they serve particular sections of the community, and for many people there is no real choice of insurer. It is possible even with only one health fund to ensure competition for the right to manage the fund on a franchise basis. A clear distinction should be made between the (strong) arguments for using market mechanisms and competition in the provision of health services, and the (weaker) arguments for competition among funding organizations.

The option of having several funds may become more attractive as the number of subscribers increases and the economy of the country develops. Choice, like other commodities, has a cost; in richer countries, more people will be able to afford the luxury of choice. A single fund, however, can achieve economies of scale in the collection and management of health fund contributions. The main point is that choice and competition will not necessarily offset the advantages of simplicity and economy of scale. The option of having several funds should thus be treated with caution.

Health funds can be owned by private profit-making, private non-profit-making, quasi-public or public organizations. In practice, these distinctions may be quite unimportant, since health funds will always operate within a clearly defined policy framework.

Nevertheless, the formal ownership of the health fund or funds can be very important if the aim is to make a clean break with the past. It may be considered desirable to establish or license organizations which are legally independent of
government, but this legal independence does not reduce the need for a policy framework, covering contribution rates, payment for services and enrolment. Nor does independence remove the need to seek ways of containing costs in the health sector and managing the collection of contributions. Profit-making organizations have strong incentives to be efficient, but some part of the premium must be retained to pay the profit.

QUESTIONS RAISED IN CHAPTER 4

(1) What are the health policy objectives of the country, and are they clearly stated?

(2) What priority is given to the development of primary care services, as compared with secondary and tertiary services?

(3) Are the existing health services capable of meeting any increase in demand that may follow the introduction of health insurance?

(4) What arrangements exist for liaison on health policy between government departments?

(5) How will human resource provision be financed and organized?

(6) Who should be covered by health insurance, and how can equity objectives be met?

(7) Should there be one health fund or several, and who should own it/them?
DESIGNING SOCIAL HEALTH INSURANCE: SYSTEM COMPONENTS
Chapter 5

POPULATION COVERAGE

5.1 Introduction

There is no general rule about the proportion of the population which should be covered by a social health insurance system, although protecting everyone in the population against the financial burden of health care in case of sickness may be regarded as an expression of social solidarity. The obvious solution is to cover the whole population. Nevertheless, there are arguments for not doing so, which carry more or less weight depending on the situation in the country concerned.

All countries with social health insurance started by protecting subgroups of the population, such as employees in large enterprises. Over time, coverage has been extended to other groups. In Korea, for example, coverage started with the employees of big firms; later, smaller firms were included, followed by other population groups such as the self-employed. Full protection of the whole population is, at best, a long-term objective in the process of establishing social health insurance.

In addition to the situation prevailing when a health insurance system is being built up, there may be historical, technical or political reasons for not covering the whole population. There are many examples of countries with established social health insurance systems which do not include certain groups. In Germany, for example, self-employed people, civil servants, military personnel and priests are not covered by social health insurance. In the Netherlands, employees with wages over a certain limit are excluded.

There may also be good reasons to establish or allow the establishment of several separate health insurance systems in a country, rather than one uniform system. This may be for historical or technical reasons (such as special requirements for registration and contribution payments, e.g., for farmers or seafarers) or because of the special needs of specific groups (e.g., miners). These issues are discussed more fully later in this chapter.

5.2 What are the target groups for social health insurance?

Before discussing the above questions in more detail, it is useful to consider the possible target groups of population coverage. A number of population groups can be distinguished, whose characteristics, size, needs, technical requirements and political influence may be different in different countries. The following table gives a brief overview of a possible set of target groups, to give some idea of the complexity of the issues involved. It should also be remembered that if the system does not provide free coverage for dependants, spouses and children will have to be considered as an additional group requiring coverage.
<table>
<thead>
<tr>
<th>Group</th>
<th>Technical and Administrative Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>employees</td>
<td></td>
</tr>
<tr>
<td>industrialized workers</td>
<td>no specific technical or administrative problems</td>
</tr>
<tr>
<td>white collar workers</td>
<td>acceptability problems with high-income groups</td>
</tr>
<tr>
<td>workers in agriculture</td>
<td>registration, income assessment, payment</td>
</tr>
<tr>
<td>seafarers</td>
<td>no technical or administrative problems, but high risk jobs</td>
</tr>
<tr>
<td>miners</td>
<td>no technical or administrative problems, but high risk jobs</td>
</tr>
<tr>
<td>casual workers</td>
<td>registration, income assessment</td>
</tr>
<tr>
<td>self-employed people</td>
<td></td>
</tr>
<tr>
<td>craftsperson</td>
<td>registration, income assessment</td>
</tr>
<tr>
<td>farmers</td>
<td>registration, income assessment, payment</td>
</tr>
<tr>
<td>owners of small businesses</td>
<td>registration, income assessment</td>
</tr>
<tr>
<td>other independent workers</td>
<td>registration, income assessment</td>
</tr>
<tr>
<td>special groups</td>
<td></td>
</tr>
<tr>
<td>civil servants</td>
<td>no real technical or administrative problems</td>
</tr>
<tr>
<td>military personnel</td>
<td>no real technical or administrative problems</td>
</tr>
<tr>
<td>non-working population</td>
<td></td>
</tr>
<tr>
<td>pensioners</td>
<td>ability to pay</td>
</tr>
<tr>
<td>unemployed people</td>
<td>registration, ability to pay</td>
</tr>
<tr>
<td>disabled people</td>
<td>registration, ability to pay</td>
</tr>
<tr>
<td>welfare recipients</td>
<td>ability to pay</td>
</tr>
<tr>
<td>students</td>
<td>ability to pay</td>
</tr>
<tr>
<td>people in training</td>
<td>ability to pay</td>
</tr>
</tbody>
</table>

Given the variety of potential target groups, several aspects need to be considered in the development of a population coverage policy:

- **political**: what is the political impact of including or excluding certain groups? Political considerations may be influenced by the fact that in most countries which plan to establish a social health insurance system, some protection schemes already exist for certain population groups. These groups may resist incorporation into a general scheme.

- **technical**: what kind of risk mix is needed to ensure a functioning health insurance system?

- **equity**: what is the impact on equity objectives of choosing a certain pattern of population coverage? Any consideration of equity and risk mix requires low-income, high-income and zero-income groups to be distinguished.

- **feasibility**: will it be feasible to cover a large number of different population groups? There may be problems associated with establishing universal coverage, such as difficulties in registering certain groups or in assessing and gathering contributions.

- **membership**: will the system be compulsory or voluntary? What are the problems associated with voluntary membership?

Each of these aspects are considered in more detail in the following sections.

### 5.3 Political aspects of population coverage

For various reasons, social health insurance schemes sometimes exclude particular population groups. For example, persons who can easily afford to
make their own insurance arrangements, either through savings or private insurance, are often excluded from social health insurance coverage. Employees whose earnings exceed a certain upper limit may fall into this category.

Self-employed people are sometimes excluded from insurance schemes, largely because of difficulties in assessing their incomes. In some countries, groups such as public servants, physicians, lawyers, and military personnel have special protection arrangements and are therefore not included in the general social health insurance system. Nevertheless, these groups may be important for mutual support and for ensuring an adequate risk mix (see below).

ILO Convention No. 130 provides some minimum standards of population coverage (2). States which have ratified the Convention are free to choose their health care systems, provided that these will eventually cover:

- employed persons, with the exception of certain groups defined in article 4 (public servants, seafarers) and article 5 (casual employees, family members of the employer, other groups not exceeding 10% of the rest of the employed population)
- at least 75% of the economically active population or
- at least 75% of all residents
- in all cases, the wives and children of insured persons must be covered.

5.4 Technical aspects of population coverage

Insurance only works if some people pay more in contributions than they take out in services, to compensate for those who cost the scheme more than they pay in. An insurance contribution is not a payment for a service, but the price for insuring a particular risk.

If the objective of social health insurance is to provide a certain level of protection for a reasonable contribution, it is very important to find a "mix" of risks that guarantees sufficient financial resources. There are some groups of the population that might be regarded as "good risks" and others that must be characterized as "bad risks" in insurance terms. Table 2 shows some of these groups.

For a good risk, the average revenue per person per year (from contributions) is higher than the average costs per person per year (for services). If the system is funded by wage-related contributions, the risk depends on two parameters: the costs per year and the wage of the individual. In a system with flat-rate contributions, there is only one parameter: the health costs per person.

Experience shows that the best risks are young wage-earners without families or with small families, and people with high wages. Pensioners and

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>POPULATION GROUPS AND &quot;RISK MIX&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good risks</td>
<td>Bad risks</td>
</tr>
<tr>
<td>healthy people</td>
<td>sick and disabled people</td>
</tr>
<tr>
<td>high-wage earners (in a system financed by wage-related contributions)</td>
<td>low-wage earners (in a system financed by wage-related contributions)</td>
</tr>
<tr>
<td>people without dependants</td>
<td>people with dependants if these are covered free</td>
</tr>
<tr>
<td>employed people</td>
<td>unemployed people</td>
</tr>
<tr>
<td>young people</td>
<td>elderly people</td>
</tr>
<tr>
<td>people in safe working environments</td>
<td>people in dangerous jobs</td>
</tr>
</tbody>
</table>
families (if dependants are covered free) are the largest poor risk groups; other poor risk groups include women of childbearing age and workers in hazardous professions.

If the insurance system is to have an equilibrium of risks, which is necessary for its fiscal health, it cannot cover only the bad risk groups that have high insurance needs. The insurance system must also include the good risks — those groups (such as high-wage earners) that pay more in contributions than they consume in services.

Private insurance companies differentiate between various risk groups by charging risk-related premiums. They attract good risks by offering them low premiums, and reject bad risks, or accept them only for very high premiums. In some countries, private insurance contracts allow companies to exclude members as soon as they turn out to be a bad risk. The result is that private insurance leaves the bad risks to be covered by the public health services.

Social health insurance does not exclude anyone who belongs to a group that qualifies for coverage, nor does it charge risk-related premiums. With premiums that are not risk-related but perhaps wage-related or flat-rate, an insurance fund has to ensure that it gets the right risk mix. This is possible only if membership is compulsory. Otherwise, people who are good risks will choose private insurance and change to social health insurance only when they become bad risks.

This issue becomes clearer when we consider solidarity between different groups in private and social health insurance:

<table>
<thead>
<tr>
<th>TABLE 3</th>
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</thead>
<tbody>
<tr>
<td>MUTUAL SUPPORT BETWEEN POPULATION GROUPS IN HEALTH INSURANCE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Form of solidarity</th>
<th>Social health insurance</th>
<th>Private health insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>the healthy with the sick</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>the young with the old</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>high-wage earners with low-wage earners</td>
<td>✓ (in systems with wage-related contributions)</td>
<td></td>
</tr>
<tr>
<td>single individuals with those with families</td>
<td>✓ (in systems with free services for dependants)</td>
<td></td>
</tr>
</tbody>
</table>

Compulsory membership in social health insurance schemes can be justified if it is seen as a "contract between generations". At some stage in life, people expect to become a bad risk; for instance, if they produce a big family or when they become older. Therefore, single and young people who pay high contributions are making an investment for future coverage of their health costs. These points are considered further in the section on voluntary membership in insurance schemes (see chapter 5.7 below).

5.5 The impact of particular patterns of population coverage on equity

In many social health insurance systems, contributions are split between employer and employee. For certain groups, such as pensioners, the unemployed, welfare recipients and disabled people, other social security branches
play the role of the employer, and pay the employer's share of the contribution. But for self-employed people there can be no such fictional "employer". Compulsory membership for this group raises problems of equity, as they would be obliged to pay the whole contribution themselves. This discourages compulsory and even voluntary coverage of self-employed people, because for them the costs of membership are much higher than for employed members, even when the employer's contributions are regarded as part of the employed person's wage.

Equity problems may arise in insurance schemes with wage-related contributions. For example, artificially created low-wage jobs can allow access to the full range of insurance benefits in return for extremely low contributions. This type of fraud can be avoided by setting a lower limit on the amount of income required to establish insurance coverage. The lower limit may be set at, for example, one seventh of the average income.

High-wage earners may consider a wage-related contribution system to be inequitable, because their contributions will be higher than those of low-wage earners. For this reason, high-wage earners sometimes opt out of social health insurance schemes (if opting out is allowed), as discussed in chapter 5.3 above. It is important to note, however, that people with higher incomes usually have a relatively low illness risk, so excluding them from the fund can be detrimental to the development of a good risk mix.

Another issue which may have equity implications relates to the decision of whether to establish one scheme or several. The reason for allowing several schemes may be that systems already exist for certain groups at the time when social health insurance is introduced. Another reason may be that the infrastructure varies greatly within a country. Urban areas normally have the best infrastructure, with the highest rates of hospitals and physicians per thousand inhabitants. In rural areas, the infrastructure is usually quite poor. Incomes in urban areas are also generally higher than in rural areas. If the rural and urban populations belong to the same system and pay the same contributions, the rural population may be financing part of the urban infrastructure, since it does not have access to comparable services. This will cause equity problems.

The objective of social health insurance is to provide equal access to services regardless of income. In this case, it may be better to establish two different systems or to create different conditions of membership (e.g., different contributions for urban and rural areas).

5.6 Feasibility

Policy objectives have to be examined in relation to the existing situation in each country. It may not be feasible to establish universal coverage, particularly if there are difficulties in registering certain groups or in assessing and gathering contributions.

In the past, most health insurance systems have been restricted, in their early stages, to employees in industrial enterprises. This was for technical rather than for policy reasons: these employees formed the biggest group with regular wages from which contributions could be deducted. Some countries distinguished between small/medium-sized and large enterprises. Registration and
monitoring of the collection of contributions is much easier in bigger enterprises.

In a country with an appreciable number of self-employed people in small or informal businesses—such as market traders, small shopkeepers, agricultural smallholders or taxi drivers—it may be impossible to include them in a compulsory social insurance scheme because of the insurmountable administrative difficulties. However, in some countries these groups and their families represent more than 50% of the population.

Developing countries in particular tend to have a small industrial sector and a large rural sector. Industrial and city populations in some countries constitute only 20% of the whole population, whereas the rural agricultural population may represent up to 80% or more. Coverage of this rural majority raises many technical problems.

Even in industrialized countries with longer traditions of social health insurance, coverage of the self-employed is a problem. Registration and income assessment create practical difficulties. Major efforts are required to avoid fraud and to guarantee fair treatment for all.

Casual workers represent another group which is difficult to register and keep track of, and whose income is difficult to assess. By its nature, casual employment is difficult to define for administrative purposes. To overcome the problem, coverage may be limited to persons with earnings over a lower income limit (see chapter 5.5) and/or to persons working a minimum number of hours per week.

The registration of family members (i.e., dependants) poses another administrative problem. Registration is often incomplete, or persons may be illegally registered as dependants. It is very important to define exactly what is meant by a dependant: does it include a wife or wives, children (how many?), parents, grandparents, grandchildren, adopted children, dependant siblings? If a country decides to allow free coverage for dependants, the concept of a dependant must be carefully defined according to prevailing custom.

5.7 Membership: compulsory or voluntary?

It is very difficult to create a system that covers the whole population right from the start. Some countries choose voluntary membership as a route to wider coverage. If access to the insurance system is offered on a voluntary basis, this removes the problems related to registration of members, since only persons who apply for membership are registered. Nevertheless, the problems of registration of family members and assessment of contributions will remain.

Offering voluntary membership may entice certain population groups to join, particularly those groups who are not presently covered by an insurance scheme and may be dissatisfied with the existing quality of health care services. On the other hand, voluntary membership may result in an adverse risk mix (too many bad risk groups and not enough good risk groups). In addition, voluntary membership can increase risk of fraud. Some examples of adverse selection and fraud are listed below:
persons not included on a compulsory basis (e.g., those on high wages and the self-employed) will choose private insurance as long as their premiums are lower than those for social health insurance (this normally means as long as they are young and do not have dependants). As soon as their premiums rise (i.e., as soon as they start to become "bad" risks), such people will switch to social health insurance.

people will not choose insurance as long as they are healthy. As soon as they fall seriously ill, they will apply for membership in the social health insurance fund.

self-employed people may make false declarations concerning their income in order to pay lower contributions (in income-related systems).

If a country decides to implement a voluntary scheme, planners must take precautions against adverse risk selection and fraud. Some design features which may serve to minimize these problems are as follows:

qualifying conditions: for example, pensioners may be allowed to participate in social health insurance only if they have already been members for a minimum period (e.g., 50% of their working life)

voluntary membership may have a qualifying period of six months, to prevent people joining only when they fall ill. This means that voluntary members have to pay contributions for six months without any entitlement to benefits

limited voluntary access: each person has the chance only once in his or her life—during the first year of professional activity, for example—to join the social health insurance scheme. People who withdraw from social health insurance because of a change of status (e.g., from employee to self-employed or by passing the upper income limit) are not allowed to re-enter.

<table>
<thead>
<tr>
<th>TABLE 4</th>
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</thead>
<tbody>
<tr>
<td>ADVANTAGES AND DISADVANTAGES OF VOLUNTARY AND COMPULSORY MEMBERSHIP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advantages of voluntary membership</th>
<th>Disadvantages of voluntary membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>- possibility of encouraging good risk groups to join</td>
<td>- adverse risk mix</td>
</tr>
<tr>
<td>- possibility of using voluntary membership as a route to wider coverage</td>
<td>- potential fraud</td>
</tr>
<tr>
<td></td>
<td>- accurate income assessment is problematic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advantages of compulsory membership</th>
<th>Disadvantages of compulsory membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>- guarantee of good risk mix</td>
<td>- may not be initially feasible</td>
</tr>
<tr>
<td>- ensures solidarity and mutual support</td>
<td>- depending on contribution arrangements, may raise equity problems</td>
</tr>
</tbody>
</table>

In summary, voluntary membership has a variety of advantages and disadvantages which must be considered in the planning process. In terms of ensuring a good risk mix and contributing to mutual support, compulsory membership, as discussed in previous sections, is preferable. But in particular situations, compulsory membership may be problematic. Table 4 provides a comparison of the two membership options.
QUESTIONS RAISED IN CHAPTER 5

(1) What are the target groups of the health insurance initiative? A table of possible population groups should be drawn up, showing the target groups and the numbers of people involved.

(2) Will there be problems with including all of the identified groups in the health insurance system? The feasibility of registering and collecting contributions from each group should be checked.

(3) What policy problems are there likely to be?

(4) What are the risk patterns and the ability to pay of each of the groups to be covered by the health insurance system? This is a crucial question for the financing of the system. There may be a need to adjust either the target groups, or the benefits, or the contributions.

(5) Which are the first groups to be included? A phased plan for extending coverage to other target groups should be drawn up.
Chapter 6
THE BENEFIT PACKAGE AND ENTITLEMENT TO BENEFITS

6.1 Introduction

The range of benefits, or specific health care services, that can be covered under an insurance scheme varies between countries and often between different population groups within the same country. The ideal benefit package for a specific country or region will depend on a variety of considerations. Clearly, a benefit package should deliver the kind and level of health care services that people are accustomed to and which are considered necessary to maintain and promote good health, but questions of cost-effectiveness in the delivery of health care services must also be part of the planning process.

Similarly, the rules governing an insured person’s rights, or entitlements, to health care benefits differ among existing insurance schemes. Entitlement provisions must be planned carefully, in the context of the socioeconomic and demographic circumstances of the insured population. Some considerations relevant to entitlement planning and the planning of benefit packages are listed below. They are discussed in more detail in the remainder of the chapter.

Issues to be considered in the planning of benefit packages

- the availability of financial resources
- the existing infrastructure and quality of services
- assessment of health care priorities
- rates of health care utilization by the population entitled to benefits
- the level and type of co-payments
- the cost of health care services
- the patterns of disease and injury in the population and the ensuing health needs of the members of the insurance scheme
- the methods for providing health care benefits.

Issues to be considered in the planning of entitlement provisions

- the diverse economic circumstances of insured people (employed, self-employed, economically dependent)
- the origins of disease and injury (work-related injuries, occupational diseases and subsequent vocational rehabilitation, self-inflicted injuries, injuries by third parties, other accidents and diseases)
- the distribution of responsibility among the different social security branches.

6.2 Issues to be considered in the planning of benefit packages

6.2.1 Financial resources

The range of benefits that can be provided under an insurance scheme depends primarily on the available financial resources. If these are large, other
problems are relatively easy to overcome. In practice, however, financial resources are limited. Therefore, the first question to ask is:

- what are the economic resources that can be spent on health?

The answer to this question will depend on:

- the level of development of the country
- the system of health care financing (contributions or tax funding)
- the ability and willingness to pay contributions by the members of the scheme
- the feasibility of collecting the contributions.

Before planning the benefit scheme it is necessary to calculate the expected revenue of the system. The simplest way of doing this is to take the expected number of members and multiply it by the expected average contribution. This requires some basic data:

- the expected number of paying members. This should be taken from population statistics, if available
- the expected average contribution. This may be calculated by assuming the contribution rate and taking the average income of the designated members.

In many countries, however, these data will not be available. When this is the case, the expected revenue will have to be estimated on the basis of any available information, such as data from the tax authorities, the turnover of certain sectors, or consumption figures. Alternatively, a study or pilot project may be carried out.

If state subsidies are planned, it will be important to know the basis on which they are to be granted (e.g., subsidies for disabled people and social aid recipients or low-income groups). Knowing this basis and its dimension (e.g., the size of the groups to be subsidized) it should be possible to calculate the level of state subsidies.

6.2.2 Existing infrastructure and quality of services

The benefit scheme is to a large extent determined by the existing infrastructure. If there are no hospitals in remote areas, patients will not be able to demand inpatient treatment. If there are no specialist physicians, patients will have no access to specialist services even if they have a technical entitlement to them. Thus the benefits offered by a social health insurance scheme are heavily dependent on the available infrastructure.

Of course, social health insurance contributions will provide resources for staff, infrastructure and equipment. However, there is a danger that money collected from contributions will be used to buy equipment and staff that are not suited to the situation in the country. High-cost equipment is only useful when:

- it can be properly maintained
- a diagnosis made using high-cost equipment is useful for subsequent treatment (and the necessary facilities for subsequent treatment are also available)
staff are available to carry out diagnosis and treatment
- cost-benefit analysis shows that there are no higher priorities for the use of the resources.

The health fund should plan the use of its scarce resources in order to avoid waste, duplication and inappropriate investment. The infrastructure must be suited to the particular social and epidemiological conditions in each country. In some countries, for example, hospitals need to provide accommodation for patients' families.

The process of introducing health insurance as a financing mechanism must include planning for infrastructure and staff training. If the right staff are not available, training facilities must be set up (see chapter 11 "Administration and management").

6.2.3 Deciding on priority health care services

Once the available financial resources are known and the capabilities of the health care infrastructure have been assessed, the next step is to define the specific health care services that should be provided, which entails setting priorities for the delivery of health care. Given resource constraints, it may be necessary to exclude certain health care services that do not have a high priority.

In general, health care benefits are classified as follows:

- primary care services in the community
- specialist physician services in individual practices, polyclinics or outpatient departments
- hospital inpatient care
- drugs
- ancillary services (e.g., X-rays, laboratory tests)
- sight tests and spectacles
- basic dental maintenance
- restorative dentistry and dental prostheses
- prostheses and appliances
- transport to and from hospital.

Some services are usually offered by other authorities, such as public health administrations or other insurance branches, or are not offered at all, for example:

- immunization
- birth control and abortion
- long-term care
- inpatient and outpatient treatment of mental illness
- rehabilitation, vocational rehabilitation.

When a list of priorities has been drawn up, the next step is to estimate the costs of the desired benefit scheme. It is therefore necessary to estimate the utilization rate and cost of each service or product.
6.2.4 Rates of health care utilization among the entitled population

In order to know what kind of benefits can be offered to social health insurance members, it is necessary to obtain data on the expected rates of utilization of health care services. It should be noted that utilization rates for any one service may change over time, depending on the benefits that are eventually included in the health insurance scheme. For example, if a particular service is excluded, it is to be expected that the demand for that service will diminish over time.

There are various ways of obtaining data on the utilization of health services:

- experience from existing schemes covering specific groups
- experience from other countries with similar social and economic patterns
- experience from a pilot project covering a specific area or population group
- data obtained from a survey.

Utilization rates should be obtained for basic services such as hospital inpatient and outpatient treatment and ambulant care by physicians and specialists. These data are not only important for estimating costs, but also for planning future modifications to the health care infrastructure.

The utilization rates of health services are influenced significantly by:

- morbidity patterns
- clinical practice
- existing infrastructure
- existing financing mechanisms
- co-payments (see below and chapter 10.4).

In general, it takes time for patients and providers to change their utilization or prescription patterns. A social health insurance scheme, if properly designed, can provide incentives for appropriate behaviour changes among patients and providers.

6.2.5 Level and type of co-payments

Co-payments are additional payments made by patients, often at the point of service, for health care services they receive. For example, a patient may pay a nominal fee for each visit to a health facility, while the insurance scheme covers the remainder of the cost of the visit. Alternatively, a patient may be required to pay a flat rate per drug prescribed. More will be said about specific co-payment characteristics in chapter 10.4.

Co-payments can be designed to influence behaviour patterns among patients and providers. More specifically, co-payments can be set at a level which should encourage or discourage the consumption of particular health care services. For example, if the aim is to discourage excessive prescription and consumption of drugs, patients can be charged relatively high co-payments for drugs that are covered in the benefit package.

Clearly, it is important to consider the consequences of including co-payment schedules in a social health insurance scheme. On the one hand, co-payments can help to encourage the provision and consumption of a priority set of health
care services. On the other hand, health care consumers may express considerable resistance to co-payments, particularly those that are levied at the point of service. These issues must be fully taken into account in the design of the benefit package.

6.2.6 Cost of services

To a great extent, the cost of the services offered determines the possible nature and volume of benefits. Some costs are related to the general standard of living and level of income in a country, especially wage costs and physicians' incomes. Others, such as the cost of high-tech equipment, medical informatics and drugs, are not adjusted to ability to pay in the consumer country. Many of these goods are produced in a small number of industrialized countries and must be imported by others.

The high cost of services requiring expensive imported drugs or equipment may be a reason for excluding them from the benefit package. One example of this would be CT scanning using expensive drugs.

6.2.7 Patterns of disease and injury in the population

The kind of services provided by a health insurance scheme may vary according to the patterns of disease and accidents in the population. For example, in a country with a high prevalence of infectious diseases, immunization and information may be among the main items of expenditure of the health fund. Alternatively, immunization costs may be borne by the state.

It is important to design the benefit package to suit the needs of the country. In some countries, the most common illnesses are malaria, tuberculosis and diarrhoea in children. In other countries, the priorities may be noncommunicable diseases and the diseases associated with an aging population. The requirements for equipment and medical staff will be completely different in those two cases. It is a serious mistake to try to adopt benefit packages from other countries where the situation may be very different.

6.2.8 Methods for providing health care benefits

There are two basic methods for providing, and receiving payment for, health care services:

- the patient has access to services without paying the provider (although there may be a co-payment — see above and chapter 10.4)
- the patient pays for the service and gets a refund from the insurance fund, which may cover all or part of the cost.

Both methods may be used with contracted providers or insurance-owned providers. This means that either:

- the health fund contracts with providers (e.g., hospitals or physicians) in order to guarantee services for its members or
- the health fund runs its own hospitals and employs its own physicians.

Further discussion of these options will be found in chapter 8 "Provider payment mechanisms".
The advantage of the first method is that the health fund has a contract directly with the provider. It pays the provider and is able to negotiate and control fee schedules and quality standards. With this system, not only is health insurance a scheme for covering expenses, but it also provides consumer protection. The disadvantage of direct payment of providers by the health fund is that patients can get the impression that health care is free and not realize the costs involved.

If the patient pays for care and claims a reimbursement from the health fund, it is more difficult for the fund to negotiate with and keep control over providers. It is the patient, rather than the health fund, who enters into a business contract with the provider. There is no direct contact between the provider and the insurance fund. There may be fee schedules, but they will not have the same effect as in the direct system. There is a risk of "erosion" of health insurance benefits if providers do not keep to a fee schedule.

The advantage of the patient paying the bill is that he/she sees how expensive health care is. However, it can cause serious problems for people on low incomes, who may not be able to advance the money and may therefore be denied treatment they need.

This method is also more expensive: the physician sends a bill to the patient, the patient has to pay it and then submit a claim to the health insurance fund. The fund then checks the bill and sends a reimbursement to the patient. With direct reimbursement of providers, the physician sends the bill directly to the health fund and gets paid according to the fee schedule. A system with employed providers is cheaper still.

6.3 Issues to be considered in the planning of entitlement provisions

6.3.1 Diverse economic circumstances of insured people

In some countries, entitlement to benefits varies according to income: high-income groups are entitled to free hospital treatment, but must pay for ambulatory care and drugs. The reasoning behind this is that people with a higher income should be able to pay for less expensive treatments from their own resources or acquire additional coverage through private insurance. It is unlikely to be acceptable in a system with wage-related contributions (since the people making the largest contributions would have the smallest entitlements), but it may be appropriate in a system with flat-rate contributions.

6.3.2 Origins of disease and injury

Entitlement to benefits may also vary according to the type or cause of illness or injury. For example, it may not cover injuries caused by accidents at work or self-inflicted injury. There are several reasons for varying the entitlement to benefits in such cases:

- many countries encourage employers to take more responsibility for health and safety by making them bear the costs of work-related injuries and illnesses. This also means that separate statistics are available for use in the design of health and safety programmes
entitlement to benefits can be varied according to the special requirements and qualifications of staff.

6.3.3 Distribution of responsibility among social security branches

The responsibility of different organizations for the provision of social protection benefits varies between countries. In many countries, cash benefits such as invalidity pensions, sick pay and maternity allowances are often administered by a single body because they have similar administrative requirements; the administration of in-kind benefits is very different. Cash benefits are often wage-related, and in-kind benefits are not.

In some countries, cash benefits such as sick pay and maternity allowances are administered by health insurance funds. The Netherlands and China have set up different systems for dealing with insurance claims for sickness and for serious diseases, because of the differing financial, administrative and epidemiological requirements. Most countries have special systems for work-related injuries and illness (see above).

Frequently, programmes for notification of and immunization against infectious diseases are assigned to a particular authority, such as the ministry of health. This is because although such programmes are in the public interest, there may be little incentive to pay for them from social health insurance.

Finally, rehabilitation and vocational rehabilitation are often covered by pension schemes, unemployment schemes or health insurance schemes. Where there are different systems with different responsibilities, it is important to ensure proper coordination.

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**QUESTIONS RAISED IN CHAPTER 6**

(1) What are the existing morbidity patterns and corresponding health needs?

(2) What are the priorities for benefits?

(3) What kinds of benefit can be provided? What is the relationship between the available financial resources, the desired benefit scheme and the associated costs?

(4) Can the existing infrastructure support the planned benefit scheme? Is there a need for additional investment and training?

(5) Are there other schemes (e.g., pension schemes, invalidity schemes) that provide services that overlap with the health sector? Will there be a need for coordination or restructuring of the benefit schemes?
Chapter 7

ORGANIZATION OF HEALTH SERVICES

7.1 Introduction

The successful development of social health insurance depends in part on the availability of high-quality, appropriate health services for the insured population. This chapter considers ways of ensuring that such services are available, and suggests some questions that need to be addressed.

The current provision of health care services in a country reflects the developments of the past, often showing a mixture of private, charitable, religious and government initiatives. Various reforms may have taken place — reforms designed to modify the pattern of health service delivery or to increase the coherence and comprehensiveness of the system. Unfortunately, the typical result of these developments is a system of health care with marked geographical disparities (between regions and between rural and urban areas), a focus on hospital services with poorly developed primary health care, and often very low status for health care professionals providing services in rural areas. Training in particular skills is often lacking even when the need for those skills has been identified. This description is as applicable to many countries with highly developed health services as it is to developing countries.

As mentioned earlier, an important distinction between a government-funded, government-provided health care system and a social health insurance scheme is that the latter gives subscribers an entitlement to specific services. Where the health service infrastructure is insufficient or inappropriate to fulfil patients' entitlements under social health insurance, the government may 1) engage in direct action to put services in place, 2) create incentives for non-government providers, or 3) monitor health service development to ensure that appropriate services are being provided. Preparation for the introduction of health insurance may require a mixture of all three courses of action.

7.2 What is the most efficient organizational and administrative structure for the service delivery system?

When considering ways of developing the health services for the introduction of social health insurance, it is important to keep a number of issues in mind. Firstly, a policy of maximizing health gains for any given expenditure calls for the cost of services to be kept to a minimum (to ensure maximum service per unit of expenditure). There must therefore be mechanisms to ensure that the right type of service is available to meet each need, and that there are incentives for cost containment. Secondly, the entitlement to services funded by insurance will not cover all health care needs. A way must be found to give priority to those with the greatest needs (i.e., those who will reap the greatest benefit from the services).

Health care reforms in many countries have been based on the understanding that a distinction can be drawn between assessment of the need for services, choice of patterns of service and service financing, on the one hand, and the
organization and management of service provision, on the other hand. The parties responsible for these two types of activity have been described as "purchasers" and "providers".

Competition between providers of health care can be a useful mechanism to improve the quality of care and reduce costs. It can also lead to loss of economies of scale, duplication and waste. Whereas, ideally, there should be at least two potential providers of any service so that the purchasers have a choice, this may not be practicable, and other measures may be needed for quality control. In this context, it is useful to consider whether "potential competition" is a possibility. In many situations, only one provider is required, but competition to be that provider can yield valuable incentives to improve standards and reduce costs. Franchising the management of a government-owned hospital is one example of such a mechanism. Although there is a market for only one hospital, there can be competition to run that hospital.

It is also possible to allow competition among health funds. This may lead to better management and better service. Experience suggests that great caution is needed in trying to use competition for this purpose. If, for historical reasons, there are already a number of funds, the members can be allowed to change funds. This will provide an element of competition. With several health funds, however, there is a danger that the price of services will be inflated and that the funds will refuse to take on high-risk subscribers. To avoid this:

- contracts with all providers should be the same for all funds
- there should be no substantial differences in the benefit packages
- the risk structures for different funds should be equalized
- the legal framework for the calculation of contributions, etc. should be consistent
- all funds should be obliged to accept any applicant from a group which qualifies for coverage.

Without these provisions, there is a serious risk of a cost explosion or of different risk pools (which means high premiums for the old and the poor).

7.3 The balance of primary and secondary care

A more serious problem in preparing the health services for social health insurance is the need to start with a reasonable balance between primary and secondary services, and between services in different areas. Controls on development may enable government to prevent services growing in areas which already have above-average provision, but it is not always possible to ensure that non-government providers will set up where needs are greatest: as the economists' saying goes "you can't push a piece of string". Government may need to invest directly in new facilities and staff training, or provide guarantees to encourage non-government providers to establish the services needed. Private investors may need financial guarantees, contracts for the initial period after the services are available or assurances that competitors will not be allowed to enter the market in the early stages. It is therefore likely that government will at least need to be involved in coordinating the establishment of the desired pattern of services.
Control over the cost of services can be largely achieved by ceilings on total health spending and payment mechanisms, both of which are discussed later in this guide. It is, however, important to understand that there are many pressures within a health care system which encourage costs to rise. Patients and health care providers prefer high-cost services at the time of use, and together they form a powerful partnership. New technologies, many of them of doubtful cost-effectiveness, are aggressively marketed by their manufacturers, and it may be difficult to exercise any control over which ones are adopted. It is unrealistic to expect the (probably overworked and underinformed) managers of the health funds to control costs completely.

The need to redress the balance between primary and secondary health care is recognized in many country policies and is strongly supported by WHO, through the Alma Ata declaration, but it has been very difficult to change the emphasis in practice. The development of high-quality primary care requires facilities, equipment, staff training and, most of all, career structures and status for primary care staff which match those in secondary and tertiary care. Those responsible for licensing health care professionals need to ensure that primary care is seen as a different, rather than an inferior, option to working in a hospital.

Once social health insurance is well established, it will not be necessary for government to be involved in the ownership of health care facilities and equipment. However, in the development of services in preparation for social health insurance, there may be a problem of timing. Individual service providers will be uncertain about obtaining contracts, and will therefore be unwilling to risk investing in facilities. The option of granting contracts in advance has its own risks. One possible solution is for government to undertake some preparatory investment, which can be followed by privatization or franchising of the facilities.

Government may be reluctant to get involved in service planning at this level, but experience in most countries suggests that failure to do so means that the services will be inadequate to fulfil patients' entitlements in many areas. For insurance to succeed, it is vital that the contributors should see an advantage in joining, even if membership is compulsory.

7.4 Relations between health insurance and providers

There are two basic forms of health care provision under social insurance: the direct method and the indirect method. In the first case, the health fund owns the providers, and in the second they enter into contracts with them.

Experience around the world shows that the direct method normally leads to quality problems and the indirect method leads to problems of cost control. Most social health insurance schemes use the direct method. The indirect method has been generating a great deal of interest, however, particularly since the development of sophisticated cost control strategies (see chapter 8 "Provider payment mechanisms" and chapter 9 "Cost estimation and cost control").

The tendency for the interests of providers to prevail over the interests of patients is a serious problem in many countries. Access to appropriate care can
be partly dependent on the inherent interests of the providers in giving the treatment, rather than the identified health needs of the patient.

There are two measures which can be taken to avoid this problem. Firstly, providers must have only a limited role in setting priorities. The process of identifying priorities and the need for services should be based on the best available evidence concerning patterns of disease and the cost-effectiveness of services to meet those needs. Providers may be asked to help in the gathering of information, but should not be allowed to determine the priorities. In practice, this means that there are advantages in keeping the health fund and the provider organizations formally separate.

Secondly, the best form of agreement between the health fund and the providers is a legally binding contract. This has the advantage that the monitoring of quality of care, volume of services and access to services can be enforced through the courts: although this is not normally necessary, it is a useful tactic to have in reserve. Contracts can provide a clear statement of the expectations of all parties and a mechanism for establishing rules for the selection and treatment of patients.

Legal contracts can only be made between legal entities. Different parts of the same legal organization cannot contract with one another. Therefore, an important step in preparing the health services for social health insurance is to establish providers as legal entities, even if they remain owned by government.

7.5 Strengthening health service management

Health care providers, especially when they have been managed as part of government, tend not to have strong, decentralized management systems. If providers are to manage services effectively and fulfill their contracts with health funds properly, their management capacity must be developed. In particular, there is a need to improve providers' internal management systems, such as those for financial and management information, and to provide training for managers.

Management information in hospitals has typically been aimed at basic accountability (i.e., whether the money has been spent as agreed) rather than ensuring that the right services, of the right quality, were provided to the right patients at the right cost. Information about hospital activities is often slow to appear, inaccurate and inappropriate. Hospitals and primary care facilities are highly complex organizations to manage, requiring reliable data on activity and expenditure. Many commercial organizations supply hospital management information systems: many of these systems are good, but they may not be well adapted to local needs. It is time-consuming, expensive and difficult to establish the data-gathering processes to produce information by which managers can manage.

Even the best information is valueless without managers who understand how to use it. Training managers is a major task in many countries and, more importantly, takes a long time. If there is a plan to introduce health insurance funding over, say, a five-year period, it will probably take at least that long to establish a core of suitably trained managers in the provider organizations.
Depending on the resources available locally, it may be necessary to send some managers for training and work experience in other countries.

Without good accounting and financial systems, timely and accurate information about activities and well trained staff, there can be no possibility of a feasible system of autonomous health care providers. The likely result is a series of financial problems among providers, with the consequent disruption of services.

### 7.6 Roles of ministries of health, insurance organizations and providers

Health insurance is a mechanism for achieving health policy goals; it is not in itself a policy. It must be clearly understood that the ministry of health, or an agency answerable to it, will continue to oversee the health insurance organizations and health care providers. The responsibilities of the ministry of health remain as follows:

- setting overall health policy goals
- creating the policy framework for the operations and activities of the health funds and providers
- monitoring the performance of health funds and service providers
- monitoring the quality of care
- ensuring that mechanisms are in place to fund and provide staff training and development
- ensuring that the overall costs of health services are kept under control.

Health funds must collect contributions from the insured population, and agree on contracts for the provision of health services to fulfil members' entitlements. As part of this process, they must be involved in setting priorities for health care, since it will not be possible to provide entitlements to all services which would benefit patients. The role of the providers of health services is to produce the quantity and quality of health care for the insured population that is specified in the agreements with the health funds.
QUESTIONS RAISED IN CHAPTER 7

(1) What are the needs for the development of primary, secondary and tertiary care facilities?

(2) What are the needs for training of human resources for health, and how is this training to be financed and organized?

(3) What system will be used for deciding on entitlements under the health insurance scheme?

(4) What will be the legal status of providers, and what framework of rules must be developed to control their activities?

(5) What is the strategy for the development and use of health care information and financial information?

(6) Who will have access to health insurance?
Chapter 8

PROVIDER PAYMENT MECHANISMS

8.1 Introduction

There are many different methods for paying providers. Each one has different effects on:

- the quality of health care services
- cost containment
- administration.

This chapter deals with the following issues:

- what is the importance and impact of provider payment systems in general? Who are the providers and what are their interests? Why does so much attention need to be paid to devising provider payment systems?
- what different provider payment systems exist? To which products and benefits are they applicable?
- how can they be set up?
- what are their effects on quality, cost containment and administration? What are their advantages and disadvantages?

8.2 The importance of provider payment systems in social health insurance

Social health insurance schemes consist of an insurance body (the health fund) on the one hand and the insured persons on the other. If any insured person has a need for a service that is included in the entitlements, he/she will receive it.

With social health insurance, however, there is also a "third party", namely the provider. Without providers, such as hospitals, physicians, nurses, and the pharmaceutical industry, there can be no health care. Providers represent the "spending side" of social health insurance.

Simply stated, expenditure on health care is determined by:

- the quantity of services and products that are prescribed or consumed
- their price.

Both these factors are influenced by the provider payment system. To a large extent the providers, especially physicians and hospitals, can determine the demand for their own services and products, once the patient has taken the first step of contacting them. It is the physician, not the patient, who specifies the kind and quantity of treatment and medication required.

It is important to consider the motivation of providers, especially physicians. Providers — like most other people — are primarily interested in maximizing their incomes. Depending on the payment system, they can do this by:
providing as many treatments as possible
attracting as many patients as possible (e.g., by prescribing many drugs, even placebos, since this often reassures patients that they are receiving proper treatment)
sending patients with financially unattractive or hazardous conditions to other providers, such as hospitals
asking patients to come back several times even when it is not necessary
unnecessarily using expensive equipment they have purchased (e.g., X-ray equipment) in order to amortize its cost.

Provider payment systems must allow the providers to achieve a reasonable income, in order to motivate them to produce services of good quality and to dissuade them from moving to better-paid jobs abroad. In addition, the potential to earn an attractive income can help to ensure a steady supply of qualified staff to provide services for members of the health fund.

A well-designed provider payment system must also prevent the kinds of waste and unnecessary service provision described above. Devising the provider payment system is therefore a very important task — these systems are a major instrument of cost containment. There are many different provider payment systems, and various combinations of different mechanisms are possible. The following subsections describe the major types of payment mechanisms and their impacts on quality, cost containment and administration.

8.3 Fee for service (and price per item)

8.3.1 Description

Fees for specific services and prices per item for drugs or appliances are the most common method of payment and the most "market-like". Providers get paid for each treatment act or product they provide. For example, a physician gets paid for a consultation or an examination, or a pharmacist gets paid for a pack of drugs or a certain quantity of pills, liquids or powders. As another example, a hospital gets paid for specific treatment acts provided by its physicians and for inpatient accommodation. These fees or prices may be uncontrolled. This means that each provider can charge as much as the market will pay.

Another possibility is a fee or price schedule. A fee schedule may be compulsory, or may represent an upper or a lower limit on the prices that may be charged. In Germany, for example, physicians who wish to treat social health insurance patients must adhere to a schedule: they are not allowed to charge fees higher or lower than the schedule fees. In France and Belgium, the fee schedule represents a recommended set of prices: physicians retain the option to charge fees higher than the fee listed in the schedule. In some countries, physicians are not allowed to charge more, but may charge less, than the schedule fees.

In general, a fee schedule has two functions:

(1) To inform people about the acts and services that may be charged to health insurance. The list must be updated frequently to stay abreast of
new methods and techniques in medicine or to react to developments in consumption, prescription and epidemiology.

(2) To inform people of the price of these acts and services. Prices may also be adjusted for inflation or to take account of developments in techniques or treatment.

The fee schedule is important for both patients and physicians. If there is no compulsory fee schedule, the health fund has to fix tariffs in order to contain costs. If health insurance funds paid whatever prices physicians charged, rising costs would become a serious problem. Patients and physicians would reach a tacit agreement about fees, and health funds and contribution-payers would have to bear the cost. It is therefore important to specify the fees that the health fund is prepared to pay.

If physicians are not obliged to stick to the fee schedule, patients often have to pay a large part of the charges for treatment. From the point of view of both the health fund and the patients, it is an advantage to have a compulsory fee schedule for all physicians who treat social health insurance patients, since it leaves no room for doubt about the charges to be expected.

For the physician, too, there is an advantage in having a fee schedule stating which items and fees are chargeable and leaving no room for dispute between patient and physician. From the physician's point of view, the best solution is a schedule of minimum fees, so that successful physicians can charge more if patients are able and willing to pay.

The same arguments apply to hospitals and other providers, including pharmacists. Unfortunately, many countries still do not have price lists for drugs. In these countries, the pharmaceutical industry and pharmacists are free to charge whatever price they like. Countries like France that have introduced obligatory drug lists have found them useful as cost containment instruments.

There are two items of information that may figure in a price list for drugs:

(1) The product itself: this means that health insurance will not pay for all products, but only for those on the list. In France, health insurance invites tenders for the products to be included in the list. It is also possible to produce a list of active ingredients, rather than specific brands or products (this model is found in Germany). This means that health insurance pays only for certain active ingredients, regardless of the manufacturer.

(2) The price: prices may be listed for specific products (as in France) or for certain active ingredients (as in Germany).

Table 5 identifies the basis for payment and the unit of billable service for a range of providers operating on a fee-for-service basis.

8.3.2 Establishment and calculation

A fee-for-service payment should be based on a fee schedule. This schedule may be fixed by the insurance fund in consultation with the ministry of health, or may be the result of negotiations between health funds and providers. A combination of the two is also possible: provider federations and health funds
TABLE 5
APPLICATION OF FEE-FOR-SERVICE PAYMENT

<table>
<thead>
<tr>
<th>Provider</th>
<th>Basis for payment</th>
<th>Unit of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>family physicians, dentists</td>
<td>fee schedule</td>
<td>act</td>
</tr>
<tr>
<td>specialists</td>
<td>fee schedule</td>
<td>act</td>
</tr>
<tr>
<td>hospitals (inpatient and outpatient treatment)</td>
<td>fee schedule</td>
<td>act</td>
</tr>
<tr>
<td></td>
<td></td>
<td>inpatient day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(accommodation only)</td>
</tr>
<tr>
<td>pharmacies</td>
<td>price list</td>
<td>item</td>
</tr>
<tr>
<td>ancillary services</td>
<td>fee schedule</td>
<td>act</td>
</tr>
<tr>
<td>protheses</td>
<td>price list</td>
<td>item</td>
</tr>
</tbody>
</table>

negotiate a fee schedule, which is then endorsed and supported by the ministry of health.

A fee schedule may contain actual prices or be expressed in points that are later multiplied by a point value. The latter system has the following advantages:

- values can easily be adjusted. Every provider needs an accurate schedule, and schedules showing actual prices must be reprinted and redistributed in their thousands every time prices change (because of inflation, for example)
- it is possible to fix or negotiate an overall budget for all services in advance and to fix the point value at the end of the financial period to keep total costs within this budget. In this way, providers cannot increase the overall budget for services.

In the construction of a fee schedule, planners must consider:

- the assumed income of physicians
- the estimated costs of providing specific health services
- the desired incentive structure.

Fee schedules can be quite complex — there may be up to 2000 different fees on a schedule. Drug lists may have up to several thousand items, depending on whether individual products or specific ingredients are listed (see 8.3.1 above), and on the range of drugs or ingredients that the health fund has agreed to cover.

Fees for specific acts are calculated using the following information:

- the factors used (e.g., labour, capital costs, materials)
- the number (quantity) of units of each factor used
- the price of one unit.

The quantity of each unit is multiplied by the unit price to give the cost of each factor: these are then added together to give the fee for one act (e.g., a vaccination performed by a physician). Table 6 shows one example in detail.

It can be advantageous to define the cost of factors in comparable units. This is relatively easy with factors that can be related to output, such as labour and materials, because they are directly correlated with the quantity of services...
produced. It is more difficult with factors that are not directly output-related, such as rent, capital costs and administration.

Costs that are not directly output-related are incurred no matter how many services are produced, and it is essential to ensure that the fees paid cover them adequately. As an example, the following procedure may be used to calculate the cost of renting premises:

- take the total cost of renting the premises (say $12,000 per year)
- estimate the time the premises will be in productive use in one year (say eight hours per day for 220 days, or 105,600 minutes per year)
- divide the first figure by the second to give the unit cost of renting the premises (i.e., $0.11 per minute).

The same method can be applied to calculate other overhead unit costs.

A crucial question in the design of a fee-for-service system is how to calculate the cost of a physician’s labour. It must either be negotiated or be set according to existing income experience in the country concerned.

| TABLE 6 |
|-------------------------|---------|---------|----------|
| Factor                  | Units   | Price   | Factor costs |
| proportional costs      |         |         |            |
| labour — physician      | 10 minutes | $0.5/minute | $5.00     |
| labour — nurse          | 10 minutes | $0.2/minute | $2.00     |
| materials               |         |         | $2.00     |
| sum of proportional costs |         |         | $9.00     |
| overhead costs          |         |         |            |
| rents                   | 10 minutes | $0.18/minute | $1.80     |
| capital utilization     | 10 minutes | $0.05/minute | $0.50     |
| administration          | 10 minutes | $0.05/minute | $0.50     |
| sum of overhead costs   |         |         | $2.80     |
| TOTAL FEE               |         |         | $11.80    |

Source: (3)
Note: The units to be used for each kind of service can be identified by empirical study.

8.3.3 Impact on cost containment, quality and administration

Providers working under a fee schedule system have three ways of maximizing their income:

- increasing the number of acts (i.e., services)
- reducing the quality of the services (e.g., by cutting the time per consultation)
- delegating more acts to lower-paid personnel (e.g., nurses, technicians).

Given the method used to calculate the fee, it is obvious that a provider has a strong incentive to produce as many acts as possible. By increasing the number of acts, physicians can:

- increase payments for their own work
- make extra profit by using the overhead factors more than is assumed in the calculation.
The effect of fee-for-service payments on the costs of the health service is clear: it encourages the production of services (even unnecessary ones) and leads to higher costs.

The impact on quality is not so clear. There is an incentive to spend as little time as possible on each treatment act in order to maximize the number of acts that may be performed in any one period. Moreover, there is an incentive to delegate work to less qualified personnel in order to increase the total profit. Both of these may have a negative impact on quality. On the other hand, providers have a strong incentive to work and to provide services. If there is competition among providers, it will not be easy to retain patients if the quality of the service is inferior.

To sum up: the fee-for-service system tends to encourage overproduction but may also lead to a higher quality of service. To a great extent, the effects of the fee-for-service system depend on the design of the fee schedule. If particular services are to be encouraged, for example, the fee should be set above the actual cost of the service. If the aim is to prevent physicians from overproducing certain services (especially services that can be delegated) the fee should be set slightly below the actual cost.

From an administrative point of view, a fee-for-service system is likely to be the most expensive form of provider payment mechanism. For the providers, billing procedures are complex and costly, under either the direct or the indirect method of health care provision (see chapter 7.4). For the health fund, the costs of processing claims will be high, and the fund must establish expensive monitoring procedures to prevent the submission of fraudulent claims.

8.4 Case payment

8.4.1 Description

The case payment system is based on a single case rather than a single treatment act. Each case the physician treats leads to the payment of a fee. Two different systems can be distinguished:

- a case payment based on a single flat rate per case, regardless of diagnosis
- a case payment based on a schedule of diagnoses.

The first model is the simplest version of case payment. It means that each case presented to the physician earns him/her the same amount of money, no matter how difficult the case is or what resources are required to treat the patient.

The second model uses systems of case classification. The most widely-known case classification approach is the "diagnosis-related groups" (DRG) system, which identifies around 470 diagnostic groups. DRG systems are most commonly used to pay hospitals for the treatment of inpatients, although the systems could have other applications. The provider is paid according to the DRG into which the patient's diagnosis falls. The diagnosis is assigned on discharge of the patient, after the results of tests and interventions. There may be different grades for some diagnoses, and fees vary according to the average
cost of treating the condition diagnosed. This system allows a higher degree of differentiation than the first model described above.

In simple terms, a case payment system is based on a “budget” paid for the treatment of a particular case or diagnosis. If the treatment is more expensive than the payment, the provider makes a loss. If the treatment is less expensive than the payment, the provider makes a profit.

Case payment systems may be used for providers whose services can be related to individual cases, such as family physicians, specialists, dentists, physiotherapists, hospitals or health centres. Case payment is not suitable for provider units that sell single product items, such as pharmacies.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Basis for payment</th>
<th>Unit of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>family physicians, dentists</td>
<td>fee schedule</td>
<td>diagnosis</td>
</tr>
<tr>
<td>specialists</td>
<td>lump sum</td>
<td>average case</td>
</tr>
<tr>
<td></td>
<td>fee schedule</td>
<td>diagnosis</td>
</tr>
<tr>
<td>hospitals (inpatient and possibly outpatient treatment)</td>
<td>lump sum</td>
<td>average case</td>
</tr>
<tr>
<td></td>
<td>fee schedule</td>
<td>diagnosis</td>
</tr>
<tr>
<td>pharmacies</td>
<td>not applicable</td>
<td>diagnosis</td>
</tr>
<tr>
<td>ancillary services</td>
<td>fee schedule</td>
<td></td>
</tr>
<tr>
<td>prostheses</td>
<td>not applicable</td>
<td></td>
</tr>
</tbody>
</table>

8.4.2 Establishment and calculation

The establishment of a case payment system is quite easy if there is only a flat rate to be paid per case. It requires an estimate of the number of cases the average physician/hospital treats during a certain period (usually one year). The next step is to calculate the average total cost of a physician’s facility (or the average total cost of operating a hospital) for the same period. This amount is divided by the estimated number of cases to obtain the amount to be paid per case. This amount may be different for each category of specialist (family physician, eye physician, orthopaedic surgeon, paediatrician, etc.) or for each hospital or category of hospital.

The advantage of a flat rate case payment system is that it is very easy to operate. The disadvantage is that it fails to differentiate between the different requirements of the cases the provider may be faced with: the provider will be paid the same for treating a cancer case or a simple case of influenza (unless different flat rates are paid for different categories of specialists). For this reason, this method of payment works best for providers whose cases are all of a similar degree of complexity.

DRG case payment systems are considerably more sophisticated. The first step in establishing such a system is to draw up a list of possible diagnoses. On the one hand, this list has to be detailed enough to match the different requirements of as many diagnoses as possible. On the other hand, it has to avoid being as detailed as a fee-for-service schedule in order to retain the advantage of simplicity. It is calculated in a similar way to a fee-for-service schedule, by finding the average cost per diagnosis (number of factor units multiplied by unit price). It is different from a fee-for-service schedule in that
there is an implicit assumption that each diagnosed problem will be handled according to a standard treatment protocol.

8.4.3 Impact on cost containment, quality and administration

In theory, case payment systems avoid one disadvantage of fee-for-service systems—the incentive to "produce" as many services as possible. However, since providers get paid by diagnosis, and not for each act, they can attempt to maximize their income by:

- recording a more complicated diagnosis than that presented by the patient. If the payment schedule contains several different grades for one diagnosis, the provider can simply choose the highest grade (this is sometimes described as "DRG creep")
- submitting claims for non-existent cases
- reducing the cost per case (i.e., the time and materials used per case), potentially producing services of inferior quality
- picking out the cases with the best cost-benefit ratio and sending other (sometimes more complex) cases to other providers, if possible.

To a certain extent these problems may be solved by:

- detailed specification of each diagnostic group
- limiting the number of items on the fee schedule, since providers' influence over the diagnosis of a case increases with the number of items on the schedule.

Clearly, there are tradeoffs between these two solutions. Therefore, a system based on diagnoses requires strict controls in order to ensure that:

- the cases are assigned to the right diagnostic groups
- patients are not needlessly transferred from one provider to another
- a certain level of quality is maintained.

The burden of control is the responsibility of the health fund. The necessity to ensure control implies that the health fund must have a good validation and claims management system. Competition among providers will help to prevent individual providers from offering services of inferior quality, but there is still a need for quality control.

In general, a case payment system with diagnostic groups is better than a fee-for-service system. The opportunities for fraud are more limited, consisting mainly of manipulation of reported diagnoses. Unfortunately, experience with case payment systems (specifically DRGs) demonstrates that providers consistently maximize their claims and the cost of monitoring and validating claims is disproportionately high.

The administration costs of a case payment system with a general flat rate per case for each kind of provider are considerably lower than those of a fee-for-service system. A case payment system which employs a schedule of diagnoses, however, is not much cheaper to administer than a fee-for-service system.
8.5 Daily charge

8.5.1 Description

Per diem fees or daily charges are used to pay providers who treat patients for lengthy periods. They are only found in hospital payment systems. Theoretically, it would also be possible to use them in other situations — to pay nurses providing long-term care in a patient's home, for example.

Per diem fees cover all services and expenses per patient per day (medical treatment, drugs and bandages, prostheses, accommodation, etc.). The fee is always the same, no matter what treatment is required (although fees may differ among providers — per diem fees would naturally be higher for a university hospital than for a hospital in a rural area). Per diem fees may be negotiated between the provider (hospital) and the health fund.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Basis for payment</th>
<th>Unit of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>family physicians, dentists</td>
<td>not applicable</td>
<td></td>
</tr>
<tr>
<td>specialists</td>
<td>not applicable</td>
<td></td>
</tr>
<tr>
<td>hospitals</td>
<td>fixed or adjustable rate</td>
<td>inpatient day</td>
</tr>
<tr>
<td>pharmacies</td>
<td>not applicable</td>
<td></td>
</tr>
<tr>
<td>ancillary services</td>
<td>fixed or adjustable rate</td>
<td>patient day</td>
</tr>
<tr>
<td>prostheses</td>
<td>not applicable</td>
<td></td>
</tr>
</tbody>
</table>

8.5.2 Establishment and calculation

A per diem fee is relatively easy to establish. There must be a detailed description (by law or regulation) of costs regarded as reimbursable (e.g., staff, materials, investment costs). The basis of the calculation is the total cost of the provider unit during a certain period (normally one year). This is divided by the number of patient days during the same period.

These two parameters may be fixed at the beginning of a year using the parameter values of the previous year. If at some point during the year it is determined that actual costs deviate significantly from the fixed parameters, an adjustment may be possible (if actual costs are higher, the daily rate is increased, if they are lower, the daily rate is reduced). Since the per diem rates can be changed, a hospital can make neither a deficit nor a surplus.

It is also possible to fix the daily rate in advance and to exclude any later adjustment. In this case, a surplus or deficit is possible. If no changes to the daily rate are allowed, the health fund bears the risk of increased costs resulting from increased morbidity in the population.

8.5.3 Impact on cost containment, quality and administration

With a per diem payment mechanism, the only parameters a hospital can influence are:

- total costs per time period
- the number of patient days.
If the daily rate is fixed, the hospital has an incentive to reduce costs and increase the number of patient days in order to make a profit. If hospitals reduce costs by better management, this is a desirable effect. Whether or not they reduce costs by sacrificing quality depends on the degree of competition and the quality control system.

If the daily rate is variable, the hospital has no incentive to reduce costs, because all recognized costs will be reimbursed anyway. Nevertheless, it still has an incentive to increase the number of patient days. It is relatively easy for hospitals to keep patients in hospital longer than strictly necessary. A large proportion of costs in a hospital are fixed (i.e., they cannot be changed in the short term). Variable costs can amount to as little as 20% of a hospital's total costs. The hospital will want to ensure that it achieves the utilization rate that is used for calculating the daily rate. It may only be possible to do so by keeping patients in hospital for longer than necessary.

Even with fixed rate calculation, the hospital has an incentive to keep patients as long as possible. This effect may be countered if the health fund establishes a global budget for the hospital, which may not be exceeded.

The administration of payment by daily rates is relatively cheap. Neither a fee schedule nor a detailed list of the services given to health fund members is required. Of course, a detailed accounting system for hospitals is needed as a basis for negotiating the daily rates. The system should be the same for all hospitals so that comparisons between them are possible.

8.6 Bonus payment

8.6.1 Description

A bonus can be paid to providers as an incentive to achieve certain objectives. These objectives may be economic in nature or may be related to the country’s health policy objectives.

An economic objective may be a lower national drugs bill. As drugs are prescribed by physicians, drug consumption can be reduced by giving physicians incentives to prescribe fewer drugs. This can be done by paying a bonus to physicians whose prescription costs per patient are below the average of other physicians of the same specialty.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Basis for payment</th>
<th>Unit of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>family physicians, dentists</td>
<td>lump sum</td>
<td>specific objectives (e.g., certain percentage of patients immunized)</td>
</tr>
<tr>
<td>specialists</td>
<td>lump sum</td>
<td>specific objectives specific behaviour patterns</td>
</tr>
<tr>
<td>hospitals</td>
<td>lump sum</td>
<td>specific objectives specific behaviour patterns</td>
</tr>
<tr>
<td>pharmacies</td>
<td>not applicable</td>
<td></td>
</tr>
<tr>
<td>ancillary services</td>
<td>not applicable</td>
<td></td>
</tr>
<tr>
<td>prostheses</td>
<td>not applicable</td>
<td></td>
</tr>
</tbody>
</table>
An identified health policy objective may be to achieve a certain percentage of immunizations among the population. Family physicians are usually responsible for immunization, so one way to achieve a higher immunization rate is to pay a bonus to every physician who succeeds in achieving a certain rate of immunization among his/her relevant patients. Bonuses may also be paid to promote other objectives of preventive medicine.

8.6.2 Establishment and calculation

The establishment of a bonus system requires sophisticated control mechanisms for monitoring the achievement of the objectives. Otherwise, there is a considerable risk of fraud. This means, for example, that all prescriptions issued by a physician must be registered or all immunizations must be registered in the name of the immunized person (in order to prevent double immunization).

There is no general rule about the calculation of the bonus. It should be high enough to be an incentive for the physician. If it is calculated as a part of the average physician’s revenue, there will be no extra administrative costs.

8.6.3 Impact on cost containment, quality and administration

Bonus payments for objectives such as prescribing fewer drugs may have a significant effect on cost containment. However, it is important to ensure that the prospect of a bonus does not discourage the physician from prescribing drugs which are actually needed. Therefore the bonus should depend on achieving the objective (e.g., prescription costs lower than the per capita limit) but it should not be proportional to the actual savings in drug consumption.

Administration costs will depend on the existence of a registration system for prescriptions, immunizations, etc. If the registration system has to be set up from scratch, a bonus system may end up costing more than it saves.

8.7 Flat-rate payment

8.7.1 Description

Flat-rate payments are frequently used to finance particular investments. Providers may receive a fixed budget to buy equipment, for example. If this system of financing is used, a basis for the assessment of the budget is required. If physicians are paid by flat rate, the basis might be the specialty of the physician (e.g., family physician, eye physician, radiologist, etc.). Under this system, each physician would be allocated a budget for a certain period, generally a year. The budget should cover amortization and interest on the capital needed to buy the equipment.

Nevertheless, it is difficult to finance the capital costs of physicians who work with high-cost equipment, such as radiologists, because the flat-rate payment will be higher than the physician’s income. Flat-rate payments are less complicated when used to finance the equipment costs of providers who work with less expensive equipment, such as family physicians or paediatricians.
Flat-rate payments may also be used to cover other kinds of costs. For example, the physician may be allocated a budget for staff costs. Additionally, flat-rate payments may be used as a source of finance for other providers, such as hospitals. In this case, a hospital may receive a lump sum to buy equipment, based on the number of beds. Hospitals in Germany are financed in this way.

### TABLE 10
**APPLICATION OF FLAT RATE PAYMENT**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Basis for payment</th>
<th>Unit of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>family physicians, dentists</td>
<td>lump sum</td>
<td>defined or approved equipment</td>
</tr>
<tr>
<td>specialists</td>
<td>lump sum</td>
<td>defined or approved equipment</td>
</tr>
<tr>
<td>hospitals</td>
<td>lump sum</td>
<td>defined or approved equipment</td>
</tr>
<tr>
<td>pharmacies</td>
<td>not applicable</td>
<td></td>
</tr>
<tr>
<td>ancillary services</td>
<td>not applicable</td>
<td></td>
</tr>
<tr>
<td>prostheses</td>
<td>not applicable</td>
<td></td>
</tr>
</tbody>
</table>

### 8.7.2 Establishment and calculation

A flat-rate payment is calculated on the basis of the typical equipment costs of a provider in the specialty concerned. All necessary equipment, such as instruments, furniture, machines, etc., is defined. The working life of each item must be taken into account, along with amortization and annual interest charges. Interest charges may change from time to time, and amortization may change as technology advances, meaning that existing equipment is out of date and thus losing value.

There are two ways of running such a system. The first is to monitor the investments made by each physician. In this case, receipts are required from the physician showing the equipment purchased over the year. Money that has not been used can be deducted from the payment for the next period. The other possibility is to give the investment budget to the physician. This allows physicians who economize on equipment costs to make a profit. In both cases, a standard list of equipment can be drawn up and given to each provider as a guide for investment decisions.

### 8.7.3 Impact on cost containment, quality and administration

The impact on cost containment, quality and administration depends on the way the flat-rate payment is handled. As mentioned above, in general there are two methods of flat-rate payment: the variable budget combined with monitoring of financial resources, and the fixed budget combined with quality control.

In the case of a variable budget, the provider has an incentive to spend all the money, even if that means buying equipment that is not needed. The provider loses any money that is not invested. On the other hand, this method of financing allows the health fund to specify equipment standards. At the same time, certain unnecessary high-cost investments (that would have to be amortized later) are excluded because the investment budget is not large enough.
The incentives of a fixed budget are different. If the provider is able to buy equipment at a good price, there may be some money left over to increase his/her personal income or to undertake additional investment. In this case, the provider has an incentive to buy cheap equipment, to wait longer before buying or to buy no equipment at all. For this reason, it is important to establish clear specifications for equipment and other measures that ensure quality control.

The administration costs of a flat-rate payment system are generally quite low. The administrative functions consist mainly of assessment and monitoring of the flat-rate payment. Once this has been done for one group of physicians or hospitals, it is not likely to change much, and monitoring may be limited to an occasional sample.

8.8 Capitation fee

8.8.1 Description

A capitation fee covers services for one health fund member over a certain period (normally one year). The fee is paid to a nominated provider who has the responsibility to provide health care, without discrimination, for the duration of the cover period. The capitation fee is based on the pooling of risk by the provider: some insured persons may not use health services at all during the period covered, thus allowing the provider to make a profit. Others may have chronic illness or disease, necessitating a number of visits or inpatient stays, the cost of which exceeds the capitation fee.

The capitation fee is paid to a provider chosen by the insured person. In order to encourage competition and high quality service, the insured person should have the right to change the nominated provider on a regular basis, again usually annually.

There are simple systems and more sophisticated systems of capitation payment. In simple systems, the provider receives the same fee for each patient registered there. In more sophisticated systems, the fees vary according to various parameters, such as age and sex of the patient or area of residence.

Capitation fees are suitable as a payment mechanism for primary care providers and for hospitals. The capitation fee would cover any or all services required at primary or secondary levels. Sometimes when a hospital is paid a capitation fee it is then held responsible for both primary and secondary care for the insured person. However, it is possible to have a "dual" capitation, where the primary care practitioner chosen by the insured person is paid one capitation fee, and a hospital either chosen by the insured person, or assigned to the insured person because of location, is paid a separate capitation fee to cover secondary care needs. In this instance, the primary care practitioner role of "gatekeeper" to secondary services is reinforced, acting as a rationing device for utilization of secondary care services.

In the case of individual specialists, working alone or in tandem with a small number of specialist colleagues, the capitation payment mechanism is not suitable. For individual specialists, other payment systems such as case payment or even fee-for-service are more practical. In addition, capitation fees are not applicable to pharmacies.
TABLE 11
APPLICATION OF CAPITATION FEES

<table>
<thead>
<tr>
<th>Provider</th>
<th>Basis for payment</th>
<th>Unit of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>family physicians, dentists</td>
<td>fixed rate per registered patient</td>
<td>all health services provided during a given time</td>
</tr>
<tr>
<td>specialists</td>
<td>application difficult (unless specialist works for capitation-paid hospital)</td>
<td></td>
</tr>
<tr>
<td>hospitals</td>
<td>fixed rate per registered patient</td>
<td>all health services provided during a given time</td>
</tr>
<tr>
<td>pharmacies</td>
<td>not generally applicable (may be useful for hospital pharmaceutical services)</td>
<td></td>
</tr>
<tr>
<td>ancillary services</td>
<td>not applicable</td>
<td></td>
</tr>
<tr>
<td>protheses</td>
<td>not applicable</td>
<td></td>
</tr>
</tbody>
</table>

8.8.2 Establishment and calculation

A capitation fee system consists of two parts:

- the fee itself, which has to be calculated
- a register of providers (physicians or hospitals) and patients who have registered with each. The administration of this list is the task of the health fund. The patient must declare to the health fund which physician or hospital he/she has chosen, so that the provider can be paid.

The fee is calculated by dividing the estimated cost of physicians' labour, materials, capital expenditures and staff by the estimated number of patients per provider. Once the capitation fee has been calculated, the provider receives a fee for each insured person on the provider's register. The number of patients who may register with one physician or hospital should be limited in order to maintain quality standards. The patient should have the opportunity to change providers after a certain period (usually one year) in order to maintain competition among providers.

8.8.3 Impact on cost containment, quality and administration

The effects of capitation on cost containment are very positive. There is no parameter the provider can influence that can lead to waste or unnecessary costs.

Capitation fees are suitable for providers who potentially have continuing contact with the patient. This makes them particularly suitable for primary care providers, as it encourages the insured person to use one physician on an ongoing basis and so build up a clinical relationship where the medical history is known. In this way, minor illnesses and chronic illnesses can be more effectively treated since the physician can respond quickly to urgent illness or acute phases of chronic illness, by referring the patient to the appropriate level of care.

There is also the possibility, however, that a capitation system can reduce incentives to provide good quality service. If a provider is guaranteed a payment for each person on his/her register, there may be no motivation to provide high
quality care. As mentioned above, this problem may be solved by giving the patients the right to change physicians. A physician who provides inferior-quality services will find it difficult to get enough patients. However, this only works if there are enough physicians to give the patient a real chance of finding a good physician whose list has not yet been closed. Another way of solving the problem is to establish and apply clear standards for the provider. If providers do not meet these standards, the health fund can withdraw them from the list of providers.

The administration costs of the capitation fee system are very low, particularly when compared with fee-for-service systems. The only real administrative complication arises when patients change providers.

8.9 Salary

8.9.1 Description

A salary system is normally based on a labour contract between the provider and the health fund. Under this agreement, the health fund pays the provider a monthly salary, plus supplementaries such as employer’s contributions to social security. The employee works on a time basis, being paid not for the quantity of services provided, but for the time he/she is at the disposal of the health fund. The amount paid is the same, regardless of the number of patients to be treated. Equipment, materials and additional staff are paid for by the health fund.

<table>
<thead>
<tr>
<th>TABLE 12</th>
<th>APPLICATION OF SALARY PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Basis for payment</td>
</tr>
<tr>
<td>family physicians, dentists</td>
<td>amount according to labour contract</td>
</tr>
<tr>
<td>specialists</td>
<td>amount according to labour contract</td>
</tr>
<tr>
<td>independent hospitals</td>
<td>not applicable</td>
</tr>
<tr>
<td>hospitals owned by health insurance fund</td>
<td>amount according to labour contract</td>
</tr>
<tr>
<td>pharmacies</td>
<td>amount according to labour contract</td>
</tr>
<tr>
<td>drugs</td>
<td>not applicable</td>
</tr>
<tr>
<td>ancillary services</td>
<td>amount according to labour contract</td>
</tr>
<tr>
<td>protheses manufacturers</td>
<td>limited application</td>
</tr>
</tbody>
</table>

The labour contract may be on a full-time or part-time basis. It may allow the employee to undertake additional commitments (e.g., private consultations) when not working for the health fund. If the provider uses health-fund-owned facilities for private work, he/she must pay a sum to cover costs.

Labour contracts are applicable to all kinds of individual providers who produce services or products, such as family physicians, nurses, pharmacists, physiotherapists, manufacturers of protheses, etc. For obvious reasons, they are not
applicable to provider units such as hospitals, health centres or the pharmaceutical industry.

Nevertheless, health funds may own hospitals, in which case staff are employed on a salary basis and the health fund takes care of additional factors, such as materials and capital. It also means that the health fund has the responsibility of organizing the combination of these factors and guaranteeing quality.

8.9.2 Establishment and calculation

The establishment of a provider payment system based on labour contracts consists of several tasks:

- finding staff who meet the requirements of the health fund and are willing to sign labour contracts; specifying or negotiating labour contracts with these providers
- organizing and administering the units where the employees work (renting or buying premises, buying materials and equipment, employing other staff such as nurses, secretaries, cleaners)
- staff organization and administration (payroll, taxes, social security and other social services, job descriptions, hierarchy and responsibilities, supervision, questions of promotion and qualification, etc.).

Any health fund using employed staff must therefore consider costs other than salaries. These associated costs are normally as high as the salary costs.

8.9.3 Impact on cost containment, quality and administration

It is not possible to say in general whether it is more efficient and less expensive to provide health care by employing providers as staff or by entering into contracts with independent providers. There is some evidence, however, that the cost of providing services may be lower with employed staff than in a system of independent providers.

Employed staff may have fewer incentives to perform well and maintain high standards than independent staff. However, employees' motivation depends to a great extent on the quality of management (the level or amount of salaries, promotion prospects, the organization and responsibilities of individual units, the scope for decision-making, etc.). The danger is that the health fund may grow to resemble other semi-public institutions, which tend towards bureaucracy, formalism, inflexibility and lack of motivation.

In a system with health-fund-managed providers, administration costs are likely to be higher than in a system using independent providers. All the additional costs that are included in the other payment systems have to be borne by the health fund directly.

In a system based on employed providers, the crucial question is whether the health fund can:

- acquire the provider's labour more cheaply
- guarantee at least the same performance (quantity and quality of work)
guarantee more efficient management and better organization than independent providers.

Existing examples are not very encouraging, but this does not mean that success is impossible. Countries with salaried providers on low incomes often find it difficult to prevent patients making illegal additional payments to physicians. In some countries, this represents a significant proportion of the physician’s income. In effect, low salaries can mean that an unofficial fee-for-service system replaces the system of salaried providers.

8.10 Budget

8.10.1 Description

A budget may be defined as the payment of a particular sum that covers the total cost of services or products delivered during a given period of time. Normally, the provider must cover any deficit, although he/she can also keep any profit. Under a budget system, both the provider and the health fund run a certain risk — namely, the risk of increased morbidity or unexpected increases in factor costs. The health fund runs the risk that real costs will turn out to be lower than the budget, while the provider runs the risk that costs will be higher than the budget.

A budget may be fixed or variable. For example, the health fund and the provider may agree that certain parameter changes (e.g., extreme changes in morbidity) will be grounds for a budget adjustment.

The budget system is applicable to many kinds of providers. Physicians and hospitals may be allocated budgets. Some health services, such as drugs, ancillary services or prostheses, can be financed by an indirect budget. This is appropriate because the demand for these services and products depends on prescriptions by physicians, so they should take responsibility for decisions about the use of the budget. In practice, this means that physicians receive a separate budget for drugs, ancillary services and prostheses.

<table>
<thead>
<tr>
<th>TABLE 13</th>
<th>APPLICATION OF BUDGET PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Basis for payment</td>
</tr>
<tr>
<td>family physicians, dentists</td>
<td>amount payable in total per year or in installments; fixed sum for prescription of drugs and ancillary services per year</td>
</tr>
<tr>
<td>specialists</td>
<td>amount payable in total per year or in installments; fixed sum for prescription of drugs and ancillary services per year</td>
</tr>
<tr>
<td>hospitals</td>
<td>amount payable in total per year or in installments</td>
</tr>
<tr>
<td>pharmacies</td>
<td>see above under &quot;family physicians, dentists&quot;</td>
</tr>
<tr>
<td>ancillary services</td>
<td>see above under &quot;family physicians, dentists&quot;</td>
</tr>
<tr>
<td>prostheses</td>
<td>not applicable</td>
</tr>
</tbody>
</table>
If a physician is allowed to earn a surplus (or incur a deficit) on an indirect budget, there is an incentive to manage the budget in an efficient way. In this case, the budget must be combined with a quality control system (see also flat-rate payment and bonus payment).

In theory, it is also possible to finance secondary care (specialists and hospitals) using budgets under the control of primary care physicians, because the latter normally decide whether a patient should have access to secondary care. However, this may be difficult in practice because these budgets would be much larger than the physician’s own budget and would constitute a considerable additional responsibility.

8.10.2 Establishment and calculation

The calculation of a budget should take place under a clearly specified set of budgeting regulations and a system of negotiation. The budget may be calculated on an input-oriented or an output-oriented basis. An input-oriented budget is based on cost experience of a provider unit. The cost experience may be described as:

- the actual costs of a particular provider unit
- the average costs of all provider units of the same size (number of beds) and kind (specialty).

An output-oriented budget is based on a provider’s performance. Estimating performance is more difficult than estimating costs. Performance does not mean the number of acts or products provided, but rather the number and kind of cases the provider is presented with. Clearly, the volume and mix of cases will depend on a variety of factors, including the age, sex and sociocultural composition of the provider’s clients, as well as the economic circumstances of the population served. These data can be obtained by establishing a registration system with physicians and hospitals. Then the average numbers and mix of diagnoses for each population group must be calculated and multiplied by cost.

8.10.3 Impact on cost containment, quality and administration

In countries where budget systems have been established, especially in the hospital sector (e.g., France, Canada), the experience with cost containment has been good: the budget system has led to a reduction in costs, or at least to a slower rate of cost increases.

Under a budget system, the provider has an incentive to contain costs. In certain cases, this may lead to attempts to save money by avoiding expensive drugs and operations, even when they are necessary, or by substituting expensive treatments with less expensive, but perhaps less effective, treatments.

This problem may be solved by:

- a flexible budget which depends to a certain extent on actual (not estimated) morbidity
- quality control measures
- competition for patients between hospitals and other providers.
Administratively, a budget system is likely to be less expensive than a fee-for-service system.

8.11 Comparison of different payment systems

The following tables provide a summary of the different payment systems and their effects on cost containment, quality and administration. Some systems have clear advantages over others with respect to one or more performance characteristics. Capitation systems, for example, score high on both cost containment and administration. It is not easy to choose between the systems, and the most efficient system for a given country will depend on the local situation.

<table>
<thead>
<tr>
<th>Payment system</th>
<th>Cost containment</th>
<th>Quality</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>fee-for-service</td>
<td>very poor</td>
<td>very good</td>
<td>very difficult</td>
</tr>
<tr>
<td>case payment</td>
<td>good</td>
<td>fair</td>
<td>difficult</td>
</tr>
<tr>
<td>daily charge</td>
<td>fair</td>
<td>poor</td>
<td>very easy</td>
</tr>
<tr>
<td>bonus payment</td>
<td>good</td>
<td>good</td>
<td>easy</td>
</tr>
<tr>
<td>flat rate</td>
<td>good</td>
<td>good</td>
<td>easy</td>
</tr>
<tr>
<td>capitation fee</td>
<td>very good</td>
<td>fair</td>
<td>very easy</td>
</tr>
<tr>
<td>salary</td>
<td>fair</td>
<td>poor</td>
<td>easy</td>
</tr>
<tr>
<td>budget</td>
<td>very good</td>
<td>fair</td>
<td>easy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle characteristics of provider payment systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definition of basis for payment (unit)</th>
<th>Technical requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>fee-for-service (price per item)</td>
<td>calculation of fee or price schedule</td>
</tr>
<tr>
<td>case payment</td>
<td>fee schedule</td>
</tr>
<tr>
<td>daily charge</td>
<td>calculation of charge, negotiation</td>
</tr>
<tr>
<td>bonus payment</td>
<td>list, calculation</td>
</tr>
<tr>
<td>flat rate</td>
<td>list of approved items, calculation, negotiation</td>
</tr>
<tr>
<td>capitation fee</td>
<td>calculation, negotiation</td>
</tr>
<tr>
<td>salary</td>
<td>negotiation</td>
</tr>
<tr>
<td>budget</td>
<td>calculation, negotiation</td>
</tr>
</tbody>
</table>

These systems can be combined, which greatly increases the number of options. Combinations can also produce a unique set of incentives, encourage certain behaviour or penalize inappropriate health service provision patterns. As an example, it is possible to combine:

- a capitation fee as the basic payment
- fees for service for certain acts (e.g., immunization, preventive medicine)
- a flat rate for approved investments
- a budget for drugs and ancillary services.
A combined payment system similar to the one described above is in fact used in the United Kingdom. Under the British system, general practitioners are paid capitation fees for every individual registered with the provider, up to a maximum number of patients. Capitation fees may vary depending on where the practice is located (urban or rural). Fees for specific services, including night calls, maternity services and adult vaccinations, are also paid. There are bonus payments for reaching certain performance targets (e.g., immunizations of children). In addition, GPs are reimbursed for overhead costs and are provided allowances for other expenses, such as equipment.

QUESTIONS RAISED IN CHAPTER 8

(1) Will providers be employees or contractors?

(2) What income and what form of remuneration are providers accustomed to at present?

(3) What kind of infrastructure exists in the country?

(4) What kind of incentives will be useful?

(5) How strong is the political influence of provider groups?

(6) Will it be possible for providers to operate under a number of different remuneration systems?
Chapter 9

COST ESTIMATION AND COST CONTROL

9.1 Introduction

This chapter is about the costs of health insurance. There are two basic questions to be considered:

(1) How will costs be calculated in the social health insurance scheme? This question must be answered during the planning process in order to ascertain the limitations of any benefit package and the required financial instruments.

(2) How will costs be contained under social health insurance? Here, it should be noted that nearly all the social health insurance schemes in the world, as with all other health financing mechanisms, are experiencing rising costs.

9.2 Cost estimation

9.2.1 Background

Social health insurance will not be introduced unless it has been assessed and found to be affordable: in some circumstances, the scheme may be abandoned even at this late stage. Once social health insurance is in place, it is just as important to have mechanisms for calculating costs and deciding who will pay for what. The cost of different packages of benefits must be calculated in order to determine priorities and the level of entitlements.

Costing in health care is never a simple or mechanical process — indeed, it is too difficult and too important to be left to the accountants. Costing requires an understanding of what services are being provided, how, when, where, for whom and by whom. There is never a single figure that represents the cost of a service — only estimates that are appropriate for particular purposes. The process of costing is different depending on who owns the health care facilities, who pays for training, how equipment is paid for and who bears the risk.

9.2.2 What information is needed to calculate costs?

The cost of a social health insurance system depends on:

- who is covered
- what services (e.g., primary, secondary care) are covered
- the cost of different items of service
- which items of service (e.g., X-rays, blood tests) are provided
- the cost of administration.

The first two questions relate to coverage and entitlement. If poorer (and therefore in general less healthy) people are covered, then the demand for services covered by the scheme will be greater. If a wide range of treatments
is available, then costs will be higher for everyone covered. In government-funded health care systems, where entitlements tend to be poorly specified, or not specified at all, the overall cost is normally laid down in advance and constrained by decisions on funding. In the case of social insurance, which lays down clear entitlements, the cost depends on the expenditure needed to meet the entitlements.

This direct relationship between coverage, entitlement and cost means that the first two must be planned in conjunction with the third.

Data on existing morbidity patterns, coverage and the use of services by different population groups can be used to calculate the overall demand for the services covered. Again, it is clear that some of the data needed will come not from financial, but from epidemiological or health service sources. When introducing insurance for the first time, it must be understood that existing patterns of health service usage may be a poor guide for the future, since the existing pattern reflects the present (and probably highly constrained) access to services. Looking at patterns of usage in other countries may help in the assessment of likely usage and therefore of costs.

9.2.3 Provider costs

The cost of meeting the entitlements depends on three factors:

- the methods and techniques employed
- the efficiency of providers
- the cost of factors of production (labour, drugs, rent, equipment).

In agreeing contracts with providers, it is essential to use a fee schedule listing the prices which the health fund agrees to pay (see chapter 8.3) and to be specific about the treatments and techniques which will be reimbursed. There is often a choice about which technique to use, which drugs to prescribe or how long a hospital stay should be. For example, some treatments can be carried out using less invasive techniques and a shorter stay in hospital, or more conventionally with a longer stay in hospital. Research shows that even common illnesses are treated in a very wide range of ways, with very different costs.

Using the most efficient techniques reduces costs. In addition, the efficiency of providers, for example in relation to bed utilization, also affects costs. No health care provider is perfectly efficient, but environment and incentives can increase productive efficiency. In order to calculate the cost of services in the future, it is necessary to look at current costs and estimate the extent to which greater efficiency is feasible. If a completely new service is to be developed, the approach should be to look at provision elsewhere, and estimate the feasibility of achieving similar or better levels of efficiency.

The cost of services also depends on the salaries and wages paid to staff in provider units. Introducing insurance could lead to a rise in health care costs if the demand grows while the supply of services remains low. It is therefore important to take into account any likely changes in the price of inputs. In addition to wages and salaries, there is a possibility that drugs and equipment, which are normally priced in dollars, may become more expensive if exchange rates change.
Health care providers need buildings and equipment. Depending on history and tradition, the capital costs of hospitals and clinics may or may not figure in the costs of providers. Government-owned hospitals may not be required to pay for facilities at all. In general, it is a good policy to ensure that the cost of capital buildings and equipment is included in fees for services. This ensures that these costs are considered carefully and that the best use is made of scarce capital resources.

Where there is no tradition of rent or capital charges, capital assets must be assigned a value, usually by assessing the cost of the building, its likely lifetime and the cost of the capital (i.e., the interest payable). From these figures, a sum equivalent to rent can be calculated. A further advantage of including these imputed rents in the charges for health services is that it can promote fair and equal competition between private profit-making, private non-profit-making and public providers.

To sum up, the costing of services requires an understanding of care processes, the best treatments and techniques to use, the efficiency of providers and the cost of inputs.

9.2.4 Administration costs

Assessing the cost of a health care system requires estimates of the cost of managing the collection of finance, contracting for services and providing the services. Health insurance may involve higher costs than a tax-funded and government-provided health care system, owing to the need to pay for the separate or quasi-separate collection of contributions, claims handling and management of services. Administration costs depend on the number of organizations and their sizes (see chapter 11.3 "One health fund or several?" and chapter 11.6 "Staff management"). If social health insurance contributions are collected using the tax collection system, this is likely to be cheaper than setting up a parallel system.

9.2.5 Calculating the overall cost of social health insurance

Measuring the cost of health services supplied through social insurance requires data on the cost of running the insurance company or companies, the services paid for under the scheme and co-payments by patients. In a fully functioning system, the accounts of the health fund (or funds) can supply the first category of information, but data on income from co-payments may need to be collected separately from providers.

9.3 Cost control

9.3.1 The problem of cost control

Controlling cost increases is one of the major problems in social health insurance. It is the experience in nearly all countries with health insurance schemes, from the USA to China, that costs tend to rise faster than gross domestic product (GDP) and faster than salaries, which leads to higher contribution rates (in salary-based systems) or to contributions rising faster than GDP (in other systems).
There are various reasons for this:

- there is a tacit alliance between providers and patients to prescribe, deliver and consume more and better products and services
- to a large extent, services and products are not paid for at the point of service delivery, but before and after by means of contributions
- technology in medicine is improving and getting more and more expensive (which to some extent is related to the improvement in services described above)
- the demand for health services remains relatively stable even if the price rises
- to some extent, providers can define the demand for their services, and thus their income
- incomes, wages and prices often rise faster in the health sector than in the rest of the economy
- the very existence of health insurance creates a rising demand for "health".

Without cost control mechanisms or constraints on access to services, health insurance leads to an explosion of costs. There are examples of this in many countries.

Attempts to reduce cost explosion are as old as the phenomenon itself, and there are as many strategies for cost containment as there are health insurance schemes. Nevertheless, it is possible to identify several strategies that could be adapted for use in a particular country.

9.3.2 Strategies for cost containment in social health insurance schemes

It is difficult, and sometimes impossible, to use cost-benefit analysis to set priorities within social health insurance. Ethical and political arguments usually come into play, which can conflict with the objective of maximizing health gains within the available resources. For this reason, cost control mechanisms are often designed as technical components of social health insurance schemes.

Strategies of cost containment are closely related to the design of social health insurance. This is why it is most important to be aware of the dangers and the possible ways of preventing them during the process of establishing social health insurance. An analysis of rising costs can concentrate on two sides of the problem, and therefore two sets of options for cost containment: the supply side and the demand side.

On the supply side, costs and their growth depend mainly on the way providers are paid (see chapter 8 for details of provider payment systems). The provider's interest in increasing his/her own income is the driving force for both the quality and the quantity of health services. It is very important to make use of the self-interest of providers, and give them incentives to produce services which generate the greatest benefit for the patient. The best way to do this is to design efficient payment systems, which must be combined with quality control measures.

Traditionally, in most social health insurance schemes, economics and medicine have been kept completely separate. It is very useful to make medical staff aware of the financial consequences of their decisions. There are various ways
of doing this (e.g., making monthly reports to physicians about the costs for which they are responsible, teaching economics to medical students, etc.).

On the demand side, there are a large number of possible measures which have the common objective of limiting demand. However, there is a danger that this control over demand will discourage people from using services from which they would derive significant benefits. This can lead to even higher costs, as people will come forward only when an illness has become serious. The main strategies for containing demand are:

- careful design of the benefit package (i.e., deciding what should be included and specifying it clearly; the package must be revised from time to time)
- co-payments and user charges (see chapter 10.4)
- restricted access to providers, sometimes known as "gatekeeping" (for example, not allowing direct access to hospitals, specialists or drugs; restricting the frequency with which patients can change their physician)
- refunding part of the contribution at the end of a year if the patient has not claimed any benefits
- restricted choice of providers or products (e.g., a limited list of drugs which the health fund will pay for)
- provision of information and education for health services users.

It is sometimes argued that preventive medicine is a cost containment strategy. A move from purely curative medicine towards more preventive medicine is very desirable, since nearly all the health systems in the world place far too much emphasis on treatment and cure at the expense of prevention. Nevertheless, it has not yet been proved that prevention can contribute to cost containment, although it can lead to a healthier life.

QUESTIONS RAISED IN CHAPTER 9

1. Who will be covered by health insurance and what services will be paid for or reimbursed?

2. What controls will there be to ensure that appropriate techniques and technology are used and what are the incentives for efficient provision of health services?

3. How many health funds will be licensed, and what will be the cost of administration?

4. What are the current and likely future costs of health care professionals, facilities, pharmaceuticals and equipment?
Chapter 10

FINANCING SOCIAL HEALTH INSURANCE

10.1 Introduction

The financing of social health insurance is related to all the issues already discussed in this guidebook, including benefit schemes (financing benefits, co-payments), population coverage (see chapter 5.4 on equity), cost control (chapter 9) and the discussion of policy in chapter 1. It will be analysed further in chapter 11 "Administration and management". The issues specifically connected with finance are:

- what are the sources of finance?
- what are the methods of financing?
- what are their impacts and incentives?

We are dealing here with health systems that have a significant element of social insurance financing. Although combinations of different sources of finance are possible, the discussion below assumes that at least part of the funding comes from contributions. (It should be noted at this point that there is an important difference between a pay-as-you-go contribution system and a contribution system based on capitalization. This distinction is discussed at greater length below in chapter 10.8.)

The following sources of finance can be distinguished:

- government subsidies and tax relief
- contributions
- co-payments
- user charges
- consumer taxes (e.g., on alcohol and tobacco or dangerous activities)
- interest on reserves
- others (e.g., fines for late payment, circumvention fees, etc. Circumvention fees are payable if a patient goes to the hospital without consulting the primary care practitioner first).

Each of these sources of finance can have a different design, different political objectives and, of course, a different impact. They are discussed individually below.

10.2 Government subsidies

10.2.1 Different forms of government subsidy

Government subsidies may take many forms. For example, they may be:

- subsidies to cover deficits
- subsidies to cover the health costs of certain groups
- subsidies to cover certain investment costs in order to influence resource allocation
- general subsidies covering a certain percentage or a fixed amount of the overall costs
- subsidies to cover the cost of certain services provided by social health insurance.

Subsidies to cover deficits are intended to limit increases in contributions. Instead of increasing contributions, the state may pay costs that exceed the revenue obtained by contributions. If this practice becomes more than a purely temporary measure, a contribution-financed scheme will gradually be transformed into a mostly state-financed one.

Subsidies to cover the health costs of certain groups are a way of achieving greater population coverage. This means that people who cannot afford regular contributions because they have low or zero incomes are nevertheless included in social health insurance, the costs being covered by the state. There are different ways of managing this. The easiest way is to assess contributions for the people concerned in the usual way and let the state pay them. The advantage is that the contributions the state pays may not be manipulated, since they are defined in advance. If the state undertakes to reimburse treatment costs for these groups without such constraints, there may be room for manipulation, either by the state or by the health fund itself.

Subsidies for certain investment costs (e.g., the construction of hospitals) normally give the state the right to dictate resource allocation (i.e., the numbers and kinds of facilities built). However, the investment is dependent on budget priorities and the budget situation.

The same kind of problem occurs with general subsidies paid by the state. If these are not precisely defined in advance (base, percentage of this base or exact amount), there is a great danger that they will fall victim to changes in political priorities.

The state may subsidize certain services provided by social health insurance (e.g., immunization) for people who are not members of the scheme. Additionally, subsidies may be provided for services that are not really health-related, but politically motivated (e.g., maternity grants) or that are provided to fulfill other social security objectives and schemes.

In addition to direct subsidies of the health fund, there are indirect ways of financing social health insurance out of the state budget. If social health insurance contributions are paid from pre-tax income, the introduction of insurance will reduce government tax revenue — which is equivalent to additional government expenditure of the same amount. This may be a problem if the social insurance scheme is focused initially on relatively rich people, whose tax savings may be very significant. It is also likely that health insurance bodies will be exempt from many kinds of taxes, such as corporation tax and taxes on assets.

It is also possible that the government will be affected by the advantages which health insurance and related developments will gain from other sources of government aid. For example, hospitals and other health care providers may be eligible for grants and subsidies open to all trading organizations. Non-profit-making hospitals may be exempt from corporate taxes, and investment incentives may (unintentionally) apply to health services as well. In many countries,
health technology is exempt from import duties, pharmaceuticals are exempt from value added tax, etc., which means that increased spending in the health sector can reduce overall tax revenue.

10.2.2 Impact

State subsidies can have advantages and disadvantages. One important feature of a health fund is a degree of independence: its budget is less subject to political manipulation and political changes than the government budget. In general, this improves acceptability and people's willingness to pay. If a major part of health insurance is financed by state subsidies, health insurance loses at least part of this advantage. The only way to prevent this is to define exactly what share the state has to bear and how and when it is due. For example, the rule might be that the state has to make contributions on behalf of certain groups of the population. The amount payable by the state — that is, the basis of the contribution, its rate or the total amount, and how it is calculated — must be absolutely clear.

In general, it is inadvisable for state subsidies to represent more than half the health fund budget. Otherwise, the state authorities will regard the health fund as part of the state budget and will try to control it. The larger the state's financial commitment, the less independence the health fund has and the greater the danger that social health insurance will lose one of its major advantages: independence from the state budget.

Of the two possible types of state subsidy for social health insurance (direct subsidies or indirect subsidies such as tax exemption for health funds or health products), indirect subsidies have less influence on the autonomy of social health insurance.

10.3 Contributions

10.3.1 Form of contributions

There are many different ways of calculating contributions. It is important to be aware that each method has a different effect on the distribution of the burden of contributions among social insurance members.

Contributions may be (in increasing order of complexity):

- flat-rate and equal
- wage-related (percentage of wage)
- income-related (total income, not just wages, is taken into account)
- related to regions (e.g., different contribution classes depending on the available infrastructure)

Any of the contribution methods listed above may include dependants, or may require that dependants have to pay their own contributions. The following methods relate specifically to the individual contributor:

- partly risk-related (e.g., related to the member's age on entry into the health insurance scheme)
- actuarial (i.e., entirely risk-related, taking into account the member's sex, age and previous history of disease).

Contributions may be paid exclusively by insured persons, or may be paid in part by the employer. In the latter case, the contribution is normally split 50:50, but in some countries employer and employee pay different shares.

10.3.2 The impact of different types of contribution

The main difference between varying types of contribution is the effect on the distribution of health costs among the members (so-called solidarity effects). Table 16 shows the solidarity effects of each type of contribution. It also shows whether this form of contribution must be combined with compulsory membership or not. Compulsory membership may be necessary to avoid fraud. For example, if flat-rate contributions (e.g., $10 per person) are not combined with compulsory membership, people will only register when they become a bad risk (when they get older, for example). The alternative to compulsory membership is restricted access to social health insurance, which allows people to join only if they are below a certain age. In France, there are some mutuals that work this way: they charge wage-related contributions and at the same time allow voluntary access up to a specified age only. However, this can conflict with the objective of universal coverage.

An additional possibility for avoiding fraud is to introduce a qualifying period before an individual is allowed access to benefits and to exclude people with existing diseases or chronic illnesses.

In most countries, contributions are in some way wage-related. They may be a percentage of the wage, or a fixed amount for people whose wage falls within a certain range (which is easier to administer in countries where there are problems with the exact assessment of wages or incomes). The advantage of wage-related contributions is that they take into account the ability to pay of each individual, so that everybody can afford social health insurance. This point becomes increasingly important as income differentials in a country rise.

The disadvantage of wage-related contributions is that there can be large differences in the contributions paid by different individuals. Therefore, wage-related contributions may have an upper limit or ceiling. This means that only the wage or the income up to the ceiling is taken into account in calculating the contribution, and no contribution is payable on income above the ceiling. Some countries have such ceilings (Germany, for example), while others do not (e.g., France).

The advantage of a ceiling is that it helps to maintain a certain equivalence between contributions and entitlement to benefits. Otherwise, people on high incomes have to pay contributions that are much higher than the expected value of their entitlements. This may cause problems of equity and acceptability for the new system. On the other hand, a contribution ceiling means that people on higher incomes are paying comparatively low premiums, which runs counter to the principle of ability to pay.

This guidebook will not describe in detail how each type of premium is calculated. However, the calculation of a wage-related premium is shown below, since it is the most frequently used. The contribution rate (CR) equals
### TABLE 16

**EFFECTS AND PREREQUISITES OF DIFFERENT TYPES OF CONTRIBUTION**

<table>
<thead>
<tr>
<th>Type of contribution</th>
<th>Distribution effects (redistribution from ... to)</th>
<th>Impact on administration</th>
<th>Prerequisites</th>
</tr>
</thead>
<tbody>
<tr>
<td>flat-rate premium</td>
<td>from healthy to sick; from young to elderly; from regions with weak infrastructure to regions with strong infrastructure(^1)</td>
<td>easy to handle and to calculate; may be collection problems due to inability to pay of some groups</td>
<td>compulsory membership required</td>
</tr>
<tr>
<td>wage-related premium</td>
<td>from healthy to sick; from young to elderly; from regions with weak infrastructure to regions with strong infrastructure</td>
<td>relatively easy to handle and calculate; assessment of wages may be difficult</td>
<td>compulsory membership required</td>
</tr>
<tr>
<td>income-related</td>
<td>see wage-related</td>
<td>see above; assessment of income may be difficult, especially for self-employed people</td>
<td>compulsory membership required</td>
</tr>
<tr>
<td>related to region (may be included in one of the above)</td>
<td>from healthy to sick; from young to elderly</td>
<td>determining the different levels of infrastructure and their impact on health costs may be difficult</td>
<td>compulsory membership required</td>
</tr>
<tr>
<td>including dependants (may be included in one of the above)</td>
<td>from healthy to sick; from regions with weak to regions with strong infrastructure(^2)</td>
<td>not easy to handle; premiums must be fixed individually; it may be difficult to establish risk tables as a basis for initial calculation</td>
<td>no compulsory membership required</td>
</tr>
</tbody>
</table>

\(^1\)ability to pay of low-income groups may be a problem

\(^2\)ability to pay of low-income groups, elderly people and people with chronic illnesses may be a problem

The total cost of the benefit package (plus any change in reserves) multiplied by 100 and divided by that part of the salary that forms the contribution base.

\[
CR = \frac{(\text{cost of benefits} + \text{admin costs} + \text{change in reserves}) \times 100}{\text{total sum of salary}}
\]

The value of the employer’s contributions is political rather than financial. Employers normally consider their contributions to be part of the wage bill. The distinction between employer and employee contributions is important in the short term, but in a fairly competitive labour market employers are concerned about the overall cost of employing staff, and see the cost of health insurance as being essentially the same as wage costs. To the employee, it may seem as if employers meet some of the cost of health insurance, but it may simply mean that employers are paying lower wages than they would in the absence of shared health insurance contributions.

The political value, and the major advantage, of employer contributions is their important role in cost containment. Employers receive little or no direct benefit from social health insurance (for indirect benefits see chapter 13 “Gaining acceptance”) so it is in their interests to keep contribution rates low and constant.
10.4 Co-payments and user charges

The concept of co-payments was introduced in chapter 6.2.5. User charges are a special form of co-payments and are thus included here.

It is worth considering the impact of co-payments on consumer behaviour and on the distribution of health care costs. Co-payments are intended to have the following effects:

- to make insured people more aware of the cost of health care and to contain consumption
- to reinforce certain types of behaviour (e.g., teeth cleaning) and to discourage others (e.g., alcohol abuse)
- to gain access to additional sources of financing and to redistribute the cost of providing services.

Co-payments may take various forms:

- flat rate (per day, per item, per prescription)
- percentage co-payment (a certain percentage of the price or fee)
- the patient pays any amount over the price or fee set by the health insurance fund and listed in a special schedule. Some providers may charge more than the fixed price, in which case the patient pays the difference

The following table shows how these different co-payment forms can be applied to a range of health benefits. It is important to recognize that a variety of co-payment combinations are possible.

<table>
<thead>
<tr>
<th>TABLE 17</th>
<th>CO-PAYMENTS FOR DIFFERENT CATEGORIES OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of co-payment</td>
<td>Category of care</td>
</tr>
<tr>
<td></td>
<td>ambulatory care</td>
</tr>
<tr>
<td>flat rate</td>
<td>per visit or per treatment</td>
</tr>
<tr>
<td>percentage</td>
<td>of fee</td>
</tr>
<tr>
<td>excess (limit fixed by health fund)</td>
<td>cost of treatment</td>
</tr>
<tr>
<td>exclusions</td>
<td>particular treatments</td>
</tr>
<tr>
<td>combinations are possible</td>
<td></td>
</tr>
</tbody>
</table>

Flat rate and percentage co-payments may be combined with an upper limit on the total sum payable during a certain period (normally one year). This may be necessary in order to protect chronically ill people. Certain people (e.g., students, retired people, the unemployed, etc.), certain diseases and certain circumstances (e.g., maternity leave) may be granted exemption from co-payment.

Studies of the effects of prices and charges on health care usage show that demand for health care is generally price inelastic — that is, demand is not greatly affected by price. However, the evidence also shows that these effects
vary greatly depending on income: understandably, people on low incomes are more likely to be deterred from using services because of higher prices than those on high incomes. It is therefore important to calculate how the financing rules are likely to affect the amount which different population groups pay for health care. In general, an insurance-funded scheme will be less expensive at the point of service than a pay-as-you-go, fee-for-service system, and may thus be expected to lead to higher utilization among poorer groups.

If insurance replaces a tax-funded system in which services were free at the point of contact, co-payments and user charges will clearly lead to a redistribution of health costs, with the sick and the elderly paying the most. This is why it is very important to have a sophisticated system of exemptions from co-payments and user charges. It is also important to take account of such costs when comparing the existing and the proposed health care systems and when comparing systems in different countries.

10.5 Consumer taxes

A variety of consumption behaviours and many kinds of human activities are hazardous to health. Billions of dollars are spent each year on the consequences of tobacco and alcohol consumption, traffic accidents and hazardous sports (skiing, motor racing, etc.). It is frequently suggested that it would be appropriate to make people pay for the consequences of their lifestyle. Some countries have already put this principle into practice, including France, where vehicle insurance premiums are subject to a special tax which is transferred to the health insurance budget. This is the only practicable way of taxing hazardous products and activities.

There are two objectives that might be pursued by such a tax:

(1) To discourage people from engaging in hazardous activities or behaviours. The problem is that demand often stays relatively stable even if the price increases, as the example of tobacco consumption shows.

(2) To cover the costs incurred by the health fund as a result of hazardous activities or behaviours. One problem here is the difficulty of calculating the real costs of these types of behaviour in order to set the tax at an appropriate level.

Despite the disadvantages, consumer taxes are likely to contribute to the achievement of the objectives listed above.

10.6 Interest on reserves

Another source of income is interest. This is closely linked with the reserves health funds are obliged — or choose — to hold. The amount of interest income depends on the quality of the health fund’s financial management. (This point will be considered in more detail in chapter 11.8 “Financial management”.) In any case, interest may be an important source of income for health funds. If a health fund’s mandatory reserve equals two months’ expenditure in a pay-as-you-go system, interest income would amount to 1.7% of revenue at an interest rate of 10%.
10.7 Other sources of income

There may be additional sources of income for the health fund, although they will represent only a small part of total revenue. Some examples are:

- fines for late payment
- circumvention fees
- payments for services provided on behalf of other authorities
- indemnities (e.g., those paid by other insurance organizations in respect of victims of traffic accidents)
- revenue from the sale of goods and services by the health fund

10.8 Pay-as-you-go versus capitalization

Capitalization is normally used for the provision of long-term benefits. The individual pays contributions which are accumulated in a technical reserve and paid out after a number of years, together with a guaranteed amount of interest. One typical example is private life insurance. Health insurance also provides long-term benefits, given that around 70% of health expenses during an average person’s life occur in later years. For this reason, in Germany for example, private health insurance companies have built up technical reserves charging actuarial premiums that are higher than the age-related costs for younger people and lower than the age-related costs for elderly people.

Social health insurance normally uses the “pay-as-you-go” method. This means that the health fund does not have a technical reserve (except the small reserve mentioned above to cover unexpected expenditure). All expenses are paid out of revenue from current contributions. If expenses exceed revenue, additional finance must be found (e.g., increased contributions, new or more effectively enforced co-payments, etc.).

QUESTIONS RAISED IN CHAPTER 10

1. What are the political constraints and responsibilities affecting the financing of health care?

2. What is the population’s ability to pay?

3. To what kinds of payment systems are patients accustomed?

4. Has there been a careful examination of the relationship between the proposed benefit scheme, the costs, and the sources of finance (the key “triangle”)?
Chapter 11

ADMINISTRATION AND MANAGEMENT

11.1 Introduction

Questions of the administration and management of social health insurance schemes depend to a large extent on:

- the organization of health services (whether providers are employees or contractors)
- the choice of a single health fund or several funds
- the degree of political independence of the health fund(s)
- historical factors (e.g., the existing administrative structure of health authorities and the political system in the country (federal state, central state, political responsibilities, etc.)
- the health policy objectives to be fulfilled by social health insurance
- the economic and social situation in the country
- the political objectives of those who establish social health insurance.

It is clear that there is no optimal organizational structure or set of management principles that can be applied in every setting, given the wide variety of factors that can influence the issues of administration and management. Accordingly, this chapter provides some insight into several of the central issues of interest that must be considered in the design process.

11.2 The political independence of the health fund

A critical issue concerns the political independence of the health fund. Although social health insurance schemes may be organized in many ways, there are two main possibilities:

(1) The health fund as a government body (e.g., part of the ministry of health). In this case, the chief executive of the health fund is a civil servant with the rank of head of department. The employees of the health fund are civil servants. All important decisions concerning the administration of social health insurance depend on the ministry. The health insurance budget is part of the public budget.

(2) The health fund as an independent body. In this case, the health fund has its own budget, its own legal status and its own management. Under this arrangement, it must be decided how and by whom the management of the health fund should be selected and appointed. Managers may, for example, be nominated by the minister, or they may be elected by those who pay the contributions (insured employees and employers). Thus, in the first case the health fund is run by professional managers, and in the second case it is run by elected representatives. Even if the managers of the health fund are nominated by the minister, the fund may have greater independence than in the first model.
Generally speaking, it is advisable to maintain a certain degree of independence between the health fund and the government. The reason for this is that there are several important advantages to an independent relationship, which are as follows:

- strict separation of budgets (there can be no use of contributions for political objectives other than health insurance). This point is very important. It may be crucial for the future development of social health insurance and for increasing people’s willingness to pay contributions.
- decision-making that is to some extent independent of changing government policies and oriented towards health objectives
- management practices and an organizational structure that are more like those in private enterprise than in public administration.

11.3 One health fund or several?

Social health insurance can be organized in one body or in several separate bodies. If there are several bodies, administration costs may be slightly higher, as some services (management, accounting, statistics, etc.) will be duplicated. With several funds, therefore, a coordination body will be needed.

On the other hand, there may be historical, social, economic and political reasons for establishing (or retaining) several insurance bodies:

- historical and political reasons might include the existence of insurance bodies covering certain parts of the population. The acceptability of a new system may be increased if these bodies continue to exist. Certain features will perhaps have to be harmonized.
- one economic reason might be that differing abilities to pay, different health needs and big differences in the existing infrastructure make it inadvisable to establish a general system which would cause equity problems.

The efficiency and flexibility of administration may be improved by giving the insured population the chance to choose between several health funds. The competition for members will stimulate the funds to improve services.

11.4 Health insurance legislation and decision-making

It must be clear which decisions may be taken by the management of the health fund and which ones should be resolved by laws and regulations. The range of decisions that will have to be taken is quite extensive, including:

- the general design of the health system
- the benefit scheme
- the adjustment of contributions
- investment decisions (which can involve large sums of money)
- employment of staff
- contracts with providers (which to a large extent determine the subsequent costs of the system).
The general design of health insurance and the benefit scheme should be defined by law. Appropriate legislation should specify:

- all questions of membership and population coverage
- organization, responsibilities and decision-making authority
- the method of financing
- the relationship with providers
- the benefits provided by health insurance.

The overall structure of the social health insurance scheme should be laid down in a health insurance law. Details that may be subject to frequent change can be established in regulations. Decisions related to contributions, investment, employment of staff and contracts with providers should be the responsibility of health funds. Consultations with the ministry of health or the ministry of social security may be required for decisions concerning such issues as the adjustment of contributions. Other technical issues, such as the investment of contributions, may require the development of special procedures.

11.5 The internal organization of health funds

An effective and efficient internal organizational structure will be characterized by a clear assignment of administrative tasks. Administrators of health funds have many tasks, of which the most important are:

- registration of members and dependants
- collecting contributions
- monitoring employers (ensuring that they register their employees and deduct contributions properly)
- assessing income of self-employed members
- advising members about entitlement to benefits
- processing and checking claims
- planning and organizing health services
- selecting and negotiating with providers
- checking invoices and vouchers for conformity with fee schedules and benefit regulations, ensuring that patients are entitled to the benefits claimed and that there is a contract with the provider, etc. (this depends to a large extent on the provider payment system and the method of registering with providers)
- developing a clinical information system to record the diagnosis and treatment given and for use in claim payments
- paying invoices and vouchers
- monitoring health providers (prescription behaviour, quality control, accreditation, etc.)
- personnel administration, training, staff development and organization
- acquisition, administration and maintenance of buildings and equipment (information technology, furniture, materials, etc.)
- financial management and planning
- accounting
- statistical analysis of activity and use of information.
The development of an internal structure and the assignment of administrative tasks must take into account:

- the needs of the insured members and their families
- regional circumstances
- the existing infrastructure and political structures
- the need for efficiency and cost containment
- the motivation and qualifications of the staff.

The overall objective in the design of an internal organizational structure is that all health fund services that require direct contact between members and insurance staff should be as decentralized as possible. This means that the tasks described above should be distributed among different levels of the health fund.

Health funds should have local offices to carry out tasks such as:

- registration
- processing claims
- advising members, dependants and employers about entitlements to benefits
- making decisions about low-cost infrastructure and materials, e.g., office equipment
- recruiting health insurance staff (in larger offices).

Provincial (or regional) offices should carry out the following tasks:

- contracts with providers
- provider payment
- assessment and accreditation of providers
- communications with employers (collecting contributions)
- monitoring employers, providers and local offices
- decisions about medium-cost infrastructure
- staff recruitment for smaller local offices.

The central level should carry out the following tasks:

- planning and decisions about high-cost infrastructure (e.g., buildings)
- contracts with providers which are organized at a central level
- financial management and accounting
- collection, collation and analysis of data
- informatics services
- staff management (personnel department)
- staff training and qualifications (training centre)
- internal monitoring.

Local and provincial levels should be able to carry out their administrative functions without a great deal of dependence on the central level. This means that offices at each level of the health fund infrastructure should have their own budgets.

A decentralized organizational structure provides more direct information about members, ensures that claims are processed properly and allows more effective control over providers. These advantages will have an important
impact on the costs of operating the fund. In addition, a decentralized structure can influence the stability of the fund’s income flows by allowing for proper registration of members and closer monitoring of the deduction of contributions.

11.6 Staff management

The overall performance of the health fund is largely determined by the quality and motivation of the staff. Critical management tasks in the process of assembling staff are as follows:

- staff selection
- drawing up employment contracts
- designing an appropriate staff payment system
- organizing payment of salaries and deduction of social security contributions and taxes; supervision of staff in respect of holidays, sick leave, etc.
- setting up principles and criteria for promotion
- staff training and development.

There is no general rule for defining the number of staff needed by a health fund. Staff size depends to a large extent on the functions of the health fund (e.g., does it employ the providers?), the degree of rationalization and decentralization, the amount of advice given to members and, most of all, the size of the fund itself.

There are economies of scale to be realized in staffing insurance funds. The number of insured persons that can be managed per staff member generally increases with the size of the fund. Table 18 provides some evidence of this pattern from Germany, where there are more than 1,000 health funds of different sizes.

<table>
<thead>
<tr>
<th>Size of fund</th>
<th>Health fund members per staff member</th>
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</thead>
<tbody>
<tr>
<td>1,000</td>
<td>220</td>
</tr>
<tr>
<td>5,000</td>
<td>480</td>
</tr>
<tr>
<td>100,000</td>
<td>690</td>
</tr>
</tbody>
</table>

*Germany, 1989

11.7 Computerized information systems

The overall efficiency of a health fund’s operations can be enhanced through the use of computerized information systems. The use of computers can help to achieve the following objectives:

- the generation of countrywide, up-to-date information
- the prevention of fraud
- the standardization of administrative procedures
- the facilitation of centralized and decentralized information on entitlements, benefits received, claim histories and contributions paid
- the production of statistical information.
Some of these objectives, of course, may also be achieved using paper-based membership records (systems in which "member history" cards are kept for each member). The use of paper-based records can also be cheaper than computerization. Without computerized systems, however, any summary or comparison of data is more difficult, or even impossible. For example, with a paper-based system it is difficult to:

- check whether a member has paid a contribution in a particular month
- compile statistics
- produce accounts
- check on the appropriateness of provider behaviour (e.g., prescription practices).

Computerization therefore brings greater clarity and a more useful database for administrative purposes. However, the effect of rationalization on the daily work load of an office should not be underestimated. To some extent, a good informatics system and a useful database will mean more work than a system based on simple membership records, but the work can be processed more easily and efficiently.

In order to make full use of a computerized information system, it is important to ensure that appropriate data is collected. Careful thought should be given to selecting areas in which information will be most useful. For example:

- in order to keep track of provider behaviour, invoices and vouchers should be standardized and computer-readable, showing the type of service given to the patient, the patient number and the provider number. This will make it possible to draw up the prescription and service history of a provider and check whether the patient actually received the service for which claims were filed
- the patient number should be a unique personal identifier indicating sex, date of birth and perhaps region and profession (although the last two may change). In order to obtain good and reliable statistics concerning utilization and individual risk, there should be an account for each member (and each dependant) showing the claim history (number, amount, kind and date of claims) and the contributions paid.

Computerization is expensive. The construction of a computerized information system includes not only the costs of hardware and software, but also associated costs such as:

- staff (for operations management, hardware and software management, user support, etc.)
- the constant updating of software
- the maintenance, repair and replacement of hardware
- staff training
- requirements for buildings and air conditioning.

It is important to ensure that the health fund's computer information system is as productive as possible, given the substantial resources required to develop and maintain one. In addition to the general objectives described above, a well-designed computer information system should be able to handle a variety of specific applications, including:
employer registration
employee, self-employed and dependant registration
recording of monthly employer and member contributions
identification of late payers and non-payers
registration of providers, status of accreditation, and applications pending from providers
recording the registration of insured persons with providers (physicians, hospitals)
allocation of social security identity (ID) numbers and production of social security ID cards
annual accounting and quarterly reports
statistical analysis

Computerization opens up the dangerous possibility that use could be made of the data in ways affecting the private life of members. Health insurance data should contain full details of the health history of members, as well as details of their income. It is therefore very important to ensure reliable data protection. For example:

- it must be guaranteed that the data are not to be used for objectives other than those defined by law
- access to the data must be selective and restricted to the field of work of the staff member concerned (i.e., no general access)
- employers should have no access whatsoever to members’ data.

11.8 Financial management

The task of financial management is to keep the health fund in financial equilibrium, which includes maintaining an adequate operating reserve (a reserve intended to cover foreseeable short term risks). Social health insurance is normally managed on a pay-as-you-go basis. This means that it covers costs out of the current income from contributions. A health fund does not need to maintain a large technical reserve (a reserve designed to cover long term foreseeable risks, such as the ageing of patients), as a pension fund does. The reasons why health funds must maintain an operating reserve are as follows:

- there may be unforeseen changes in morbidity (epidemics, accidents, etc.)
- there may be unforeseen changes in costs (staff costs, equipment costs)
- there may be unforeseen changes in income (e.g., higher levels of unemployment, which may reduce the level of contributions).

Normally, health funds can raise contribution rates when there is a change in costs or income. A change in contribution rates will be a political decision, however, which may take several months. In the meantime, the health fund could be forced to borrow, which may also take some time to arrange.

For this reason, health funds should maintain an operating reserve, the size of which will depend mainly on the size of the health fund. A small fund with less than 10,000 members will need a proportionally larger reserve than a large fund with millions of members, because in a larger health fund the risks are distributed more widely. Normally, the reserve should be at least two months'
revenue. For a new health fund, it is advisable to start with a larger reserve, and only reduce it when it becomes clear that a lower level is adequate.

It is one of the tasks of financial management to invest the money properly. Part of it should be invested in medium-term securities and a smaller amount should be available on demand. It should be clearly defined by law what types of financial transactions are allowed using the reserve resources. It is inadvisable to invest reserve resources in stocks or high-risk bonds.

It is also part of financial management to forecast income and costs (see chapter 11.12 “Planning”). Health fund planners must observe developments in the economy and the labour market (collective bargaining for wages, unemployment, inflation) and the development of health costs (for each benefit sector) in order to prepare adjustments to contributions. These tasks will be easier with an efficient and up-to-date computer-based control system, as described in the previous section.

11.9 Accounting

The importance of proper accounting deserves particular emphasis. Accounting and frequent reporting form the basis for planning, efficient administration and cost containment. The accounting system must outline a clear picture of all the financial flows in the health fund. Moreover, it should be accompanied by an efficient statistical information system. These two systems go hand in hand, although they are discussed separately here.

The basis of an efficient accounting system is proper recording of data (see chapter 11.7 “Computerized information systems”). The accounting system should contain detailed data on the areas shown in the following illustration:

<table>
<thead>
<tr>
<th>FIGURE 3</th>
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<tbody>
<tr>
<td>ROUTINE FINANCIAL REPORTS</td>
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<tr>
<td>Statement of income and expenditure</td>
</tr>
<tr>
<td><strong>INCOME</strong></td>
</tr>
<tr>
<td>Contributions</td>
</tr>
<tr>
<td>Interest from capital investments</td>
</tr>
<tr>
<td>Other income (rent, sale of old equipment or certain products, subsidies, reimbursements, refunds, etc.)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>SURPLUS (DEFICIT)</td>
</tr>
</tbody>
</table>

Of course, an authentic statement of income and expenditure would require more detail than is shown in Figure 3. For example, the category "staff costs" should have separate lines for each kind of staff, for basic salary and bonuses and for social security contributions, taxes, etc.
Routine financial reports should include a balance sheet in addition to a
statement of income and expenditure. A balance sheet depicts the financial
status of the health fund at a particular point in time, whereas the statement of
income and expenditure shows financial flows during a particular period of time.

The accounting system should be very carefully designed, as subsequent
changes to the system will affect the ability to compare figures for different years
and will require expensive software amendments.

11.10 Statistical analysis

Good statistical information provides the basis for planning and control.
 Routinely gathered statistics are necessary in order to:

- monitor health service providers (costs and quality)
- monitor utilization patterns
- plan infrastructure in the light of social, regional and epidemiological data
- devise new kinds of services (e.g., preventive care, immunization) in the
  light of epidemiological data
- control administration costs, etc.

Some of the statistical data which will be useful to the health fund will be
generated internally. Other valuable data may be gathered from publicly
available sources. This section is concerned only with health fund data, but it
should be borne in mind that public sources may need to be consulted from time
to time.

In order to support the processes of planning, administration and management,
the health fund should be able to generate the following statistics:

- Health sector costs
  - costs per kind of service (hospital treatment, drugs, etc.)
  - costs of health care for specific member groups (e.g., according to age,
    sex, status) or specific regions
  - costs per provider
- Administration costs by
  - category of cost
  - costs per administrative unit
- Revenue by
  - type of revenue
  - region
  - status of members
- Utilization rates by
  - consultations, inpatient days, prescribed items
  - provider
  - group of patients
  - region
- Diagnoses by
  - age and sex
  - profession
  - region
Members and dependants by
- age and sex
- profession
- region
- status (active, retired, unemployed, dependant, disabled, etc.).

It is important for statistical information to be comparable from one year to the next. This means that the information collected should be as consistent as possible. If changes are made to particular statistical categories (e.g., in methods of calculation), they should be specified very clearly so that their effects on comparability can be controlled.

The feasibility of obtaining good statistics depends on the design of the information system (the availability of databases, the possibility of linking them, the quality of data input, etc.). This shows once again that, before developing a computerized information system, it is important to know what information is needed (and why), for whom it is intended and at what frequency it should be collected.

11.11 Other applications of information

The data that is compiled in the health fund's information systems is useful not only for administrative and managerial purposes; it can also serve as an input into the development of more effective preventive health care strategies. The health fund's ability to gather and use information on health status and health developments will of course depend on the means available, the social characteristics of the population concerned and, most of all, on the health problems involved. Nevertheless, it should be possible for the health fund to gather demographic and epidemiological data that would be useful for developing strategies to deal with:

- public health
- immunization
- maternity care
- health screening for children
- family planning
- AIDS prevention.

Naturally, information collection activities and the development of preventive health strategies would require close cooperation between health funds and other authorities, such as the ministry of health. However, it is important for health funds to take a leading role in the process of strategy development—the funds will bear the costs of poorly designed, or non-existent, disease prevention and health promotion programmes.

Part of the process of promoting new health strategies involves disseminating information on disease prevention and health promotion. The health funds can participate in this process by employing the following means:

- broadcast and print media, courses and meetings
- personal visits by qualified health insurance personnel, especially to remote areas
- information desks in local offices offering information and advice.
11.12 Planning

Planning is an integral part of managing a social health insurance scheme. Some specific planning activities are listed below:

- annual budget planning (forecasting costs and revenue in order to adjust contributions over time)
- planning of infrastructure (in order to provide appropriate services for members)
- planning of health activities and programmes (to meet objectives such as contending with particular diseases — see chapter 11.11 above).

Annual budget planning must take into account developments in the domestic economy, such as employment, growth of gross national product (GNP) and increases in wages (in order to plan the expected revenue). It will also be necessary to monitor inflation (especially in the field of health services) and health services utilization.

Infrastructure planning should be based on population and epidemiological data. One of the primary objectives of infrastructure planning is to coordinate investment and training plans. Such planning may be the responsibility of councils at the provincial and central levels, under the supervision of the central health fund office. The membership of these councils may include:

- health funds
- ministry of health
- regional authorities
- providers.

11.13 Internal and external monitoring

Finally, it is important to establish monitoring procedures for the social health insurance scheme. There is a distinction between internal and external monitoring. Internal monitoring is a task for the health fund management. It concerns all questions related to the internal management of health funds, such as analysing administration costs, cost-benefit relationships and organization of activities, and developing proposals to improve performance. Internal monitoring should be the task of a qualified internal auditor.

Internal monitoring is also concerned with the provision and utilization of health services. Internal monitoring must be based on appropriate information (see chapter 11.10 above) about general developments in disease patterns, prescription practices, utilization patterns and prices.

Detailed internal monitoring is needed of:

- entitlement to benefits
- invoices and vouchers
- demand for services from providers
- quality of service provision.

The quality of monitoring will have a major impact on the costs and effectiveness of social health insurance. Good monitoring depends on the skill level of
the administrative staff and the available data. In order to improve monitoring, the health fund may employ physicians or pharmacists to give a second opinion on certain services and prescriptions dispensed by providers. They may even advise physicians or hospitals about ways of improving certain treatments or prescriptions.

External monitoring is the task of the authority responsible for the supervision of social health insurance. It consists above all of budgetary control. There must be controls to ensure that health funds stay within the law (e.g., as regards acceptance of members, provision of benefits, assessment of income and collection of contributions).

QUESTIONS RAISED IN CHAPTER 11

(1) How can the independence of health funds be guaranteed?

(2) How will health fund managers be appointed?

(3) Who decides what?

(4) How will social health insurance be brought as close as possible to the members?

(5) Are skilled staff already available in the country, or must they be trained?

(6) How will staff be selected?

(7) How will staff be motivated?

(8) What kind of information will be needed and where?

(9) What are the information objectives to be met by computerized information systems?

(10) How will fraud and waste be avoided?
SECTION V

DRAWING ON EXPERIENCE

AND BUILDING CONSENSUS
Chapter 12

DRAWING ON THE EXPERIENCES OF OTHERS

12.1 Choosing systems of finance and provision

In previous chapters, we have explored the need for a clear health policy and discussed requirements for the introduction of social health insurance as a major or partial source of funding for health services. Social health insurance can only work if the system is introduced in appropriate circumstances. It is useful to draw on the experience of other countries, both those that have adopted social insurance funding, and those that finance services through taxation. All systems need clear policy objectives, and mechanisms for achieving them. All systems are, to a greater or lesser extent, the product of the history and culture of a country. Thus it is possible to learn from the experience of other countries, but unwise to copy them exactly.

This chapter gives a brief description of the health sector and experiences of different countries. This is not a substitute for a careful study of the different systems, but shows the diversity of possible options and the ways in which different countries have attempted to meet their policy goals. Some common themes also emerge, which do not depend on the system chosen. All countries are concerned with cost containment, all need mechanisms to enhance the quality of care, all have some form of control over access to services, and all fall short of the aspirations of the population.

This chapter describes experiences in the following countries: United Kingdom (mainly tax-funded, with mainly public providers), Canada (mainly tax-funded, with mainly private, not-for-profit provision), Thailand (where social insurance is being introduced into a mainly government-funded and government-managed system), Egypt (which has a mature system of social insurance covering a minority of the people), Costa Rica (which has a comprehensive system of social insurance) and Germany (which was the first country to use social health insurance). These countries represent the diversity of possible approaches to health sector finance and provision.

12.2 Countries with mainly tax-financed systems

The profiles of the United Kingdom and Canada show that great diversity is possible within this form of financing. Both systems separate the responsibility for funding and providing care, although government-owned providers are dominant in the U.K. Both countries achieve effective cost containment through global budgets for services, although physicians are salaried in the U.K. and mainly work on a fee-for-service basis in Canada.

The U.K. health care system

General description and population coverage. Health services in the U.K. are financed mainly by government (87%) through general taxation, are mainly free at the point of use and are mainly provided by government-owned hospitals and
other services. This system has been very successful in containing the overall cost of health care.

The National Health Service provides preventive and primary care and hospital services for the whole population. Less than 10% of the population have supplementary private medical insurance, and there are only limited co-payments by patients.

**Health service provision.** Funds are allocated to District Health Authorities on the basis of the resident population (with some allowance for the age structure), and the authority is then responsible for agreeing contracts with hospitals and other providers for the provision of services. The authority is thus acting as an agent for patients. Referral to specialist services is through a general practitioner (GP), who acts as a gatekeeper for the more expensive specialist services. Some rationing of non-emergency services is by waiting list.

Patients can choose their GP, but in practice have little choice of specialist provider or hospital. Hospitals remain owned by government, but are mostly legal bodies, able to enter into contracts for the supply of services. They have to pay rent on their buildings and equipment. They have a measure of independence, while remaining publicly owned. Those that fail to win contracts lose staff and facilities. Private hospitals are free to compete in the provision of services, but few significant contracts have been placed with private providers.

**Payment systems.** Health care professionals in hospitals are mainly paid by salary, and the incentives come from the need for the hospital or unit to retain contracts for the supply of services. Hospitals are generally paid on the basis of an agreed global payment for a given volume of work ("cost and volume" contracts), with some "block" contracts for the supply of open-access services. Little attempt is made to classify cases by severity or other factors that affect cost, but contracts require hospitals to take referred patients up to the level of the contract, without discrimination.

GP services are paid by a mixture of capitation, allowances and some small fee-for-service items. In addition, GPs can receive bonus payments for achieving certain performance targets.

Patients have to make co-payments for drugs prescribed outside hospital (although many categories of patient are exempt), and contribute to the cost of dental and optometry services. There are no co-payments for GP consultations or normal hospital services.

Despite government involvement throughout the system, a significant degree of diversity, decentralization and independence has been achieved.

**Sources and levels of funding.** Health care funds come from general taxation, and the amount is agreed annually. No earmarked taxes are used. In real terms, public spending on health services has grown over the last two decades, but this growth has been slower than in most comparable countries.

**The Canadian health care system**

**General description and population coverage.** Health services in Canada are characterized by public financing and private provision. Each of the 10 prov-
inces has jurisdiction over health, so each provincial health system is different. Nevertheless, in practice each province operates a public reimbursement scheme that covers the entire population for the cost of all ambulatory and institutional care.

The system is governed by four principles:

- universal access to care with equal terms and conditions for all
- cover for all necessary expenses
- benefits that are portable between provinces
- provision of services on a non-profit basis.

Health service provision. Hospitals are run by boards of trustees on a non-profit basis. Hospital capital acquisition is approved by the provincial government — this has the effect of controlling expenditure and the diffusion of new technology. Most physicians are private practitioners.

Payment systems. Hospitals receive global operating budgets from the provinces. These budgets do not include the cost of physician services, which are paid for on a fee-for-service basis. Fee schedules are negotiated by physicians and provincial governments.

Patients pay for services not covered. These include spectacles, drugs prescribed for outpatients, dental care and nursing-home fees. Private insurance schemes, some based on the place of work, can be taken out to cover the cost of services not covered by the public scheme. Certain groups in the population are exempt from some charges. Private insurance companies are not allowed to offer insurance for services available under the public scheme.

Sources and levels of funding. Funding comes from taxation, at both the federal (approximately 40%) and provincial level. Canada has been successful in providing universal access to (generally high-quality) care with lower absolute and relative funding than the USA.

12.3 Countries with some social health insurance financing

The two countries described here are taking very different approaches to social health insurance: in Egypt it has evolved gradually, and in Thailand there has been an attempt to introduce the system more rapidly.

The health care system in Egypt

General description and population coverage. The health care system in Egypt is mainly tax-funded and publicly provided, with a small but long-established social insurance sector and some private funding and provision.

Some health care cover is available to the whole population through the public system. Social insurance provides a higher level of provision for 8.4% of the population (ranging from only 3.4% in the area with the lowest coverage to 12.7% in the one with the highest).

Health service provision for social insurance members. The benefits package covers primary care, outpatient hospital services, dental care, pharmaceuti-
icals, medical appliances, hospital care and even evacuation for specialized surgery. It does not generally cover dependants.

Services are provided by a mixture of public and private providers. Most outpatient care is given by private practitioners, working in their own facilities or in public or private clinics under contract to social insurance. Hospital care is mainly provided in hospitals owned by the Health Insurance Organization (HIO).

**Payment systems.** Hospitals are mainly owned by HIO and are funded directly. Contracts for care by private providers are mainly on a fee-for-service basis.

**Sources of funding.** Social health insurance is funded by contributions of 4% of earnings, of which 75% is paid by employers and 25% by employees. Pensioners pay 1% and widows 2% of their income. For government employees, the contribution rates are 1.5% for the government and 0.5% for the employee. There is a ceiling on the level of income used to calculate contributions and there are small co-payments for the use of services. HIO is subsidized by the Employment Injury Scheme.

Benefits under social insurance are six to seven times greater than those offered by the state health services. Half of HIO spending is on drugs, and around one third is on its own facilities.

**Future developments.** There are plans to extend the scheme to cover more occupations, dependants and some self-employed people, bringing coverage to around 35%. The main constraint is the lack of administrative capacity to develop the scheme in these more difficult areas.

**The health care system in Thailand**

**General description and population coverage.** The health care system in Thailand uses mainly public providers, funded by a combination of taxation and user fees. A number of medical benefit and health insurance schemes have existed in Thailand for a long time, including the Civil Servants' Medical Benefit Scheme and the voluntary health card scheme, which covers the cost of care in government facilities.

The 1990 Social Security Act (SSA) aims to extend considerably the use of social insurance funding for health services. The SSA presently covers all workers in companies of 20 or more employees, approximately three million people in total. It is planned to expand coverage to smaller companies in 1994, and to the informal sector in 1995.

**Health service provision and payment systems.** The Thai model borrows from the idea of managed markets. At the beginning of each year, employees register with a hospital (which, as the main provider, is required to make primary care available to those registered with it). The hospital is then paid a capitation fee for each person registered. This fee covers all health services except a few identified expensive conditions for which a "special payment" schedule is used.

The option of registering with a different hospital at the beginning of each year was included in order to stimulate competition between providers to maintain a high quality of care. The capitation mechanism was designed to contain costs.
Unfortunately, at the beginning of the scheme, limited administrative capacity prevented employees from choosing which hospital to register with: the decision was made by the employer. Consequently, employees had to travel long distances to obtain care, utilization rates were much lower than expected and there was little incentive to provide a high-quality service. After piloting individual choice of hospital in three areas, the decision to widen the facility to the whole country has been taken.

For a hospital to act as a main contractor, it must have a minimum of 100 beds. Hospitals may subcontract certain services to smaller and more cost-effective providers, such as polyclinics. There has been an unexpected effect on other insurance schemes, in particular the Workmen’s Compensation fund: physicians are attributing an increasing number of complaints to work or working conditions rather than covering the cost of treatment out of the capitation fee. There are plans to merge the two schemes. As the SSA expands to cover informal-sector employees, its relationship with the health card scheme will also come into question.

Sources of funding. The scheme is financed by equal contributions from the insured person (1.5% of salary), the employer and the government, it is compulsory for all companies unless they can show that they provide a higher level of medical benefits through another scheme.

12.4 Countries with mainly social health insurance funding

Two very different countries are considered here. Germany has a complex system of health funds, developed over 100 years, with subtle checks and balances. Costa Rica has developed social health insurance over the past 50 years. Hospital care is mainly provided by hospitals owned by the insurance organization.

The health care system in Costa Rica

**General description and population coverage.** The health sector in Costa Rica is mainly funded by social insurance, with preventive services provided by the ministry of health (MOH). The Costa Rican Social Security Fund (CCSS) was created in the early 1940s to administer the social security insurance system.

The system has been very successful in improving the health status of the population. Costa Rica’s health indicators resemble those of Europe, the USA and Canada, rather than those generally exhibited by countries with similar per capita incomes (US $1750).

Population coverage has expanded, and access to CCSS health services is now more or less universal.

**Health service provision.** The MOH (17% of total expenditure in 1990) oversees health promotion, disease prevention and environmental health. The CCSS (80% of total expenditure) provides curative and rehabilitative care, individual preventive services (e.g., immunization) and some educational services. The National Insurance Institute (INS) covers the treatment, rehabilitation and compensation of policyholders for occupational illnesses and injuries and automobile-related injuries.
The CCSS owns and operates all the country's 29 hospitals, providing 95% of hospital services and around 70% of all consultations. Except for three private clinics, virtually all health facilities are operated by either the CCSS, the MOH or the INS, and form part of the national health system.

Non-emergency patients enter the system through their local clinic or district hospital. Patients often have to wait a long time to be seen and are occasionally turned away. They cannot choose their physician, and often complain that the time they spend with the physician is inadequate to deal with their case. Insufficient supplies and equipment at some clinics lead to inappropriate referrals to higher-level facilities. In practice, patients often seek alternative routes into the system, such as attending emergency departments or consulting a physician as a private paying patient.

While the quality of care for inpatient services is considered quite high, dissatisfaction with the quality of care provided in ambulatory settings is increasing.

*Payment systems.* Health care providers in the MOH and CCSS are mainly paid by salary, although the CCSS has been experimenting with other options, including the Company Medicine Scheme (where a company pays the physician's salary and provides a clinic for employees) and capitation payments to physicians or cooperative clinics.

*Sources and levels of funding.* The main sources of financing are:

- compulsory contributions to the CCSS by employers, employees and the state
- taxes
- the hospital lottery
- income from rent and interest.

Only about 1% of income comes from fees (self-employed workers can elect not to contribute to the CCSS, but must then pay a fee for using CCSS services — services for the indigent are paid for by the state). The contributions paid by employers, employees and the self-employed who elect to contribute are among the highest in the world.

Financing and the quality of health services are likely to remain important issues. The high contribution rate for employers and employees has significantly raised the cost of labour in Costa Rica. Further increases could seriously damage the competitiveness of Costa Rican products.

**The German health care system**

*General description and population coverage.* Health services in Germany are funded through compulsory contributions to health funds (normally referred to as "sickness funds"). These are non-profit-making organizations, operating either over a particular geographical area or for particular occupational groups. Although nominally independent, the system is tightly regulated by state governments (i.e., not the federal government). Money is reallocated between funds to take account of differences in the incomes and risk profile of their members. Care is provided by self-employed physicians and a mixture of
government and private hospitals. Coverage extends to almost all of the population.

Even though there are a large number of funds, for the purposes of negotiation with providers they form a single buyer of care.

*Health service provision.* Patients can choose services from any appropriate provider. This has the advantage that all patients can see themselves as customers who can take their custom elsewhere if they wish. For outpatient care, almost all physicians have their own surgeries and are self-employed. Around 40% are general practitioners and 60% are specialists.

Around one-third of hospitals (but nearly half the beds) are publicly owned, 35% of beds are provided by non-profit-making and voluntary organizations and 15% by private profit-making hospitals.

*Payment systems.* Physicians are mainly paid fees for service, based on a points system for units of work done. Few work as salaried employees. The total funding for physician services is agreed, and then divided up on the basis of the number of treatments given by each physician. If all physicians work harder, the effect is to reduce the sum paid for each treatment. If some work harder, they make money at the expense of their colleagues. This has been an effective way of controlling the cost of physician services, but there are signs that the system is under pressure, and it is under constant challenge by physicians. Only physicians who belong to the relevant associations are party to the contracts and are therefore reimbursed by health funds for services provided. Although this is a type of fee-for-service system, it has cost containment built in.

Hospitals are paid on the basis of daily charges covering reasonable costs. They must provide information to prove that the costs are reasonable. Cost containment for hospital services and drug costs has not been very successful.

Contracts between hospitals, physicians and health funds are generally reached through negotiation between the associations representing the three parties. The contracts which specify the pay of providers are signed with associations rather than individual providers.

*Sources and levels of funding.* Contributions to the health funds are paid by employers and employees, who are both represented on the boards of the funds. The average contribution rate is around 13% of payroll. Members receive a comprehensive set of health services, although there is some (very limited) variation in the benefit packages. Co-payments are uncommon (except for dentures) and generally low (6% of health spending).

At present, about half the economically active population are able to choose their health fund, and all will be able to do so after 1995.

The German system has been successful in giving choice, ensuring high-quality care and containing the rise in physician fees. It has been less successful in controlling overall costs, and it depends on a complex system of statutory regulation and traditions. It has evolved a long way from the original system set up 100 years ago.
12.5 Some general lessons from the experience of countries

All countries and all health care systems are different. However, some very general lessons emerge from the experience of the countries cited above. A few of them are discussed below.

12.5.1 Diversity

There is no right or wrong way to combine systems of finance and provision. Social insurance can be combined with private providers, social insurance providers or public hospitals.

12.5.2 Excess demand

Services cannot meet all the needs of all the population. In Costa Rica and the U.K., this means long waiting lists. In Thailand, physicians are attempting to shift costs into the area of occupational health. In Germany, the problem is one of controlling costs.

12.5.3 Service quality

The problem of ensuring a high quality of service can emerge in many different systems. Costa Rica has social insurance and the U.K. has a tax-funded system, but both get many complaints from users. Incentives for high quality are likely to be incompatible with good cost containment.

12.5.4 Cost containment

Global budgets (Canada, U.K., Costa Rica), capitation (U.K., Thailand) and insurance-owned facilities (Costa Rica, Egypt) can be effective mechanisms for cost containment. Fees for service (in Germany for hospitals, in Canada for physicians) are a poor mechanism for cost control.

12.5.5 The role of partial systems

Egypt has mobilized significant additional resources for health by using social health insurance for some groups only. Costa Rica has developed a system with universal cover through social health insurance. Even if social health insurance is not feasible for all groups in the population, it can help to extend access to services.

12.5.6 Administrative constraints

The experience in Egypt and Thailand shows the importance of administrative skills in developing social health insurance. A lack of personnel and training can be more of a constraint than a lack of health service infrastructure. Many of the advantages of social insurance funding are lost without good administration.
Chapter 13
BUILDING CONSENSUS
AND GAINING SUPPORT

13.1 The political impact of social health insurance

The development of social health insurance may affect the interests of many groups in the population:

- employers, because they may have to pay contributions
- employees, because membership may be compulsory and contributions may be deducted from their income
- trade unions, because the interests of their members are affected and because they will not want to lose their influence over any labour issue
- providers of health care, because they may be subject to payment regulations and quality control
- existing organizations such as health insurance schemes for certain population groups or private insurance, because they may fear abolition or loss of customers
- government ministries (the ministry of agriculture may be responsible for social security for farmers, the ministry of finance for all kinds of deductions, the ministry of labour for social security, the ministry of health for health policy or infrastructure, the ministry of internal affairs for public hospitals).

Any country that is planning to develop social health insurance should be aware of these interests and of the fact that the lack of a consensus and support in favour of the new system may have a negative effect on the success of social health insurance.

13.2 Information and transparency

The provision of information and the maintenance of transparency are ways of making the new system more acceptable and making the start-up period easier. During the planning phase, it is important to provide full information about the planning process to all relevant groups, and to involve the groups in discussions before any plans are implemented. If all the groups concerned feel they have participated in the planning process, they are less likely to raise objections.

During the planning process, those responsible for the design of the social health insurance scheme should solicit preferences and suggestions from all interested parties. It may be appropriate to engage in negotiation about specific issues. Clearly, not all demands can be met, but it is better to be aware of potential obstacles to the eventual implementation of the plans.

The plans for the new system should be made public and should be opened to debate. Before new legislation comes into force, there should be an information
campaign to ensure that all members and employers know their responsibilities and are aware of the advantages of the new system.

13.3 Pointing out the advantages

In addition to the more general advantages of social health insurance outlined in chapter 2.3, there are specific benefits to be gained by the relevant interest groups. It would be useful to point out these benefits, in order to ensure that the social health insurance scheme receives broad support. Some examples are as follows:

- employers may observe productivity gains because of their employees' improved health status
- members and their families will have access to health care. Population groups who already have health insurance may keep their own systems or may obtain the right to buy complementary protection
- trade unions and employers may participate in the administration of health funds
- providers and certain industries will have an additional and more reliable income. The majority will be better off under social health insurance because greater financial resources will be available. Moreover, they may get their remuneration directly from the health funds, which increases reliability. Additional opportunities for training will emerge.
- the government will be interested in the effects on employment. For example, a fund with 10 million members may need 10,000 employees. Moreover, additional staff will be needed in hospitals, physicians' practices and other provider units.
- provincial and local governments will benefit from an improvement in infrastructure, which will increase the attractiveness of their regions.

QUESTIONS RAISED IN CHAPTER 13

(1) Who favours the social health insurance plan and who opposes it?
(2) Does the plan involve the main interest groups in the country?
(3) How can the plan be made more acceptable to those who currently oppose it?
(4) What can be done to reduce suspicions about the plan?
(5) Are all relevant interest groups aware of the advantages of social health insurance?
(6) What use can be made of modern communications media in order to provide information and increase acceptability?
CHECKLISTS FOR PLANNING
SOCIAL HEALTH INSURANCE
Checklist:

ANALYSING THE ECONOMIC AND POLICY ENVIRONMENT

Health policy

(1) What are the country’s health policy objectives?

(2) Have the objectives been placed in a priority order?

☐ Yes  ☐ No

(3) Has that priority order been publicly accepted?

☐ Yes  ☐ No

(4a) Could the objectives be achieved by changes in the financing system?

If yes, in the long run or the short run?

(4b) Could the objectives be achieved by devoting additional resources to health?

☐ Yes  ☐ No

(5) Is it known how much money would be needed to achieve the health policy objectives?

☐ Yes  ☐ No

(6) Is it agreed that health spending should have a higher priority? Can the country afford to spend more on health?

☐ Yes  ☐ No
(7) What are the opportunity costs of increased health spending in the present economic circumstances of the country?

(8) Is the development of health services restricted by the lack of mechanisms to channel resources into health, rather than the affordability of health services?

☐ Yes ☐ No

(9) Is the growth of the economy sufficient to allow significant development of health services?

☐ Yes ☐ No

Desirability

(1) Would a move to social health insurance, bringing greater visibility of resources for health services, lead to more efficient use of the existing spending?

☐ Yes ☐ No

(2) Do historical or cultural conditions allow for the introduction of social health insurance at present?

☐ Yes ☐ No

(3) What is the current level of deductions from the payroll, and is it sensible to impose further charges under the prevailing labour market conditions?

☐ Yes ☐ No

Feasibility

(1) Is the formal sector large compared with the informal sector, and will it be possible and economical to collect health fund contributions?

☐ Yes ☐ No

(2) Has the potential net increase of resources for health through the introduction of insurance financing been assessed? Does the expected gain in resources justify the effort?

☐ Yes ☐ No
(3) Is there a core of well educated administrators who could be trained to operate a social health insurance system?

☐ Yes ☐ No

(4) Is there a framework of law and enforcement procedures to support a social health insurance law?

☐ Yes ☐ No

(5) Do existing administrative structures and procedures offer mechanisms for collecting contributions?

☐ Yes ☐ No

(6) Is there an adequate health service infrastructure to ensure that health fund members will receive the services to which they are entitled?

☐ Yes ☐ No

(7) Will the scheme be able to offer significant advantages to members without denying emergency care to the rest of the population?

☐ Yes ☐ No
Checklist:

DESIGNING SOCIAL HEALTH INSURANCE

Preliminary issues

(1) Are the health policy objectives of the country clearly stated?
   □ Yes □ No

(2) Have the new benefit entitlements been publicly accepted/demanded?
   □ Yes □ No

(3) Have measures been taken to develop health services to meet the new entitlements?
   □ Yes □ No

(4) Has planning begun for liaison between government departments and agencies?
   □ Yes □ No

(5) Has the organization and financing of staff training been considered?
   □ Yes □ No

(6) Are mechanisms in place to ensure an appropriate balance between primary, secondary and tertiary care?
   □ Yes □ No

(7) Who should be covered by health insurance, and have equity considerations been taken into account?
   □ Yes □ No

(8) Have the number and ownership of health funds been decided?
   □ Yes □ No

System components

(1) Has a table been drawn up showing the target population groups and numbers in each group?
   □ Yes □ No

(2) Is it feasible to register and collect contributions from the target groups?
   □ Yes □ No
(3) Have the patterns of risk and disease of the target groups been analysed?
☐ Yes ☐ No

(4) Has an assessment been made of the target groups' ability to pay contributions?
☐ Yes ☐ No

(5) Has it been decided which groups in the population will be offered cover first?
☐ Yes ☐ No

(6) Has a mechanism been agreed for deciding on entitlements?
☐ Yes ☐ No

(7) Have checks been made for a possible overlap with the services available from other funders or providers?
☐ Yes ☐ No

(8) Do providers of services have an appropriate legal status to allow them to enter into contracts with health funds?
☐ Yes ☐ No

(9) Are structures in place to monitor and regulate health care providers?
☐ Yes ☐ No

(10) Is there a strategy for generating health care information and financial information?
☐ Yes ☐ No

(11) Will health funds be allowed to provide services as well as fund them?
☐ Yes ☐ No

(12) Will the chosen provider payment systems limit cost escalation and provider-induced demand?
☐ Yes ☐ No

(13) How will the health funds be governed, and will they have sufficient independence from government?
☐ Yes ☐ No

(14) Has a strategy on computerization been agreed?
☐ Yes ☐ No
Checklist:

DRAWING ON EXPERIENCE
AND BUILDING CONSENSUS

Drawing on experience

(1) Has the experience of a set of typical countries with established primarily tax-financed, primarily contribution-financed or mixed systems been studied?

☐ Yes ☐ No

(2) Have these experiences been discussed with interest groups in the health care financing and delivery system and with the general public?

☐ Yes ☐ No

Building consensus

(1) Have those who favour and those who oppose the social health insurance plan been identified?

☐ Yes ☐ No

(2) Does the plan involve the main interest groups in the country?

☐ Yes ☐ No

(3) Has action been taken to reduce suspicions about the plan?

☐ Yes ☐ No

(4) Is everyone aware of the personal advantages they can gain from social health insurance?

☐ Yes ☐ No

(5) Is the best use being made of modern communications media in order to provide information and increase acceptability?

☐ Yes ☐ No
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