Legal access rights to health care
Legal access rights to health care

GERMANY, JAPAN, KENYA, THAILAND

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The country profiles were prepared by Simone Bösch, an independent health policy consultant and lawyer based in London (UK), who also developed the survey tool with David Clarke.

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Introduction

The four country profiles on legal access rights to health care analyse the capacity of the laws of Germany, Japan, Kenya and Thailand to deliver universal access to health care in each jurisdiction. They provide an overview of each country’s approach to enshrine access rights in law, including statutory insurance schemes, coverage of different population groups, benefit packages (including legal mechanisms to define benefits and enforce access rights), anti-discrimination provisions (including legal complaint mechanisms), and access barriers to health care.

These country profiles are part of ongoing work by WHO’s Department of Health Governance and Financing (Health System Governance, Policy and Aid Effectiveness) to strengthen the recognition of law as an essential tool to achieve universal health coverage. This document provides an overview of the work to date as background to these country profiles and explains the methods used to develop them.

Law and Universal Health Coverage (UHC)

Countries committed to achieving Universal Health Coverage (UHC) in the Sustainable Development Goals (SDGs): SDG 3.8 obliges governments to work towards achieving UHC by ensuring that all people have access to the quality care (essential health services, essential medicines and vaccines) they need without suffering financial hardship.

The law plays a key role in a country’s progressive realisation of UHC. The quality of a country’s health laws and legal practices significantly contributes to the efficient, effective and equitable use of the available health resources and, consequently, the attainment of a country’s health system goals. Therefore, creating an enabling legal environment for UHC is a critical investment to ensure implementation of UHC policies and programmes.

Survey tool for national UHC laws

In 2018, WHO’s Department of Health Governance and Financing developed a legal survey tool to analyse and better understand a country’s use of law to realise UHC. The survey tool consists of a set of indicators across four domains:

1. UHC policy: laws providing the legal capacity to deliver the three aspects of UHC – universal access to health care, financial risk protection and quality of health care
2. Governance, rule of law, human rights and access to justice
3. UHC partnerships
4. Policy process, implementation and enforcement

The first three domains measure how the law is used to implement UHC on paper while the fourth domain focuses on the practice of law, i.e. the enactment, implementation and enforcement of laws.

Each indicator comprises a diagnostic question, a guidance note clarifying the scope of the indicator (including examples) and best practices. The guidance notes and best practices help a user to answer the diagnostic question in a structured way and to write a summary.

While the survey tool is constructed to provide a comprehensive overview of a country’s legal environment regarding UHC implementation, indicators can also be used on their own if one domain or a sub-section is of particular interest. Indicators are self-contained as much as possible so that they can be used on their own.
The country profiles of Germany, Japan, Kenya and Thailand were developed to test the usefulness of the survey tool in one restricted domain: universal access to health care, as enshrined in the national body of laws of these countries. The development of the country profiles was also used to understand what resources (human, financial, time) would be needed to complete a full survey of all indicators.

The four countries were chosen to represent different WHO regions, health systems and socioeconomic contexts.

The country profiles were drafted using initial input from in-country contacts who provided key laws governing UHC (except for Germany). Desk research on additional laws available in English and publicly accessible background materials complemented the initial sets of laws. The available laws and background materials were analysed using the indicators and guiding questions on universal access to essential healthcare, essential medicines and vaccines of the survey tool (see Annex). For each indicator, the findings were summarised to provide an overview of each of the four countries’ legal framework regarding legal access rights to health care.

Where the available material was unclear, the in-country contacts provided valuable clarifications and input.

**Limitations**
For some indicators, comprehensive material was not readily available in the publicly accessible literature and relevant information could not be extracted from existing laws. Unpublished work or research, or publication in other languages than English and German (particularly in Thai or Japanese), may exist, but it might also be that some indicators would have required formal interviews with in-country legal and medical experts knowledgeable about UHC. While in-country contacts provided valuable input to the profiles, they were gracious enough to do so on a voluntary basis in addition to their regular work load and were not formally tasked to support this project. Consequently, there were certain gaps that could not be addressed as it would have required substantial investment of time, which was not feasible.

Available material was particularly limited on discriminatory access barriers in existing laws, both with respect to health laws as well as other bodies of law such as labour regulation or criminal law. It was also limited with respect to legal complaint mechanisms to report and sanction discrimination as well as to enforce access rights. Lastly, it was not always completely clear what the benefit packages included and excluded. To fully examine and analyse these indicators would have gone beyond the scope of these country profiles.

In addition, customary law could not be considered in the legal analysis as it would have required additional resources to source the relevant information for each country.

**Annex: Indicators to survey universal access to essential health care**

The below listed indicators and questions were used to guide the development of the four country profiles on legal access rights to health care.

**1. Legal recognition of access rights to essential health services, essential medicines and vaccines**

**Diagnostic question**
Do all people in the country have formal legal access rights to essential health services, essential medicines and vaccines?

**Guiding questions**
- Is a right to universal health coverage and/or to a defined package of essential health services enshrined in law?
- Who is entitled to the right to access a defined package of essential health services, vaccines and medicines (benefit package)?
- Does a legal mechanism exist to define the package of essential health services to which people are entitled to?
- Do legal mechanisms exist to enforce access rights to health care?

**2. Anti-discrimination provisions applicable to health care**

**Diagnostic question**
Have anti-discrimination provisions been implemented to protect individuals from discrimination when accessing essential health services, essential medicines and vaccines?

**Guiding questions**
- Has the country ratified international human rights instruments that prohibit discrimination?
- Has the country enacted anti-discrimination provisions?
- What kind of individual characteristics are protected by existing anti-discrimination provisions?
- Do other discriminatory barriers to access health care exist?
- Has any work been carried out to ensure existing laws do not create access barriers?
- Do legal complaint mechanisms, including complaint bodies, exist to report and sanction discrimination?

**3. Limited set of essential health services, essential medicines and vaccines accessible to all including groups without health coverage**

**Diagnostic question**
Is a formal right to access a limited range of defined essential health services, essential medicines and vaccines granted to all people independent of their right to health care?

**Guiding questions**
- Do legal means exist to grant access to a limited range of essential health services, essential medicines and vaccines to anyone in the country, independent of whether they are included in health coverage schemes?
- If such provisions exist, which essential health services, essential medicines and vaccines are accessible to all?

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**References**

1. Universal Health Coverage is defined as “all people receiving the health services they need, including public health services designed to promote better health (such as anti-tobacco information campaigns and taxes), prevent illness (such as vaccinations), and to provide treatment, rehabilitation and palliative care (such as end-of-life care) of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship.” Tracking universal health coverage. 2017 global monitoring report. World Health Organisation and International Bank for Reconstruction and Development / The World Bank. 2017. Available from: [https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/](https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/)

2. Customary law (also called unofficial law) encompasses established legal practices within a community (or country) that are not written down but which all relevant actors consider to be law (opinio iuris). Customary law creates rights and obligations through long-standing, consistent practice and custom that can be objectively verified. Sometimes, customary law is supported by case law as a result of judicial review of cases by courts that are based on customary law.
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GERMANY

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Legal recognition of access rights to essential health services, medicines and vaccines

Contributions to the statutory health insurance schemes depend on income with caps on maximum co-payments to prevent financial burden. Contributions to private insurance schemes are based on health status, age and gender. Private insurance companies are required to offer a basic rate commensurate with entitlements under the statutory health insurance scheme. [4]

An exception to the above are EU citizens who obtain their residency rights through their children, who are unemployed or without sufficient funds to provide for themselves. During the first five years of their stay, they cannot participate in the statutory health insurance scheme and are only provided medical care once every two years for a duration of up to one month as part of the social services benefits they receive. Health care services are limited to urgent medical and dental care and pain management, including medication, dressings and other services necessary to ensure healing. Resident EU citizens excluded from the statutory health care scheme can purchase private health insurance. [5]

It is mandatory for citizens and long-term residents to enrol in a health insurance scheme. Two systems exist. Civil servants, students, self-employed persons and those belonging to a “free profession” (Freiberufler) can choose whether they enrol in a statutory or private health insurance scheme (75% remain in the statutory health schemes). [1-4]

All others (e.g. employees or pensioners) must belong to a statutory health insurance scheme unless they earn a yearly salary exceeding EUR 60,750 (2019), in which case they can choose to join a private health insurance scheme instead of a statutory one or complement statutory insurance with private insurance. The salary threshold allowing opting-out of statutory insurance is subject to yearly reviews and has been steadily increased in the last years. Non-earning dependents are covered by the statutory insurance schemes. [3, 4]

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Long-term care insurance
Based on Book XI of the Social Security Code (SGB XI), all members of statutory sickness funds are automatically enrolled for long-term care insurance; privately insured persons are required to enrol in private long-term care insurance. Unlike benefits of the statutory health insurance, benefits of the statutory long-term care insurance are only available upon application and approval by the Medical Review Board, a joint operation by sickness funds and long-term care funds. Beneficiaries in need of care of more than 6-month duration are placed in one of three tiers depending on need; shorter care is provided through the statutory health insurance scheme. Beneficiaries can choose between cash benefits to purchase their own care (Pflegegeld) or a range of benefits in kind (Pflegesachleistungen) such as general care (Grundpflege), domestic help, support of carers and care equipment provided at home or in nursing homes. The Federal Ministry of Health is responsible for long-term care and it is funded through equal contributions of employers and employees. A public holiday was converted to a working day to offset employers’ additional costs for long-term care insurance. [6, 7]

Non-resident EU citizens
EU citizens who are job seekers or not capable of working are not entitled to be covered by statutory health insurance. They can purchase private health insurance. [3]

Based on EU law, EU citizens lose residency rights and are treated like third-country undocumented immigrants after three months of residency in Germany if they have insufficient funds and no insurance coverage (e.g. if they are incapable to work or are not able to secure a job). Urgent medical care is covered (Book XII of the Social Security Code). Pregnancy-related care is not considered emergency care and uninsured pregnant EU citizens are advised to return to their home countries. The Ministry of Labour and Social Affairs can cover travel costs. [3, 8]

86% of the population are covered by statutory sickness fund

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**Citizens and residents**

**Health insurance**
It is mandatory for citizens and long-term residents to enrol in a health insurance scheme. Two systems exist: a statutory system, governed by Book V of the Social Security Code (SGB V), or substitutive private insurances. The statutory system consists of over 100 sickness funds which are non-governmental, not-for-profit health insurances that compete amongst each other. Free choice exists as to which sickness fund to join. Around 86% of the population are covered by statutory sickness funds (Gesetzliche Krankenkassen – GKV) and around 11% by private health insurances (Private Krankenkassen – PKV). The remaining population is covered through special programmes for military members, police and other public-sector employees. [1, 2]

**Non-resident EU citizens**
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Documented non-EU migrants

Entitlements to medical care of asylum seekers, refugees, holders of a residence permit for humanitarian reasons, persons with a “temporary tolerated stay” and those obliged to leave are regulated by the Asylum Seekers’ Benefits Act. They do not have the same entitlements as citizens and residents. During the first 15 months of their stay in Germany, they may receive basic health care services covering:

- treatment for severe illnesses or acute pain and everything necessary for curing, improving or relieving the illnesses and their consequences, including dental care;
- antenatal and postnatal care;
- vaccinations;
- preventive medical tests and anonymous counselling and screening for infectious and sexually transmitted diseases. [9, 10]

After 15 months of residency in Germany, documented migrants are subject to the same conditions as German citizens when accessing the German health care system. However, the 15-month limitation of benefits can be extended for an unlimited duration for documented migrants who illegally tried to affect the duration of their stay in Germany. [3]

Documented female migrants are entitled to the same benefit package for pregnancy-related care as citizens and residents are under the statutory health care scheme. [19]

Children of documented non-EU migrants are subject to the same entitlements and system as adults. §6 of the Asylum Seekers Benefits Act stipulates that additional medical services can be granted if they are necessary for the “special needs of children”. However, the Act does not define what such services encompass. [10]

Seriously ill foreigners can be granted a “temporary tolerated stay” based on Section 60a.2 of the Residence Act based, amongst other reasons, on medical grounds or, in the case of illnesses that cannot be treated in their home countries, humanitarian grounds. During the duration of the tolerated stay, foreigners cannot be expelled if their medical condition makes expulsion impossible. Foreigners suffering from chronic diseases can be granted a residence permit if a physician certifies travel is not possible and treatment must be continued in Germany; the residence permit terminates once the person is able to travel (Section 25-5 Residents Act). [14]

Undocumented non-EU migrants

Undocumented non-EU migrants and their children have the same entitlements to health care and must follow the same procedures as documented non-EU migrants during their first 15 months of residency in Germany according to the Asylum Seekers’ Benefits Act. However, authorities must report undocumented migrants to immigration authorities, thus preventing undocumented migrants to seek care (see below for access barriers). [3, 10]

Undocumented pregnant migrants are afforded a “temporary tolerated stay” six weeks before and eight weeks after delivery during which they cannot be expelled. During this time, they can access care without fearing repercussions. [3]

Legal mechanism to define the benefit package

The joint Federal Committee (Gemeinsamer Bundesausschuss, G-BA) is the supreme decision-making body of the joint self-administration of doctors, dentists, psychotherapists, hospitals and health insurances in Germany. Its members are the associations representing statutory health insurance physicians, statutory health insurance dentists, hospitals and sickness funds. Representatives of accredited patient organisations participate in the G-BA with consultation and suggestion rights. [15, 16]

Non-prescription medicines considered standard in treating severe diseases are included in the benefit package based on a G-BA directive (§ 34 SGB V). [19]

Health services not included in the list of services which are defined by the law as “sufficient, appropriate and economic” patient care, e.g. medical cosmetic procedures and acupuncture, are excluded from the benefit package (§92 SGB V). These “individual health services” (Individuelle Gesundheitsleistungen - IGL) have to be fully paid by patients and are usually not reimbursed. Certain health care services are not automatically included in the benefit package, but can be accessed with prior authorization (e.g. short-term nursing care at home, rehabilitative services). [2, 6, 18]

Ocucional accidents and disease are covered by a statutory scheme governed by Book VII of the Social Security Code (SGB VIII). [19]

Legal mechanism to enforce access rights to health care

A system of social courts exists for social insurance disputes, including those related to Germany’s statutory health insurance scheme. Sixty-nine (69) social courts exist (4 at State level); the last instance is the Federal Social Court. Differential user fees are applicable depending on who the claimant is (insured person, provider, social insurance institution or private-sector actor). Social courts resolve disputes on corporatist decisions (e.g. decisions of sickness funds and long-term care funds); laws and regulations and can be used by patients to sue their statutory sickness fund for benefits they are entitled to. G-BA directives can also be subject of a social court complaint by statutory health insurance actors. [4]
**Access barriers**

Municipal social service departments issue health vouchers to documented migrants. Due to their lack of medical expertise, they apply the Asylum Seekers’ Benefits Act inconsistently. Based on this heterogeneous interpretations of the Act, documented non-EU migrants’ entitlements to health vouchers vary by municipality. [3]

**Anti-discrimination provisions applicable to health care**

Hospitals providing emergency care to undocumented migrants are bound by professional confidentiality as are the social service departments to which they need to report to receive reimbursement. The social service departments must verify, as part of the reimbursement process, that patients are in need, which requires them to contact the immigration authorities. Thus, undocumented migrants do not seek emergency care for fear of being reported and expelled. [4]

Those not able to access health care through statutory health insurance face economic access barriers, which is the most common reason for not receiving the required health care in Germany. [23]

Access to counselling, testing and outpatient care for sexually transmitted diseases (STDs) and tuberculosis is open to anyone; however, in practice, only persons with at least a temporary residence permit have access. Additionally, the duty to report some diseases including the patient’s name provides another access barrier. [3]

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**Ratification of international human rights instruments**

Germany has ratified the International Covenant on Economic, Social and Cultural Rights; the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities. Germany is also a signatory to the European Human Rights Convention. [21, 22]

**National anti-discrimination provisions**

The German Constitution’s Article 3 on equality before law stipulates protection against discrimination based on sex, parentage, race, language, disability, homeland or origin, faith, religious or political opinions. [20]

The General Act on Equal Treatment contains anti-discrimination provisions in sections 1 and 2, prohibiting discrimination based on race or ethnic origin, gender, religion or belief, disability, age or sexual orientation, including in the health care setting. The Act implements Germany’s obligations under various EU directives on anti-discrimination on a national level. It establishes a Federal Anti-Discrimination Agency with reporting, information and arbitration functions and defines the rights of anti-discrimination organisations in legal proceedings in support of the disadvantaged person. The Act also includes a reversal of the burden of proof, whereby the defendant has to prove that the act was not discriminatory (rather than the disadvantaged person proving it was a discriminatory act). [24]

The Act on Equal Treatment of People with Disabilities aims to decrease barriers for people living with disabilities when accessing public buildings, communication or IT. The Act establishes a monitoring body, the Federal Office for Accessibility (Bundesfachstelle Barrierefreiheit), overseen by the Federal Ministry of Labour and Social Affairs, and a Federal Government Commissioner for Matters relating to Persons with Disabilities. The Act also sets up an arbitration service for complaints under the Act and defines legal complaint mechanisms other than arbitration. The Act has been implemented on a subnational level by state laws (Ländergesetze) on equality of disabled people. [25-28]
Limited set of essential health services, medicines and vaccines accessible to all, including groups without health coverage

Based on §19 of the Infectious Diseases Protection Act, anyone is entitled to counselling, testing and outpatient care for sexually transmitted diseases (STDs) and tuberculosis. However, in practice, only persons with at least a temporary residence permit have access. Additionally, some diseases must be reported to authorities naming the patient (e.g. hepatitis, but not HIV), which provides another access barrier. (10)

To counter these access barriers, health authorities in larger cities set up counselling services for STDs which are accessible to anyone, independent of legal status. They offer anonymous services including counselling and testing and sometimes doctor consultations. Nevertheless, interested persons must apply for vouchers to use these services, resulting in a lack of accessibility for undocumented migrants. (11)

References
(All links verified on 28 March 2019)

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JAPAN

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Legal recognition of access rights to essential health services, medicines and vaccines

Citizens and residents

Citizens are required to enrol with either National Health Insurance or Employees’ Health Insurance. Enrolment is based on age, employment status and/or place of residence. [1]

Employed persons and their dependents are covered by the Employees’ Health Insurance System run by the Japan Health Insurance Association and Society-Managed Health Insurance, which is regulated by the Health Insurance Act. [1, 2]

Self- and unemployed people are covered by the National Health Insurance (NHI) run by municipal governments, based on the National Health Insurance Act. Some professional groups are covered by their own insurers based on respective laws. [3] Citizens and residents aged 40 years of age and older are mandatorily enrolled in long-term care insurance provided by municipalities, based on Art. 9f of the Long-Term Care Insurance Act. [1, 3, 4]

Elderly aged 75 and above are required to enrol in the late-stage medical care.

Elderly aged 75 and above are required to enrol in the late-stage medical care system for the elderly instead of NHI. This separation was introduced in 2008 with the Act on Assurance of Medical Care for Elderly People. [5]

NHI enrolment must happen within two weeks of becoming eligible for coverage. This might happen because of immigration from overseas, moving to another municipality, birth to parents not covered by an employees’ scheme, losing coverage through an employees’ scheme (e.g. due to redundancy or becoming self-employed), or increased income (i.e. not being eligible anymore for coverage under the social welfare system). [6]

Foreigners moving to Japan are required to enrol in the NHI after three months of residency in Japan, unless they are covered by Employees’ Health Insurance. [1]

The co-payment rate is 30% for all insured persons aged 6 to 69 years. To prevent financial hardship, monthly out-of-pocket thresholds exist which vary according to the insured’s age and income. In addition, annual household out-of-pocket ceilings are in place, which also vary according to age and income. Payments above the ceilings get reimbursed. Monthly ceilings also exist for people on low income. Persons insured through NHI (unemployed, retirees and self-employed) are entitled to reduced premiums if they are on a low income. Persons insured through the Employees’ Health Insurance System do not pay premiums during parental leave. [4]

People living below the poverty line are covered by the social welfare system. They receive the same care for free.

Co-payment reduction programmes exist for various population and disease groups to reduce catastrophic health expenditure:

- Patients suffering from 331 specified intractable or chronic diseases pay reduced co-insurance rates (varying by income) as long as they use designated health care providers. [1]
- Persons suffering from disabilities and mental health issues are also eligible for co-payment reductions based on the Services and Supports for Persons with Disabilities Act; however, this is restricted to those falling below pre-defined limits of household income. [8, 9]
- Based on the Child Welfare Act and the Maternal and Child Health Act, co-payment reduction is granted for children with low birth weight, tuberculosis or chronic diseases. [10, 11]
- Diagnosis and treatment for some infectious diseases is covered by prefectures for all. For more information, see below under title “Limited set of essential health services, medicines and vaccines accessible to all, including groups without health coverage”. [12]

Japan’s private health insurance companies do not provide traditional private health insurance but offer supplemental income in case of illness (sick pay). Most of Japan’s population buys private health insurance to supplement or complement their statutory cover with cash benefits in case of illness. Private health insurance companies pay lump-sum payments or daily payments over a defined period, mostly for specific chronic diseases. [4]

Undocumented migrants and visitors

Undocumented migrants and visitors are not covered by Japan’s statutory health care system and need to pay for health care out of pocket. [4]

Documented migrants

Documented migrants are treated the same as residents (foreigners living in Japan for more than three months) based on Article 7 of the NHI Act and Article 35 of the Health Insurance Act. Both acts do not distinguish documented foreigners based on their legal status. [2, 3]
The benefit package for both the NHI and Employees’ Health Insurances schemes are the same.

The benefit package covers hospital, primary, specialty, and mental health care; hospice care; physiotherapy; most dental care; approved prescription drugs; ante-natal care and delivery in case of pregnancy complications (normal pregnancy is not covered); and home care services by medical institutions (if provided by non-medical institutions, then home care services are covered by long-term care insurance). Optometry services are only covered if provided by physicians, corrective lenses are excluded except for children aged under 9 if recommended by a physician. [2, 3]

Based on the Maternal and Child Health Act, parents receive the Maternal and Child Health Handbook, which contains information and all data on their ante- and post-natal check-ups, delivery and complications; continued guidance and consultation from public health nurses during pregnancy; screening for congenital metabolic diseases after delivery; three well-baby check-ups (at 3-4 months, 18 months and 3 years of age); hepatitis B vaccination; and, if the mother lives with hepatitis B, free immunoglobulin.

Most municipalities provide up to five additional health check-ups for babies and children. [1]

Preventive services, such as general medical check-ups, screening, counselling and health education, are not included in the NHI scheme, but covered by municipal governments (Art. 82 of the National Health Insurance Act). In addition, employed persons have a right to yearly health check-ups, including mental health, paid for by their employer based on the Industry Safety and Health Act. [1, 3]

Ante-natal care and delivery for pregnancies without complications are excluded but covered through the municipal governments which grant lump sum payments upon application (Article 581) of the National Health Insurance Act and Articles 101 ff. of the Health Insurance Act). [1, 2, 3, 4]

Immunization services are also excluded from the NHI benefit package but covered through municipal governments who pay for children’s vaccinations and the pneumococcal vaccine for persons aged above 65. Orthodontics, cosmetic surgery and treatments as well as single-patient bedrooms are excluded from the NHI benefit package and have to be paid for out-of-pocket. [1, 4]

Work-related injuries and conditions are also excluded as they are covered by the workers’ accident compensation insurance plan, run by the Government. The insured entities are private companies. The legal basis is the Industrial Accident Compensation Insurance Act. [11]

Coverage can be limited or refused for injuries or conditions incurred intentionally or as a result of extreme misconduct, crime, fighting or drunkenness. [2, 3]

Medical costs are not reimbursed if patients fail to follow instructions regarding their treatment or do not provide necessary paperwork or undergo necessary examination to support reimbursement claims without a justifiable reason. [2, 3]

Persons suffering from pollution-related diseases can receive various benefits based on the Law Concerning Pollution-Related Health Damage Compensation and other Measures: medical expenses, medical care allowance, disability compensation, survivors’ compensation, survivors’ lump-sum compensation, child compensation allowance, and funeral expenses. [14]

Legal mechanism to enforce access rights to health care

Health care providers enter into contracts with insurers and directly claim for reimbursement for treatments provided to persons insured through the NHI. If insurers refuse to pay for provided services, health care providers can use the complaints process set out in Articles 91ff. of the National Health Insurance Act. Health care providers may file an application for examination verbally or in writing with the responsible National Health Insurance Examination Board within 60 days of the insurer’s decision to refuse payment of an insurance claim (or other decisions or actions deemed unjustful, e.g., how the monthly or annual cap is applied). An application for examination must be filed with the Examination Board of the prefecture governing the location of the insurer or municipality which took the disputed action; if a complaint is submitted to an Examination Board without jurisdiction, it must promptly transfer the application to the correct Examination Board, notifying the claimant of the transfer. Each prefecture has a National Health Insurance Examination Board composed of nine part-time members representing insured persons, insurers and the public (three each). Examination Board members serve three-year terms and can be reappointed. The majority of an Examination Boards’ members must be present to have quorum, and decisions are taken by majority; in case of a tie, the Chairman decides. Decisions cannot be appealed by health care providers and they are required to cover the costs not reimbursed by insurers. If the insurer and health care provider cannot come to an agreement, then the beneficiary could claim for reimbursement directly from their insurer. However, this is quite rare given the fact that health care providers need to cover unpaid fees, not the beneficiaries. [1, 4]

The complaints process for the Employees’ Health Insurance is similar to the one of the NHI. Health care providers claim for reimbursement, and in case of disagreement with the insurers’ decisions, they can submit a complaint to the Social Insurance Examiner. A total of six examiners are appointed by the Ministry of Health, Welfare and Labour. Health care providers can demand for a re-examination if they disagree with the Examiner’s decision. A decision following re-examination is final. If a request for examination is not decided within two months, dismissal of the examination is assumed. If a complaint is dismissed, health care providers must cover the amount not reimbursed by insurers. If the insurer and health care provider cannot come to an agreement, then the beneficiary could claim for reimbursement directly from their insurer. However, this is quite rare given the fact that health care providers need to cover unpaid fees, not the beneficiaries. [1, 4]
Anti-discrimination provisions applicable to health care

Ratification of international human rights instruments

Japan has acceded to the International Covenant on Economic, Social and Cultural Rights and has ratified the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities. [15]

National anti-discrimination provisions and complaint mechanisms

The Japanese Constitution stipulates in Article 14 equality before the law and prohibits discrimination with political, economic or social consequences based on race, creed, sex, social status or family origin. [16]

The Public Assistance Act’s Article 2 contains a non-discrimination and equality clause with respect to receiving public assistance through the Ministry of Health, Welfare and Labour. The clause does not list the characteristics based on which discrimination is prohibited. [17]

The Basic Act for Persons with Disabilities includes an anti-discrimination clause in Article 4 to prohibit discrimination based on disability. The Act for Eliminating Discrimination against People with Disabilities defines measures applicable to both government authorities and private companies to eliminate discriminatory behaviour and access barriers for people living with disabilities. [17, 18]

The Act on Securing Equal Opportunity and Treatment between Men and Women in Employment sets out measures in Articles 12 and 13 requiring employers to protect women from discrimination during pregnancy and after childbirth. [19]

In February 2019, parliamentary endeavours started to develop a basic law governing health care, which might include anti-discrimination provisions protecting patients from discriminatory treatment. [4]

Access barriers

Foreigners residing in Japan have a higher mortality rate than Japanese citizens. The language barrier impedes access to health care and a legal framework mandating medical language interpretation does not exist. In view of the 2020 Olympics in Tokyo, efforts are under way to minimise language barriers, introducing interpretation services in various languages. However, these seem to be mostly aimed at relatively wealthy foreigners. [20-22]

An additional access barrier is a lack of understanding of how the Japanese health care system works, how to access insurance and what benefits the statutory insurance system provides. Many foreign residents, for example the Nepalese who are the largest immigrant group in Japan, lack awareness of the system and their rights and are not informed appropriately by their employers, the Japanese municipalities where they live and the immigration agencies they use. In addition, companies employing vulnerable groups such as visa overstayers, foreign trainees and Nikkeijin (Latin Americans of Japanese descent) sometimes discourage enrolment in the Employees’ Health Insurance in violation of labour laws to avoid payment of the employer’s half of insurance premiums. [22, 23]

Ethnic minorities and other minority populations also face economic access barriers to the health care system. Citizens and residents eligible for NHI but who do not enrol or keep up their NHI enrolment are required to pay two years’ worth of premiums upon re-entering the system. If they cannot afford the payment, they cannot enrol in the insurance scheme and have to pay out-of-pocket for treatment. [8]

A scarcity of systematic empirical evidence impedes an accurate estimate of access barriers to the Japanese health care system. [1]

Clinics and physicians are required by law to provide treatment and may not refuse treatment without just cause.

Clinics and physicians are required by law to provide treatment (except cosmetic surgery, preventive measures and normal delivery) and may not refuse treatment without just cause. However, hospitals are encouraged by the Government to strictly check identity documents and insurance cards prior to treatment. This creates access barriers to anyone not covered under one of the insurance schemes or who is in arrears with premium payments. Some hospitals deny care to people without insurance because they are left with unpaid bills, prioritising fee payment over provision of care; charge higher fees to uninsured people, or discharge them earlier. In addition, identity checks raise fears of undocumented migrants, visa overstayers and some asylum seekers’ being reported to immigration officials. [20, 22-24]

Physicians treating people for a legally defined set of infections must report the cases to authorities, including the patients’ name, age and gender, which constitutes another access barrier for patients with an irregular legal status. [12]
Limited set of essential health services, medicines and vaccines accessible to all, including groups without health coverage.

Based on the Act on the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases, prefectures are mandated to bear costs for anyone irrespective of legal status for diagnosis, medicines and therapeutic materials, medical procedures, surgery and other therapy as well as care and other nursing incidental to medical treatment for class I or II infection, new infectious diseases or novel influenza. For tuberculosis treatment, the prefecture bears 95% of costs. If a patient or relative is deemed able to cover costs partly or wholly, the prefecture can mandate the patient or relative to bear the costs (wholly or partly). Treatment for listed infectious diseases is covered if it is received in designated hospitals, unless the prefectural governor permits treatment in another medical facility or in cases of emergency. Treatment costs are directly reimbursed to health care providers by local governments for those patients unable to bear costs wholly or partially; health care providers send their reimbursement applications to the prefectural governor via the chief of the public health centre responsible in the area of the patient’s residency.

If a patient does not seek treatment for a class I or II infection, tuberculosis or novel influenza, the prefecture has the right to forced hospitalization for up to 72 hours. If the prefecture considers continued hospitalization necessary after 72 hours, it must convene an expert committee to decide if continued forced hospitalization up to ten days (30 days for tuberculosis) is necessary.

Physicians treating patients for infections included in the Act on the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases must notify the prefectural governor via the chief of the nearest public health centre, including the name, age and gender of the patient. Health care providers' applications for reimbursement to the local governments also include personal details of the patient. Consequently, patients who are undocumented or in Japan illegally might not seek health care even though they have a statutory right to receive free treatment for listed infections.

References (All links verified on 28 March 2019)

[9] Information provided by Hirosu Sakamoto, Department of Global Health Policy, Graduate School of Medicine, The University of Tokyo.
[26] [12, 25]
Legal access rights to health care

COUNTRY PROFILE
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Legal access rights to health care

KENYA

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Legal recognition of access rights to essential health services, medicines and vaccines

Commitment to achieve UHC

Vision 2030, Kenya’s long-term development strategy for economic, social and political planning launched in 2007, contains as one of its flagship projects for the health sector the creation of a mandatory national health insurance scheme. President Uhuru Kenyatta’s “Big 4 Agenda” includes 100% UHC coverage by 2022 as one of Kenya’s four most important development priorities (alongside food security, affordable housing and manufacturing). And Kenya’s Health Policy 2014-2030 includes the provision of essential health care as a key objective. [9-11]

In December 2018, the Kenyan Government launched their UHC programme through pilots in four counties. It is planned to scale the UHC programme to all of Kenya’s 47 counties within four years. The underlying UHC strategy was developed in collaboration with the World Health Organization. [4]

Rights-based approach

The Constitution of Kenya stipulates in Article 43 that every person has the right to the highest attainable standard of health, including the right to health care services and reproductive health care; it does not define “highest attainable standard of health”. Article 43 also sets out that a person shall not be denied emergency care, and that the State shall provide support to those unable to care for themselves or dependents (including health). Additional health-related rights enshrined in Article 43 encompass the rights to reasonable standards of sanitation, adequate housing, clean and safe water, freedom from hunger and adequate food of acceptable quality as well as social security. [7]

The Health Act also enshrines the right to health, defining health as “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (Article 2). It includes the progressive access to promotive, preventive, curative, palliative and rehabilitative services (Article 5). The Health Act also enshrines the right to reproductive care (Article 6) and the right to emergency care (Article 7). [4]

Citizens

Based on the National Hospital Insurance Fund Act, the National Hospital Insurance Fund (NHIF) provides social health insurance to Kenyans in the formal and informal sector, their spouses and children. The NHIF is a state corporation which formerly was a department at the Ministry of Health. Anyone is eligible to join the national scheme who possesses Kenyan citizenship, is 18 years of age and has monthly earnings of more than KES 1,000 (ca. USD 10). Applicants are not filtered for pre-existing conditions and there are no limits on included dependents. Salaried persons pay contributions based on income, ranging between KES 150-1,700 (ca. USD 1.5-17) monthly, through statutory salary deductions, remitted to the NHIF via the employers. Self-employed and informal sector workers as well as retirees can purchase the Supa Cover for a fixed monthly rate of KES 500 (ca. USD 5) on a voluntary basis. [7-10]

Salaried persons pay contributions based on income.

Civil servants and disciplined services (e.g. police, prison staff) are covered under the Civil Servants Scheme (CSS). The CSS is funded by the Kenyan Government, with funds being managed by NHIF in a fund separate from its other funds. Paying members are limited to register six dependents for free (additional members can be registered by paying additional fees). Around 600,000 civil servants and their dependents are enrolled in the CSS. [10]

The Health Insurance Subsidy Programme (HISP) is a scheme for poor Kenyans which provides free insurance coverage. It targets those living in extreme poverty, orphans and vulnerable children, the elderly and persons with severe disabilities. In 2016, around 170,000 households were insured through HISP, covering around 600,000 persons. [8, 11, 12]

NHIF offers additional packages targeting specific groups: the Linda Mama programme provides free maternal health care, while the Edu-Afya programme offers free insurance for all students in public secondary schools. [13, 14]

Insurance coverage has been increasingly rising. In 2009, 8.17% of Kenyans had insurance, of which 1.56% were covered by NHIF. By 2014, 19.59% of Kenya’s citizens had insurance, of which 15.80% were covered by NHIF. Insured people not covered through NHIF were insured through private or employer-provided insurance, microfinance or community-based health insurance. All others had to pay for treatment out-of-pocket or receive health care via non-governmental organisations or international organisations. [7]

NHIF membership is biased towards people working in the formal sector: In 2017, 24% belonged to the informal sector even though 83% of employed persons in Kenya work in the informal sector. [11]

NHIF states that 22 million people are insured through them (7.3 million contributing members plus their dependents). Other publications put the number of insured, including dependents, at around 6.6 million members in 2017. [9, 11]

Residents

Foreigners with a work or study permit can enrol for insurance cover through the NHIF just like Kenyan citizens. [9, 11]

Undocumented migrants

Undocumented migrants cannot enrol for insurance cover under the NHIF and have to pay for treatment out-of-pocket or receive health care through non-governmental organisations or international organisations.
The Plan’s aims were to ensure that the KEPH is made available to vulnerable populations

The NHIF developed their own benefit packages for their different schemes, modelled on the KEPH as included in the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014-2017. As part of Kenya’s UHC initiative, the Ministry of Health announced the constitution of a two-year Advisory Panel for the Design and Assessment of the Kenya UHC Essential Benefit Package in June 2018. It consists of 15 members and two secretaries and their different schemes, modelled on the KEPH as included in the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014-2017. As part of Kenya’s UHC initiative, the Ministry of Health announced the constitution of a two-year Advisory Panel for the Design and Assessment of the Kenya UHC Essential Benefit Package in June 2018. It consists of 15 members and two secretaries and its Secretariat is housed at the UHC Delivery Unit of the Ministry of Health. The Advisory Panel is tasked to develop criteria for the inclusion of services, medicines and medical supplies, using an evidence-based approach and taking into account cost effectiveness and equity, proposing a benefit package and costing it; and proposing a uniform pricing strategy. The Advisory Panel is required to conduct a consultation with stakeholders, including health professionals, consumer representatives and the private health sector regarding the proposed pricing framework.

The Advisory Panel first developed an initial set of services and products for inclusion in the UHC pilot programme, launched in December 2018. The Advisory Panel considered, and largely adapted, the KEPH and the National Essential Medicines List when developing the initial set of services and products. This set was not widely circulated, but it was used by policy-makers to inform decisions on what services could feasibly be included in the pilot phase until the Advisory Panel develops a full benefit package and pending necessary administrative reforms, such as consolidation of risk pools and government financing. Furthermore, only limited enabling legislation exists around the mechanisms for decision-making on the package design, the specific mechanisms for ensuring limiting access, monitoring and redress. Lastly, uncertainties exist on the division of national and county responsibilities.

The Advisory Panel is now in its second phase, and significant progress towards the definition of a full-fledged benefit package is expected. It is also anticipated that the ongoing reforms associated with the introduction of UHC will bring some alignment to previously fragmented initiatives and processes.

Entitlements under the NHIF benefit packages

The NHIF’s general cover includes outpatient services including general consultations, diagnosis and treatments of common conditions and sexually transmitted diseases, laboratory diagnosis, prescription drugs, chronic disease management (HIV/AIDS, diabetes, asthma, hypertension, cancer), radiology, physiotherapy, referral to specialised services, family planning, midwifery services, ante- and post-natal care, health and wellness education and health counselling, screening and immunization and vaccines according to the schedule of the Kenya Expanded Programme on Immunization. Covered inpatient services include surgical procedures (hospital charge and nursing, prescription drugs, operating theatre charges, health care professionals’ fees), specialist consultations, delivery (incl. caesarean section), ante- and post-natal care, renal dialysis, cancer treatment, emergency road evacuation, overseas treatment and rehabilitation for drug and substance abuse.

Cover for civil servants and disciplined services under the CSS scheme is similar to the general NHIF coverage, but includes the added outpatient benefits of optical care, occupational therapy and minor surgical services. Different caps apply depending on seniority level.

The Linda Mama cover includes ante-natal, delivery and post-natal care, referrals as well as infant care.

The secondary school cover Edu-Afya includes inpatient and outpatient care, dental and optical care, overseas treatment as well as air and road emergency rescue.

Excluded from outpatient coverage are cosmetic procedures and fertility treatments. Workers who receive compensation or damages for work-related injuries and disability under the Work Injury Benefits Act are not entitled to benefits under their NHIF cover to the extent to which such compensation or damages are recoverable.

Even though the benefit package provided by the general cover of the NHIF is comprehensive, the actual range of benefits beneficiaries can access is oftentimes limited due to non-navigability of services and medicines at health care providers. In addition, it is skewed towards the CSS which pays six times more per enrolled member than the national scheme for its beneficiaries.

Legal mechanism to define the benefit package

An early attempt at defining a benefit package resulted in the Kenya Essential Package for Health (KEPH) laid out in the Health Sector Strategic and Investment Plan 2013-2017. The Plan’s aims were to ensure that the KEPH is made available to vulnerable populations (such as prisoners, refugees, minority groups, sex workers, people living in remote areas, women) and to significantly improve access to the KEPH. The KEPH was devised as a guide of which services were to be provided at Ministry of Health facilities, but often were not due to lack of funding, personnel or supplies.

The plan’s aims were to ensure that the KEPH is made available to vulnerable populations

The Health Act contains a complaints process which can be used to lodge a complaint about the manner of treatment received at health facilities.

Legal mechanism to enforce access rights to health care

Beneficiaries of one of the NHIF insurance schemes can lodge complaints by email. However, neither the NHIF website nor the National Hospital Insurance Act set out a complaints process. The Health Act contains a complaints process which can be used to lodge a complaint about the manner of treatment received at health facilities. However, it is unclear if this complaints process may be used to enforce entitlements under the NHIF schemes. It seems that patients lack recourse if they are refused services to which they are entitled to under their NHIF insurance cover, or if they are made to pay out-of-pocket for covered services and medicines.

Access barriers

One of the main access barriers to insurance coverage is the lack of affordability of premiums. The NHIF increased its premiums in 2015, the first increase since 1988, resulting in significant raises in monthly fee payments of 400% for lowest-paid formal sector employees and 213% for informal sector workers. Probably as a result of affordability issues, the attrition rate of informal sector workers insured through the NHIF was 73% in 2017, and 75% of informal sector workers state that they cannot afford the insurance premiums.

To counter affordability issues, the NHIF introduced the HISP for poor Kenyans with support from the World Bank Group and Rockefeller Foundation in 2014 with the aim to insure nine million Kenyans living in extreme poverty by 2020. However, an impact evaluation conducted in 2017 showed there was no statistically significant impact on health care utilisation and out-of-pocket payments by beneficiaries of the Programme.

The lack of knowledge on insurance options and enrolment procedures impedes access to insurance, as does a bias to service provision in urban facilities, resulting in geographic access barriers for rural populations. In addition, informal sector workers cite differential treatment of CSS members and beneficiaries of the national scheme of the NHIF by health care providers as reasons not to sign up for insurance cover.

Irregular migrants choose to avoid health care due to distrust of authorities and fear of deportation. Additional access barriers for migrants are stigma, language barriers and lack of health literacy. As a result, many prefer to seek treatment at private, oftentimes not licensed health care facilities.
Anti-discrimination provisions applicable to health care

Ratification of international human rights instruments


National anti-discrimination provisions and complaint mechanisms

Equality, human rights, non-discrimination and the protection of marginalised groups are enshrined as national values in the Kenyan Constitution, and the Constitution’s non-discrimination clause protects from discrimination based on race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth. Children’s rights to health care (as well as health-related rights to basic nutrition and shelter) are separately mentioned. The Constitution also requires the State to put in place affirmative action programmes for minorities and marginalised groups to provide reasonable access to health services (and access to water). [32]

The Health Act contains a non-discrimination clause protecting patients from discrimination based on race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth. [33]

Based on Article 59 of the Constitution, two commissions were established by statute in 2011: the Kenya National Human Rights Commission and the Kenya National Gender and Equality Commission. Out of Art. 59 was also borne the Commission of Administrative Justice (CAJ), the Kenyan Ombudsman Office, which is governed by the Commission on Administrative Justice Act. These three commissions are referred to collectively as the “Article 59 commissions”. [34-37]

The Kenya National Human Rights Commission has two main functions: it monitors the Government in the area of human rights and provides human rights leadership. It investigates human rights complaints, reports on them and makes recommendations. The Kenya National Gender and Equality Commission monitors the Government regarding gender inequalities and discrimination and provides leadership with respect to equality and freedom from discrimination. It investigates discrimination complaints, reports them and makes recommendations. Both Commission do not have jurisdiction where a person has a right of appeal or other legal remedy, unless the Commission deems it unreasonable to expect a claimant to appeal or take other legal remedies. [38-41]

The CAJ investigates maladministration in the public sector at national and county level, such as complaints of delay, abuse of power, unfair treatment, manifest injustice or discourtesy. The CAJ’s complaints handling includes inquiries, investigations, adjudication or alternative dispute resolution. It can also join public interest litigations (as a party, an interested party or friend of the court). CAJ decisions can be reviewed by the CAJ or challenged in court. [42, 43]

Based on the Health Act, every person has the right to lodge a complaint about the way they were treated. The complainant can appeal the action or decision at the Kenya Health Professions Oversight Authority. However, the Health Act does not stipulate by when national and county governments have to develop their complaints procedures based on which complaints can be lodged.

Discriminatory access barriers

For different schemes and services, NHIF concludes different contracts with the same health care providers. As a result, the same health care facility is subject to multiple provider payment mechanisms and rates, creating incentives to treat patients and services differently depending on financial rewards. Consequently, beneficiaries of the CSS, the most lucrative patients, are treated preferentially at the expense of the rest of the population. [35]

A 2012 ruling of the High Court of Kenya at Nairobi found that the Anti Counterfeit Act 2008 limits access to generic drugs for the treatment of HIV and AIDS, thus breaching the constitutionally guaranteed rights to life, dignity and the highest attainable standard of health. It asked the State to reconsider the application of the Act with respect to access to generic drug for HIV/AIDS treatment. [36]

Based on the Health Act, every person has the right to lodge a complaint about the way they were treated.
Limited set of essential health services, medicines and vaccines accessible to all, including groups without health coverage

A formal right for anyone independent of legal status to access a limited range of defined essential health services, essential medicines and vaccines (e.g. screening and treatment for sexually transmitted diseases or highly contagious diseases) does not exist in Kenya.

References

1. The increase was due to the expansion of coverage to outpatient services and the inclusion of additional inpatient treatments, including chronic diseases, surgical care, chemotherapy, renal dialysis, kidney transplant, MRI and CT scans.

2. Marginalised group means “a group of people who, because of laws or practices before, on, or after the effective date, were or are disadvantaged by discrimination” based on race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth (Article 260 of the Constitution of Kenya).

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Legal access rights to health care
Acknowledgements

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Legal recognition of access rights to essential health services, medicines and vaccines

Rights-based approach

Section 47 of the Thai Constitution stipulates several rights pertaining to health care: every person is granted the right to access public health services provided by the State; destitute people may access public health services free of charge; and the prevention and treatment of harmful infectious diseases is free for all. Section 55 of the Constitution reiterates the right to universal health care, and additionally mandates the State to provide health promotion and preventative services and to support Thai traditional medicine. Section 71 reinforces the State’s obligation to promote the population’s health, while Section 258(g)(5) mandates the Government to establish a primary health care system with an adequate number of family physicians. [1]

The National Health Act defines health as “the state of human being which is perfect in physical, mental, spiritual and social aspects, all of which are holistic in balance” (Section 3). It stipulates the right to live in a healthy environment (Section 5) and the right to health promotion for women, children, elderly, socially deprived persons, people living with disability and other groups with specific health characteristics (Section 6). [2]

Every person has the right to a standard and efficient health service.

Based on Section 5 of the National Health Security (NHS) Act, every person has the right to a “standard and efficient health service” as provided for in the Act. The National Health Act provides further health-related rights, such as the right to confidentiality of a person’s health data (Section 7) and the right to receive adequate health information (Section 8). [3, 4]

Citizens

Citizens are covered by one of three public health schemes:

- Civil Servant Medical Benefit Scheme (CSMBS) for public sector employees and their dependents (spouse, parents, children under 20 years of age), mandated by Royal Decree on Medical Benefits of Civil Servant and managed by the Comptroller General Department at the Ministry of Finance. [4]

- Social Health Insurance (SHI) scheme for private sector employees between the age of 15 and 60 years at companies with at least ten employees (no cover for dependents, except for maternity), managed by the Social Security Office at the Ministry of Labour. Persons who are neither employees nor specifically excluded by the Social Security Act can enrol on a voluntary basis by notifying the Social Security Office. The legal basis of the scheme is the Social Security Act for non-work related conditions and the Workmen’s Compensation Act for work-related injuries, disabilities and mortality. [4, 5]

- Universal Coverage Scheme (UCS) for the rest of the population not covered by the CSMBS or SHI scheme. The UCS is administered by the National Health Security Office, an autonomous public agency. About 76% of the population are covered by UCS. [4, 6]

The UCS provides free care at the point of service, accessed by the insured by presenting a smart card. Beneficiaries can choose their preferred provider amongst the approved health care providers under the scheme. The National Health Security Office maintains a registry of eligible persons, based on the Ministry of Interior’s population database, which is shared with other social health protection organisations. [4, 7]

UCS and CSMBS are tax-financed, with progressive tax deductions. The SHI scheme is funded by tripartite payroll contributions with equal contributions of 1.5% of the salary by the employee, employer and government. [4, 5, 8, 9]

The three public health insurance schemes are not harmonized resulting in duplication of investments and different clinical practice guidelines for the same conditions. [4]

Private health insurance in Thailand is mostly offered as part of life insurance, but a very small market for health insurance alone exists. [4]

Persons awaiting proof of Thai nationality

Persons awaiting proof of Thai nationality (PWTN) are a minority group of around 450,000 people holding citizen cards issued by the Government, but with identity numbers of a different category than the ones of Thai nationals. Consequently, they are not considered Thai nationals and cannot access the UCS until they receive Thai nationality. PWTN are also not considered migrant workers and as such cannot access the insurance schemes open to migrants. [4]

PWTN fall in three categories: people born in Thailand but who were not registered at birth and for lack of a legal birth certificate cannot receive a Thai national identity number; hill-tribe minorities in the northern provinces living along the Thai border; and people who immigrated to Thailand a long time ago. [4]

PWTN are covered through the Ministry of Public Health, which provides an annual budget based on the number of PWTN registered with the Bureau of Registration Administration at the Ministry of Interior. PWTN have to register with a health care provider network in their domicile province to receive a similar benefit package to those covered under the UCS. [4]
The Ministry of Public Health established the CMIH without a legal basis. To improve health care access for migrants, the Ministry of Public Health started implementing additional health services in 2003 such as volunteer community health workers, volunteer community health educators recruited from migrant communities and workplaces, mobile clinics for migrant communities, bilingual signposts and information in health clinics (mostly Thai and Burmese) and outreach services in the workplace. [8]

Documented migrants

Documented migrants with a work permit employed in the formal sector have the same access rights and benefit entitlements under the SHI as Thai nationals. [4]

Documented migrants working in the informal sector are not covered by SHI and must enrol in the Compulsory Migrant Health Insurance (CMHI), run by the Ministry of Public Health, to get health care coverage for themselves; enrolment of their dependents (spouse and children) is voluntary. Tourists and foreigners of Caucasian descent are not eligible to enrol. The scheme’s aims are to provide health care to migrants and to screen for and treat infectious diseases. Enrolment does not require a work permit or proof of residency. Migrants apply for CMHI coverage at the hospital where they receive their mandatory yearly health screening for tuberculosis, syphilis, microfilaria, malaria, HIV and leprosy (if tested positive, they receive treatment). Inpatient and outpatient care are linked to the hospital where they register for the insurance scheme. Enrolment in the scheme is based on an annual premium of 2,200 Baht (around USD 62)4, prepaid by the employer and deducted from the wage throughout the year. The scheme is solely financed by premium payments and does not receive employer or state contributions. Migrants pay 500 Baht (around USD 15) for the yearly screening which is compulsory for continued insurance coverage. Insurance for migrant children up to seven years of age is available at 365 Baht (around USD 12). [8, 10-12]

The Ministry of Public Health established the CMHI without a legal basis. Therefore, the Ministry does not have the legal authority to force migrants to enrol in the CMHI, nor to sue employers who do not purchase an insurance card for their employees. Consequently, the CMHI is not compulsory as its name may suggest. [12]

Undocumented migrants

All other migrants, independent of their work, citizenship or legal status, can opt to enrol in the CMHI on a voluntary basis to receive coverage for themselves and their dependents (spouse and children). The enrolment process and coverage are equal for undocumented migrants as for documented migrants. If they do not enrol in this voluntary scheme, they must pay for treatment out of pocket or seek help from non-governmental organisations and international organisations. At the discretion of hospital staff, they sometimes get exempted from fee payment, subsidized by hospital revenue. [8, 12]

The additional health services implemented by the Ministry of Public Health in 2003 also target undocumented migrants. Due to international pressure and to increase uptake of health insurance and enable wider screening for infectious diseases, a multisectoral policy was introduced in 2014 to encourage illegal workers to register for temporary permission to stay. The policy was managed by the Immigration Bureau of the Interior and the Ministries of Commerce, Labour and Public Health. [4]

The benefit package’s scope is defined by the NHSO’s Benefit Package Subcommittee using a structured process.

Benefits of the SHI scheme are defined by the Social Security Office at the Ministry of Labour and prescribed by Royal Decree (Section 40 Social Security Act). The Royal Decrees are drafted and issued by the Social Security Office and approved by the Cabinet. [14]

Benefits of the CSMBs are defined by the Bureau of Medical Welfare, which is part of the Comptroller General Department at the Ministry of Finance. The Bureau considers the benefit packages of the NHSO and SHI scheme as well as the National List of Essential Medicines in its decisions on the CSMBs’s benefit package. [14]

The benefits of the CMHI are defined by the Ministry of Public Health. [19]

Legal mechanism to define the benefit package

The initial UCS benefit package rolled out in 2001/2002 was defined such that it reflected the benefit packages of the already existing CSMBs and SHI scheme. Since then, the benefit package’s scope is defined by the NHSO’s Benefit Package Subcommittee using a structured process using health technology assessment and criteria such as cost-effectiveness analysis, budget impact assessment, equity, ethical considerations, ability to scale up and demand for services based on changing population expectations. The process also requires consultation with stakeholders, including policy-makers, medical specialists or representatives from the Royal Colleges, public health experts, the general public and representatives of the medical device and pharmaceutical industries as well as civil society organisations and patient groups. [4, 18]

The broad areas included in the UCS’s benefit package are defined by Section 55 of the Thai Constitution as health promotion, control and prevention of diseases, medical treatment and rehabilitation. [1]

The UCS benefit package focuses on primary care and covers outpatient, inpatient, accident and emergency services; antiretroviral therapy; renal replacement therapy (peritoneal dialysis); kidney and bone marrow transplantations for cancer treatment; dental care (preventive and curative); high-cost care; diagnostics; special investigations; medicines included in the National List of Essential Medicines; medical devices (720 covered items); maternity care (limited to two deliveries), as well as clinic-based preventative and health promotion services. Excluded are cosmetic surgery and treatments whose effectiveness is not proven. The benefit package is almost identical to the benefit package of the SHI scheme. [4, 7]

While some hospitals provide mental health services, most of mental health care is provided through the Department of Mental Health at the Ministry of Public Health and does not form part of UCS. Long-term care has traditionally been provided by the patients’ families and relatives and is not covered in the UCS benefit package which focuses on acute care. However, endeavours are under way to implement strategies and financing for long-term care to avoid overburdening of hospitals. [4]

The SHI scheme covers ambulatory and inpatient care; accident, emergency and rehabilitation services; antiretroviral therapy; renal replacement therapy (haemodialysis and peritoneal dialysis); cornea transplantation; kidney and bone marrow transplantations for cancer treatment; dental care (limited to twice per year at 300 Baht, around USD 9, per treatment); medicines included in the National List of Essential Medicines; renal replacement therapy (peritoneal dialysis); kidney and bone marrow transplantations for cancer treatment; dental care (limited to two deliveries, provided as lump sum cash payments). Excluded are cosmetic surgery and treatments whose effectiveness is not proven. [4, 9]

The CSMBs covers ambulatory and inpatient care; accident, emergency and rehabilitation services; antiretroviral therapy; renal replacement therapy (haemodialysis and peritoneal dialysis); organ transplantations; dental care (no limits); medicines on the National List of Essential Medicines; medicines not included in the National List of Essential Medicines if three doctors approve it in the hospital; medical devices (387 covered items); and unlimited coverage of maternity services. Excluded are cosmetic surgery and treatments whose effectiveness is not proven. [4, 9]
Since neither the CSMBS nor the SHI scheme cover clinic-based preventative and health promotion services, the UCS provides these services for all Thai citizens.

The CSMBS does not offer an effective process to handle complaints of beneficiaries. (4)

Legal mechanism to enforce access rights to health care
The complaint mechanism for beneficiaries of the UCS scheme is set out in the National Health Security Act (Section 57 ff.) and supervised by the Quality and Standard Control Board (QSCB). Beneficiaries can call a 24-hour hotline at NHSO headquarters for a flat rate of 3 Baht per call (around USD 0.03) from anywhere in Thailand. The hotline provides information and handles complaints. Beneficiaries can also complain using email, letter, fax or contact the NHSO directly. Complaints investigations must be concluded within 30 days, with a possible extension of another 30 days; a further extension is subject to the QSCB’s approval. The QSCB can issue orders, penalising infringing health care providers. The QSCB’s decision can be appealed with the National Health Security Act stipulates that the Board’s decisions are final, it is standard practice that they can be appealed using the administrative court system, just as any other government decision. (4, 13, 14)

In 2015, the NHSO received 4,269 complaints, of which 37% related to health care providers not providing services as set out in the benefit package and 22.4% to health care providers charging fees without legal basis. 74.05% of complaints could be settled within 25 working days. (16)

Beneficiaries of the SHI can complain using the SHI website, a phone hotline or sending a letter. Appeals against orders under the Social Security Act can be submitted to the Appeal Committee. The Appeal Committee’s written decision becomes final unless it is appealed against at the Labour Court within 30 days of receiving the written ruling. (4, 5)

The CSMBS does not offer an effective process to handle complaints of beneficiaries. (4)

Access barriers

Despite government efforts to increase health care access of migrants, utilisation of outpatient and inpatient services is low because of poor service experience. Additionally, migrants do not access health care for fear of litigation due to precarious 30-day work permits7 or illegal immigration status (enrolment in the CMHI without identification document requires taking fingerprints and a photo). (19, 10, 20)

Some workers are prevented from enrolling by their employers. In addition, health insurance is not portable: insurance is linked to the employer and the health care facility where migrants enrolled which is problematic if they move. (8, 16)

Lastly, migrants sometimes face language barriers or do not understand the insurance available to them, finding it too complex or not aligned with their health beliefs while healthy migrants do not see the need to enrol and/or find the premiums too high. (21)

Hospitals treating migrants often face financial difficulties because they frequently do not get reimbursed for up to four months for treatment they provide. They also face the challenge that beneficiaries of the CMHI “rent out” their insurance cards to uninsured migrants. As a result, some hospitals ask for legal documentation before issuing insurance cards to deal with the resulting financial difficulties, even though documentation is not required for insurance enrolment. (10, 11)
Anti-discrimination provisions applicable to health care

Ratification of international human rights instruments

National anti-discrimination provisions and complaint mechanisms
The Thai Constitution contains an anti-discrimination clause in Section 27 which does not permit discrimination based on origin, race, language, sex, age, disability, physical or health condition, personal status, economic and social standing, religious belief, education, or political view which is not contrary to the provisions of the Constitution, or on any other personal characteristic.

The National Health Act stipulates in its Section 6 the right to health protection of women, children, elderly, socially deprived persons, people living with disability and other groups with specific health characteristics.

The complaint mechanism described above to enforce rights under the UCS benefit package can also be used to complain about discriminatory behaviour of health care providers (see title “Legal mechanism to enforce access rights to health care”).

Limited set of essential health services, medicines and vaccines accessible to all, including groups without health coverage
No legal provisions exist to provide access to a limited range of essential health services, medicines and vaccines for all. Since almost all citizens and foreigners have access to a health insurance scheme, migrants afraid of or not able to afford enrolment in the CMHI are the only population group that could benefit from access to such a limited benefit package. They have no legal right to receive such limited services (e.g. for infectious disease control), but they sometimes get exempted from fee payment at the discretion of hospital staff, subsidized by hospital revenue.

References
1 The NHS Act has not been amended since its enactment in 2002. Amendments to the Act are currently being discussed to close existing gaps. Potential amendments would concern the scope of health care and health facilities included in UHC, but the right to health care would not be affected. Further amendments might lead to changes regarding fund management and the governance of the National Health Security Board and the National Health Security Office.
2 Section 40 of the Social Security Act excludes those covered by the CSMBS; employees of foreign governments and international organisations; Thai’s abroad; temporary and seasonal workers; teachers or headmasters of private schools under the law on private school; and students, nurse students, undergraduates or interning physicians who are employees of schools, universities or hospitals. Further categories of employees can be excluded based on Royal Decree.
3 The National Health Security Office (NHSO) was established and is ruled by the National Health Security Act of 2002. It is governed by the National Health Security Board (NHSB) which is chaired by the Minister of Public Health.
4 Cambodian migrant workers who registered before 31 October 2014 based on the Order of the National Council for Peace and Order (NCPO) in 2014 pay a yearly insurance premium of 1,100 Baht (around USD 31). They pay the same amount for the compulsory yearly check-up for infectious diseases (500 Baht) as all other migrants.
5 An official English translation of the Thai name of the bureau (กองสวัสดิการรักษาพยาบาล) does not seem to exist.
6 The Thai Health Promotion Foundation (ThaiHealth) is chaired by the Prime Minister and financed by a 2% tax on alcohol and tobacco levied on manufacturers and importers which generates annual revenues of around 3 billion Baht (around USD 100 million).
7 Seasonal worker permits for short-term labour providing little legal status and social protection.
8 Including the optional protocol to the Convention on the Rights of Persons with Disabilities.
9 Including the optional protocol to and the inquiry procedure under the Convention on the Elimination of All Forms of Discrimination against Women.
10 Including the optional protocol to and the inquiry procedure under the Convention on the Rights of the Child.
References (All links verified on 29 March 2019)


