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Social Health Insurance

Report and Documentation of the Technical Discussions
held in conjunction with the 40th Meeting of CCPDM
New Delhi, 4-5 September 2003

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The report and recommendations of the Technical Discussions on Social Health Insurance, held in conjunction with the 40th meeting of CCPDM, were presented to the fifty-sixth session of the Regional Committee for South-East Asia. The Committee noted the report and endorsed the recommendations. The Regional Committee also adopted a resolution on the subject (SEA/RC56/R5).

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Part I – Proceedings*

* Originally issued as "Consideration of the Recommendations Arising out of the Technical Discussions on Social Health Insurance" (document SEA/RC56/17 dated 9 September 2003)

1. INTRODUCTION

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

1.1 Opening Remarks by the Chairman

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

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

implementable recommendations to be considered by the 56th session of the Regional Committee.

1.2 Introductory Remarks

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

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

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

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

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

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

2. DISCUSSIONS

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

Countries were in different stages of health care reforms, and some laid more emphasis on development of social health insurance with the aim of achieving universal coverage. Four countries (India, Indonesia, Myanmar and

Thailand) were implementing social health insurance on a national scale with varying degrees of coverage. Most of the other countries had some experience of health insurance programmes either through private sector or community-based financing schemes. It was agreed that national SHI schemes should include the following characteristics:

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

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

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

2.1 Role of SHI as an Alternative for Health Financing

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

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

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

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

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

SHI, i.e. to guarantee equitable health benefits to those with similar health needs regardless of the level of contributions (income).

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

2.2 Role of Private Sector in the Development of SHI

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

2.3 Community-based Health Insurance

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

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

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

3. CONCLUSIONS AND RECOMMENDATIONS

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

The group made the following recommendations:

To Member Countries

- An in-depth study of the possible options for alternative health care financing, within the context of national socioeconomic and development policies, should be undertaken.
- Countries that already have a wider coverage of social health insurance should document their experience on various social health insurance schemes by comparing the target population and coverage, contribution mechanism, management of funds, packages of services and their accessibility and quality.
- Countries considering adopting social health insurance need to review the basic prerequisites for introducing SHI, such as labour and financial market structure, existence of other forms of insurance schemes, possibility of collecting contributions and the capability to manage funds, the existing of health infrastructure (both public and private), including their accessibility and quality.

- Based on the evidence collected from the in-depth studies, a policy framework has to be developed for introducing or expanding social health insurance by reaching a consensus through different policy development mechanisms. In this regard, parliamentarians could play a crucial role in soliciting a national consensus.
- Steps should be explored to increase public health expenditure by increasing the allocation of national budget or through earmarked taxation.

To WHO

- Technical support should be provided for reviewing country situations and providing evidence-based research findings for implementing SHI on a countrywide basis.
- The work on the development of an Organization-wide policy on health care financing should be expedited.
- Member Countries should be supported in developing a national framework for expanding social health insurance or in adopting national legislation for introducing SHI as an alternative to health care financing.
- With the involvement of WHO collaborating centres and national centres of excellence and national and regional expertise on health economics and health policy analysis, policy options and models should be developed for consideration by countries and for facilitating policy debates among stakeholders including donor coordination.

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

Part II – Resolution, Agenda and Working Paper

Resolution*

The Regional Committee,

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

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

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

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

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

* SEA/RC56/R5

3. REQUESTS the Regional Director:

   (a) to share evidence-based information and country experiences on social health insurance and other risk-pooling mechanisms;

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

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

Sixth Meeting
12 September 2003

Agenda*

1. Introduction
2. Overview of health care financing
3. Current status of social health insurance schemes
4. Key issues for further expansion
5. Conclusions and recommendations

* Originally issued as document SEA/PDM/Meet.40/TD/1.1 dated 25 July 2003

Annotated Agenda*

1. INTRODUCTION

2. OVERVIEW OF HEALTH CARE FINANCING

- Overview of health care financing – outcome on fair financing and improving the functions relating to revenue collection, pooling of resources and purchasing; expenditure patterns and trends.
- Major issues of concern regarding health care financing in the countries of the Region (increasing expenditure; high cost of health interventions; need to address unfinished health agenda; decline in government funding; increasingly higher proportion of out-of-pocket expenditure; and other factors such as globalization, liberalization of trade, including in finance and health sectors.
- Clarification on concepts, definition and approaches on health care financing, including social health insurance.

3. CURRENT STATUS OF SOCIAL HEALTH INSURANCE SCHEMES

- Type of social health insurance (SHI) schemes, target population and coverage; contributions; benefit packages, national vs. local.
- Organizational arrangements (collection, payment, purchasing); capacity strengthening.
- Impact and the role of SHI in relation to national health financing options in order to protect financial and health risks.
- Difference between national health insurance and other functions of health financing, including community health financing.
- Role of the state in financing health care and the role of private-for-profit insurance.
- Future development of SHI.

* Originally issued as document SEA/PDM/Meet.40/TD/1.2 dated 25 July 2003

4. KEY ISSUES FOR FURTHER EXPANSION

- National consensus on social security – solidarity and fair financing.
- Role of SHI as a method of financing health care in the existing health care systems of the countries.
- Prerequisites for introducing or expanding coverage of SHI.
  - Data and information required to initiate SHI
  - Pooling of various SHI schemes, including reassurance
  - Economic sustainability
  - Human capital – actuarial scientists; mathematicians; health economists; fund managers
- Strategic planning for expansion of SHI – what type; whom to cover (expansion for covering people with irregular income, especially those working in the informal sector); how to cover; what level of premiums; benefit packages; purchasing etc.
- Role of private health insurance, co-payment, third party mechanisms
- Role of government.

5. CONCLUSIONS AND RECOMMENDATIONS

Working Paper*

1. INTRODUCTION

The 48th session of the WHO Regional Committee for South-East Asia, in September 1995, debated the topic of "Alternative financing of health care" as a subject of technical discussions. The Committee urged Member States to undertake various alternative financing reforms, within the framework of solidarity, equity and expanding essential coverage[1]. A follow-up regional consultative meeting, held in Bangkok in October 1995, reviewed the regional experience of health care financing reforms, including development of social health insurance, and noted the importance of careful studies on various policy options and adoption of appropriate policy decisions[2].

In May 1999, the Health Ministers of the Region participated in the "Ministerial Round Tables: Lessons learnt on world health" held during the Fifty-second World Health Assembly in Geneva. The Health Ministers agreed on the need to assess the consequences of health care financing reforms through an update of national health accounts and related studies[3]. At their Sixth Meeting held in Yangon, Myanmar, in February 2001, the Health Secretaries of the Region debated the experiences on health care financing reforms. They noted that while each country may have adopted different health care financing reforms based on its specific socioeconomic, political

* Originally issued as document SEA/PDM/Meet.40/TD/1.3 dated 25 July 2003

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

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

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

and health systems, there were a lot of lessons that could be learnt from one another. They requested WHO to share such evidence-based policy options[4].

Several countries of the Region initiated reforms of health systems, including those for health care financing, especially in attempting to expand the coverage of social health insurance or similar social protection for the poor. Subsequently, the 55th session of the WHO Regional Committee, in September 2002, having expressed its concern at the high level of out-of-pocket health expenditure and the low level of public spending on health in almost all countries, decided to hold Technical Discussions on "Social Health Insurance (SHI)" at the fortieth meeting of the Consultative Committee for Programme Development and Management (CCPDM), to be held prior to the 56th session of the Regional Committee in September 2003[5].

This working paper highlights the broad framework of health care financing and explains the major issues in implementing various SHI schemes within the context of health care financing reforms. It examines similar experiences elsewhere, with possible policy options for promoting and expanding SHI within the Region.

2. OVERVIEW OF HEALTH CARE FINANCING

Revenue Collection

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

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[4] WHO, *Report of the Sixth meeting of Health Secretaries, February 2001, Yangon, Myanmar (SEA/HSMeet/6)*

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

In 1981, an indicator, "the number of countries with at least 5 per cen of GNP spent on health", was proposed for the purpose of monitoring and evaluation of the global strategy for health-for-all by the year 2000 (HFA2000).[6] While WHO and its Member Countries have not been able to formally adopt this indicator, the numerical level, i.e. "5 per cent of GNP spent on health", was used as frequently as possible in many policy debates and even mentioned in some cases as "WHO recommended target".

According to World Health Report 2001 (WHR2001), the countries of the Region, on an average, had a total health expenditure (THE) of around 2-8 per cent of GDP. In reality, except four countries - Bhutan, India, Maldives and Thailand - others could not spend more than 5 per cent of GDP on health. Similarly, many countries around the world never achieved this "fictitious target". A recent IMF study suggested that effective health coverage would require around 12 per cent of GNP in low-income countries in order to meet the international development goals[7].

An appropriate percentage benchmark or target for health spending, like the fictitious target above, is extremely difficult to set. Research is under way to better define the ***minimum amounts*** of finance that countries should invest in order to optimally develop their health systems. In its report in 2001, the WHO Commission on Macroeconomics and Health (WHO-CMH) recommended that the low-income countries should increase their domestic spending on health by an additional 1 per cent of GNP by 2007, rising to 2 per cent by 2015, keeping in view existing and future trends of economic growth[8]. Good governance, strong political leadership and political will of all stakeholders are required for increasing investment in health.

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

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

[7] IMF study *"Public spending on health care and the poor",* 2001

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

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

The World Bank, in 1997, estimated that when a country's taxation is low (10 per cent of GDP or lower), it would take 30 per cent of government revenues to meet 3 per cent of the GDP health expenditure target through formal collective health financing channels[9]. Usually, poorer countries have widespread tax evasion among the rich and middle-class in informal sectors, leading to low taxation. They also rely heavily on taxation on international trade (exports and imports) and have the added limitation of broad-based taxes such as income tax or value-added tax.

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

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

[9] World Bank, *Sector Strategy Health, Nutrition and Population,* 1997

countries spend their health resources according to the health needs efficiently and effectively. The output of effective spending according to health needs is reflected in the level of inequities in health outcome.

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

A worldwide study on external assistance to the health sector between 1972 to 1990, conducted in the early 1990s, revealed that the least developed countries received more funds from external assistance, either in loans and grants, and the total funds accounted for around 20-30 per cent of the total health expenditure[10]. The WHO-CMH report indicated that the least-developed countries received an annual average of US$ 2.30 per person during 1997-1999 as donor assistance for health while the total outlay of donor assistance for health for these countries was around US$1.4 billion[11].

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

[10] *C. Michaud & C.J.L. Murray, Bulletin of World Health Organization,* 1994
[11] WHO-CMH Report *op cit*

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

The recent entry of Rotary Club members and other national and international entrepreneurs as private philanthropists, in health and other social sectors such as the Sasakawa Health Trust, the HP Foundation, the Ted Turner UN Foundation, the Bill and Melinda Gates Foundation, Rotary Club, with multi-billion dollar contributions to specified funds and programmes for global health development, are making health an important investment for development. Presently, their inputs are usually aimed at special health development funds or programmes and/or assigned for certain geographical areas.

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

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

community trust funds for the purchase of drugs and other essential supplies for the poor, mainly at the local level.

The Royal Government of Bhutan established the *Bhutan Health Trust Fund* in 1998 with the aim of safeguarding the primary health care services through a continuous supply of essential drugs and vaccines for its population. By June 2003, the Trust Fund had received donations, sponsorships and partnership totalling nearly US$ 18 million. The famous "Health Walk" by the Minister of Health and Education and his team, done as part of the World Health Day 2002 "Move for Health" campaign in late September 2002, resulted in additional funds of around US$ 1.7 million. Bhutan Nu.1.4 million (US$ 30,000.-) will be used in mid-2003 for the purchase of hepatitis B vaccines. It is understood that once the level of the Fund reaches US$ 24 million, the interest earned would cover a major portion of the annual health expenditure for essential drugs and vaccines[12].

In many countries, the out-of-pocket payments (OOP) form a major part of the total health expenditure (THE). Analysis from the NHA Tables in WHR2002[13] indicated that in 60 per cent of countries with incomes below $1 000 per capita, OOP consist of 40 per cent or more of THE, whereas only 30 per cent of middle and high income countries depend as heavily on this kind of financing. Most countries in the Region have more than 50 per cent of THE coming from out-of-pocket payments.

While people have the freedom of choice to pay out of their pockets for health care - and it might provide, especially the rich, with high satisfaction - there is no guarantee that the majority of the population can afford to pay for health care needs by out-of-pocket payment. The real situation in many developing and even in developed countries is the issue of a high proportion of catastrophic expenses of households in all income deciles, especially among the lowest and the highest deciles.

People become impoverished due to higher and rising cost of medical bills, because of the uncertainty of the amount of expenditure to meet health care needs on individual basis. In some cases, people have to spend 'under-the-table' expenditure for getting access to public health facilities. And, in other cases, the unskilled and unqualified private providers might charge

[12] Web access: Bhutan Health Trust Fund: http://www.bhtf.gov.bt
[13] WHO, The World Health Report 2002, *Reducing Risks, Promoting Healthy Life, Annex Table 5,* 2002

higher rates for their service in the exploitation of quick and easy access and convenient service hours. Strong stewardship of the government is required to rationalize the provider-consumer relationship. In fact, strong purchasing power could play a better role in controlling health care costs to a certain extent.

Resource Pooling

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

The essence of health insurance is the pooling of funds and spreading the risk for illness and financing. Health insurance may be classified into "social" and "commercial" health insurance. The social health insurance has in general three main characteristics: public, mandatory membership, contribution based on community-risk rating, and the objective is to meet the health needs rather than meeting the individual demand for health care. Commercial health insurance, on the other hand, is private, voluntary, individual risk rating in most cases and the objective is to meet the individual's need. A few countries have tried to expand different types of social health insurance (SHI) schemes to achieve ***universal coverage***[14] or near universal coverage. Evidence shows that people with health insurance coverage, both social and commercial health, tend to utilize more health care services than those with less or those with no insurance at all.

Recently, various mechanisms and schemes for voluntary, private, and multiple risk-pooling have emerged in many developing countries. These risk-

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

sharing schemes started to cover informal sectors, especially in rural areas, and their existence highlights the importance of national or sub-national governments ensuring financial risk sharing extended to the vast rural population. Section 3 provides an overview of regional experience on resource pooling, especially of social health insurance.

Purchasing

In order to have an effective and efficient health insurance, the essential health care packages should be available to the consumers literally free-of-cost, rather than fee-for-services and arrangement for reimbursement, in addition to having a large amount of co-payment. The insurance agency or agency managing insurance fund must make various arrangements for purchasing services from health care providers, on behalf of consumers (insured). Health care providers from national public or private health care systems should ensure that the health care packages which they provide have to be responsive and financially fair. This can be achieved through strategic purchasing[15].

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

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

The strategy to use public funds to buy clinical and non-clinical services as well as preventive and promotive health care from private providers is intended to improve the productivity of public resources by purchasing the gains in efficiency perceived to exist in the private sector. Service contracting

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

(capitation, global budget, DRG, etc.) is primarily to improve the efficiency and/or increase the quantity of services that can be made available for a given amount of expenditure. Appropriate payment system also stimulates a better quality of health care. This kind of a competitive approach has also been introduced in a few countries of the Region.

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

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

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

Many countries have promoted or are in the process of promoting privatization efforts in the health sector, with or without the active participation of health ministries. Some countries have attempted to reduce public involvement in the management and delivery of health services like hospital or health centre autonomy as part of their privatization efforts. Rapid privatization without effective legislative action leads to higher and higher user

charges and increasing burden to the consumers spending more from out-of-pocket to meet their health needs. Without balancing privatization effort with expansion of social health insurance coverage, the privatization would increase inequity in health status, unfair in financing, and in long run, it might lead significantly to a lowering of the health status.

3. CURRENT STATUS OF SOCIAL HEALTH INSURANCE

Basic Concept

Social health insurance is a mechanism for financing and managing health care through pooling of health risks of its members on the one hand, and the financial contributions of enterprises, households, and the government, on the other.[16] SHI is generally perceived as a financial protection mechanism for health care, through health risk sharing and fund pooling for a larger section of the population.[17] It usually forms part of a broader ***social security*** framework, covering all contingencies which need financial protection and risk sharing. SHI is not merely a new method to collect money to co-finance services. It is a method that is able to achieve a stable financing for a package of health services (health insurance benefits), while at the same time achieving greater access to health care among the population.

SHI must have certain characteristics to be used with the terms "social" and "insurance". Countries which implement various SHI schemes on a national scale usually adopt broad social security policies and legislative framework, within the policy framework stipulated under the National Constitution. In some cases, the policy framework is determined by society consensus. The major characteristics of SHI schemes are:

(a) Compulsory or mandatory membership of individuals and/or groups or households, initially targeted to cover civil servants, and other formally employed people, from public and private, commercial, semi-commercial, industrial and agricultural establishments and their

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

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

dependents; and, usually expanding coverage to informally employed people, non-working people, retirees and even students (*inclusion of target population does not necessarily depend on the structure of the economy*);

(b) Responsibility for contributions by the members (employees) with proper organizational arrangement to collect regular income-related contributions or flat-rate contributions from individuals/groups, with added contribution from employers and the government (*earmarked deduction as insurance contribution*[18] *from regular pay-roll or pre-set collection amount from individuals or groups*);

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

(d) Choice of health care according to the health needs (*Basic benefit packages usually set by many countries, which also allow the members to make co-payment or purchasing supplementary health care services in addition to basic packages*);

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

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

(g) Covering a large segment of the population, and

(h) Funds collected from contributions are pooled into single or multiple fund arrangements administered by a quasi-independent public body that would act as a purchaser of health care.

According to the International Labour Organization (ILO) Convention No.130, its Member Countries are free to choose different "Social Security

[18] There is some fundamental difference of "prepaid" or "prepayment" for insurance with other "prepaid" services like "prepaid telephone card" or "prepaid goods". The money spent for the goods or services by the consumers in such cases is limited to the amount prepaid, whereas, in health insurance, the goods./services received by the consumer might get will be costing many times the actual value prepaid. The term "insurance contribution" may be better used than "prepaid". (Personal communication with Professor T. Hasbullah)

Schemes-SSS" inclusive or with a separate SHI scheme. A country will fall into the category of "those with SHI" only if the major proportion of the population of that country is legally covered under a SHI scheme with a designated (statutory) purchaser through non-risk-related insurance contributions separated from general taxes or other legally mandated payments.

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

The SHI schemes and the general revenue-based health care financing system share similar characteristics of pooling risks. In SHI, people as members of insurance schemes are directly aware of their insurance contributions (*explicit*)[19]. Usually people contribute from their daily, weekly, or monthly pay-roll. Such contributions are the pre-set proportionate pre-paid collection from employees, employers and the governments.

In the general revenue-based or tax-funded systems,[20] the resources for health care come directly from general revenue and, in some cases, from special or earmarked taxes or revenue. In this method of financing, people or enterprises contribute from their income, but in an indirect way via general taxation. Thus, people are not aware of the amount they contribute solely for health care (implicit).

Most SHI schemes run with compulsory or mandatory membership. This ensures inclusion of certain underserved groups such as the poorest and vulnerable people, who are usually left out in voluntary private health insurance schemes. The compulsory scheme would guarantee an appropriate mix of good and bad health risks. Private health insurance schemes usually base contributions on the level of good or bad health risks of the individuals or groups of consumers. People who are at a higher risk pay more and each

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

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

scheme may adopt a different benefit package (like insurance for car and house).

SHI schemes aim at reaching ***universal coverage.*** Once the target is achieved or near achievement, there is a strong potential to foster efficiency and effectiveness of health systems performance, by pushing forward the ***monopsony***[21] of purchasing power, in ensuring the quality of care and efficient resource consumption. Many countries with SHI schemes that relied on fee-for-services payment mechanisms are modifying them into more closely regulated payment mechanisms, such as capitation, global budget and Diagnosis Related Groups (DRG). It is more of a self-sustaining health care financing mechanism, provided it is properly managed.

Regional Experiences on SHI Schemes

The introduction of SHI schemes as a method of financing health care in the Region dates back to the last half a century. As the socioeconomic and political development of the countries varied widely, it affected the development of SHI schemes in various countries. According to WHR 2000, more than 50 per cent of industrialized countries selected SHI as their health financing mechanism. Not a single developing country with GNP per capita US$ 760 or below had a full-fledged SHI scheme. Among the lower middle-income countries (with GNP per capita between US$ 761 and US$ 3 030), the only country with a fully-fledged SHI was Costa Rica[22]. India, Indonesia, Myanmar and Thailand have mixed health care financing systems with a certain percentages of coverage of SHI schemes.

The development of SHI schemes over the decades, from a single to multiple-fund arrangements, is worth noting. Even in some East Asian countries with substantial economic growth, the expansion of SHI to achieve universal coverage has been slow and steady for over 30-50 years. Thus, each country considering the introduction and expansion of SHI needs to review seriously the time-line, whether one should go slow to achieve universal coverage, or to make a "big-bang" transformation by jumping certain steps.

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

[22] See *WHR 2000*, op cit

India introduced the Employees' State Insurance Scheme (ESIS) in 1948, as part of the mandatory social security benefit to workers in the formal employed sectors (earlier to all power-using non-seasonal industrial establishments employing 10 or more people, and later extended to cover employees in all non-power using factories with 20 or more people, including people working in service sectors like hotels and restaurants, cinema houses, road transport and newspaper printing, but not covering people working in mines and plantations or any other establishments offering health care as good as or better than ESIS package). The scheme now covers more than 33 million employees and retirees. The pre-payment contribution is based on the proportion of pay-roll tax by employees (1.75 per cent), employers (4.75 per cent) and state governments (12.5 per cent). ESIS provides health care from its own network of health establishments, and if not accessible, the members are entitled for reimbursement for fee-for-services.

India also established a Central Government Health Scheme (CGHS) in 1954, providing comprehensive health care to employees of the Central Government (Civil Servants) and their families. The premium is progressive with salary scales ranging from Rupees 15/- to 150/- per month. The beneficiaries include nearly 4.5 million central government civil servants and their families.

Since 1986, the General Insurance Corporation (GIC) of India, a public sector undertaking, along with its subsidiaries, has offered various voluntary health insurance schemes (*Mediclaim Plan and others*), usually as health riders to other insurance packages. Some national and private commercial establishments have created their own health facilities in order to provide basic and specialist health care packages and they have created their own "reimbursement of health expenses" to employees. Since 1995, a series of private insurance companies, as major parts of larger insurance corporations or financial institutions, have introduced specialized private health insurance schemes, with a lot of adverse selection criteria.

In addition, the central and state governments have initiated a series of initiatives for expanding social health insurance coverage for target vulnerable groups, such as family planning acceptors, people below the poverty line, etc. with the aim of providing financial protection to the poor. Some state governments have established a multitude of community-based health insurance schemes with an estimated coverage of 30-50 million people.

Indonesia introduced the Civil Servant Welfare Scheme wherein health care expenses are reimbursed to civil servants, since its independence. The formal/national social health insurance for civil servants was started in 1968 by mandating all civil servants paying a contribution of 5 per cent of monthly basic salary. After a series of reforms, the scheme was transformed into the agency run by a for-profit state-owned company, called ***PT Askes,*** in 1992, to manage mandatory social health insurance to all civil servants, beneficiaries and military personnel. The contribution is 100 per cent payment by the civil servants and is reduced to about 2 per cent of monthly basic salary. From 2003, the central government contributes 0.5 per cent of the basic salary as counterpart funding, and it is expected to increase to 2 per cent. The beneficiaries include about 14 million civil servants, their spouses and two children less than 21 years old.

In 1992, Indonesia introduced the social health insurance scheme for formal employees, called the ***Jamsostek***. The scheme is managed by PT Jamsostek, another for-profit public company, with insured members of about 3 million employees and their spouses, and children below 21 years, up to the third child. The scheme provides mandatory insurance for all private employers with 10 or more employees or with monthly pay-rolls exceeding Rupiah 1 million, if the employers could not provide health benefits better than those offered by the ***Jamsostek.*** Employers contribute 100 per cent premium on the basis of 3 per cent of basic salaries for single and 6 per cent for married. Employees do not need to contribute. Due to the opt-out clause, many employers who are provided with health benefits or are self-insured, or could purchase more generous health packages have opted out, which is estimated to be more than 90 per cent of total employees.

The Ministry of Health, through the Health Act of 1992, introduced a nation-wide, "Managed Health Care Scheme" called ***Jaminan Pemeliharaan Kesehatan Masyuarakat (JPKM***), using the model of the United States Voluntary Health Maintenance Organizations (HMO). It is strictly not a social health insurance, but promoted as a socially-oriented scheme. The main purpose is to provide comprehensive health benefits through a network of health care providers managed by public and private health maintenance organizations. By the end of 2002, there were 24 licensed ***JPKM bapels*** (Indonesian HMOs) which are basically health insurance carriers, mandated to provide comprehensive health benefits through public and private health care

providers and to make payment to providers on capitation. The total estimated population covered under JPKM scheme is around 1 million.

Since the 1970s, Indonesia has introduced many community-based risk sharing schemes, including nation-wide programme called, ***Dana Sehat*** (community-based micro-health financing schemes). After the economic crisis in the late 1990s, the government introduced different approaches for providing subsidy for health through the nation-wide ***social safety net (SSN)*** programme in order to reduce the financial burden of the people, especially the poor. Latest information showed around 12 million people benefited from the SSN for health. The introduction of SSN for health significantly reduced the need to establish/expand ***Dana Sehat*** schemes by the communities.

In 2002, the President of the Republic of Indonesia established a "Presidential Taskforce on Social Security" to look into the restructuring of existing SHI schemes with a few possible policy options (all inclusive): (a) to integrate public and private employee schemes into one scheme, creating specialized SHI management under a National Social Security System, with uniform benefits for all; (b) to possibly merge the *PT Askes* and *PT Jamsostek* into a single independent SHI agency at the national level, like "National Health Insurance"; (c) to make the new carrier to be independent, not-for-profit, controlled by a tripartite body (representation from employees, employers and the government). Currently, a few alternatives are under consideration. Although Indonesia has considerable experience in implementing SHI on a nation-wide scale, the growth has been very slow due to inconsistent implementation of the principles and policies. Current implementation needs improvement in expansion strategies as well as other areas such as benefit packages, premiums, management, and payment to providers.

Myanmar introduced a nation-wide SHI scheme in 1956, within the stipulation of the National Social Security Act of 1954. The scheme is managed by the Social Security Board (SSB), under the Ministry of Labour. The scheme provides the mandatory insurance of formal employed people from both public and private sector enterprises. Dependants are not yet included under the scheme. The benefits include free medical care, and payment of partial or full salary for some period based on illness and injuries. The scheme covers around 765 000 workers from around 25 000 establishments. The SSB has also established its own health care facilities

(3 hospitals and 89 dispensaries). The premium contribution is derived from proportionate deduction of monthly pay-rolls from employees (1.5 per cent) and employers (2.5 per cent). Government provides the overall budget in current and capital items depending upon the annual expenditure of SSB. A revised policy framework for the expansion of SHI is under consideration. Myanmar Insurance Enterprise, another public agency, provides special benefit packages as health riders for their life insurance policy-holders. Benefits include lump sum reimbursement for hospitalization, major surgery, disability, delivery and death. Since the early 1990s, Myanmar has introduced various community-based health finance options in order to reduce the financial burden on the poor.

Thailand introduced the financial protection scheme for poor and low-income households as part of the national social welfare scheme in 1975. This low-income medical welfare scheme (MWS) was originally introduced as free medical care for poor workers from the formal sector and later extended to include the elderly, children under 12 years, secondary school students, the disabled, veterans and monks. The service package includes free care at public facilities for ambulatory and in-patient care. By 2000, around 20 million people were covered under this scheme. The budget was allocated through global budget and later on through capitation. Due to difficulty in the mean testing for selecting poor, the real poor households were excluded on many occasions.

In 1978, with a Royal decree, Thailand introduced the Civil Servant's Medical Benefit Scheme (CSMBS), to cover health insurance protection for all civil servants (including those of state enterprises), pensioners and their dependents (parents, spouses and children). The scheme is managed by the Comptroller's Office. It has around 6 million beneficiaries. The scheme works on a fee-for-service (FFS) reimbursement model. This has resulted in longer hospital stay, frivolous use of drugs and diagnostics, and other charges. The source of funds was the general revenue of the government. Following various studies and due to the after-effects of the economic crisis in the late 1990s, the government reformed CSMBS to include the capitation for ambulatory care, global budget and diagnosis-related groups (DRG) for inpatient care. An electronic disbursement system was introduced for inpatients using DRG.

Based on the Social Security Act of 1990, the government introduced national mandatory social health insurance for all private enterprises with

more than 20 employees using a capitation, low-cost contract model. The scheme is managed by the Social Security Organization (SSO), under the Ministry of Labour. In 1994, the coverage was extended to the private or commercial establishments with more than 10 employees, and by 2002, it included small enterprises with more than one employee. The scheme covers around 4 million employees. The financial contribution was progressive with a five-fold gap between the contribution of the highest and lowest wage-earners. Benefit packages include both outpatient and inpatient care, and the providers are contracted through capitation.

The Voluntary Health Card (VHC) project started in 1983 covering initially MCH care. Its coverage extended in 1994 to include village health volunteers and local leaders with 100 per cent government subsidy. The VHC covered around 11 million people. By the mid-1990s, the programme was revised with a single card for individuals or families, offering a comprehensive health benefit package. Since 1994, the government has subsidized with Baht 500/- for every Baht 500/- family card.

Thailand introduced the Universal Coverage (UC) Scheme, notably known as the "30 Baht Scheme" in October 2000, with the idea of replacing the "Social Welfare Scheme" and the "Voluntary Health Card Scheme". The programme was operational nation-wide by mid-2001. The main purpose is to incorporate the 30 per cent uninsured population into the "Single SHI Scheme". UC plans to provide comprehensive health care coverage with virtually no co-payment by users, apart from a nominal fee of just "30 Baht" per each health visit or hospital admission. The scheme is mainly subsidized by general tax revenue, with an estimated budget of Baht 1 400 per capita per year. The coverage of "30 Baht scheme" by the end of 2002 was around 76 per cent of the total population. The remaining population is still covered by the CSMBS (11 per cent) and SSO (13 per cent). The National Health Security Organization (NHSO) is now fully operational to undertake full universal coverage in the near future.

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

welfare policy and schemes are under consideration. As part of tourism, some private insurance companies operating in Maldives are covering a few proportion of the people as “health riders on life insurance”.

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

Experience on SHI in Selected Asian Countries

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

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

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

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

Philippines' total health spending pattern has remained unchanged for the last few decades, with around 3 per cent of GDP. More than half of this was out-of-pocket private expenditure. Voluntary SHI for formal sector employees and their dependents under the national social security system (SSS) started in 1972. The medical benefits included reimbursement of inpatient and outpatient care provided by both public and private health facilities. The premium was a mandatory pay-roll deduction of 2.5 per cent of monthly wages up to a ceiling of Peso 3 000/- with employers and employees contributing equally. The government also introduced the Government Service Insurance System (GSIS) around the same time to provide medical benefits for civil servants. Both schemes are operated by a government agency, the Philippines Medicare Commission (PMC), established under the

Medicare Act of 1969. It is almost self-financed with limited public subsidies. By the early 1990s, PMC covered around 40 per cent of the population.

With the enactment of the National Health Insurance Act in 1995, the Philippines Health Insurance Corporation (***PhilHealth***) was established as a parastatal corporation attached to the Department of Health with quasi-judicial functions, and administered the national SHI programme. It has expanded the coverage to around 75 per cent of the total population (consisting of employees from formal and informal sectors, sponsored indigent members and non-paying sector (retirees and pensioners who enjoyed life-time coverage). Voluntary individual membership to ***PhilHealth*** has grown from around 165 000 in 1999 to 7 million in 2002. Efforts are being made to reach universal coverage as soon as possible. The government provided the finance for SHI through regular pay-roll deduction (1.25 per cent of the salary by employers and employers, with a salary cap of US$ 189 per month), and general tax revenue. Another factor was the strong involvement of local governments and their commitment to the subsidized indigent programme. The number of indigent members has increased from about 15 000 in 1997 to 7 million in 2003 due to increasing sponsorship by local government units, legislators, private wealthy citizens, NGOs and other government agencies.

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

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

47 million population of South Korea are covered under the mandatory social health insurance scheme. The remaining 4 per cent of the population are covered by a medical aid programme for the poor fully subsidized from the general revenue of the government. The proportion of public to private health facilities decreased from 40 per cent in the 1970s to less than 10 per cent by the 1990s.

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

Role of Savings for Medical Expenses

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

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

approach less attractive to policy makers as a choice of the health care financing in most cases.

One possible approach of using savings for medical expenses is to develop an additional component to the national SHI schemes, as pioneered by the famous "3M" health financing schemes, i.e. **M**edisave***,*** **M**edishield and **M**edifund of ***Singapore***[23]**.** The ***Medisave*** scheme is an individual saving scheme for which the savings accumulated could be used for medical care expenses. It generally excludes the expenses for outpatient services, in order to take care of paying for infrequent but highly-cost inpatient care. As the scheme depends on inter-temporal pooling over the individual's life cycle, it is not actuarially feasible for ***Medisave*** balances to insure against truly catastrophic contingencies. To solve this problem, Singapore introduces ***Medishield***, a back-up health insurance programme based on cross-sectional risk pooling, designed to finance the extreme catastrophic tail of risk distribution. In addition, the Government of Singapore also introduced ***Medifund,*** which is an endowment fund for those whose health care costs are beyond their means, even with Medisave and Medishield.

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

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

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

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

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

The attractiveness of the "mixed financing" system with ***savings*** for medical expenses comes with several issues in its implementation[24]. Firstly, management of such savings require a strong political will and heavy burden of administration and management capability and competency at various levels to regularly collect money, process claims, manage accounts, and invest the funds. This would be difficult for countries with predominantly rural populations or countries with a large proportion of those in the informal

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

employed sectors. Secondly, the poor or people with chronic diseases or the disabled would not have adequate savings. Introducing "medical" savings and high cost-sharing without adequate social safety nets would result in financial inaccessibility. It could also lead to an increasing number of households with catastrophic spending and increasing income inequality. Lastly, the stewardship role of the government is crucial in the "mixed system" despite the concept of increasing individual responsibility. Singapore itself demonstrates many of its stewardship roles such as control on the provider, wide and extensive public education, and the provision of a social safety net.

Role of Private Health Insurance

The role of the private sector in providing health care is expanding rapidly in the Region as a result of many national health systems not being able to cope with rising costs, especially for co-payment, and the increasing demand for services. WHR2000 has indicated that "low income countries could encourage different forms of pre-payment-job-based, community-based and provider–based - as part of a preparatory process of consolidating small pools into larger ones." Development and expansion of national SHI and private health insurance schemes should be seen in the context of globalization and rapid liberalization of international trade, including the opening of markets for the private sector.

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

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

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

While the total market outlay of private health insurance in ***India*** is unknown, it is expected to be less than 1 per cent of the total health expenditure. Since 1999, after India adopted the Insurance Regulatory and Development Authority (IRDA) Bill, which seeks to open up the insurance sector to foreign and private insurance investors, a series of policy debates and feasibility studies were conducted to review various possibilities. The IRDA Bill aims to facilitate the establishment of the Authority to protect the interests of insurance policy holders by regulating, promoting and ensuring orderly growth of the insurance industry. International investors can hold up to 26 per cent equity[25]. The IDRA Bill will also apply to the health insurance market. Many NGOs, which have established various community-based health insurance schemes, expressed concerns on the IRDA Bill, mainly on its regulation of capital outlay requirement. A few life insurance and non-life insurance companies have started promoting different schemes of individual and group health insurance as "health riders".

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

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

In other countries, there may be a non-life insurance company (usually mutual funds or medical aid or health insurance) which provide individual or group life insurance policies. The premium is linked to the benefits offered. The insurance business is usually tightly regulated by the government because of the public financial liability and national security. Thailand adopted a series of legislative measures for private insurance including health insurance, with the most recent amendment in 2000 allowing foreign investment (up to 25 per cent equity). Even though the number of insurers in foreign insurance companies is around 6 per cent of the total insured by private insurance, the premium volume is one-third of the total estimated funds of 115 million bahts[26].

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

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

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

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

Community-based Health Insurance

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

A few countries have developed various forms of CHI schemes, through non-formal sector health insurance, initiatives to cover certain targeted groups such as poor women, low-wage workers and the semi-employed, both in rural and urban settings. The major policy challenge is how to accelerate the development of community health-risk-sharing initiatives and facilitate a broader coverage of people. Continuous and sustained support and incentives from national and local governments are required to improve the managerial skills and to provide opportunities for pooling of funds to generate greater financial viability and sustainability.

Large financial pools are better than small ones as they can provide for a better sharing of health risks, and, at the same time, raise more revenue. A larger pool can also take advantage of economies of scale in administration and reduce the level of contributions required to protect uncertain needs, while ensuring that sufficient funds are available to pay for services. Experience has shown that pooling risks to cover both health problems and financial burden have increased the efficiency of health systems, creating better health outcomes.

WHO-CMH recommended "that out-of-pocket expenditures in poor communities should increasingly be channelised into 'community financing' schemes…. [through] an incentive scheme, in which each $1 that the community raises for pre-paid health coverage would be augmented, at some rate of co-financing, by the national government (backed by donor assistance)…. This method would offer a degree of risk spreading so that households would not face financial catastrophe in the event of an adverse health shock to household income…"[27]. The World Bank, in its World

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

Development Report 2002, has emphasized the relevance of community-based health financing schemes[28].

Community-based health insurance (CHI) schemes have voluntary private membership using the principle of pooling health risks and resources, usually known as rural health insurance, mutual health organizations or associations, medical aid societies, medical aid schemes etc. These are different from other forms of community-based health financing, like community cost-sharing and drug funds, in which risk sharing can even be absent.

These non-formal, community-based health insurance initiatives are usually launched on a no-profit basis, to cover certain targeted groups. A few studies have shown that a smaller number of such schemes cover a large proportion of groups, while larger number have lower coverage of the eligible population. Most people join these schemes only at the time of illness. WHO and ILO studies have indicated that enrolment was very low, and more than 90 per cent of the schemes did not bear the bulk of the financial risk[29,30,31,32]. Existing CHI schemes in most countries cover limited medical care benefit packages and sometimes include preventive health care, including minimum medical and diagnostic services. There is a possibility that if a comprehensive package is introduced, these schemes would collapse.

CHI schemes with a small pool of participants are not viable financially in the long run. Experience shows that CHI schemes with less than 100 000 participants are not viable. Many schemes are usually provider-driven, initiated by wealthy people as a trust or linked with or are part and parcel of national or sub-national poverty reduction programmes including those of micro-financing schemes.

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

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

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

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

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

CHI schemes are often carried out as sideline benefit packages. This hampers sustainability. Many community-based schemes have a limited scope, as they are often expensive, considering the high hidden costs which are covered by donors and governments. Once donor funding ceases, only 10 per cent of such schemes survive. In order to overcome this, CHI should be implemented as a 'core business' addressing the poor, as shown historically in Germany and the Netherlands where such schemes were initially established as sickness funds.

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

4. KEY ISSUES FOR FURTHER EXPANSION

There is a danger that rapid expansion of health insurance coverage without appropriate safeguards could result in health systems moving away from the primary goals of efficiency, effectiveness and protection of the poor and vulnerable. The success of health insurance in achieving health reform goals is closely related to its particular institutional characteristics and managerial capacity.

Usually, middle- and high-income countries, whose economies can sustain a larger proportion of employed labour workforce, are capable of expanding the coverage of social health insurance as quickly as possible. They initially start with multiple agencies handling social health insurance or social mutual funds through prepaid schemes and are later consolidated into small funding groups. They act as fund managers and purchase services from both public and private health care providers.

Several countries around the world which relied heavily on tax-based health financing are moving towards expanding social health insurance. Many households are spending a large proportion of their household expenses (out-of-pocket expenditure) when they used public funded health care facilities (which are supposed to provide health care literally free-of-cost). There are many reasons for the inefficiency of public health care providers for low quality, inadequate coverage, bypassing of care, under-the-table and over-the-counter (unofficial) payment, rising cost of travel expenses, overcharging by private providers, etc.

Most countries have a mix of specific arrangements for insurance such as social health insurance (independent or within social security), commercial health insurance, community prepayment schemes and they are varied across countries. Ultimately, it is the government that must provide subsidies for the poor and disadvantaged groups, by ensuring the financial and health risk protection for those who cannot afford to fully finance their own health expenses. Some countries have made detailed studies on this aspect, in collaboration with external agencies including ILO, GTZ, UNDP, UNICEF, the World Bank and ADB, etc. More information is required to study these issues comprehensively in the Region.

Prerequisites for Introducing or Expanding Coverage of SHI

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

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

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

(a) It can provide a stable source of revenue for health care.

(b) It would ensure self-reliance financing of health care compared to loans, grants and other external sources.

(c) The flow of funds into the health sector is visible.

(d) It can assist in establishing patients' rights as customers.

(e) It combines risk pooling with mutual support, by allocating services according to need, and distributing financial burden according to the ability to pay.

(f) It can operate within government health policy goals, yet maintain a degree of independence.

(g) It can be associated with efficient provision of health services.

(h) It solves equity and affordability of health care financing contribution which private health insurance fails to facilitate[33].

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

All of this is a normal consequence of combining the political processes of governance and collective decision-making with the widespread recognition that public policy must play a significant role in guiding the health system. Therefore, the design of health financing in any particular context should not only recognize political influences but explicitly address and take advantage of the opportunities presented by political debate and governance. What kind of alternative financing options should be considered depends upon the intensity and source of pressure. It is not of alternatives but the

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

balanced mixture of many alternative health financing options that the countries need to consider.

The former central-market-economy-oriented countries in Eastern Europe and similar Asian countries like Myanmar, India and Sri Lanka, with a low level of public health spending, low salaries for health care professionals, and inadequate quantity of health care interventions and facilities do require a higher level of health funding by the governments. The main pressure usually comes from health professionals (both public and private) to improve their incomes.

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

Expanding social health insurance coverage is one possibility. This expansion is traditionally linked with national social security policy and programmes. Only 4 out of the 11 Member Countries of the Region introduced SHI schemes, but do not have wide coverage except Thailand. Other countries have not yet implemented SHI schemes on a national scale.

Since the labour market is growing rapidly in countries where governments provide free health care utilizing funds from general tax revenue, these countries may need to consider the SHI scheme as an alternative health financing. Health ministries usually have limited budgets and are competing with other sectors. In situations where basic services are already free, SHI could be an added advantage in ensuring access to health services, especially from private providers.

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

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

health care. The schemes have to work in an environment where health care facilities are functioning in an adequate manner so that access to health care by the insured people is not denied for any reason. It does not mean that the schemes themselves should establish their own health care facilities. Traditionally, social security schemes in India and Myanmar established their own health care facilities in order to fill the gaps left by public health care providers. Similarly, big state or private enterprises like mines, railways, electricity, petro-chemical industries and other heavy industry complexes have established their own health care facilities. Some even have secondary and tertiary health care facilities that inadvertently led to inequity. Those population groups who are not insured (due to differences in their employment status, especially people in the informal sectors and mainly from agricultural, fishery and animal husbandry sectors) are often not able to get appropriate health care due to their inability to pay contributions regularly or, in most cases, because of lack of social health insurance coverage. Thus, the main aim of SHI schemes is to add on the health financing resources for universal coverage, but not for just an alternative.

- ***The management infrastructure***: The SHI schemes need a large ***social capital*** in all aspects: appropriate human resources with skill and knowledge in social science, commerce and economics, disease burden, clinical management, public health management, banking and financial management (i.e. health economists, insurance mathematicians, actuarial scientists, social economists, accountants, demographers, epidemiologists, medical record keepers and statisticians, information specialists, public health legislators). Many countries do not have much national capacity to fulfil the requirement of national social capital. Regional solidarity may be required to improve and strengthen the capacity of social capital. In addition to the need for setting up appropriate collection of funds, there must be a nationally approved mechanism for managing this fund. It is critical to ensure the independence of the "Health Fund" from the general management of public finance. There is also a need to ensure transparency in how the fund is being managed, particularly to strengthen the people's trust in public management of fund. Some countries are still keeping the social security agency or

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

Issues in Expanding SHI Schemes [34,35]

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

In those countries where public health facilities provide health care free of cost at the point of use of care (although the expenditure may be through general revenue or any other financing mechanism), the expansion of SHI will need a lot of awareness building amongst the general population to accept the idea of prepayment and cost-sharing. There is the possibility of resistance to change a system where payments are more visible. In countries where so-called health care provision is literally free of cost at the time of receiving care, but a system of unofficial payment flourishes, the introduction of SHI schemes may be possible if under-the-table payments are well-controlled. Usually, higher-middle and high-income countries whose economies can sustain a larger proportion of employed labour are able to achieve complete or near universal coverage through social health insurance. They initially started with multiple finance managing agencies handling various social health insurance

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

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

schemes, some as part of overall social security measures. They tended to contract out health care provision to both public and private care providers.

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

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

The ultimate goal of health care financing is to achieve universal coverage. Health care financing based on general tax source is the fairest way. Some countries with a high proportion of salaried workers in formal and informal employment sectors might need to consider implementing or expanding the SHI schemes.

Experience has shown that several SHI schemes are facing difficulties in controlling costs if fee-for-service billing is the major form of provider payments. There are different methods available for reimbursing service providers[36]. These include salaries, fee-for-service, capitation/block contract,

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

fixed budget, daily allowance and case-based payment. The following table shows each of these methods associated with certain negative behaviours by service providers.

Table: ***Payment method and provider behaviour***

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

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

- ***Poor understanding of basic conceptual framework of social health insurance and lack of nation-wide consensus*** between stakeholders is a major issue in the adoption of SHI as a means of achieving universal coverage. An appropriate policy framework has

to be adopted to ensure the basic concept and ground rule of SHI, i.e., to guarantee equitable health benefits to those with similar health needs, regardless of the level of contributions.

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

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

The main ingredients of successful expansion of SHI schemes are:

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

growth spreads more equitably within the country, the willingness and ability to pay SHI contributions could be enhanced.

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

especially the type of social health insurance, the level of the premium, what proportion of contribution to be made by the government, employers and employees, what are the benefit packages, how to contain costs, who are the providers and how they are paid, and what are the total financial returns, etc.

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

countries of the Region would take several decades to achieve universal coverage.

Role of Community-based Health Insurance

Most countries have adopted different forms of community-based health insurance (CHI), through non-formal insurance initiatives, covering certain targeted groups such as poor women, low-wage labourers and the semi-employed, both in rural and urban settings. Several of these initiatives have exclusion criteria and problems of economic sustainability. Some of these initiatives could be merged into the national health insurance policy framework, as in Thailand and now in Indonesia. Many other countries have not made any major policy efforts to expand these schemes or to integrate them within the national SHI stream.

There is no doubt that community-based health insurance is well established in some Asian countries as part of their social and cultural norms for community risk-sharing. Households in the community tend to assist each other with finance and voluntary labour in various social events like births, marriages, religious ceremonies, health crisis and deaths. They always share equally the expenditure and, in some cases, even capital costs like building schools, health centres or hospitals. Some of the funds generated as trust funds are also managed by them.

As most countries where the government-financed health care system is inadequate to provide financing for all health care activities, the community provides resources to share the burden. Various cost-sharing schemes have mushroomed in these countries with the aim of increasing access to essential drugs and diagnostics. Drug-revolving funds have been established to reduce the financial burden of purchasing drugs. People have to pay some fixed amount for each consultation or user-charges are levied for the type of illness and for the medicines prescribed. The funds accumulated are used locally to purchase supplies, to maintain the health facilities and to provide incentives to carers.

Evaluation studies are needed to review these funding arrangements to determine whether they are viable in the long-run. Preliminary results have showed mixed responses, indicating that some are viable and good providing increased access to essential drugs. Some studies have also showed that

people were willing to pay more for better health care services. A few other studies have showed non-viability when the system is not properly developed and managed.

In some countries, pre-paid voluntary health insurance schemes have been initiated at the community level, mainly provider-initiated or by wealthy or dedicated persons, or piggy-backing on other micro-insurance schemes like *Gonosasthya Kendra* (GK) and *Grameen Bank* in Bangladesh, or *SEWA* in India and other community-based schemes as indicated earlier. Some schemes are implemented as part of the national or sub-national poverty reduction programmes.

While CHI plays a significant role in institutionalizing the idea of pooling risks and strengthening the capacity to manage at the community level, its role in expanding coverage is still limited. There is no doubt that it would reduce the burden of the OOP expenditure (despite minimal amount)[37]. It would also ensure health care reaching the poor and underserved population, familiarizing them with financial and health risk pooling, customizing health benefit packages and promoting self-reliance and the spirit of solidarity. The CHI could be used as a transitional mechanism before full implementation of nation-wide SHI schemes or tax-based health care systems. The CHI could easily be integrated into other community-based financing, mainly initiated through poverty reduction programmes. Even though CHI schemes play a role in health financing, they cannot replace government's health financing.

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

- ***Policy commitment***: National poverty reduction strategies and related strategic programmes (like mircocredit schemes) usually address the issue of financial risk protection for poor families. However, the so-called social subsidy for poor, food-for-work or other social safety net (SSN) programmes or similar national programmes for subsidizing the poor families, especially households below the poverty level, are not addressed for promoting community-based health insurance schemes. There is strong evidence that governments should regulate, promote and assist in

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

designing new CHI schemes, provide financial incentives and even subsidize funds earmarked for poor families, and monitor implementation of these schemes.

- ***Technical issues***: The CHI schemes tend to use a lot of adverse selection or risk selection if they enrol only specific population groups such as pregnant women, workers in stone quarries or other hazardous workplaces, fishermen etc. As all are already in high-risk groups, this adverse selection could lead to higher health care costs and discontinuation of insurance unless funds are pumped in from other sources, including government tax revenue and mostly from external donor funding. The contributions for each individual could become very high and the scheme may not be viable by losing potential members. The CHI should have a larger pool of low and high risks and also cater to both ambulatory and inpatient care.
- ***Existence of socially cohesive groups:*** Some countries are promoting development cooperatives, mircocredit organizations or other social groups based on the people's trust. It might be easier to initiate CHI in such communities. The health care system in China was successful in the 1970s with a wide coverage of the rural cooperative health care systems which were in place in almost 98 per cent of villages. With the breakdown of collective economic units in the communes which resulted from market economy reforms, the collective health care financing schemes were reduced to less than 10 per cent by 1993. After some years, the Chinese Government re-introduced in 2002, the rural community-based health insurance schemes based on pre-paid risk sharing principles, in a phased manner. Similar approaches may need to be revived, introduced or expanded in some countries of the Region.

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

5. CONCLUSIONS AND RECOMMENDATIONS

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

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

Increasing Public Allocation

The most obvious option of health financing for all governments to consider is to increase the level of resources in health financed through general revenue and also by increasing the level of public and quasi-public finance (social health insurance). There are many valid reasons for countries to increase public investment in health care. Policy-makers need to review the differential allocation among sectors and adopt their fiscal policy in order to adjust financial allocations so that the health sector can have a higher level of resources. According to WHO-CMH, each 1 per cent rise in income leads to a slightly more than 1 per cent rise in health spending. National income in countries of the Region has been rising steadily over the years. While the annual economic growth might have showed slowing down for a while due to the Asian economic crisis in the late 1990s, most countries are recovering rapidly. The annual growth of the health budget for public spending should be at par with, or even more than the overall annual economic growth.

While a few countries have for long been facing internal civil strife and political unrest, many have experienced stable political situations. Even in countries experiencing conflict, peace initiatives are in progress. Once the

socioeconomic burden of civil strife or political instability is under control, there could be increasing concentration on social development including health.

Expansion of SHI Coverage

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

With improvement in employment conditions both in quantity and quality, social health insurance schemes have the highest potential to improve health care coverage. Social security and social health insurance schemes that are covering only regular income earners/employees could extend their coverage to their families/dependents, without additional investment. Those countries where community health insurance schemes are well established should also find ways and means to expand and consolidate them.

Research into Policy and Practice

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

Regular updating of national health accounts (NHA) will provide the necessary guidance for policy options and useful insights into health sector finances. It would also provide appropriate interpretation and analysis to decision-makers and planners to review how they can and should allocate

public resources for health, what should be the level of public and private expenditure, and how private resources can be mobilized for public health expenditure, etc. Practical difficulties might arise in updating NHA in many countries, such as difficulty in getting the total expenditure of private sector health care institutions; estimating community financing (donations/trust funds); estimating external donor inputs in the health sector, especially when these donor agencies work directly with NGOs and communities and the need for capacity building for national NHA teams.

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

Development of Social Capital

Gathering, sharing, analysing and reporting information on health systems development could be done by agencies within and outside ministries of health. In addition to the health planning and policy units, bureaus and departments usually established under the direct responsibility of the ministries of health, there are several institutions and individuals who can be involved in the national cause, such as national research institutes, institutes for policy studies, academic departments of universities, semi-government and nongovernmental organizations, local and international research and development institutions, and they could be exploited for the national cause. Many such institutions are parastatal, not-for-profit institutions and they could be effectively utilized to gather and share intelligence and expertise. The ministries of health could still play the role of appropriate contract setting, facilitating and overseeing the work of these institutions.

In conclusion, it is critical to recognize that in recommending any policies for financing the health system, no country starts with a clean slate. The appropriateness of particular strategies in any country will depend on its specific history, institutions, culture, politics, and economic resources. The development of a mix of health care financing mechanisms could be judged by how well they are likely to achieve the goals of equity, better health and

responsiveness, and fair financing. There is a need to have a higher level of fairly distributed prepayment schemes with appropriate strategic purchasing.

Existing systems of taxation, social security institutions, and the organization of health care service providers and insurers have developed out of historical processes and conditioned by experiences of nation-building, colonialism, labour movements, wars, communal and kinship patterns, and technological change. From this, citizens have already developed their beliefs and expectations, with regard to payment mechanism. As with all social arrangements, there are ways and means to introduce reform, but they require inputs from social institutions and support from all stakeholders.

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

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

It is important to emphasize the need to attend to the process of health financing reform and its related transitions because such a reform requires changes in institutions, management, accountability mechanisms and population behaviours that take time and resources. SHI is not merely a new method to collect money to co-finance services. It is a method that can achieve stable financing for a package of health services (health insurance benefits), while at the same time achieving greater access to health care for the population. While SHI is a promising alternative source of financing in order to promote equity and efficiency, it cannot be the main solution to bridge the gaps of financial resources required for additional health funding. SHI schemes are not a panacea or remedy to replace other mechanisms or

forms of health care financing, particularly financing based on general tax revenue. The government should not shirk its responsibility to ensure and regulate the provision of health care including essential public health functions, whether directly or by public or private health care providers.

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