Introduction

Universal Coverage of Health Care: Challenges for th Developing Countries

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Introduction

Universal or near universal coverage of health care has been a prominent objective of health care reform in many countries, particularly in most of the rich and many middle income countries. Universal coverage can ensure equitable access to health care and help to achieve a nation's dual objectives of equity and efficiency for its people' health.

Universal coverage is defined as a situation where the whole population of a country has access to good quality services (core health services) according to needs and preferences, regardless of income level, social status or residency. It may be financed through tax or through contributory insurance schemes, and organised through one national scheme or a number of different schemes. To achieve this coverage of health care, the sources, levels and the management of finance need to be well designed to ensure its sustainability.

There are two major paths to achieve this goal of universal coverage of health care, undertaken by most developed and developing countries. One is through compulsory or social insurance (known as the Bismarck model), and the other is through taxation (the Beveridge model).

The question then arises as to how these developed and developing countries have achieved this coverage of health care. Each of them is at a different level of development with regard to economic status, labour markets and health care systems. Is it through insurance-based systems or tax-based systems? The results and implications of their experiences could provide valuable lessons for other developing countries, who wish to develop this kind of universal coverage policy.

Characteristics of Developing Countries

Many developing countries share problems or difficulties in achieving universal coverage of health care, mainly due to unfavorable economic, political and social factors. Several characteristics are common in many of these countries, and could become major obstacles to progress in the future.

Economic Factors

- **Lack of funds and resources**

The most urgent problem for developing countries is that they lack funds to finance the health services urgently needed by their citizens. Health care services in developing countries are mostly financed by the public sector, and relatively small private investments are made in this area. Private health care services are targeted at the wealthy groups in urban areas, but not at the rural poor who are the vast majority of the population in developing countries. So the functioning of their health care systems is very much determined by the availability of national resources.

- **Lack of adequate infrastructure**

Many developing countries lack the necessary infrastructures, both in social and economic terms. Furthermore, the development of health infrastructure is less likely to be a country's top priority until other economic infrastructures are well developed. In order to provide adequate quality of health care services to people, hospitals and health centres need to be built, and they need to be staffed with qualified health personnel, adequate supplies, drugs and equipment.

These countries are also lacking in the areas of information technology and managerial infrastructure, which are essential for establishing and managing insurance plans or community financing. It is particularly difficult to develop health insurance plans when hospitals and clinics do not have a uniform system of accounting and clinical records.

Political Factors

- **Poor political stability**

Political stability is closely linked to economic stability. As seen in many countries, hit by economic crisis, they are likely to lose their political and social stability. Unstable economic conditions always leads to political instability, a common situation in developing countries. Political support is essential for the successful implementation of national policies. Any policy which requires drastic reforms to an existing system demands a strong political base to implement plans.

- **Inefficient use/allocation of resources**

Lack of social stability such as riots, religious conflicts and civil wars can be another factor that becomes an obstacle to the development of social programmes. When a country faces any threat in national security, the government tends to allocate more resources to military defence, rather than to education, social welfare programmes and health care. Such inefficient allocations of government budgets can be frequently observed in many developing countries. Some governments in developing countries are closely linked with particular interest groups, which hold strong economic and political influence over government policies. This often leads to ineffective policy and planning and inefficient allocations of national resources.

Social Factors

- **Inadequate human resources**

Human resources are a further important element for achieving an effective and efficient health system. To provide good quality health care services, adequate numbers of health personnel need to be in place at every level of health care facilities. It is also important to have a well balanced distribution of human resources in different regions, as well as health care facilities. In addition to medical staff, other health care workers such as midwives, sanitarians, and village health volunteers are required to meet the needs of the rural population which always have inadequate access to physicians.

As mentioned above, investment in human resources is essential to ensure a better functioning health system. However, it is likely to be neglected or less valued in many developing countries. Adequate training should be provided at every level, so that health care workers work in an efficient and effective manner, in order to meet quality standards and live up to consumer expectations. The introduction of new mechanisms, such as a

co-payment systems and Diagnostic Related Groups (DRG), requires extensive training of personnel.

- **Inadequate investment in Education and Social Welfare**

In most developing countries, investment in education and social welfare is relatively small when compared to economic sectors, as countries face more urgent needs for infrastructure or economic development. In most cases it is the poor who have less opportunity to be educated, even though they are the vast majority of the population.

Few people are aware of the importance of health insurance. Making people aware is crucial if we wish to develop a National Health System. Such self-awareness and social-awareness of health protection against large financial risk is crucial in developing a National Health System to achieve universal coverage. Ideas of solidarity and equity underlying health insurance need to be cultivated amongst the citizens, so that a more equitable distribution of health resources and financing will be ensured, and society will be willing to subsidise the health insurance premiums of high-risk, low-income persons and accept the consequent tax burden.

- **Large gaps between urban and rural areas**

In urban areas, industrialisation is increasing and workers' real wages are rising. Accordingly, the government can organise a social insurance programme to cover workers employed by large firms, or it can rely on private insurance programmes to cover them. Either option will make it possible to mobilise more funds for health care. Efforts in the urban industrial sector will create greater imbalance in coverage between urban and rural residents. The government must come up with some measures to balance this gap by offering technical and managerial support to rural communities. This will enable them to develop their own system of financing health care for their own local communities.

Lessons Learned from Countries Which Achieved Universal Coverage Recently

Before World War II, almost all countries in Asia and Latin America except Japan were developing countries. After World War II, some countries in these regions could

achieve the goal of universal coverage of health care for their people. Many lessons can be drawn from these countries which have already achieved universal coverage or near universal coverage of health care. There are also important lessons to be learned from the experiences of those which are yet to achieve universal coverage or are on the way to achieve it. This paper attempts to identify some conditions as common factors or pre-requisites and also as obstacles in achieving universal coverage by reviewing experiences of both developed and developing countries in Asia and Latin America.

The reasons for choosing not to review countries in Europe and America are mainly because their systems of universal coverage have developed over half a century or more, whereas the Asian and Latin American developed and developing countries under review introduced their goals of universal coverage more recently. They have had many examples to refer to, and partly as a result, have achieved universal or near universal coverage in only 12-30 years. In Asia, Japan followed European and American models, and adopted, changed or discarded ideas that did not work. They achieved universal coverage in 35 years. Korea and Taiwan adopted the Japanese system, amongst others, and achieved universal coverage in 15 years, or less. The arguments are similar also for the Latin American countries, reviewed in this paper.

Asia

Japan

Japan was the first country in Asia to establish a high level of social security systems as can be found in Western countries. In the 1920's, commitments to the establishment of social security systems started. Japan's historical path to universal coverage can be divided into three major periods: namely the pre-war period, the post-war period, and the economic growth period.

Pre-war Period: In the pre-war days the main emphasis of social security was placed on the concept of "social defence" for upholding the national goals of increasing industrial production, national wealth and military power. However, it lacked the modern concept of "social security" which was introduced after the War. The essential programmes of a social insurance system began with the establishment of Health Insurance for employed people in 1922. In 1930 the universal medical care insurance and universal pension systems were introduced.

Post-war Period (1945~54): Establishing the Basic Principle of Social Security: During this period, the country struggled with post-war confusion and lost most of its infrastructure for medical care provision. Because of this, the country was in urgent need of relief and infrastructure improvement.

Major reforms such as the democratisation of the economy and liberalisation of education were carried out by the allied forces in this period. It was also decided that the country should develop new principles of social security. The new Constitution of Japan explicitly noted that the Japanese people "shall have the right to maintain the minimum standards of wholesome and cultured living" and that the State "shall use its endeavours for the promotion and extension of social welfare and security, and of public health" for this purpose. This formed the basis of Japan's social security system.

Economic growth period (1955~): Achieving Universal Coverage: Japan's economy grew rapidly through a large-scale business boom, as chiefly led by the flow of capital investment, which started in 1955. As people's living standards improved, relief measures for the

needy because of sickness or aging, and measures to prevent ordinary people from getting into poverty, became more important. Therefore, a medical insurance and pension system to cover all citizens was introduced. This prompted a shift from a period of public assistance programmes financed by public funds to a period of social insurance programmes in which participants paid insurance premiums and prepared themselves for such risks as sickness and old age. The Four-Year Plan was created to expand the application of National Insurance, a community-based insurance programme. Later in 1961, those such as the self-employed and farmers, who were not covered by the employees' health insurance, were enrolled in the National Health Insurance scheme on a compulsory basis, thus achieving universal medical insurance coverage for the entire nation.

Japan's health care system thus made rapid developments in the post-war period. In addition, strong national consensus during wartime pushed through the government's policy of extending social security to all Japanese citizens, and the early stage of development of the social security scheme emerged in this period. Japan achieved universal coverage for health care in the midst of post-war high economic growth. It can be seen that high economic growth was a major factor which enabled the government to extend coverage for health care under the social security scheme. Other important characteristics of Japan's health care system in the early development phase, in accordance with its high economic growth, were a relatively young population structure and an employment system into which social security was integrated.

Korea

A similar trend can be seen in Korea, which has experienced extremely rapid development of the health insurance system in terms of population coverage. Korea achieved universal coverage fairly early in 1989, during a period of average annual economic growth of around 10%. It took only 12 years after the implementation of the social insurance programme. Rapid economic growth allowed Korea to expand employment and job opportunities. Without the economic boom, such a rapid expansion of health insurance coverage would not have been possible in Korea.

From the experiences of Japan and Korea, we can see that the economic status of the country is an important factor in expanding health insurance coverage for the population.

Economic growth can facilitate the development of health infrastructure including human resource development and systems development for tax/premium collection, which are indispensable for both health insurance and tax-based systems. The development of an equitable tax system is important for a government tax-funded system. As the economy grows, more and more people shift into formal sector employment, which makes them more accessible in terms of registration and payment contributions. Countries enjoying stable economic growth are in a good position to introduce a policy of universal coverage.

Taiwan

Like Japan and Korea, Taiwan achieved high coverage of health care in an extremely short period of time, but in a different way: by establishing a single National Health Insurance Fund. After the Taiwan government inaugurated its universal health insurance scheme in 1995, following a six-year planning period, the scheme achieved a population coverage of 98% within a year, which was a remarkable achievement since it started from just 50% coverage the previous year. Taiwan also enjoyed high economic growth in the 1970's and 1980's, and experienced rapid socio-economic structural changes, shifting a large number of workers from the agriculture sector to the industrial sector. Taiwan's health reform efforts and movements towards universal health insurance coverage are uniquely characterised by strong political factors that underline these development efforts.

Three important lessons can be drawn from Taiwan's ability to achieve universal health insurance coverage. Firstly, its strong political forces made a success of carrying out the country's health sector reforms, especially through enacting a national health insurance act. Secondly, a stable and healthy economy absorbed the additional increase in health care expenditure caused by the introduction of universal health insurance, as Taiwan successfully initiated its national health insurance policy at a time when its economy was in rather good shape. Lastly, Taiwan's health care system responded well to the reforms. The health system in Taiwan had the capacity to absorb the additional health care demand, covering previously uninsured groups with existing health resources, i.e. health infrastructure, and financial and human resources.

Singapore

Singapore's health care system is uniquely characterised by establishing Medical Savings Accounts (MSAs), and it is the first and most developed system of MSAs. Singapore's current health care financing reforms were developed in three stages. Medisave, which represents a form of compulsory savings and the MSA component of the system, was introduced in 1984. Employees and employers each contribute 20% of the employee's wages to the Central Provident Fund (CPF), which serves as a national social security and pension fund based on savings. Medisave funds are never adequate to cover all or most high-cost health expenditures, so there would be significant demand for health insurance. Medishield was introduced as a catastrophic insurance plan in 1990. Medishield premiums are automatically deducted from the Medisave, unless account holders request otherwise. Medifund, a third financing component, was established by government endowment in 1993 to support health care for the poor. Government budget surpluses are used to fund additional contributions to Medifund.

While costs and demand continue to rise in Singapore, it is widely believed that unnecessary expenditures for inpatient care have been reduced without dramatic limits on physicians' incomes or the availability of high-technology treatment. However, it is important to emphasise that Singapore uses a fairly narrow definition of services eligible for MSA expenditures (e.g. excluding most outpatient care), has a fixed fee schedule for medical services, and does not have comprehensive insurance. But universal access to public health care is guaranteed through a system of targeted subsidies and subventions from tax-based sources, as well as a last-resort Medifund endowment for the indigent. It does not use MSAs as the sole mechanism for financing care, nor does it treat MSAs as a single solution to all health policy problems.

There are also examples of countries like Hong Kong which have followed the U.K. system, by trying to implement universal coverage using a tax-based system. Some newly emerging economies like Thailand and Philippines are seeking their own way by learning from their neighbours and trying to develop their policy of near universal coverage of health care in a mixed system which is still not yet fully matured.

Latin America

Colombia

Colombia is one of the Latin American countries which has made dynamic health sector reforms in order to achieve the goal of health for all by the year 2001. It perceives that achieving universal coverage is a progressive step towards national health objectives. Active transformation in health service institutions was initiated in the 1980s. In 1991, under the new Constitution, fundamental reforms of the social security system were put in place, and at the end of 1993, Colombia passed legislation to reform its health care system. The essence of the system reform is to provide universal insurance coverage to all Colombians, improve access to health services for the poor, and enhance quality and promote efficiency in the provision of health services. Colombia began a full implementation of its health sector reform in 1995 and it has made measurable progress in several areas. Key elements of reforms are efficiency, universality, solidarity, comprehensiveness, unity, and social participation. The health sector reform in Columbia brought a number of changes in organisation and management systems. The new system reinforces solidarity by providing all Colombians with access to a comprehensive health protection plan.

Under the reform, approximately an additional 3.5 million Colombians are covered by the Contributory Regime. Before 1995, it was estimated that 10.9 million people had health insurance through various schemes. At the end of 1995, 14.4 million people were under the Contributory Regime or private insurance programmes. Compared to other Latin American countries, this increase in coverage is a significant achievement. In total, approximately 16.8 million Colombians (53%) are neither enrolled in the Contributory or Subsidised Regime, nor insured by private insurance programmes.

Chile

Under the Constitution of 1980, health is considered a basic human right and it is the State's duty to ensure that all citizens are able to exercise their right to protect their health and to live in an unpolluted environment. In 1994 and 1995, the Plan for Strengthening and Modernising the Public Health Sector was carried out to improve efficiency and quality of care, particularly the care provided to the poor. The most important strategic action under the plan was to develop an integrated Social Security System to cover the entire population through a set of individual and collective benefits with mutual financing. A key feature of the Chilean system is that those who can afford it have been advantaged to opt out of the public system into private health maintenance organisations.

This is causing increasing problems as the poor and those with high health risks remain with the public system, and are joined by those for whom private insurance becomes unaffordable as health risks and hence premiums rise with age. Universal coverage thus co-exists with a rather inequitable organisation of funding and provision.

Other than the objective of universal coverage, health reform efforts in Chile are aimed mainly at reducing waiting lists, helping to overcome extreme poverty, humanising health care, improving the treatment of users, strengthening and modernising the public health care system, increasing social control and involvement in the health sector, improving coverage and quality of care for the elderly, and enhancing health care for adolescents.

Extensive changes in existing legislation are being carried out under the health sector reforms. The principal legal reforms currently under consideration or being undertaken are: the draft law on professional remuneration and incentives; a series of proposed laws aimed at advancing the legislative effort at decentralisation; and a new law regulating the working conditions and compensation of physicians, dentists, and pharmacists.

Universal Coverage: Lessons Learned from Asia and Latin America

What we have learned from these case studies is that there are various ways to achieve universal coverage, and there is no bible or a single ideal model for any country to just simply apply. Each country needs to consider various factors determining its economic, political and social status and apply the most suitable and feasible option. In addition to this, there are some common issues for a country to consider. Four major issues in achieving universal coverage are considered here in discussing feasible measures for developing countries to take.

1) Fast-track implementation (big bang) vs. gradual incremental approach

A fast-track implementation approach requires major reforms, especially with health legislative changes. It requires considerable efforts from the government and strong political will to carry out the policy. As such, it is not the most favoured method adopted in practice. The gradual incremental approach would be to bring the new scheme in phase by phase, gradually phasing out the old schemes. This is the approach that would be more suitable for most countries which have already started other schemes.

Columbia and Taiwan may be counted as utilising a fast-track method, whereas Japan and Korea took a more gradual, incremental approach.

2) Bismarck approach vs. Beveridge approach

Once the decision has been made as to how fast the health scheme should be implemented, the next step is to decide on the scheme itself. As mentioned earlier, there are two approaches to choose from, namely the Bismarck or the Beveridge models. These are the two major approaches which have been implemented in many developing and developed countries in respect of health care financing.

The Beveridge Model is a tax based system, i.e., **a tax-funded system**, which pays for health services out of general government revenue. There may also be some special health taxes (e.g. on health damaging goods or activities). Decisions about the overall funding of services are made as part of the overall planning of government expenditure. The United Kingdom and Canada are typical examples of a Beveridge model. It seems that no countries in Asia and Latin America can be claimed to achieve full universal coverage of health care by adopting this approach on its own, and relatively few countries in developed areas have adopted the Beveridge system.

The Bismarck Model is an insurance based system, i.e., **a social insurance system,** which pays for health services through contributions to health funds. The most common basis for contributions is the payroll, based on ability to pay, and access to services depends on need. The health fund is usually independent of government, but works within a tight framework of regulations. Germany is the country which initiated this approach and countries like Japan, Korea, and Taiwan have adopted the Bismarck model into their health systems. Countries with under-developed tax collector systems see the Bismarck model as being more feasible and applicable to their countries' needs.

The Bismarck model has been applied by many countries in Asia, mainly due to the following reasons. They chose this model because it results in less political conflict, a more decentralized means of fund management, and provides greater consumer choice. However, a choice between the Beveridge model and the Bismarck model should be

based on each country's economic status, and level of development of tax systems and health systems.

3) Financial Management: the choice between a Single fund and Multiple funds

Another important decision to be made is how to manage the fund(s), and again there are two approaches currently in practice, namely single fund and multiple funds.

The single fund and multiple funds approaches are two different ways of managing the money collected from the population for their health use. Taiwan is a good example of a country which has adopted a single fund system for its health system, whereas many other countries, like Japan, Korea and Chile, employed a multiple funds system. Like many other countries, Japan initially used a multiple funds approach as a health care fund already existed for government employees when the government commenced its policy of expanding health care coverage. The multiple funds approach gives certain advantages in its adoption, for example it leads to less political conflict, as it can be easily developed based on existing health insurance funds. However, its major disadvantage is that it can produce inequity of provision of services as happened in Korea and Chile. The administrative cost of managing many funds can also lead to inefficiency of the system. Facing its present economic crisis, Korea has rigorously reformed the multiple fund system into a single one. The merging of existing health insurance funds to a lesser number of funds is a phenomenon also presently happening in countries in Latin America. A single fund system is more easily administered under a tax based health system, as it requires no additional institutional arrangement.

4) Comprehensive benefits coverage vs. catastrophic illness benefit coverage

The Singapore health system is purposely designed to move away from the comprehensive and overly generous insurance models that may be unsustainable, using a combination of taxation and savings, with limited insurance for catastrophic illness only. The declared objectives are different from those of other models having universal coverage, by limiting insurance only to "insurable" expenditure (i.e. high-cost events of low probability and not low-cost events of high probability for which other types of financing would be more efficient and effective). Thus, the role of the state is as a last resort to support the truly needy, while average individuals and families are expected to contribute towards greater cost-sharing of increasingly expensive health care, so as to

encourage self-reliance. For all other countries like Japan, Korea, Taiwan, Chile and Colombia, the benefits covered are still comprehensive, where the advantage is that minor illness can be taken care of before it changes to be more serious, which will require intensive and more expensive treatment.

Conclusion

Universal or near universal coverage of health care has been a prominent objective of many countries, especially in this era of health care reform. Many developing countries have taken it as one of the most challenging goals for their health care system reform efforts. But being developing countries, many political and social characteristics are obstacles which make their progress to the goal difficult. These characteristics are the lack of funds and resources, lack of adequate infrastructure, poor political stability, inefficient use of resources, inadequate investment in education and social welfare, and not enough capable human resources. Lessons learned from countries which have recently achieved universal or near universal coverage of health care, especially in Asia and Latin America, provide at least four issues which should be taken into consideration before any developing county should decide to proceed with universal coverage plans. The first issue is whether they will gradually increase population coverage or whether their economic and political situation is up to the level which will allow them to use a fast-track approach by legislative measures like in Colombia and Taiwan. The second is whether the historical evolution of their health care system and the availability of resources invested in the present health care system by the government is enough for them to rely on general tax revenue to finance their health care systems as in the Beveridge model, or to adopt the insurance-based system of the Bismarck model, or a mixed model as in the case of Thailand and Philippines which are seeking the most suitable route to universal coverage. The next issue is whether there is enough capable manpower in the country to manage a single fund or multiple funds, and which option is more efficient to manage. The initial choice of a single fund tends to be preferable to the changes which are presently happening in Korea and Latin America. And lastly, whether the infrastructure of each country and financial resources are adequate for the benefits to be covered by universal coverage, and whether this should be comprehensive as appears in most countries, or limited to catastrophic illness only as in Singapore.

Developing countries which aim at the goal of achieving universal coverage of health care in their health care reform need to consider their situation and learn from other countries carefully before any decision is made. These lessons from countries which presently achieve universal or near universal coverage at least can provide information on policy origins and consequences which will help other developing countries to adjust the goal according to their situation and to identify the mistakes which should not to be repeated in their implementation. As they adapt systems from the lessons learned, developing countries may come up with many other models for achieving universal coverage of health care which are more appropriate for developing countries in the future.

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Theories and Concepts

Enhancing the Insurance Function of Health Systems : A Proposed Conceptual Framework

Joseph Kutzin

Introduction

*Error! Bookmark not defined.***Health insurance and public policy objectives**

Defined in very simple terms, health insurance provides two basic functions:

- access to effective health care services when needed, and
- effective protection of family income and assets from the financial costs of expensive medical care.

Thus, insurance coverage implies protection against the *risk* that if expensive (relative to an individual or family's means) health care services are needed, the services will be available and of adequate quality, and the cost of using these services will not drive the family into poverty. Universal coverage with this *effective health care risk protection* means the extension of these access and income/asset protection functions to the entire population. Defined in this way, universal health insurance coverage embodies important health policy objectives, notably equity of access and good quality care, as well as the broader social welfare objective of poverty avoidance. Thus, enhancing the *insurance function of health systems* is a policy objective. The notion of "enhancing" insurance can be clarified with two further definitions:

- *depth* of coverage, meaning the range of services that are available to people without exposure to out-of-pocket payment, and
- *breadth* of coverage, meaning the proportion of the total population that has effective health care risk protection.

Thus, enhancing the insurance function can be described as *deepening* and/or *broadening* effective protection. Because efficiency in the use of resources is also a (social welfare as well as health) policy objective, the overall objective for countries can be summarized as: **achieving universal coverage with effective health care risk protection *at the least cost possible*.** Efficiency is an objective in its own right, but it is worth noting that where the scope for mobilizing additional resources for health care services (from any source) is limited, improving sectoral efficiency in the administration of the insurance function is also a means, perhaps the only means, by which insurance protection can be broadened, thereby increasing equity of access. These definitions of insurance, universal coverage and the objective of public policy with respect to health care risk protection form the basis for this paper.

In effect, the definition of insurance used here takes the perspective of the individual citizen or family rather than an institutional perspective based on membership in a statutory insurance scheme. Thus, for example, a citizen in a country that has an effective National Health Service funded from general tax revenues, such as the United Kingdom, is just as 'insured' as a citizen in a country having universal coverage with social health insurance funded through mandatory contributions of employers and employers, as in Germany. If the social costs and distributional effects of providing the risk protection are the same, public policy is indifferent to whether 'insurance' is mediated through independent firms or within government systems. Based on this, another fundamental concept underpinning this paper is that while insurance as a *function* is an objective of health systems, insurance as any *specific set of institutional arrangements* is not.

The last sentence suggests that though the public policy objective is proposed to be universally applicable, there is no 'blueprint' for how to achieve this objective. The means by which countries can make progress towards this objective should differ, given differences in a number of contextual factors. Specific country strategies should be adapted to the local economic, cultural and political context as well as the 'starting point' of the existing institutions and resource allocation mechanisms for health care. It is proposed, however, that health policy makers use their public policy objectives as evaluation criteria. Since the objective is to move towards universal population coverage with effective risk protection at the least cost possible, specific policies can be assessed according to the extent, efficiency and equity with which they enhance this insurance function.

The recent global 'epidemic' of health sector reforms frequently appears to confuse the policy tools meant to achieve a broad system objective with the objective itself. This confusion between the *ends* (objectives) and *means* (reforms) of policy is reflected, for example, by measurement of reforms involving privatization or expanded user fees according to the number of assets divested to the private sector or the rate of cost-recovery, rather than the effects of these changes on measures of the efficiency and equity of the health care system. This has certainly been the case with many reforms involving health insurance, where the focus has usually been on establishing or refining insurance *schemes*, while the effects of these on the efficiency and equity of the *overall system* are either assumed or neglected entirely. The simple point emphasized in this paper is the importance of distinguishing between ends and means in health policy in general, and in health insurance in particular.

Scope and structure of the paper

Health insurance is concerned with access to health care and financial protection against the risk of incurring very high expenditures for such care. Thus, the scope of the paper is limited to personal health care services (services provided to individuals), rather than 'health' more broadly. Thus, many important 'classic' public good interventions in health (e.g. disease vector control, anti-pollution measures) and non-health sector interventions that have positive health effects (e.g. women's education) are not addressed in the paper. It is important to note that personal health services do include many preventive interventions (e.g. immunizations) and curative interventions with externalities (e.g. treatment of tuberculosis). The focus is, therefore, on financing and resource allocation arrangements with respect to health care services that are delivered to individual clients.[1]

Given the public policy objective with respect to universal health care risk protection described above, the purpose of this paper is to provide a conceptual framework to assist countries to design policies to deepen and broaden the insurance function in an efficient manner. The section following this introduction to the paper examines "traditional" definitions of insurance and health financing and suggests why these are no longer very useful. This is followed by a presentation of the proposed conceptual framework as a tool for thinking about the insurance function in a comprehensive national context. The framework includes three main elements: (1) sources of funds, allocation of funds and associated institutional arrangements for health care; (2) broad health system support functions; and (3) the benefit package. The discussion includes an identification of key policy questions arising from different elements of the framework, as well as suggestions for the kinds of analyses that are needed. The section following this presents a country-based example of how the framework can be used as a tool for comprehensive assessment and policy development with regard to the insurance function. The paper concludes by highlighting some key messages and priority issues for countries to consider, based both on theoretical analysis and country experiences. Some recommendations are also made for further policy and analytic research.

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[1] This should be interpreted with some flexibility, however. For example, it is conceivable that health promotion interventions targeted at groups rather than individuals would be appropriate for consideration in the framework presented in the paper.

Traditional Definitions of Insurance Systems

Box 1

National Health System (general tax-funded)

Social Health Insurance (compulsory)

n Social Health Insurance fund(s)

n Employer mandate

Voluntary (private) Insurance

n private commercial

n private not-for-profit

n employer self-insurance schemes

n voluntary participation in publicly managed or social insurance schemes

n community pre-payment schemes

Health systems have been frequently described by their source of funding (Box 1). Systems described as tax-based were presumed to rely on public provision as well as finance, with providers paid through budget allocations in a relatively inflexible manner. The specific services to be provided by the system to which the population was entitled (i.e. the benefit package) were usually specified imprecisely, if at all. "Social health insurance systems" implied the existence of an identifiable fund (or several non-competing funds) which was used to both pool collections from employers and employees and to pay providers for services rendered to the insured population. Benefits were usually specified to a greater extent than in tax-funded systems. "Private insurance systems" were considered to be based on voluntary contributions made by or on behalf of individuals to one of many competing insurance funds, and covered persons were entitled to a clearly specified package of benefits. Recent experience with health sector reforms in a number of countries suggests that these 'source-based' definitions are inadequate for describing entire systems of finance and resource allocation.

Several countries have introduced significant reforms without changing their main source of funding. In Finland, for example, general tax funding has remained as the main source of funds, but in 1993 the basis for allocating public funds to each local government (municipality) for health care changed from a cost reimbursement basis to a prospective

needs-weighted capitation formula in the hope of improving efficiency (WHO 1996). In Sweden, which also has a general tax-funded health system, reforms in the way that some local governments (county councils) purchase health services for the population have involved the use of patient choice as a basis for paying providers (Saltman 1994). In Germany, where health care is funded primarily by compulsory contributions to social insurance funds ("sickness funds"), recent reforms have expanded competition between these funds by increasing people's right to choose the sickness fund with which to enroll (Chinitz, Preker and Wasem 1998).

A mix of systems is emerging as countries, especially in Western Europe but also elsewhere, recognize that the source of funds need not determine the institutional composition of the sector, the mechanisms by which resources are allocated, nor the precision with which entitlement to benefits is specified. These reform experiences suggest that terms like "tax-funded systems" or "social insurance systems" are no longer adequate descriptors of systems, and that *traditional thinking* about health insurance imposes unnecessary limits on the range of policy choices open to countries. A way to conceptualize the disaggregated components of health financing sources, resource allocation mechanisms and associated institutional arrangements is needed so that systems can be described and reform options identified and assessed in a more comprehensive manner.

A Proposed Conceptual Framework

Given the need described above, the conceptual framework[2] shown in Table 1 is proposed as a tool for *descriptive analysis of the existing situation* in country health systems with respect to the insurance function, and equally as a tool to assist the identification and assessment of policy options.

[2] The proposed framework has roots in previous work, developed independently and at different points in time, by Barnum (1993) and Saltman (1994; 1995).

<table>
<tr><th>FINANCE SOURCES</th><th>ALLOCATION TO PURCHASERS</th><th>ALLOCATING INSTITUTIONS (PURCHASERS,INSURERS)</th><th>ALLOCATION TO PROVIDERS (PROVIDER PAYMENT)</th><th>SERVICES & PROVIDERS</th></tr>
<tr><td>General revenues/MOH

Employers & employees

Individuals & households

Donor agencies</td><td>Historically-based patterns

Weighted per capita formula (risk adjustment)

Fixed percent of salary or income

Risk-rated or community-rated premium payments</td><td>MOH local arm, local government, or ‘Area Health Boards’

Compulsory insurance fund(s)

Private insurance funds

Fundholding providers</td><td>Prepayment (e.g. budgets, capitation)

Reimbursement (e.g. fee-for-service)

Mixed systems</td><td>Public, NGO, & for-profit providers of services (e.g. hospitals, clinics, pharmacies)</td></tr>
<tr><td colspan="5">HEALTH SYSTEM SUPPORT</td></tr>
<tr><td colspan="5">Pharmaceutical procurement, distribution, and management
Technology assessment and physical assets management
Regulation and the definition of standards</td></tr>
<tr><td colspan="5">BENEFIT PACKAGE (COVERED SERVICES & METHODS OF ACCESS)</td></tr>
<tr><td colspan="5">“Essential package”
Catastrophic costs
Amenity services
Access rules
Role of patient cost sharing</td></tr>
</table>

Table 1: Proposed conceptual framework

The table summarizes three aspects of health systems that have critical implications for the insurance function:

- institutional features and resource allocation mechanisms of health care systems,
- health system support functions, and
- the benefit package provided by national health systems or sub-systems ("schemes").

Below each of the headings of the columns (and the broad headings of health system support and benefit package) are examples of the kinds of options or arrangements that are possible. These are illustrative; they are not proposed as defining exhaustive lists of the options available. The five columns across the top of the table represent the main institutional arrangements (3 shaded columns) and resource allocation mechanisms (2 unshaded columns) in the sector. The institutional arrangements relate to the sources of funds for health care, the accumulation and use of funds to purchase services from health care providers, and the structure of health care provision. The mechanisms for resource allocation deal with the allocation of funds from their original sources to the purchasing institution, and with provider payment (i.e. the allocation of funds from the purchaser to the provider). While these five elements can be used to describe the flow of funds and resource allocation arrangements in a health system, other aspects of health systems can affect how well effective health care risk protection can be provided to the entire population. Key among these are the (explicit or implicit) benefit package and related policies on user fees/cost sharing, and systems support measures such as those to improve the efficiency and effectiveness of the pharmaceutical subsector, those to establish and raise standards of care in the health sector, policies with respect to the acquisition of expensive medical technologies, and measures to change and strengthen the regulatory environment and capacities of government. Even though these areas are not traditionally thought of as part of health insurance, they are important, not only in their own right but also because they have the potential to enhance (or curtail) the overall insurance function by their effects on health system quality and efficiency.

The contents of the table suggest that there are a variety of options available with respect to institutional arrangements, resource allocation mechanisms, and the health services to which the population (or subgroups of the population) is entitled without out-of-pocket payment. While certain combinations of each of these options are commonly found

together, in most cases *there is no necessary causal link* between decisions with respect to the options chosen for one feature and the options chosen for another. For example, creating a scheme wherein employers are a source of funds does not necessarily mean that a "social health insurance" fund or funds must be created or that providers are paid through reimbursement or capitation. By focusing on the *ends* of health and public policy, governments can be open to various options as to the mix of *means* of financing sources and resource allocation mechanisms and institutions that might best achieve this. By not confusing ends and means, new approaches may well break the confines of standard notions of health insurance.

The rest of this section contains a description of each element of the framework, indicating the ways in which each is relevant to the values embodied in the objective of universal insurance coverage. In addition, important lessons from country experience are highlighted where relevant, as are the kinds of analyses that are likely to be important for each element of the framework. The framework can thus help to clarify the policy levers that are available to governments to broaden and deepen the insurance function as efficiently as possible.

Sources of funds

Very often, reform is motivated by a perception that the level of resources in the sector is insufficient to meet coverage and quality objectives. Thus, attention is often focused on "insurance" as a source of funds, by introducing or expanding the use of earmarked taxes as part of a program of social health insurance. This is notably the case in a number of countries in Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS) (Saltman and Figueras 1997). The key policy questions that governments need to consider with respect to the source of funds for health care are:

- To what extent is the failure to achieve universal health care risk protection a result of inadequate levels of funding for health care?
- What is the scope for diversifying funding sources or increasing funding from existing sources, and what are the potential consequences of either of these choices?

The first question cannot be addressed directly without first examining the overall efficiency and equity of resource use within the health care sector, which relates to the

issues considered in the rest of the framework. It is important to raise this question initially, however, in order to avoid what is often a misplaced emphasis on the level of resources without sufficient attention being paid to the efficiency with which current levels of resources are being used. As noted by Schieber and Maeda (1997), there is a social cost associated with the mobilization of additional resources for health. In addition, as Ensor (1997) points out, a number of circumstances constrain the ability of systems to expand the contribution base for health care, especially those related to macroeconomic and labor market conditions. Thus, it is essential to recognize that the *factors affecting the level of funding for health care are largely outside the control of health sector decision makers.* If macroeconomic conditions are favourable, there may be scope for new types of resource mobilization schemes. If the economy is in recession and the level and growth of the proportion of the population in formal sector employment are low, it is difficult and potentially harmful to impose or increase 'social insurance' taxes for health care. In either case, before investing too much energy seeking ways to raise more funds, health sector policy makers should seek to ensure that the means that are within their control for improving the equity and efficiency of the system are explored fully.

Box 2

General government (including donor) revenues allotted to the Ministry of Health

Earmarked taxes for health care

Compulsory contributions to an insurance fund by employers and employees

Voluntary contributions to an insurance fund, by employers and/or individuals

When considering changes in the level of funding or the mix of funding sources, it is useful to begin by describing the existing situation (Box 2). The typical categories used to describe sources of funds for the health sector (e.g. Van Doorslaer and Wagstaff 1993) are general tax revenues, compulsory contributions related to wages (usually from the formal or "organized" sector of the economy), and voluntary contributions by individuals and households (either to insurance funds or as direct out-of-pocket payment to providers). In most countries, at least two of these sources are significant, and it is useful to determine the level of contributions from each source. A National Health Accounts study can be conducted for this purpose (Berman 1996). For some developing countries,

it helps to include donors as a source of funding, although for considering changes in financing policy it often makes sense to consider donor funds as a part of general revenue funding.

In their analysis of equity in the financing of health care in 10 OECD countries, Van Doorslaer and Wagstaff (1993) found that, overall, general taxation was the most progressive form of revenue raising (i.e. contributions by individuals were most closely related to their incomes), followed by compulsory contributions (social insurance), and voluntary contributions to private insurance funds, with out-of-pocket payment by individuals as the most regressive modality. However, the conditions in the 10 countries studied that led to these findings may not be the same in other countries, especially those which are middle or low income. For example, if non-progressive taxes are the source of a substantial percentage of general revenues, then a reliance on general tax revenues as the main source of health care funding may not be the most progressive choice for a particular country. The relative progressivity or regressivity of relying on various funding sources has to do with the mechanisms used for collecting and allocating them to intermediary institutions (therefore, the next subsection addresses these issues as well). The reasons why compulsory contributions tended to be less progressive than general tax funding (apart from the existence of a progressive income tax and a proportional compulsory contribution rate) was the existence of individual contribution ceilings.[3] If ceilings can be eliminated (a politically challenging task), this source of regressivity in social insurance taxation can be eliminated. Private insurance tended to be even more regressive, because contributions tend to be defined either as flat rates (community rating), with the same level of premium for everyone, or with premiums related to individual risk.

There are other issues for government to consider as part of an attempt to increase revenues through the introduction or expansion of compulsory or voluntary insurance schemes. In particular, when people make an explicit contribution to an insurance scheme, this determines a benefit to which the contributor is entitled.[4] This is a potential

[3] A contribution ceiling is a defined maximum amount of contribution per person. Thus, if the contribution rate is set at 5% of salary, with a ceiling of $500, persons earning more than $10,000 will contribute less than 5% of their salary, making the contribution structure regressive.

[4] This is an important exception to the general statement that there is no necessary causal link between

constraint on equity because those who are able to contribute will receive better benefits than the rest of the population. It is not really feasible to sever completely the link between a defined contribution and a defined benefit, because this would undermine any incentive to contribute (in a voluntary model) and induce resistance by the contributors in a compulsory system. Thus, where entitlement depends on insurance contributions (rather than citizenship, for example), it is difficult to achieve universal coverage unless government is able to fund the 'premiums' of non-contributors from general revenues (Ensor 1993). This is especially problematic in countries where a large percentage of families have no one working in the formal sector of the economy. Where most are contributing and where there is a broad social consensus on the need for universal coverage, there may not be a lot of resistance to provisions made to include the poorest in the system (as in many OECD countries, for example). However, where a contributory scheme would include a minority (though still significant) of families, it is very difficult to offer the same benefit to non-contributors, as this would dilute the willingness of workers and employers to contribute. In this context, the challenge is to ensure that there is a benefit package to which all are entitled, while contributors are entitled to a bit more (e.g. amenity services such as private rooms for inpatient care).

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the different elements of the framework. In this case, it is not really feasible for there to be no link between the source of funds (compulsory or voluntary contributions to an insurance scheme) and the benefit package (the services covered by the scheme).

Allocation from sources to allocating institutions

Box 3

General Revenues

- n historical patterns related to infrastructure or utilization
- n 'needs-based' weighted capitation formula
- n premium payment for participation of otherwise uninsured
- n allocation first to local government, and then to health care providers or purchasers

Earmarked/Compulsory Revenues

- n percent of salary or income
- n risk-adjustment before allocation to insurers

Voluntary Contributions

- n experience-rated or community-rated premium payments
- n risk-adjustment before allocation to insurers

There are a number of different ways that financial resources can flow from their original sources to the institutions that will allocate these resources to providers, and there are also a number of allocation mechanisms that can be used as the basis for these transfers (Box 3). In many countries, the allocation process from sources to allocating institutions involves multiple stages, and additional mechanisms and institutions. The key policy implications and questions inherent in different choices with respect to the flow of funds and allocation mechanisms used primarily relate to the objective of equity.

For public budget funds that have been allocated to a Ministry of Health[5] or that have been allocated to local governments and from there to the 'local MOH', the framework helps to identify questions and issues with respect to the way these funds flow to

[5] The framework does not address, specifically, the process by which general public revenues are allocated to the health sector. In other words, this analysis of allocation mechanisms does not address how a Ministry of Finance determines the size of the budget for a Ministry of Health. Such an analysis may be relevant to the insurance function in some countries, but this political process is likely to be too country-specific to be addressed in a generic framework such as this.

intermediary allocating institutions (or directly to provider institutions). Understanding these flows requires first that the 'endpoints' (i.e. the source and the allocating institution(s) or service providers) be identified clearly. A first step with budget funds, therefore, is to determine if there is any allocating institution at all, or if budgets are allocated directly from the MOH to service providers. The next step is to describe the allocation mechanism used to determine the size of the budget allocation to each allocating institution or service provider. Thus, for example, if the central MOH allocates funds to a decentralized arm of the MOH (e.g. a provincial or district health administration), the relative size of this allocation may be determined according to a number of criteria. These might include:

- historical patterns of allocation (e.g. last year's allocation, plus or minus some percentage), often determined by the extent of the health care infrastructure or utilization patterns in each region; or
- the relative size of the population for which the allocating institution will be responsible, perhaps weighted by various indicators of need or cost ("weighted capitation").

In an attempt to improve equity in the receipt of public subsidies for health, some countries have implemented reforms that involve shifting towards the second of these options, that is, moving from historical infrastructure or utilization-based allocation to an allocation based more on the health care needs of the population. Countries that have implemented population-based formula for the allocation of budget funds to allocating institutions include the United Kingdom (OCED 1992) and, more recently, the Philippines (Perez, Alfiler and Victoriano 1995).

Changes in the mechanisms used to allocate funds from compulsory insurance contributions to insurers, involving several stages, can be found as aspects of reforms to improve equity in some countries that have multiple insurance funds as part of their social health insurance systems. In Germany and Korea, for example, the main source of funds for health care is the mandatory contribution to health insurance funds made by employers and employees. While the different funds are required to offer the same benefit packages and use the same methods for provider payment, they set their own premium rates. Because there are systematic differences in the health care needs of people covered by different insurance funds, the fact that some funds charge higher

premiums than others is related to the populations they cover rather than to the funds' administrative efficiency. Inequities have arisen because poorer and older people tend to have greater health care needs and often end up having to pay higher premiums. To address these inequities, both countries are making use of *risk adjustment* to reallocate premium revenues across insurance funds. In Korea, a risk adjustment fund serves as a kind of re-insurance mechanism funded by the different insurance societies. It reallocates some premium payments to societies with higher percentages of elderly members (Lee 1995). In Germany, the risk adjustment formula includes the income, age, sex, and invalidity pension status of the insured population. The introduction of this formula in 1994 led to a notable decrease in the contribution rates of some funds which previously served relatively high risk populations (Chinitz, Preker and Wasem 1998). In both cases, risk adjusting the premium payments involves an additional institutional arrangement and allocation mechanism in the process of transferring resources from sources to allocating institutions.

It is interesting to note that a needs-weighted population-based allocation formula for budget funds and a risk adjustment formula for compulsory or voluntary insurance contributions are conceptually similar. The purpose of each is to ensure that the allocating institution has the 'right' level of funds to finance the defined benefit package for its 'risk pool'. Risk adjustment of contributions to insurance funds serves the further purpose (not needed with general revenue financing) of trying to improve equity in the finance of care by reducing the scope for relating contributions to the expected health care risk of the contributors.

The allocation mechanism used for voluntary contributions to insurance funds can be set as a fixed percentage of income/salary, as a fixed flat rate for everyone living in a defined geographic area ("community rating"), or in direct relation to the expected health care costs of each insured person or group ("tiered rating"). In their analysis of the dynamics of private health insurance markets, Chollet and Lewis (1997) note that all systems of voluntary purchase of insurance suffer from the problem of *adverse selection*. Because individuals have better knowledge of their own health status and potential need for health care than insurers, and because those who expect to use health services are more likely to seek insurance, persons who seek to purchase health insurance voluntarily tend to be costlier to insure than the average person in the population. Consequently, private insurers have developed techniques to limit adverse selection or its financial effects.

These measures include underwriting,[6] tiered rating, durational rating,[7] limiting coverage to members of groups formed for reasons other than to buy insurance coverage, excluding pre-existing conditions from coverage, excluding certain high-cost services from coverage, and patient cost sharing. They have one thing in common: *in an attempt to ensure the financial viability of a particular insurance scheme, they detract from the depth and breadth of the insurance function for the population as a whole.*

The enforcement of a clear set of regulations on the insurance industry is necessary to promote universal coverage in countries that rely on competing insurers as their allocating institutions for health care. Types of measures that need to be enforced include restricting the practice of underwriting, restricting the right of insurers to set premiums on the basis of health status, and requiring all insurance plans to cover a defined basic benefit package. Enforcing such a package of regulations effectively is difficult for any country, and, as noted by Chollet and Lewis (1997), many middle income countries (e.g. Argentina, Brazil, South Africa, Turkey) have done a poor job of regulating the private health insurance industry in the public interest. This suggests that it is very difficult to make efficient progress towards the goal of universal coverage relying solely on a competitive insurance market.

Allocating institutions (insurers)

Allocating institutions (Box 4) are responsible for accumulating funds from their original sources and paying providers of health care on behalf of the population for which the allocating institution is responsible. In other words, allocating institutions are the *insurers* for a defined population. They are also often called *payers* or *purchasers*. As such, the role that these institutions play in the health care system has important implications for the coverage and efficiency of the insurance function of health systems. Thus, there are two critical broad policy questions that need to be addressed with respect to allocating institutions for health care:

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[6] This is described as "the practice of evaluating individual health status and either rejecting potential buyers who are deemed to pose exceedingly high risk or placing them in plans with other people who represent approximately the same risk" (Chollet and Lewis 1997, p.82).

[7] Charging more for renewal of the insurance contract than the initial enrollment premium (Chollet and Lewis 1997).

Box 4

Decentralized Parts of MOH (e.g. district or provincial health departments)
Local Government Health Authority
Area (e.g. district or provincial) Health Boards
Social Health Insurance Fund(s)
Voluntary Insurance Funds
Fundholding Providers

- What is the role of this (these) insurer(s) with respect to the providers of care? Do they serve merely as a financial conduit, channelling funds to providers with no questions asked, or do they take an active role in using their financial power to promote improved quality and efficiency in the delivery of health care?
- What is the market structure of allocating institutions? Is there a single payer covering the population in a defined geographic area? Are there multiple insurers, and if so, do they compete for 'market share', or are persons assigned to them in a non-competitive system? Does the publicly funded health system actually have an identifiable purchasing function, or are funds simply transferred directly to providers?
-

Role of the insurer

In many countries, the focus of reform could usefully be put on the actual functions carried out by the allocating institution(s). Evidence from both developing (Kutzin and Barnum 1992) and industrialized countries (Saltman and Figueras 1997) indicates that, largely as a result of information asymmetries that give providers powerful influence over consumer demand for health care, incentives and regulations oriented towards the supply side of the market (e.g. provider payment methods, utilization review) are far more powerful policy tools than those oriented solely towards the demand side (e.g. user charges). Thus, perhaps the most important factor in the efficiency of health care systems is the extent to which the allocating institution(s) actively uses its financial power

to encourage providers to act in the interests of efficiency and quality. To the extent that the insurer is simply a financial intermediary, pooling revenues and paying providers without meaningful conditions on the actions of the providers, the result is invariably provider-led cost escalation, often accompanied by potentially harmful expansion of unnecessary service delivery. What is needed is for allocating institutions to use their financial power to promote efficient and high quality service delivery. This type of change is suggested by the phrase, "moving from passive financing to active purchasing."

'Active purchasing' by allocating institutions can take several forms but essentially means purchasing services in a way that promotes the objectives of quality and efficiency. The creation of an active purchaser in the context of a rapidly expanding private provider sector may be more effective in promoting public policy objectives than simply relying on government's traditional regulatory tools, if the purchaser has sufficient financial power and exercises this effectively. The following are some of the kinds of actions that insurers can undertake with these objectives in mind (Kane 1995), and these provide a useful 'checklist' for characterizing the 'active-ness' of allocating institutions in a health system:

- provide targeted *financial incentives*, through the use of provider payment methods aimed at achieving specific efficiency or quality objectives (these are discussed in more detail in the subsection on provider payment);
- require that non-emergency specialty services are available only on the recommendation of a primary care *gatekeeper*, and back up this requirement with (on the demand side) strong financial penalties for self-referral, and/or (on the supply side) financial incentives to the gatekeeper;
- maintain *provider profiles* for monitoring provider (usually physician) treatment, referral and prescribing practices and costs, using this information to provide feedback to providers and impose sanctions if necessary;
- *selectively contract* with providers (in contexts in which the provider market is competitive), requiring them to cooperate with certain utilization controls and provide services for a discounted price or fee schedule, in return for an expected high volume of patients;
- undertake *utilization review* (UR) and *quality assurance* (QA) activities in order to reduce

inappropriate care and improve quality by reviewing, and, if necessary, intervening in the medical decision-making process; and

- as part of the UR and QA activities, promote the use of *standard treatment protocols* to compare the practices of contracted providers with defined clinical standards, such as adherence to national essential drug lists and prescribing protocols.

It is worth noting that the above features are described by Kane (1995) as "elements of managed care". However, there is no reason why these managerial functions need to be limited to a particular form of health insurance institution, or to a "market-oriented" health system. Indeed, many of these features, such as the use of primary care gatekeepers, have existed in European health systems for many years before the rhetoric of "managed care" became popularized in the United States. A summary of these features as they existed in the early 1990s in selected West European countries is presented in Annex 1.

Market structure

The above discussion suggests that there is a public policy interest in creating conditions to facilitate active purchasing. An understanding of the existing market structure of allocating institutions is therefore critical for informing the kinds of measures that governments can take to promote this function. Conceptually, the conditions for active purchasing are best if there is a single allocating institution (a "single payer system"[8]) that is a public body. In this case, there is no need to devise a set of incentives or regulations to encourage active purchasing; the publicly owned 'fund' can simply be directed to implement certain reforms as part of government policy. The main constraint on implementing this is that in many publicly funded systems, there is no purchasing institution: MOH budgets are simply allocated to MOH providers. While it is theoretically possible to insure the population in this way, market failures in health care suggest that even if budgetary resources for health are ample, resource use will not be very efficient. Thus, some countries, including low income countries such as Kyrgyzstan and Zambia, have recently introduced reforms to create regional institutions responsible for purchasing services from providers (a "purchaser-provider split") with general revenue funding on behalf of their populations.

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[8] A 'single payer system' implies that there is a single allocating institution responsible for purchasing services from providers on behalf of the entire population living in a defined geographic area. It does not necessarily imply a single 'fund' serving the entire population of a country; in Canada, for

Country experience and certain elements of market failures in the health sector suggest a number of reasons why the market structure of insurers is important. There are theoretical advantages to a single payer system (either a public institution or a tightly regulated but independent 'quasi-public' agency, such as a social insurance fund serving the population living in a defined geographic area) because a monopoly purchaser (monopsonist) of services on behalf of the population has great potential to use its financial power to ensure that service delivery occurs in line with the objectives of efficiency and high quality. A single payer can offer a coherent set of incentives to providers, whereas the existence of multiple institutions that pay the same providers often results in diluted incentives and strategic cost shifting behavior by providers, as in the United States and Thailand, for example. In addition, the need to monitor and regulate the actions of multiple insurers means that the administrative costs of the *system* will be high, even if some individual insurers are efficiently run. In many countries, however, multiple (often private) insurance funds exist, and the appropriate and realistic role for governments in this context is to improve its regulatory framework and ability, rather than to try and dismantle the insurance industry (Chollet and Lewis 1997). Thus, the issue for any country is not about the theoretically best method of organization (whether that is with a single payer or otherwise), but rather, given the existing market structure of allocating institutions in a country, what is the appropriate direction for policy changes that will facilitate active purchasing in the public interest.

Some countries have systems characterised largely by multiple but noncompeting insurance funds. For example, Thailand has five different statutory health insurance schemes, most of which cover a well-defined population group (i.e. civil servants, formal sector workers, elderly, poor, children, etc.) and one of which is a voluntary scheme (the Health Card Scheme). These have different contribution structures, benefit packages, and provider payment methods (Nitayarumphong 1995). In the Republic of Korea, national health insurance has been administered by 413 (as at the end of 1994) independent and non-competing insurance societies. While premiums vary across the different societies, there is a standard benefit package and a common method of provider payment (Lee 1995). In contexts such as in Thailand, the appropriate direction for policy change to enhance efficiency may be to coordinate benefit packages and provider payment methods across the different statutory schemes (in the Thai reform process, this

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example, there is a single payer established in each of the country's provinces.

is referred to as "merging funds"), essentially moving in the direction of a single payer (or at least, a reduced number of payers). In contexts such as in Korea, there are two broad directions for policy to improve efficiency in the insurance function. The first would maintain a non-competing multiple payer system and seek to identify an optimal scale for each insurance society in order to reduce system-wide administrative costs. In the Korean case, this would mean a reduction in the number of insurance societies and an increase in the average number of insured persons per insurance society. The other alternative would be to move towards competition among the insurance societies by giving individuals the right to choose their insurer. This type of reform was introduced in Germany in 1996 (Chinitz, Preker and Wasem 1998). It must be noted, however, that the introduction of choice into this kind of system requires substantial government capacity to regulate effectively in order to prevent an erosion of solidarity and system-wide efficiency, given the problems (noted in the previous subsection) of adverse selection and the actions that competing insurers take in response to this. The challenge is to get insurers to compete on the basis of the quality and cost of the services that they offer, rather than to compete by attempting to register young, healthy people who are likely to be less expensive to insure. Establishing the appropriate framework for this "managed competition" among insurance funds has proven elusive, even for the few developed countries that have attempted to do so. For example, the Netherlands has spent about 10 years trying to put in place a system of regulations needed to maintain equity in financing and promote efficiency through competing insurers, but the challenges have proven so great that they have not been willing to implement the reforms that they have been planning since 1987 (Chinitz, Preker and Wasem 1998; Saltman 1995).

Allocation from insurers to providers (provider payment)

Box 5

Prospective

n Line item or global budgets, according to various criteria

n Capitation, according to patient choice or size of defined catchment area

Retrospective

n Patient choice or negotiated contracts

n Fee-for-service, with/without fee schedule

n Case-based ('bundled')

Mixed Payment Systems

As noted above, one of the most important ways that insurers can affect provider behavior is through the incentives generated by specific methods of provider payment (Box 5), and payment reforms have been implemented in many countries in an attempt to achieve progress towards the objectives of efficiency and quality. Typically, two broad categories of provider payment are recognized (Barnum, Kutzin and Saxenian 1995):

- prospective (i.e. payment in advance of service delivery), including budgets (line item and global) and capitation; and
- retrospective (i.e. payment after service delivery), including fee-for-service[9] or case-based reimbursement.

Within these broad categories there is considerable room for variation. In a capitation-based system of provider payment, for example, there are several different ways that the amount of funds going to a provider can be determined. The "steering

[9] Direct out-of-pocket payment by users at the time of service provision is a form of fee-for-service provider payment, though its source is an individual, not an allocating institution. This source of payment is significant in many countries, and an analysis of provider payment methods should account for how formal and informal cost sharing by users affects the overall mix of methods and incentives. In this framework, however, patient cost sharing is discussed in the subsection dealing with the benefit package.

mechanism" for the payment may be consumer choice, whereby consumers decide with which provider they will enrol, and the funding from the allocating institution follows that choice. Alternatively, the capitation payment could be simply assigned to providers according to the size of the population in its catchment area. In this case, capitation is virtually indistinguishable from a population-based budget allocation. Or, as was initially the case with Thailand's Social Security health insurance scheme, the enrolment choice was made by employers on behalf of their employees, and this steered the flow of funds to providers on the basis of capitation. Saltman (1995) notes also that a contract can be negotiated between insurers and providers that specifies the provider payment method; this implies that a managerial decision is the steering mechanism for the provider payment method. In fact, most countries use mixed methods of provider payment, often with the explicit intention of countering some of the adverse incentives of "pure" systems of provider payment (Barnum, Kutzin and Saxenian 1995).

There is no right method of provider payment, although international experience and a conceptual understanding of market failures in the health sector suggest that unmanaged fee-for-service reimbursement is a wrong method because it induces provider-led cost escalation. All methods create incentives that have potential benefits and costs to the system in terms of efficiency, quality of care, and equity. These are summarized in Annex 2, which also includes a description of measures that an active purchaser can use to mitigate some of the negative incentives. Moreover, the appropriateness of any method of provider payment cannot be divorced from the market context of service providers and allocating institutions. With this is mind, the key policy question to address with respect to provider payment is:

- What *mix* of payment methods will be most likely to lead to progress in improving the efficiency and quality of health care delivery, in the existing market context of service provision and allocating institutions? To what extent will the benefits of various options be limited by the administrative capacity of the system, or what kinds of administrative systems and skills need to be developed?

Service providers

As with allocating institutions, understanding the market structure of service provision (Box 6) is essential for designing appropriate reforms to encourage efficiency and strengthen the insurance function. The distribution of providers is also critical for the attainment of universal health care risk protection, since people living in underserved areas cannot be said to be effectively insured. Important policy questions with respect to the insurance function are:

Box 6

> Primary (First Contact) Care, Secondary and Tertiary Care Providers, Pharmacies, etc.
>
> n Government-owned providers
>
> n Insurer-owned providers
>
> n Independent providers contracted by system
>
> n Independent providers, without contracts
>
> n Individual practitioners, single-specialty group practices, and multi-specialty groups

- Are there different providers for each different allocating institution (insurance subsystem)? To what extent is the structure of service provision competitive or monopolistic? How does this vary in different markets within the country (e.g. urban and rural), and for different kinds of services (e.g. primary care, inpatient care, drugs, etc.)?
- How does the market structure interact with the basic demand characteristics (consumer- or provider-driven) for different kinds of services?
- What is the distribution of service providers? Are there parts of the country that have no effective access to health care? Are there particular population groups (e.g. those who are not members of a statutory insurance scheme) with very limited access to health care?

Market structure

Understanding the market structure of health care service provision is essential for developing appropriate and comprehensive reforms to enhance the insurance function. Thus it is useful to describe, for the health system as a whole or for each insurance subsystem (scheme), whether each allocating institution (if there are more than one) has its own providers in an exclusive relationship, or if the same providers can receive payment (and patients) from different insurers. Do insurers own providing institutions (i.e. are they managed by the same organization), and do these serve only members of the

scheme? For example, does the social health insurance scheme have its own hospitals that serve only its own beneficiaries? Alternatively, do allocating institutions contract with independent providers? Are publicly owned facilities organized by level of government, so that, for example, provincial hospitals are funded through provincial governments and district hospitals and health centres are funded through district governments? Answers to these questions will give an indication of the extent to which different allocating institutions have their own health systems, and also of the nature of the relationship between payers and providers in various geographical markets (e.g. multi-payer multi-provider, multi-payer single-provider, single-payer multi-provider, single-payer single-provider).

Based on analysis of the existing market structure, the appropriateness of market vs. planning approaches to reform should not be an ideological decision but rather one based on an assessment of the specific mix of approaches that is most likely to yield improvements in efficiency, quality and equity. In general, the supply of primary curative care services will be more competitive than referral and specialized care. Where there is a relatively large number of primary care providers (GPs, for example) in a relatively small geographical area, it may be appropriate to use consumer choice of GP as the basis for allocating budgets to providers. In non-competitive markets for particular services, consumer choice is unlikely to be a useful mechanism for steering provider payments because no real choice exists. The analysis of the market structure of service provision may also suggest opportunities for system-wide efficiency gains by moving from an organization of provision based on schemes to a more population-based system.

Demand characteristics of different kinds of services

It is important to recognize that health care contains a mix of services with different economic characteristics (Preker and Feachem 1995). Some personal services provide health benefits that accrue solely (or largely) to the individual receiving them (purely private goods, such as aspirin for a headache or setting a broken bone), while others have broader benefits (mixed goods, such as immunizations and communicable disease treatment). It is important to design policies to promote a socially desirable level of provision of mixed goods, with targeted payment incentives (e.g. "bonus" reimbursements for reaching immunization targets) one example of this. However, an important input into the design of appropriate policies has to do not with the distribution of the benefits from particular services but rather with whether the *demand* for the service

is determined primarily by the consumer or is heavily influenced by the provider. In general, the demand for first-contact, primary care services is largely consumer-driven, since the contact with the health care system is motivated by the individual who is seeking care. However, the demand for referral and specialized care is generally (but not always) provider-driven, because the provider's greater knowledge about the nature of illness and the types of treatments available puts him/her in a position to identify the need for specialized or referral services on behalf of the sick person, who rarely has such knowledge. While this "supplier-induced demand" is not always negative (indeed, one of the important functions of primary care providers is to identify the need for referral services), it is the central factor explaining the cost escalating effect of fee-for-service reimbursement, despite the presence of cost sharing (co-payments) in many health systems. This is the basis for suggesting that reforms aimed at changing incentives to providers (e.g. provider payment changes) have a much greater impact on efficiency than do those aimed at consumers (e.g. patient cost sharing), because provider incentives affect both sides (i.e. supply and demand) of the market (Kutzin and Barnum 1992; Kutzin 1998; Saltman and Figueras 1997). These factors need to be considered in the design of policies to encourage efficient, effective and equitable use of resources for specific kinds of health care services.

Distribution of providers

The distribution of providers directly affects access to care and thus the breadth of the insurance function. Insurance cannot be said to be effective if people do not have reasonable physical access to primary care, emergency services, or necessary referral care. This implies that insurance involves more than just financial protection. To be truly protected against the risk of ill health, there must be physical as well as financial access to care. Therefore, analysis of the existing insurance function and proposals for reform must include an assessment of the geographical distribution of providers, irrespective of whether or not individuals happen to be members of an identifiable insurance scheme. In Costa Rica, for example, poorer persons who were ostensibly covered by the social security health insurance system suffered from very long waiting times that limited their access to primary care. The solution to this was not to expand financial protection (which they already had) but to establish 800 basic health teams to provide comprehensive primary care (Salas Chaves 1995). Thus, the insurance function was enhanced by expanding the availability of service delivery.

Health system support

The overall health system functions of regulation and standard setting (e.g. definition of an essential drug list, technology assessment: Box 7) are essential for promoting efficiency in the health sector. Therefore, these functions can also contribute to the depth and breadth of the insurance function. While it is possible for these functions to be implemented by a specific allocating institution, it is best if they are carried out for the population as a whole (e.g. by one insurer or by the MOH on behalf of entire system) so as not to dilute the effectiveness of these functions or limit the benefits to members of particular schemes. If each insurer has its own technology assessment policy and drug formulary, for example, this yields higher than needed administrative costs (from the perspective of the entire system) and induces cost shifting by providers according to the rules of the scheme by which patients are covered. The absence of these functions means that providers are free to obtain whatever equipment or drugs they deem necessary or marketable. The dilution of these functions across several schemes may result, for example, in over-investment (from the perspective of the entire population) in high technology medical equipment. Thus, policy changes designed to shift the implementation of these functions to the system level on behalf of the entire population are an appropriate part of reforms aimed at enhancing the insurance function.

Box 7

Regulation and Standard Setting
n essential drug list
n prescribing and other treatment protocols
n licensing and accreditation of providers
n technology assessment

This paper does not go into detail with respect to specific health system support measures like pharmaceutical policy or technology assessment, for which good reference material exists (for pharmaceutical subsector policies, see Bennett, Quick and Velasquez 1997; for technology assessment, see Banta and Luce 1993). The point made here is that the description of the insurance function in a country should include a description of these functions. This would include an assessment of how well these functions are being performed *and* who (what institution or institutions) is performing them. As mentioned in the previous paragraph, the effectiveness of these functions for the system as a whole is diluted when they are carried out by multiple actors by or on behalf of individual schemes. The effectiveness of these measures in enhancing efficiency in health care depends on the capacity of governments to perform essential regulatory functions (or be able to 'contract in' this capacity).

Benefit package

As suggested by Table 1, the benefit package (Box 8)is much more than a list of services to which the population (or members of an insurance scheme) is entitled. Operationally, it is useful to conceptualize the benefit package as those services, and means of accessing services, that the health system (or scheme subsystem) will pay for. This definition implies that benefit packages can be defined so as to encourage appropriate use of defined referral mechanisms (e.g. by excluding non-emergency primary care services provided in tertiary care facilities). It also means that *services not included in this package can be defined as those for which direct out-of-pocket payment by users is required to fully or partially finance their provision* (i.e. fully or partially uninsured services). This definition is also useful for looking at the financing of the health care system in a comprehensive manner, with fees/cost sharing viewed as a part of the entire financing system rather than just an isolated tool for raising revenues or deterring demand. The composition of the benefit package, including the level of user fees, is directly relevant to the idea of the *depth* of effective insurance protection. Key policy questions with respect to this are:

Box 8

Explicit or Implicit, Detailed or General

"Essential Package" of Clinically Cost-Effective (Mostly Primary Care) Interventions

"Catastrophic" Package of Relatively Low Frequency, High Cost Interventions

Comprehensive Package

Amenity Services (e.g. Private Rooms)

Patient Cost Sharing/User Fees
- levels for covered services
- governed by adherence to referral system?
- subsidized for low income?
- can be covered by supplementary insurance?

- What is the basis for determining entitlement to benefits? Is there a common benefit package for the entire population or a mandated minimum package to which the entire population is entitled and has access? Alternatively, are different allocating institutions completely free to determine their own packages?
- What is the nature of the services covered by the system or scheme(s)? To what extent is the package comprehensive, catastrophic, or based on an assessment of the relative cost-effectiveness of medical care interventions? Where people can make use of more than one benefit package (e.g. entitlement to a publicly financed system

plus membership in a private insurance scheme), how well do the different packages 'fit' to provide efficient insurance protection?

- Is policy on user fees explicitly related to the benefit package? Are fees designed to promote efficiency through appropriate use of the referral system? Are there provisions to enable access for low income persons who would otherwise be deterred from necessary service use as a consequence of fees?

Entitlement to benefits

As noted in the subsection on sources of funds, the way that the health care system (or schemes within the system) is financed sometimes determines the entitlement of the population to benefits (Ensor 1997). In general, in countries that have schemes involving either voluntary or compulsory earmarked contributions to an insurance fund, such contributions by or on behalf of individuals or families determine the entitlement to benefits. Health care systems funded from general tax revenues tend to offer benefits to the entire population (citizenship entitles people to benefits). However, in many middle income and low income countries, such coverage through general tax revenues is only theoretical for parts of the population who lack effective access to services of adequate quality.

There are some exceptions to the contribution-entitlement link described above. In China, the "Government Insurance Scheme" is funded out of general revenues and entitles civil servants and university students to free medical care (WHO 1995). Thus, there is a generous benefit for part of the population that is not linked to any specific contribution. In Costa Rica, it is estimated that contributions are made to the social security health insurance system for about 85% of the population. In the 1980s, the government decided to make social security-funded health services available to the entire population, meaning that about 15% of the population receives the entitlement without a defined contribution (Salas Chaves 1995).

Services in the benefit package

The issue of the benefit package to be guaranteed by health systems has received intense attention since the publication of the *World Development Report 1993* (World Bank 1993), which, among other things, promoted the idea that countries should define and publicly fund an "essential package" of clinical health services based on an analysis of the cost-effectiveness of medical interventions for these services. This recommendation has been

very influential and has also generated considerable debate (e.g. Hammer and Berman 1995; McGreevey et al. 1996; Kutzin 1996). The main concern raised with the recommendation has to do with the implications of allocating public funds on the basis of intervention cost-effectiveness in countries that lack privately-funded health insurance for protection against the risk of high-cost illness. Where no other source of insurance protection exists, targeting public expenditures to the most cost-effective interventions will leave people at financial risk for unanticipated high-cost medical care, thereby ignoring "the insurance function of health policy" (Hammer and Berman 1995, p.38). The validity of the arguments in favor of an "essential package" or a "catastrophic package" cannot be addressed in isolation from the other elements of the insurance function and an understanding of the market structures of insurers and providers. In other words, the effectiveness of policy with respect to the benefit package in deepening or broadening the insurance function of health systems depends critically on other aspects of the health system as reflected in Table 1. For example, without active purchasing to control unnecessary use of specialized care, public funding of a hospital-based "catastrophic package" is likely to lead to excessive and medically unnecessary use of expensive care. Thus, the analysis of the existing benefit package, and options for reform, need to be considered in the light of the comprehensive system of financing, allocation mechanisms, and associated institutional features.

When considering the possibility of implementing new schemes or changing the benefit packages of existing schemes, an assessment should be made of how well such changes will enhance the overall insurance function in the country. For example, if formal sector employees already have good financial access to private sources of primary care financed through direct out-of-pocket payment, setting up a scheme for them covering an "essential package" of cost-effective interventions will do little to expand the insurance function. The creation of a scheme for a relatively well-off part of the population that provides comprehensive protection for both low cost and high cost health care represents a good example of how countries can confuse policy objectives and policy tools. By focusing on getting people into an "insurance scheme", the objective of expanding the insurance function may be lost as policymakers focus on "insuring" that part of the population least in need of insurance. This kind of problem has occurred in many low income countries with relatively small percentages of the population in formal employment (Kutzin 1997). Countries should thus be wary of implementing schemes offering comprehensive or "essential" packages for relatively well-off parts of the

population who can afford to pay for primary curative care, since all they really need to be insured is catastrophic protection. Comprehensive schemes may only be warranted for this part of the population if they include sufficient 'active purchasing' functions to improve efficiency in the health care system.

One interesting model of potentially well-coordinated benefit packages involves combining schemes for individual savings (or very limited community risk pooling) to pay for relatively low cost services with a "backup" insurance arrangement protecting against the cost of financially catastrophic health care. The only country with an explicit combination of savings and insurance schemes with coordinated benefit packages is Singapore (Nichols, Prescott and Phua 1997). While many countries may not wish to pursue the 'Medical Savings Account' approach (combined with backup catastrophic insurance protection) as it exists in Singapore, the concept of combining different arrangements for the population to insure against different kinds of risks may be worth considering. In particular, in contexts (e.g. rural areas of some countries) where there is not great expressed demand for broad-based risk pooling (Creese and Bennett 1997), it may be feasible to combine public budget funding of high cost services with limited community risk sharing or individual savings (e.g. through 'health cards' entitling users to a fixed number of health centre visits) to cover health care costs that are low in absolute terms but still significant for relatively low income persons.

Role of direct payment by patients

The framework suggests that direct payment by patients (i.e. user fees) is conceptually linked to the concept of the benefit package. If a service is "fully covered", there is no requirement for patient payment at the time of use. If a service is "partially covered", then patients have to pay something at the time of use ("cost sharing"), but not the full costs. "Uncovered" services are those which have to be completely financed by the user if they are to be provided at all. With these definitions, it becomes clear that the depth of health care risk protection can be assessed, in large part, by the extent to which people have to pay for care at the time of use. In the Republic of Korea, for example, the National Health Insurance system has (relative to other countries) very high levels of explicit cost sharing for services in the benefit package and also entirely excludes from coverage many high technology services (e.g. CT scans, MRIs, lithotripsy, ultrasonography). Thus, while Korea has made a remarkable achievement in extending the National Health Insurance scheme to the entire population, it must be said that the

protection offered to the population is quite limited (Yang 1995); the insurance in Korea is not very *deep*.

Examining the role of patient cost sharing in health systems and schemes gives insight into whether people are truly protected against very high out-of-pocket expenditures in case of severe illness. Two particular features give an indication of whether catastrophic financial protection is offered: a "benefit maximum" or an "out-of-pocket maximum". A benefit maximum means that there is a defined limit on the amount of health care costs that will be paid by the insurer, leaving individuals at risk for expenditures above this amount. An out-of-pocket maximum, conversely, defines a limit on the total out-of-pocket payments for which individuals are responsible, with the insurer paying all the costs of care over this amount. In virtually all West European countries, there is either no cost sharing or an effective out-of-pocket maximum for inpatient care, meaning that populations are financially protected against the risk of high-cost health care (Kutzin 1998). In many other countries (e.g. Korea), there is either no out-of-pocket maximum or there is a defined benefit maximum, leaving even "covered" persons at risk for a substantial level of out-of-pocket expenditure in case of serious or prolonged illness.

When reviewing the role of user fees in health systems or schemes, therefore, it is important to identify whether these are designed and implemented as part of a coordinated and comprehensive system of financing and targeted incentives, or whether they are simply used as an isolated instrument for raising revenue from users. Used appropriately, cost sharing can be an essential part of the active purchasing function. To support appropriate use of the referral system, many health systems and schemes require that persons first seek at a defined primary care provider. This provider is intended to be a gatekeeper to higher level referral services. This gatekeeper function is strengthened if it is backed by a policy to charge high fees to persons who bypass the gatekeeper (for non-emergency services) and self-refer to high cost services. In such a system, the benefit package can be defined as including referral services if the patient has been referred from the primary care gatekeeper, but excluding higer-level services to which the patient self-referred. This is why the benefit package can be described not only as a list of services, but also as the *means* by which the services are accessed.

Using the Framework: A Country Example

The preceding section identified key issues and policy questions in the various elements of the health care system with implications for the insurance function. While the importance of interaction between different elements of the framework was mentioned, the emphasis was on the issues arising *within* each element. In this section, the use of the framework as a tool for comprehensive analysis of the sector is illustrated by applying it to the health care system of Kyrgyzstan, a 'transitional' Central Asian CIS country of about 4.5 million people. First, an analysis is made of the 'pre-reform' health care system, as it existed shortly after the country's independence in 1991. Then, an analysis of the reformed health care system is presented. For each, the framework is used to 'map' financial flows and institutional arrangements in the sector.[10] This diagrammatic tool is a very useful way to show the interactions between several elements of the framework.

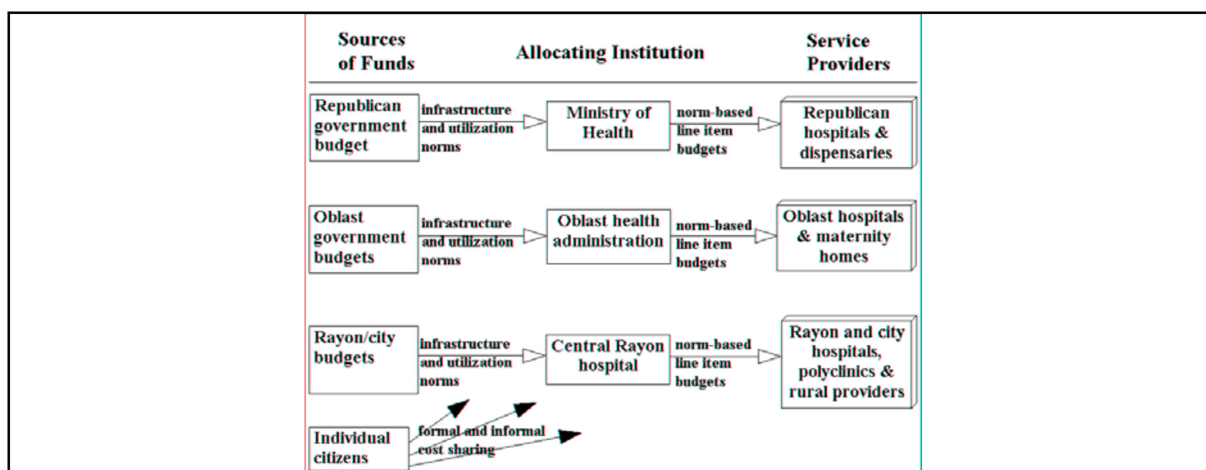
Pre-reform situation

During the first half of the 1990s, health status in Kyrgyzstan was in decline, as reflected by rising infant and crude mortality rates, rates of vaccine-preventable diseases, and other measures. Most of the problems in the health sector were attributed to the deterioration in the overall macroeconomic environment in the country. Indeed, by 1994, real GDP had fallen to about half its 1990 level. However, the health care sector was also plagued by longstanding problems of inefficiency, excess capacity, and outdated protocols for service delivery. Thus, while the rapid decline in the availability of public resources for the health care sector meant severe under-funding of the existing system, it was not clear how much of the problems were a consequence of sectoral inefficiencies, as opposed simply to resource shortfalls.

The flow of funds and institutional arrangements are summarized in Figure 1. The administrative structure of government in Kyrgyzstan has three main levels: Republican (central government), oblast (roughly equivalent to a province or state), and rayon (roughly equivalent to a district). There are also some municipalities (cities) with their own government administrations.

[10] Unless otherwise noted, the information in this section comes from MOH Kyrgyzstan (1996).

Figure 1: The flows of funds and initiational arrangement of grovernment in Kyrgyzstan.



Sources of funds, allocating institutions, and service provision

As noted above, the macroeconomic situation in the country has deteriorated rapidly since 1990. This has led to a dramatic decline in overall government health expenditure, from an estimated US$156 in 1990 to US$37 in 1993 (measured in real 1990 purchasing power parity terms). Household survey data suggest that out-of-pocket spending through formal and informal user fees is increasing but is still less than half of public expenditure.

The figure reflects the fact that service delivery was organized and funded by level of government. Republican budgets funded Republican facilities, oblast budgets funded oblast facilities, and rayon and city budgets funded rayon and city facilities. The "allocating institutions" did not really purchase services; they simply allocated pre-determined budgets to 'their' facilities.

Service delivery suffered from a number of inefficiencies. Overall, there were too many hospitals, and many of these were rather narrowly defined specialty facilities. Kyrgyzstan's 11.8 beds per 1,000 population in 1992 placed it considerably above the average of 8.4 for the countries in WHO's European Region. The fact that each level of government had its 'own' facilities contributed to this excess capacity. The country also was well-endowed with physicians, having an estimated 3.37 per 1,000 population in 1990, again above the European average. Yet there was no effective primary health care system in the country. People's point of first contact with the health care system was the polyclinic, but because virtually all of the country's physicians were trained as specialists,

relatively few patients were successfully diagnosed and treated at the first contact point. Most patients were referred to specialists.

Resource allocation mechanisms

As suggested by Figure 1, budgets for health facilities were determined according to norms related to the size of the infrastructure (e.g. number of beds) and levels of utilization. These were all calculated at the central government level; therefore, as noted above, the "allocating institutions" actually only administered the allocation decisions made at the central level. The basis for determining facility budgets contributed to the inefficiency of the overall system. Because budgets were related to the number of beds, for example, there was no incentive to reduce excess capacity. Indeed, there was an incentive to expand capacity. In effect, the system of financial resource allocation was based on meeting the 'needs' of the infrastructure rather than the health care needs of the population.

Health system support

Medical care practice was based on norms determined under the former system of the Soviet Union. Many of the treatment protocols were outdated and potentially harmful. Because the protocols required treatment in specialized facilities for a number of conditions (tuberculosis hospitals, dermato-venereal hospitals, oncology hospitals), they too contributed to the substantial infrastructure that existed in the country. There were no functional processes for technology assessment or for promoting essential drugs.

Benefit package

The benefit package was not explicitly specified, although certain services were subject to official user charges and numerous categories of exemption existed. There was also no financial penalty for persons who self-referred to specialty care. However, the organization of care in the entire country was based on catchment areas, and everyone living within a defined catchment was supposed to seek care from the catchment polyclinic.

Summary of main problems and challenges facing the system

During the first half of the 1990s, the Kyrgyz health care system was plagued by a number of problems. Inefficiencies were reflected in excess physical capacity, overspecialization, very high rates of hospital admission and referral, and very long

average lengths of stay. There was no real continuity of care (no assigned family physician at the polyclinics), and the system suffered from growing shortages of drugs and other medical supplies. Equity was also being compromised as reflected in the rising incidence of informal fee charging. In effect, many people no longer had health care risk protection. The existing infrastructure could no longer be fully resourced, and access depended increasingly on ability to pay.

The figure and brief analysis above suggest that the institutional structure of the health care system, resource allocation mechanisms, and inherited patterns of service delivery all contributed to the problems noted above, in addition to the macroeconomic deterioration in the country. Thus, reforms to address these problems had to be comprehensive to address their multiple causes. For example, changes in provider payment mechanisms would have little effect if standard treatment protocols were not changed. The need for a comprehensive approach formed the basis for the reform program.

Reforms to enhance coverage efficiently

The objective of reforms in health financing and resource allocation was to help to address many of the problems described above. In particular, a shift from resource allocation guided by the needs of the infrastructure to methods driven by the health care needs of the population was seen to be essential. The package of reforms currently being implemented in the country involves changes in virtually all aspects of the system addressed by the framework: sources of funds, allocating institutions, the organization of service provision, mechanisms for allocating to purchasers, provider payment changes, reforms in health system support functions, and clearer specification of the benefit package.

Increasing funding sources

Shortly after independence, the government passed a law requiring the creation of a compulsory Health Insurance Fund (HIF). It was hoped that this would provide an important new source of funds for health care (payroll tax of 2% on employers), given the decline in the availability of budget funds. However, the conditions were extremely unfavorable for the introduction of this form of funding, and the HIF was not implemented until the beginning of 1997. Its potential to mobilize significant new levels of funds is questionable, at best.

Creating an active purchaser

An analysis of the pre-existing 'market structure' of allocating institutions revealed a fragmented system. In order to move to a population-based system, the need to merge the various allocating institutions was identified, with the oblast determined as the appropriate level for doing so. Before, the oblast and the rayons within each oblast funded their 'own' health facilities in a parallel manner. The proposed reform was to *pool* all oblast and rayon budgets (called "local budgets") for health care at the oblast level, and to enable each oblast health administration to be a purchaser on behalf of the entire population of the oblast.

The creation of a 'single payer' within each oblast was complicated by the legislation creating an independent Health Insurance Fund. As originally planned, this would have created a new allocating institution purchasing services on behalf of the 'insured' population (employees for whom employers had contributed, plus pensioners and the registered unemployed). A solution was negotiated that maintains the separate institutional identity of the HIF but enables the creation of what is essentially a single payer system within each oblast. The compromise, called the "Jointly Used Systems" approach, calls for each oblast HIF (arms of the national "Republican" HIF) to perform several functions jointly with each oblast health administration. These include systems for provider payment, accounting, quality assurance and utilization review, and computing/information.

Restructuring service delivery

Moving to a population-based health care system meant that the notion of health facilities 'owned' by different levels of government had to be eliminated. In order to implement proposed changes in provider payment (see below), service delivery within oblasts is being restructured into three basic institutions: (1) primary care, to be provided by newly formed Family Group Practices (FGPs), staffed by a pediatrician, internist, obstetrician/gynecologist, and nursing team; (2) hospitals, providing inpatient and emergency services; and (3) outpatient specialty services, to be provided in polyclinics or the outpatient departments of hospitals. Moreover, to create a true purchaser-provider split, each of these institutions will be given increasing managerial autonomy, implemented gradually as the capacity to take on new managerial functions is developed.

Allocation to allocating institutions

It is intended that the level of the budget allocated to each oblast health administration

will be determined by a weighted capitation formula. Thus, there will be a shift from the old infrastructure and utilization-based norms to a system based more on population needs. Because a purchaser-provider split is being created, the Ministry of Finance need no longer be concerned with the health infrastructure. The change to a population-based formula is essential for enabling the MOH to proceed with its program of closing unneeded hospital capacity ("rationalization"), so that the resources saved through the rationalization process can be redistributed within the health sector.

The 2% payroll tax on employers for 'health insurance' is collected by the national Social Fund as part of the overall taxes collected for social protection (e.g. pensions, unemployment, etc.). This is transferred to the Republican HIF, along with amounts intended to cover the health care needs of pensioners and unemployed. Funds are to be distributed from the Republican HIF to each oblast HIF in accordance with the number of beneficiaries living in each oblast.

Provider payment

Much of the reform effort has focused on provider payment changes. Primary care providers (FGPs) will be paid on the basis of capitation, according to the number of people who enroll with each FGP. In other words, FGPs will compete to enroll people, and the decisions made by the population (i.e. consumer choice) will steer the distribution of capitation payments across FGPs. Plans are also being made to test the feasibility and desirability of making FGPs fundholders for referral care. The main reasons for implementing consumer choice-based capitation were the market structure of service provision (a potentially competitive market, given the volume of physicians) and a broader desire on the part of the country to give citizens a greater role in the society. It is also hoped that the creation of FGPs and the population enrollment process will encourage continuity of care through closer doctor-patient relationships.

Outpatient specialists will be paid on a fee-for-service basis according to a national fee schedule, and hospitals will be paid on a per case basis according to the assignment of the patient into one of the 54 clinical case group categories (conceptually similar to DRGs) that have been defined. In practice, however, payment methods for referral care will be mixed, with a combination of budget allocations and the reimbursement methods just described.

Health system support

It has been clearly recognized that changes to health financing and resource allocation would be insufficient for the reform process to be effective. Thus, a number of other changes are being implemented concurrently. Some of the most important of these are:

- clinical re-training to create a cadre of general practitioners (GPs);
- revisions to standard treatment protocols to promote quality and efficiency;
- licensing and accreditation of hospitals;
- reforms in drug procurement and the definition of an essential drug list; and
- public information ("marketing") campaigns to educate the population about the reforms and their rights and responsibilities regarding enrollment with FGPs.

Benefit package and user fees

A list of services to be included in the benefit package has not been defined. However, the system is structured to encourage appropriate use of referral channels. Thus, it is recommended that persons who do not seek non-emergency first contact care from the FGP with which they are enrolled will have to pay substantial ('full cost') fees, and access to specialist care requires a referral from the FGP. This would mean that the benefit package is defined in terms of the channels by which people use the services.

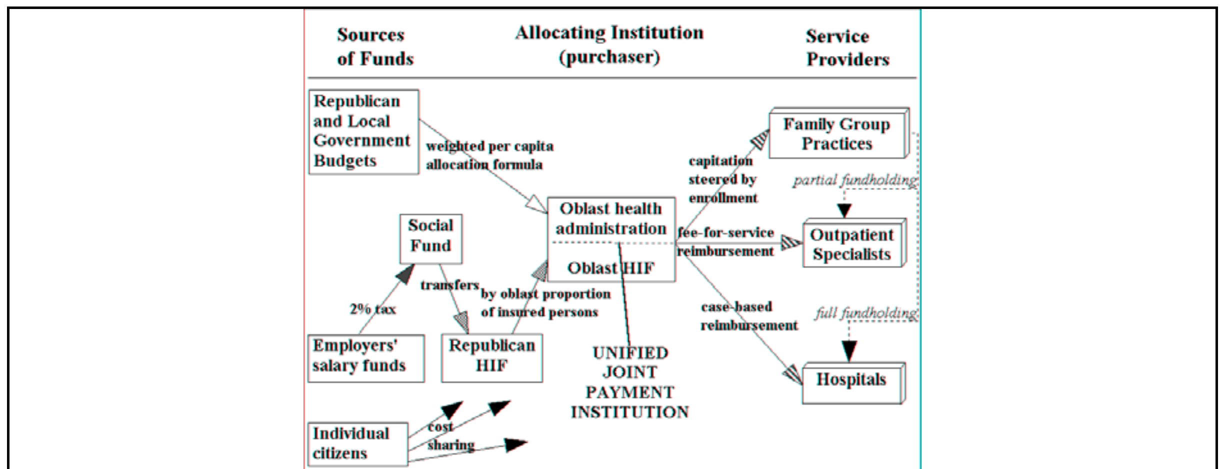
The existence of the HIF poses a challenge to the unity of the health care system. Currently, it is proposed that the extra benefit to be received by 'insured' persons is free outpatient drugs. While this may appear to compromise equity somewhat, it is a practical solution if the reforms are to have the support of the HIF and its contributors. Moreover, the equity implications of this extra benefit are not entirely clear, since the majority of HIF beneficiaries are pensioners, who tend to be relatively low income persons.

Summary of the reforms

The reform package in Kyrgyzstan is comprehensive. The new flow of funds, institutional arrangements, and resource allocation mechanisms at the oblast level are summarized in Figure 2 (Savas et al. 1998). The figure suggests the importance of analyzing the health care system in a holistic manner as a basis for reform. Clearly, the reforms are inter-related. The implementation of new provider payment methods required the restructuring of service delivery, and both of these required institutional changes at the level of the purchaser to enable the pooling of funds for the health care of

the entire oblast population. Rationalizing the physical capacity of the system would be impossible unless the basis for determining the size of the budget shifted from infrastructural norms. Finally, all of these structural changes and allocation reforms would amount to very little if changes were not implemented in the way medicine is practiced.

Figure 2: The reform of flow of funds and initiational arrangement in Kyrystan



The figure shows the intended state of the reformed health care system. In reality, implementation of various aspects of these changes is occurring at a varied pace. Nationally, work is proceeding on clinical retraining and revisions to standard treatment protocols. The HIF has been created, as have the jointly used systems. Things are furthest along in one pilot oblast, where public budget funds have been pooled, the population has enrolled with FGPs, and the FGPs are being paid on a capitation basis.

Conclusions: Priority Issues for Enhancing the Insurance Function

The framework presented in this paper is proposed as a tool for descriptive analysis of an existing health care system and for identification and assessment of policy options to enhance the insurance function in countries. The 'tour' of the components of the health care system provided above suggests that the depth and breadth of the insurance function in a country depend on more than one element of policy or systems development. One of the objectives of this framework is to promote the idea that progress towards the goal of universal coverage at the least cost possible requires a comprehensive approach involving coordination among multiple aspects of health care systems (e.g. provider payment, benefit package, organizational structures) rather than an approach aimed at reforms in these aspects in isolation from each other. Appropriate policies with respect to enhancing the insurance function require a clear focus on this goal (not confusing ends and means) and an understanding of national and sub-national 'markets' (i.e. nature of supply and demand) for both health insurance and health care. Thus, insurance is not just a "health care financing" issue. Indeed, the framework suggests that even where macroeconomic circumstances limit the scope for additional resource mobilization, there are many policy levers available to governments to enhance the insurance function. Reforms to the institutional structure of health systems, service delivery, pharmaceuticals, technology, etc. are of critical importance for this. As a policy objective, enhancing the insurance function of health systems requires well-coordinated policies under the leadership of government decision makers.

The paper concludes by identifying some key lessons and messages with respect to the insurance function. This is not meant as a comprehensive review; instead, some messages believed to be very important are highlighted.

Schemes vs. systems: avoid confusing ends and means

As noted in the introduction to this paper, achieving universal coverage with effective health care risk protection at the least cost possible is a policy objective, but the use of any particular set of institutional arrangements to achieve this is not. Another way to say this is that the objectives of policy relate to the entire population and thus the overall health care system; insurance 'schemes' (and reforms related to them) should be assessed in terms of how the schemes contribute to the system-wide insurance objective. As

noted earlier, for example, many of the actions taken by private insurers to enhance the financial viability of their schemes (e.g. underwriting, coverage exclusions) can be in direct conflict with the objectives of the health care system as a whole. Thus, policies that can improve the efficiency and sustainability of individual insurance schemes can, at the same time, have negative consequences for the efficiency and sustainability with which the entire health care system pursues the goal of universal coverage.

This does not mean that schemes and systems are necessarily in conflict. The challenge to governments is to create the conditions for schemes to contribute to system objectives. By identifying the existing institutional arrangements and financial flows for health care, policy makers can see more clearly how various sources of funds can be channelled to *complementary* purposes, rather than being isolated into overlapping yet self-contained subsystems. With a good understanding of the various elements of the framework, the role of schemes can be defined or modified to serve overall system objectives in an efficient manner. Thus, for example, benefit packages can be made complementary, and certain administrative functions can be shared across schemes or managed jointly with the public system. Schemes can also be directed or encouraged to make use of government-supported policies with respect to drug regulation, treatment protocols, technology assessment, etc.

Efficiency is essential for equity

Universal coverage is fundamentally a reflection of the policy objective of equity in access to care and financial risk protection. Very often, the objectives of equity and efficiency are portrayed as being in conflict. With the system-wide insurance objective in mind, however, there is no significant efficiency-equity trade-off in most countries. In other words, measures that improve the efficiency of the system also tend to be good for equity, and a deterioration in efficiency also tends to cause a deterioration in access for the poor. This is especially true in contexts where the real level of funding for health care is either stagnant or declining. Thus, the kinds of inefficiencies that have been associated with the fee-for-service reimbursement mechanisms in the Korean or Chinese health insurance systems, for example, mean that the resources of the health care system are skewed to a greater extent in favor of relatively well-off people. Where higher levels of finance are unlikely to be forthcoming, the only way to make more resources available for re-distribution is through efficiency gains. Again, however, efficiency needs to be assessed from the perspective of the system rather than that of individual schemes.

Active purchasing is essential for efficiency

In theory, it is possible to achieve universal coverage without an active insurer or even an identifiable purchasing function. Thus, it is possible to imagine a publicly funded system where a Ministry of Health simply gives budget allocations to health care providers and which offers universal access and financial risk protection. At best, however, this is a very inefficient way to provide insurance because it offers few options for counteracting market failures (especially information asymmetry) in the interactions between patients and providers. At worst, the 'guarantee' of universal coverage through public budget allocations is fictional; the reality on the ground is of limited access to care, especially for poor persons and those living far from health care facilities. Just as insurance is more than a question of finance, it is also more than a question of identifying the "right" benefit package. Recognition of the importance of *managing* the health care system (and not just funding it) by health policy makers in most West European countries has meant that many systems funded from general tax revenues, as well as those funded mainly by compulsory contributions to social health insurance funds, have introduced a clear "purchaser/provider split" into their health systems (Saltman and Figueras 1997). From an economic perspective, the technical basis for doing so is a recognition that information asymmetries in health care make providers the key drivers of cost, quality and efficiency, and active purchasing is a way to concentrate reforms on providers. Demand side measures, such as user fees or consumer choice among competing insurers, are not as effective for enhancing efficiency and tend to have negative consequences for equity (Saltman 1995).

The existence of an identifiable purchaser does not necessarily mean that an active purchasing function exists. In Korea and China, for example, insurers serve largely as financial intermediaries and have done little to promote quality and efficiency in health care (Kutzin and Barnum 1992). Thus, governments need to promote actively the concept of "purchasing in the public interest" in all health care systems. As noted above in the discussion of allocating institutions, this requires attention to both the market structure of purchasers and their actual functions. Although a publicly owned single payer is a situation best suited to a purchasing function guided by public policy objectives, this may not be a realistic option for many countries. Based on an analysis of the existing market structure of insurers, governments need to determine the range of relevant policy options and as part of any option, determine the steps needed to facilitate

active purchasing. Hence, a pragmatic approach is called for in order to identify the right 'next steps', given the existing situation, towards improved efficiency.

It should also be recognized that it is politically difficult to create active purchasing, as powerful interests with a financial stake in the 'inefficiency' of the system (even if they do not recognize it as such) are likely to oppose reforms oriented in this direction. The failure of the Clinton administration to win approval for nationwide health care reform in the United States may be attributed, at least in part, to opposition of various groups whose interests would have been threatened by the creation of a more organized and managed health care system. Similarly, reformers in countries like China, Korea and Thailand may expect strong opposition to attempts to rationalize the distribution and use of high technology medical equipment. Thus, much of the job involved with facilitating active purchasing is political rather than technical. Government policy makers need to identify allies with an interest in system wide efficiency. Where employers are a major source of funds for the health system, governments should explore the potential for a strategic 'alliance for cost containment'.

Be cautious with regard to "market-oriented" reforms

Reforms in some countries are guided by a belief that an increasing reliance on the "market" (i.e. competition and consumer choice) and reduced emphasis on the "state" (i.e. government planning, finance and delivery of services) will improve overall efficiency. Evidence from countries, however, suggests that a general reliance on the "market" is dangerous, but a targeted introduction of competitive mechanisms within an overall planned system may be effective in some contexts. The evidence also suggests that *for competition to be effective in promoting overall sectoral goals, the state must strengthen and increase its regulatory functions.*

Based on an assessment of the experience of a number of countries, Saltman (1995) concludes that competition among insurers for the premiums paid by or on behalf of people has been plagued by a number of problems: adverse selection and the actions taken by insurers in response; high administrative costs for the system as a whole; and a compromise in the equity of health financing. In their analysis of the experience of countries in WHO's European Region, Chinitz, Preker and Wasem (1998) note that introducing competitive markets into the financing of health care is very risky, and the potential benefits have not been proven. They conclude:

> "Countries that have not yet secured universal coverage, or whose universal coverage is fragile, would be well advised to look at other ways to improve their health care systems than to turn to competitive market forces as the source for their health care financing. Countries with universal schemes should proceed with caution, aware of the implications for solidarity of the introduction of competition in the finance of health care."

Similarly, Evans et al. (1994), in advising the Chinese government on health financing policy reforms, stated:

> "One reform of the Chinese health system that would be most destructive of its proper objective would be to allow the development of COMMERCIAL health insurance. Western countries that use health insurance to finance their health sectors do so either through public insurance or very tightly REGULATED, NON-COMMERCIAL social insurance." [authors' original emphasis]

Areas for further exploration

Measuring coverage

Defining insurance as a function rather than as membership in a scheme raises questions of measurement: how can a country determine the proportion of its population that is *effectively covered*, and how can changes in this coverage be assessed over time? If insurance is defined as participation in a scheme, measurement simply involves calculating the percentage of the population in schemes. This neglects the possibilities that (1) persons who are in a scheme may not be effectively covered, and (2) persons not in a scheme may be effectively covered. What is needed is a way to measure both the breadth and depth of health care risk protection, and it may be unlikely that these two elements can be captured in a single index measure (i.e. percent covered).

Since the insurance function is concerned with access to effective services and financial protection, methods are needed to measure each of these. This poses many difficulties, one of which is that conceptually, there are many degrees of access and protection; they are not really discrete variables. Measures of access will need to include assessments of physical and financial access to care. In terms of physical access, it may be possible for

countries to examine access to key 'tracer' services, such as basic primary care, emergency services (e.g. emergency obstetric services), and referral hospitals. Financial access can probably best be measured with the help of data on care seeking behavior and out-of-pocket health care expenditures derived from household surveys, although indirect information gleaned from health facilities (e.g. changes in the number of people exempted from fees) may be of some use. Financial risk protection may be examined at the policy level (e.g. is there an out-of-pocket maximum?), but the analysis of actual financial risk protection probably also needs to involve analysis of household survey data showing, for example, changes in the percentage of total household expenditure devoted to health care.

Assessing the depth of protection requires information on the kinds of services to which people have effective access. The challenge will be to develop a reasonably low cost and accurate method for measuring this directly or developing alternative proxy measures.

National Health Accounts

The framework is useful for identifying and "mapping out" the financial flows and institutional arrangements for health care. Its power as a descriptive analytic tool would be greatly enhanced if the relative size (in financial terms) of the various flows and institutions could be quantified. One purpose of National Health Accounts (see Berman 1996 for a discussion of methods and country examples) is to identify and quantify sources and uses of funds in the health system. This would offer a more complete description of existing systems and a more realistic portrayal of policy options, involving not only the sources and uses of funds, but also the role of allocating institutions, resource allocation mechanisms, benefit packages, and so forth. Therefore, the potential gains and limits of linking the insurance framework analysis described here with the National Health Accounts methodology should be explored.

Annex 1. 'Active Purchasing' Features in West European Health Care Systems (Early 1990s)

Feature / Country	financial incentives	gate-keeper	physician profiling	selective contracting	UR/QA	protocols
Austria		X			R	X
Belgium			X			X
Denmark		X	S			
Finland	X,P	X				
France			X			X
Germany			X,R		X	
Iceland					X	X
Ireland	X	X	X,R		S	
Italy	X	X				R
Netherlands	X	X		X	X	X
Norway	P	X			S	
Spain		X			X	
Sweden		X			X	X
Switzerland	P				S	
United Kingdom	X	X	S	X	X	X

X: element in place throughout the system
R: element recommended by government but not yet implemented
P: element implemented on a pilot basis
S: element being studied for future implementation

Sources: OECD (1992); OECD (1994); GAO (1994); Ham and Brommels (1994)

Notes on Annex 1 table

Austria: There is a positive drug list in "Register of Medicines", which also indicates protocols for "exercise of economy" in prescribing.

Belgium: Profiles have been developed since 1979 for each prescribing doctor and paramedic. These can give rise to sanctions or further investigation of outliers. There is a list of drugs approved for reimbursement. Government is also responsible for the accreditation of hospitals, doctors, and ancillary care providers.

Denmark: Most of the population opts for the program that includes GPs as gatekeepers. Efforts are under way to collect data on GP services to facilitate comparison by administrators and provide feedback to GPs to encourage efficient practice.

Finland: Municipal health centres pay their doctors by capitation and purchase secondary and tertiary care from mostly public hospitals. The "personal doctor" experiment uses mixed payment systems to encourage doctors to be responsive to patients (using elements of fer per visit and fee for service, in addition to the basic salary).

France: Statutory insurers monitor physician activity "and feed back the results in the hope that this will influence ... volume. Excessive prescribing may be sanctioned." A positive list (formulary) for drugs exists, as does a negative list of non-reimbursable items.

Germany: Regional physicians' associations monitor each physician's practice patterns to identify volume outliers. There were plans, not yet implemented, to audit physician prescribing practices, with financial consequences for excess use.

Iceland: There is a restricted list of reimbursable drugs.

Ireland: There is a recommendation to monitor the public time commitment of physicians. Also, the Payments Board monitors volume and prescribing practices of GPs serving as "medical care holders" and investigates outliers. GPs are paid by capitation, "supplemented by fees for a few, specified procedures" (e.g. maternity care).

Italy: GPs contracted to the NHS are paid by capitation, "with additional payments for certain services." Recent law reorders drug classification from previously ineffective list. GPs are gatekeepers, but this has not been effective for limiting drugs and diagnostic services.

Netherlands: Quality assurance (QA) is provided by medical inspectors and hospital accreditation. Fund holding is by public insurance societies and private insurers, some of which selectively contract with providers.

Norway: The family doctor project in 4 municipalities uses mixed payment methods, including fee-for-service (FFS). There are many studies and plans to introduce a variety of QA measures.

Spain: QA is implemented for hospitals and primary care providers.

Sweden: County councils contract with hospitals for the purchase of services on a per case basis, creating a purchaser/provider split. There is also a restricted drug list.

Switzerland: There is experimentation with HMOs and also bonus-linked schemes that reduce premiums for non-use of services over time.

United Kingdom: Some GP practices held budgets for referral services. GPs are paid by mix of capitation, practice allowance, and FFS for specified preventive services and night visits. District health authorities and GP fundholders are free to contract selectively with any hospital. There is a limited list of reimbursable drugs. 1989 legislation encouraged district health authorities to "dialogue" with GPs about their hospital referrals.

Annex 2. Advantages and Disadvantages of Provider Payment Alternatives

Payment Method	Main Advantages	Main Disadvantages	Measures to Minimize Disadvantages
Line Item Budget	Allows strong central control; desirable where local management very weak Predictable expenses for 'insurer' (unless supplemental budgets provided)	No direct incentives for efficiency Provider may under-provide services Imposes fixed resource use, directly impeding efficiency	Monitor performance to encourage best use of resources within constraint of fixed factors of production
Global budget	Predictable expenses for insurer, low administrative cost Unified budget *permits* reallocation for efficient resource use	No direct incentives for efficiency Provider may under provide services Needs strong management skills at facility level	Monitor performance and provide performance based incentives (link global budget to performance, bonuses)
Capitation	Predictable expenses for the insurer Provider has incentive to operate efficiently Eliminates cost escalation from supplier-induced demand Moderate administrative costs	Financial risk may bankrupt provider. Provider may seek to minimize risk by "cream skimming" (enrolling low-risk patients) Provider may under provide services	To minimize excessive provider risk, consider capitation "carve outs" and adjusting capitated payments to reflect the underlying risks of population enrolled Enforce contracts to ensure services provided
Fee for service (no fee schedule)	Incentives to provide services	Unpredictable expenses for insurer Cost escalating: strong incentives for supplier-induced demand	Utilization review to limit excessive use
Fee for service with fixed fee schedules	Incentives for productivity and somewhat for efficiency if prices set well Efficiency is greatly enhanced when combined with a global budget cap	Unpredictable expenses for insurer Cost escalation: incentives for supplier-induced demand Higher administrative costs (price controls must be established, revised periodically and enforced)	Reduce unpredictability of expenses and cost escalation by capping total spending within a preset budget, and adjusting payment rates to keep expenditures within this limit Utilization review to limit excessive use
Case-based	Strong incentives to operate efficiently (reduce cost per case, while increasing number of cases)	Unpredictable expenses for insurer High administrative costs, but less than fee-for-service Provider has incentives to select low risks within case categories or under-treat Case based payment less suitable for outpatient care (difficult to define case)	Adopt detailed case-mix category system Adopt mixed payment system

Adapted from Barnum, Kutzin and Saxenian (1995)

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The introduction of Universal Accessto Health Care in the OECD: Lessons for Developing Countries

Alexander S. Preker

INTRODUCTION

This paper presents a discussion on the introduction of universal access to health care in the OECD during the 20th century and its relevance to developing countries that are trying to introduce similar financing reforms.

At the end of the previous century, most western countries relied mainly on direct out-of-pocket payment and unregulated markets to finance and provide health care. In 1938, New Zealand became the first country with a market economy to introduce compulsory participation and universal entitlement to a comprehensive range of health services, financed largely through the public sector (the UK followed a similar path when -- 10 years later -- it established the National Health Services (NHS) in 1948). Universal access to health care in many eastern European countries -- Albania, Bulgaria, the Czech Republic, Slovakia, Hungary, Poland, Romania and the USSR -- was achieved through similar legislative reforms. A number of other middle- and low-income countries have followed a similar path.

Today, the population in most OECD countries (with the exception of Mexico, Turkey and the US) enjoy universal access to a comprehensive range of health services that are financed through a combination of general revenues, social insurance, private insurance, and user charges. In 13 of the OECD countries, universal access was achieved through landmark legislative reforms that guaranteed their population such benefits, while most other OECD countries achieved similar coverage through voluntary and regulatory mechanisms. The focus of this paper is mainly on those countries that achieved universal access through specific landmark legislative reforms and a single payer financing mechanism rather than through incremental expansion of a multiple payers through voluntary and regulatory mechanisms.

PAST ACHIEVEMENTS

Improvements in health and shifts in priorities

This century has witnessed greater gains in health outcomes than at any other time in history. These gains are partly the result of improvements in income with accompanying improvements in health-enhancing social policies (housing, clean water, sanitation systems, and nutrition) and greater gender equality in education. They result also from new knowledge about the causes, prevention, and treatment of disease, and the

introduction of policies, financing, and health services that make such interventions accessible in a more equitable manner.

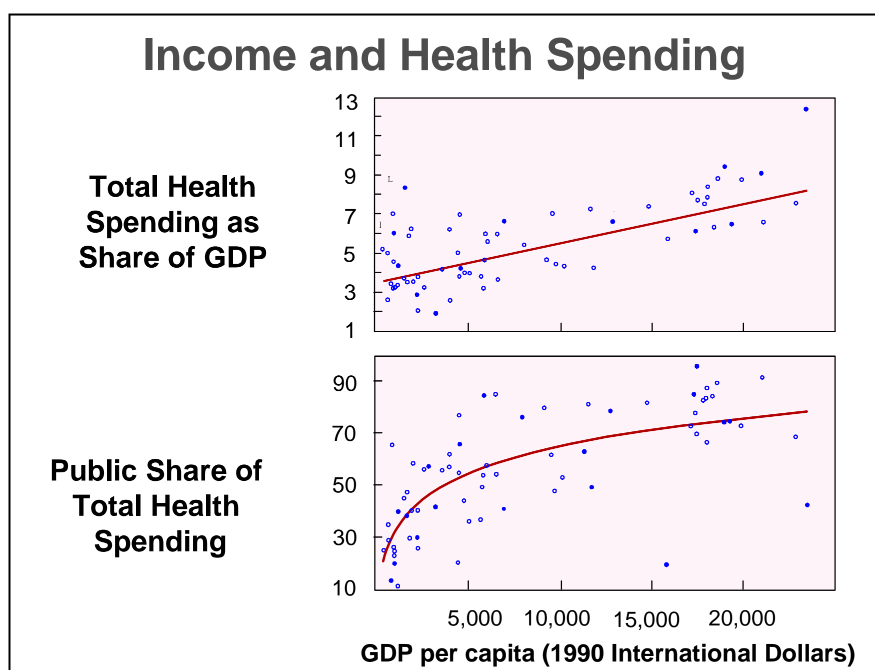
Parallel to these developments, the disease patterns of the past century are changing high mortality and fertility to low mortality and fertility. The share of global disease burden due to non-communicable diseases (mainly cardiovascular and neuro-psychiatric diseases, and cancers) is expected to increase from 36 percent in 1990 to 57 percent in 2020, while the burden due to infectious diseases, pregnancy, and perinatal causes is expected to drop from 49 to 22 percent. Even with effective prevention, this epidemiological shift will have a profound impact on the health care institutions that are needed to treat the resulting illnesses.

Growth in financial resources

Fortunately, there has also been a growth in the resources available to the health sector. Global spending on health care was about US$2,330 billion in 1994 (9 percent of global GDP), making it one of the largest sectors in the world economy. While low- and middle-income countries account for only 18 percent of world income and 11 percent of global health spending (US$250 billion or 4 percent of GDP in developing countries), 84 percent of the world's population lives in these countries, and they shoulder 93 percent of the world's disease burden.

At a global annual growth rate for GDP of 3.5 percent, health care expenditure will increase by about US$82 billion a year worldwide, or US$9 billion a year in low- and middle-income countries. Since health care behaves like a superior good in economic terms, a country's expenditure on health care rises as income increases both in absolute and relative terms (see Figure 1 for the relationship between per capita GDP and the share of GDP spent on health).

Figure 1: The relationship between per capita income and health spending



MAJOR OUTSTANDING ISSUES

Despite their achievements, low- and middle- income countries throughout the world face many difficult challenges in meeting the health needs of their populations, mobilizing sufficient financing in an equitable and affordable manner, and securing value for scarce resources spent on preventive and curative health services.

Throughout most of history, people used home remedies, private doctors and other health care workers, and non-governmental hospitals when they were ill. Often only the rich could afford such care and the range of effective treatment was limited. Today, in low-income countries — where public revenues are scarce (often less than 20 percent of GDP) and institutional capacity in the public sector is weak — the financing and delivery of health, nutrition and population (HNP) services is largely in the private sector. In many of these countries, large segments of the poor still have no access to basic or effective care for a variety of reasons discussed below.

In most developed countries — and many middle-income countries — governments have become central to social policy and health care. This involvement by the public sector is justified on both theoretical and practical grounds to improve: (a) equity, by securing access by the population to health, nutrition, and reproductive services; and (b)

efficiency, by correcting for market failures, especially when there are significant externalities (public goods) or serious information asymmetries (health insurance).

The main actions taken by governments to correct for such market failures, from least to greatest intervention, include: providing information to encourage behaviour changes needed for long-term improvements in health, nutrition, and population outcomes; enforcing regulations and incentives to influence public and private sector activities; issuing mandates to indirectly finance or provide services; financing or providing subsidies to pay for services or influence prices; and direct public production of preventive and curative health services.

One of the clearest cases for strong government intervention in the HNP sector can be made when there are large externalities (the benefits to society are greater than the sum of benefits to individuals). This is true in the case of clean water, sanitation services, vector control, food safety measures, and a range of public health interventions (e.g. immunization, family planning, maternal and perinatal health care, control of infectious diseases, and control of tobacco, alcohol, and illicit drug abuse). Medical education and R&D are two other areas for active government intervention.

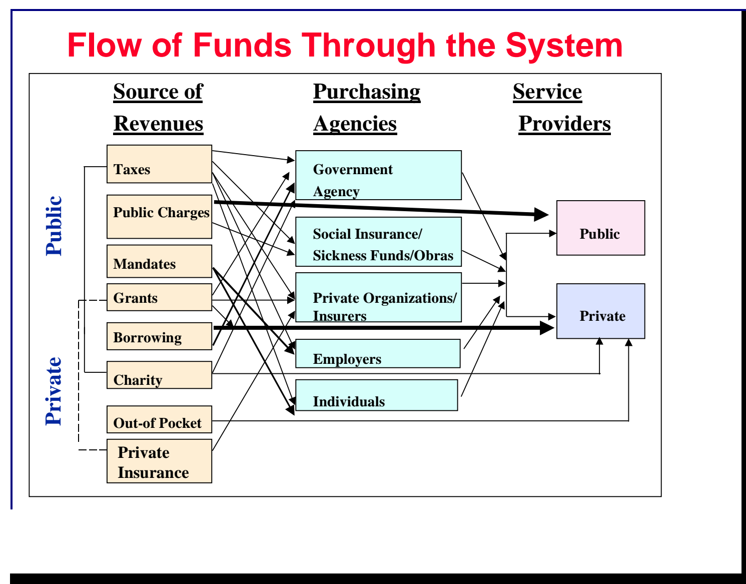
A second area for strong government intervention is in the area of health care financing because private voluntary health insurance is particularly prone to a number of market imperfections, many of which relate to information asymmetries. While insurance may succeed in protecting some people against selected risks, it usually fails to cover everyone willing to subscribe to insurance plans and it often excludes those who need health insurance the most or who are at greatest risk of illness. This happens because insurers have a strong incentive to enrol only healthy or low-cost clients (risk selection or cream-skimming). Private insurers also have incentives to exclude costly conditions or to minimize their financial risk through the use of benefit caps and exclusions. This limits protection against most expensive and catastrophic illnesses.

Because of these factors, individuals who know they are at risk of illness have a strong incentive to conceal their underlying medical condition (adverse selection). Individuals who are — or at least think they are — healthy will often try to pay as low premiums as possible. This prevents insurers from raising the funds needed to cover the expenses

incurred by sicker or riskier members. Worse, the healthy may even deliberately under-insure themselves, in the hope that free or highly subsidized care will be available when they become ill (free-riding). When third-party insurers pay, both patients and providers have less incentive to be concerned about costs, and some may even become careless about maintaining good health. This leads not only to more care being used (the reason for insurance), but also to less effective care, or care that would not be needed if people maintained good health (moral hazard).

This paper focuses mainly on the experience of the OECD in mobilizing financial resources in an equitable and efficient manner. Issues relating to health status and improving the performance of the health care providers (public and private) are not discussed, although the inter-linkages between these three systems (see Figure 2) are important to the impact of health care financing reforms.

Figure 2: The Health Financing System



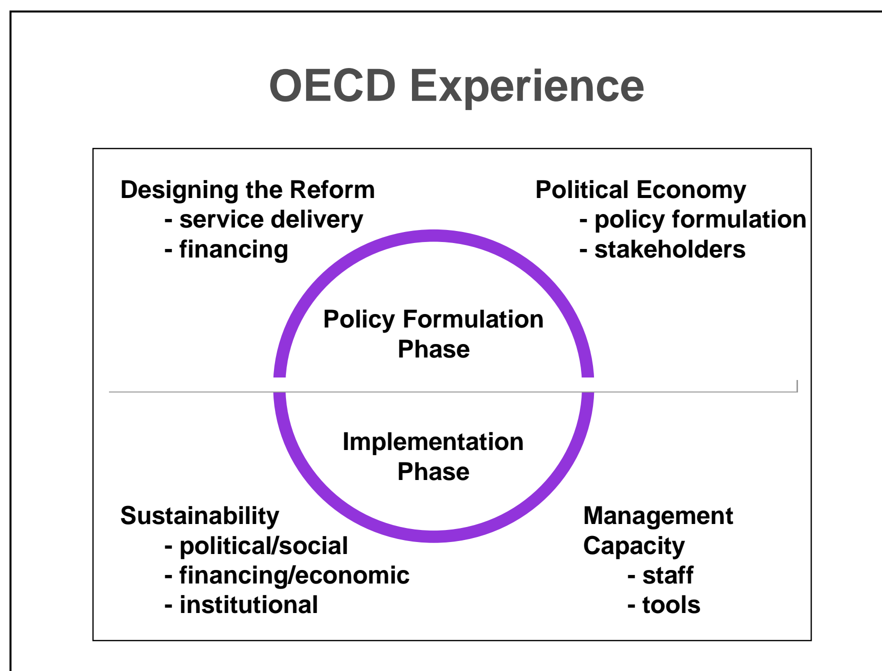
TWO DIFFERENT REFORM PROCESSES TO UNIVERSAL ACCESS

The OECD experience in introducing universal health care can be regarded as taking place in two phases: the policy formulation phase; and the implementation phase (see Figure 3).

During the policy formulation phase, the design of the reform needs to consider both the financing and service delivery aspects. Without access to health services, legislation that mandates universal financing is little more than a paper law.

After the design of a successful system of financing universal access, a major stumbling block in most countries has been the political economy of policy formulation and dealing with various stakeholders with vested interests that may resist such reforms for a variety of reasons that will be discussed later.

Figure 3: Phases in the OECD experience



In the OECD, this policy formulation phase was, however, only the first phase in the introduction of universal access. An equally important phase during which the reforms were sometimes derailed was the implementation phase. During this phase, both management capacity (staff, resources, and administrative tools such as information systems) and sustainability factors (financial resources, political commitment, and institutional infrastructure) played a critical role in securing the success of the reforms.

The OECD countries that enjoy universal access to health care can be separated into two groups (see figure 4) based on:

- the extent of legal entitlement and physical access offered to the population under public schemes (universal versus restricted)
- the nature of participation in the public or privately mandated schemes (compulsory versus voluntary membership)
- the number of financing sources (single payer versus multi-payer)

Figure 4: Different approaches to universal coverage

Different Dimensions of Universality

Entitlement	1 Restricted	4 **Universal**
Participation	2 Voluntary	5 Compulsory
Financing Mechanisms	3 Multi-payer	6 Single payer

Group I	123456	**Group I I**	123456
Australia	- - -+++	Austria	+- +- +-
Canada	- - -+++	Belgium	+- +- +-
Denmark	- - -+++	France	+- +- +-
Finland	- - -+++	Germany	+- +- +-
Greece	- - -+++	Ireland	+- +- +-
Iceland	- - -+++	Japan	+- +- +-
Italy	- - -+++	Luxembourg	+- +- +-
New Zealand	- - -+++	Netherlands	+- +- +-
Norway	- - -+++	Switzerland	+++- - -
Portugal	- - -+++		
Spain	- - -+++	**Group I I I**	
Sweden	- - -+++		
UK	- - -+++	Mexico	+++- - -
		Turkey	+++- - -
		United States	+++- - -

Group I countries listed in the left column of the figure are characterized largely by compulsory participation and universal entitlement to comprehensive services that are financed through a single payer, while Group II countries listed in the right column lack one or more of these characteristics.

These different dimensions of entitlement, participation and financing mechanisms are explored briefly in the sections below.

LEGAL ENTITLEMENT AND DIMENSIONS OF ACCESS

Universal entitlement implies that the whole population is eligible for benefits irrespective of income, health status, membership in good-standing or other constraints. All Group I

countries have passed legislation that provides such benefits, while Group II countries restrict entitlement to a targeted portion of the population such as low-income earners, children, pensioners and other groups of the non-employed.

Many Group II countries, such as Belgium, France, Germany, Japan and the Netherlands, achieved almost universal coverage through extensive membership of different sickness funds and other insurance organizations. Most of the Nordic countries and the United Kingdom passed through a similar historical phase before extending coverage to the whole population under a single legislative act. Because most Western countries offer supplemental health insurance to cover higher standards of care, private accommodations in hospitals and so on, entitlement is a question of degree and open to interpretation.

The dates of the legislative reforms that introduced universal entitlement in eight of the Group I countries are provided in Figure 5.

Figure 5: Dates of achieving universal coverage

Legislative Reforms Leading to Universal Entitlement

New Zealand	1938
England/Wales	1946
Sweden	1953
Norway	1956
Finland	1963
Canada	1966
Denmark	1971
Iceland	1972
Australia	1974
Portugal	1978
Spain	1978
Italy	1980s
Greece	1980s

Universal entitlement is meaningful only to the extent that there is reasonable access to services. In practice, a lag often occurs between the time that policies are formulated, legislation prepared and laws passed, and the date that programs are implemented, services offered and entitlement exercised. This is a particular problem in many low- and

middle-income countries where entitlement is often restricted to publicly provided services and where such services are either of a low quality or absent altogether.

Where geographic, financial, cultural or functional barriers exist, legal entitlement may loose some of its significance. This issue remains the topic of ongoing debate on equity in most of the OECD. In most of the countries that have achieved universal access, measures had to be introduced to mitigate such problems after the initial legislation was passed. For example, compulsory universal health insurance in Sweden led to universal entitlement to health services in 1955. But it was the Seven Crowns Reform of 1969 that re-organized the health service and expanded access to the whole population. Likewise, compulsory universal health insurance was introduced in Finland in 1964, but it was the Public Health Act of 1972 that extended access to the whole population.

The range of services offered through various forms of entitlement have changed greatly over time, and vary from one country to another. The minimum standards for health care provided through social security advocated by the ILO in 1952[11] were much more limited in scope than the more comprehensive requirements needed to satisfy the WHO.[12] Even the core contents of many programs, such as health promotion, prevention, curative treatment, rehabilitation and chronic care, have changed over time. One of the most clear-cut cases of segmentation into a limited range of services occurred in Canada. The National Hospital and Diagnostic Services Act of 1957 called for compulsory participation and universal entitlement to hospital care only. Treatment by doctors was not included until 1967 under the Medical Care Act.[13] Even this act excluded most ambulatory services not provided by doctors. Today, many low- and middle-income countries are pursuing a similar strategy by restricting universal access to a limited range of essential health services (the basic package).

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[11] International Labour Office (ILO), Social Security (Minimum Standards) Convention, No. 102 (Geneva: ILO, 1952).

[12] World Health Organization (WHO), Regional Office for Europe (ROE), *Targets for Health for All: Targets in Support of the European Regional Strategy for Health for All* (Copenhagen: WHO, ROE, 1985): 23.

[13] Most other ambulatory services, dental care, chronic care, pharmaceuticals and so on were included under either piece of legislation.

NATURE OF PARTICIPATION

The meaning of voluntary and compulsory participation has been equally open to interpretation. Denmark has been credited for having achieved a remarkably high membership with the so-called voluntary sickness funds prior to the 1970s. However, only the upper echelons of a means-tested population could afford to opt out. Medium to low-income workers did not really have this choice, since failure to be a member in good standing in a sickness fund meant automatic loss of eligibility to a number of other social benefits such as pensions, unemployment benefits and so on.

Canadian participation still depends largely on provincial compliance because the federal government has no real direct jurisdiction over most aspects of health care. When the Federal Government introduced its Medical Care Act in the late 1960s, Ontario was allowed to qualify for federal co-financing once it had achieved a 90 per cent rate of voluntary participation even though the law called for 100 per cent participation. All other countries that have been classified as having compulsory participation under Group I offer some voluntary programs through supplemental or private health insurance to cover above-standard services provided by both the private and public sectors. Only Australia and Denmark have in the past allowed those who participate in these programs to opt out of their public programs. Likewise, all the countries that have been classified in Group II have compulsory participation for part of their populations.

In most OECD countries, the nature of participation in a particular scheme has been heavily influenced by the interests of a few major stakeholders. For example, during the early twentieth century, when doctors and hospitals had a difficult time making ends meet, there was little objection to extending membership in the friendly societies or sickness funds to ensure participation of low-income earners. Later, when compulsory participation attempted to extend such coverage to high income groups, it was seen as state interference in the doctor-patient relationship. Similar arguments are often seen in low- and middle-income countries that are trying to introduce compulsory schemes.

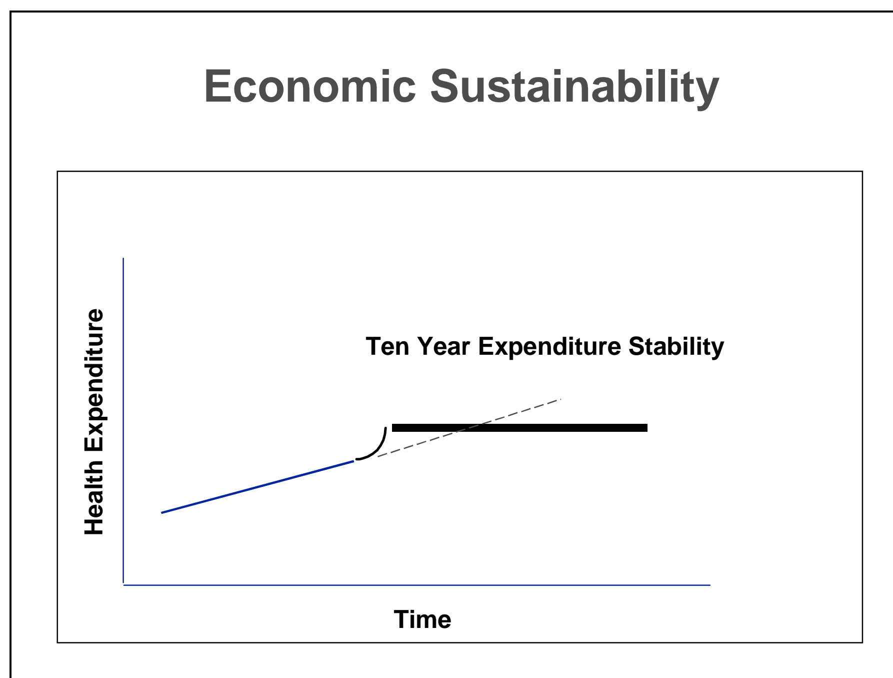
FINANCING MECHANISMS

The actual source of financing used to achieve universal access varies greatly in the OECD, relying on a combination of general revenues, social insurance, private health insurance and direct charges. Today, Group I countries rely more heavily on general

revenue financing while Group II countries rely more heavily on a mix of general revenues, social insurance, and private insurance. Group I countries use a single payer mechanism and all the Group II countries use multiple payer mechanisms.

Despite the doomsday prediction of many critics, almost all the OECD countries that passed major legislative reforms to introduce universal access to health care experienced a decade-long period of stability in health care expenditure following the reform (see Figure 6).

Figure 6: Effect of Reform on Health Care Expenditures



Several explanations can be provided for this levelling off in health care expenditure following the introduction of universality:

- greater policy control over expenditure;
- elimination of the inflationary pressures created by private health insurance;
- saturation of the service delivery system even when entitlement increased; and
- near universal coverage in some countries prior to the reforms.

RELEVANCE OF OECD EXPERIENCE TO THE DEVELOPING WORLD

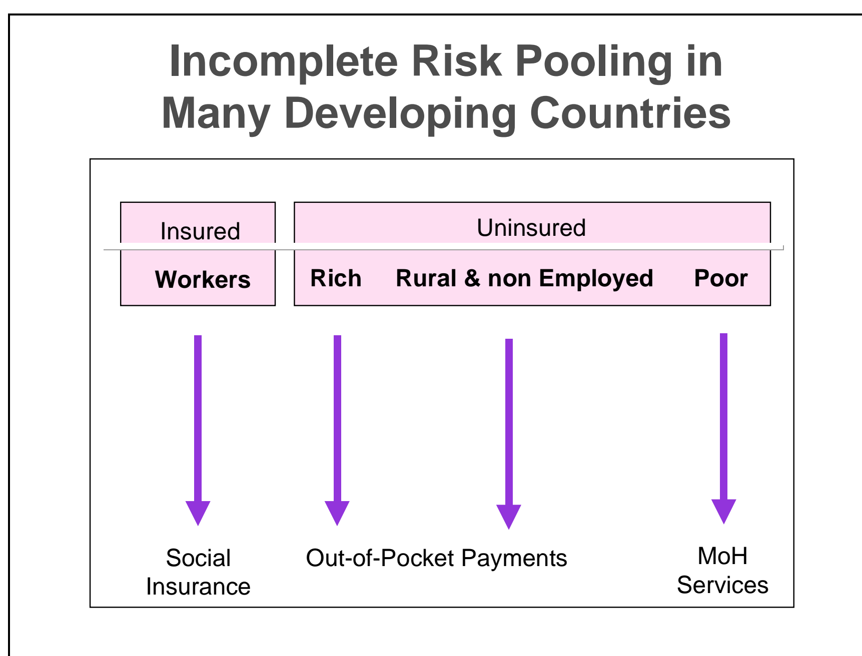
In health care financing, blind faith in the market is no more likely to resolve the complex problems that face the health sector than a naive belief in government. A central lesson from the OECD experience, which is equally applicable to developing countries, is that whereas the private sector plays an increasingly prominent role in service delivery, strong government will be needed in most countries to secure adequate risk pooling, sustainable financing, cost containment, and equitable resource allocation.

Pooling of risks.

Some people are much sicker than others. Sharing of risks across population groups is a fundamental aspect of social protection in the HNP sector. Furthermore, people use health care most during childhood, the childbearing years for women, and old age — when they are the least productive economically. Income smoothing across the life-cycle can, therefore, also contribute to social protection in the HNP sector.

Yet, as in 19th century Europe when health care was still in a primitive stage of development, direct out-of-pocket health expenditure continues to be a distinctive feature of many low- and middle-income countries (see Figure 7).

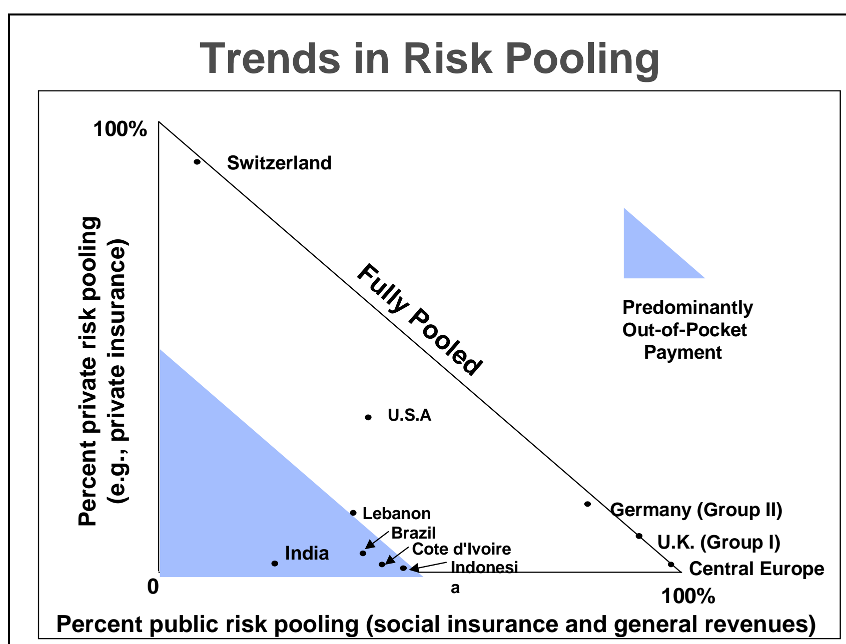
Figure 7: Financing pattern for health care in developing countries



Household payments can account for as much as 80 percent of total health expenditures because of: nontrivial user fees charged in public facilities (official and unofficial); high copayments required in health insurance schemes; and use of private health services (hospitals, clinics, diagnostics, medicines, and health care providers). This undermines the social protection that could be provided by the HNP sector even in low-income settings.

Experience has shown that strong action is needed by the public sector to take advantage of the substantial resources that can be mobilized through private channels, while at the same time ensuring social protection for vulnerable groups. Because of cost and the pronounced market failure that occurs in private health insurance, this is not a viable option for risk pooling at the national level in low- and middle-income countries (see Figure 8 for the pattern of risk pooling in the OECD and selected developing countries).

Figure 8: Degrees of risk pooling

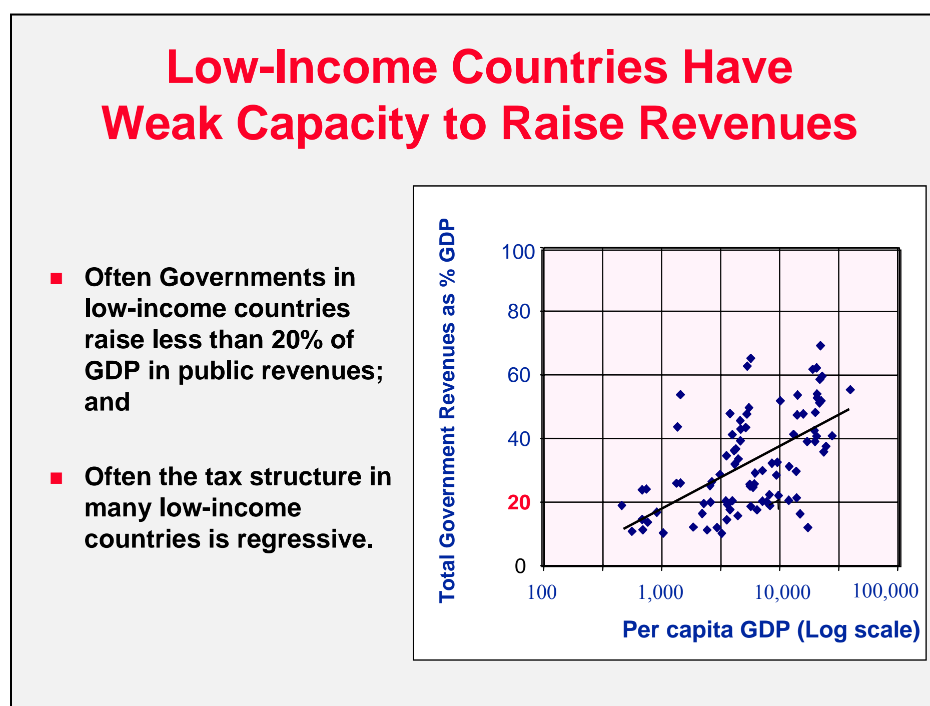


Securing Adequate Levels of Financing.

Strong, direct government intervention is needed in most countries to finance public health activities and essential health, nutrition, and reproductive services, as well as to provide protection against the impoverishing effects of catastrophic illness.

In low-income countries, total government revenues may constitute 20 percent or less of GDP (see Figure 9). Although it is impossible to define a lower threshold precisely, a country with a per capita income in the range of US$300 to US$800 would have to spend in the range of 1.5 to 3 percent of GDP (equivalent to 7.5 to 15 percent of government revenues) to finance a minimum level of preventive and essential clinical services. Many low-income countries spend less than this, and have weak capacity to mobilise further tax revenues (Figure 9). Governments in these countries may need to mobilize additional financing from community sources and international donors to pay for public health interventions with large externalities and essential programs for the poor.

Figure 9: Tax Capacity by Country GDP per capita



In middle-income countries, with per capita incomes above US$800, even at low tax collection rates, governments may choose to spend as much as 3 to 5 percent of GDP on health care. This is usually sufficient to pay for care that goes well beyond essential preventive and clinical services for the poor.

In these countries, other considerations become important, such as tailoring the mix of broad-based financing instruments to each country's individual circumstances. Critical factors in this respect would include equity and efficiency in collection mechanisms, administrative simplicity, budget mechanisms, cost containment, willingness to pay, affordability of the benefit package, and stability in the underlying macro-economic environment. Countries must also ensure that a large share of financing derives from a prepaid source of revenues (risk pooling through general revenues, and/or social or mandated health insurance that is community rated) to avoid the equity and efficiency problems associated with extensive reliance on user charges.

Containing Costs and Fiscal Discipline.

Even in low- and middle-income countries, a significant share of national product and public resources is spent on health care. Although there are no fixed upper limits, fiscal concern may be warranted if total health spending is greater than 6 to 7 percent of GDP or if it is rising rapidly, since public funds are often involved. In too many countries, high expenditure levels involve public money spent on ineffective services that benefit only a few, while large segments of the population still do not have adequate access to essential care. In cases where expenditure control becomes an issue, governments have recourse to three broad types of policies:

- Policies that contain costs in the public sector through supply, demand, and price control strategies;
- Policies that regulate the private sector, discourage the use of indemnity insurance, and encourage capitation payments rather than fee-for-service; and
- Policies that strengthen monitoring and tracking of health expenditure patterns (using health accounts).

Improving Budget Practices and Resource Allocation.

Unfortunately, in a large number of low- and middle-income countries, one of the key issues relating to health care financing is neither lack of adequate resources nor run-away expenditures. Rather, problems in health care financing often result from poor budget practices, including a habit of deficit financing and a misallocation of scarce resources on ineffective care. Three policies help countries balance their budget:

- Avoiding unfunded mandates (ensuring that financing is available to cover such expenditures);
- Ensuring that income from all sources exceeds expected aggregate expenditure levels by a margin (often 3 to 5 percent) that is sufficient to cover capital depreciation, and maintenance;
- Setting clear sanctions against budget overruns and the accumulation of irreducible debt; and
- Allocating a large part of the budget envelope to effective interventions that improve outcomes.

WESTERN EUROPEAN SOCIAL HEALTH INSURANCE SYSTEMS: A TWO-SIDED COIN?

Bart Criel

Introduction

Western Europe has a long-standing tradition of social health insurance. These systems of collective aid and support developed in a specific historical context. It is likely—even necessary—that they will further evolve and look different in the future. Although they have a good track record in reducing exclusion and uncertainty, they also face a number of challenges. Health planners and politicians are, in the first place, concerned with the explosion of costs and the increasing problems of financing these systems. The focus in this paper, however, is not on financing, but on more "qualitative" issues: the perception and interpretation of solidarity, and the political and social dynamics of community-based mutual aid arrangements.

The paper more specifically discusses how and why European society came to develop such collective arrangements to cope with individual adversities. Historically, social health insurance evolved from small-scale population-based solidarity arrangements to huge bureaucratic and centralised but nevertheless effective and reasonably efficient organisations. The issue of solidarity has been, and still is, quite crucial in this history. The paper briefly attempts to define what solidarity is about. Finally, it discusses one of the main challenges faced by European social health insurance systems: i.e. the need to (re)discover values and emotions behind the figures and the data. There are lessons to be learned from European experience for those middle-income countries that consider the introduction of social health insurance systems.

The Genesis Of Collective, Nation-Wide And Compulsory Arrangements To Cope With Individual Adversities

In the period of early industrial capitalism and accelerating urbanization at the end of 19th century Europe, small-scale voluntary mutual insurance movements were created in order to cope with changing needs. 'Traditional' mutual aid mechanisms, based on kinship and on the tradition of craftsmen's guilds (which have existed in Europe since medieval times) were no longer adequate in this dramatically changing environment. Strong associations developed where workers put part of their meagre salary aside—often on a weekly basis—for a common fund that would help their families in case of loss of employment, disability, old age, death, etc. In that period, the health care system was still of limited effectiveness and coverage of health care was of rather marginal importance in these mutual aid dynamics. Benefits were mainly of a non-medical nature. In England

and Wales these dynamics took the form of 'friendly societies' (almost half of the adult male population belonged to a society by the middle of the 19th century); in France these associations were called '*Sociétés de secours mutuel*' (i.e. mutual aid societies).

The management of these associations was relatively autonomous, but many of them were inherently weak and vulnerable because of the limited knowledge of actuarial science. Contributions were set according to vague rules. The general lack of administrative skills facilitated corruption, fraud, and favoritism. Small in terms of membership and capital, these associations brought together people with similar social, professional and even demographic characteristics, and often with common political ideas. The homogeneity of the membership reinforced a sense of togetherness; but it also led to a concentration of risks of (occupational) disease or loss of work. The fact that people within these associations often were of the same age-group meant that they would grow old together: the burden of paying for relief in old age would become too heavy when the proportion of non-working members would suddenly increase. The trade-off was apparent, even if not explicitly recognised, between, on the one hand, social homogeneity and concomitant concentration of risks, and, on the other hand, a more heterogeneous membership with dispersion of risks but with weakening of social cohesion.

De Swaan (1988) identified two key concepts that are useful in our understanding of how and why social health insurance developed in Western Europe: external effects on the one hand, and the intensification of chains of human interdependence between rich and poor on the other. Both legitimised the need for collective action.

The concept of 'external effects', as it is used in welfare economics, refers to the fact that one person's suffering also affects others. All have a stake in avoiding someone else's suffering, if only out of mere self-interest. The rich in 19th century London had a reason to invest in proper water and sanitation infrastructure for all inhabitants—including the poor. Mass epidemics of cholera were rapidly recognised as the consequences of poor living conditions among the urban poor. If the rich wished to prevent cholera from spreading to their own living quarters, then a collective effort was necessary.

The second concept refers to the extension and intensification of the 'chains of human interdependence' over the course of time. This interdependence dramatically increased as

a result of nation states, and because of the development of capitalism and the processes of urbanisation and secularisation that went with it. States established bureaucratic networks linking people together as taxpayers, army recruits, students, patients, voters, etc. Capitalist entrepreneurs connected people in networks of production and exchange as workers and consumers. All this led to increasing interdependency and to new, further reaching effects of one person's adversity upon others. Someone else's sickness had not only consequences for that individual's health, but also for socio-economic life in general. People had to be healthy to produce, to consume, and to function in society at large.

When looking at the particular case of social health insurance systems, the following phases can be distinguished in their development. First, there was the long-standing tradition of collective mutual aid movements, which experienced a tremendous boost at the end of the 19th century in a period of rapid industrialisation, increasing interdependencies, and class struggle. This movement was then gradually institutionalised and was subject to increasing intervention by a strong state in the 20th century as a result of growing social claims. The first nation-wide compulsory insurance scheme was established in Germany under Chancellor Bismarck[14]. In most other European countries, a compulsory health insurance system was implemented for wage earners in the wake of the Second World War. The system was extended to non-wage earners in the 'golden sixties'—when there was plenty of money and economic growth.

Why this need for compulsion? It is because collective action also means that a joint effort by some may benefit those who do not contribute to it: collective action is hampered by the "free-rider" phenomenon. This dilemma could only be solved by either mutual trust or by compulsion. Mutual trust, however, has limited scope for overcoming this dilemma, certainly when the scale of the collective arrangement increases. This explains why these arrangements were increasingly based on compulsion and carried by the state or by some public body invested with the authority needed to impose compliance, and with the necessary bureaucratic apparatus for its implementation. Nation-wide, state-controlled, compulsory institutions of social security also provided

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[14] Initially, this took place with resistance from the workers' movement and against much opposition in parliament. The Social Democrats feared that social insurance, on a compulsory basis and with more state control, would cripple their movement. Social insurance also was a political instrument for the Bismarck regime—in coalition with industrialists—to strengthen the state and its apparatus and to improve its ties with the industrial working class. The short-term objective was to stem and

greater security—the state being the most creditworthy risk-bearer. The increasing intervention of the state in the field of health care was consistent with the paradigm of health care as a public good in European societies—in contrast to the United States (Bank, 1997).

This take-over by the state enabled a dramatic increase in coverage and scale, certainly after World War II. Quasi-universal coverage was achieved in most Western European societies in the early 1970's (Kurdle & Marmor 1995). This process was, however, accompanied by qualitative transformations in terms of social relations between members. Professionalisation and bureaucratisation increased; rules, regulations, and objective procedures took the upper hand. Insurance became the business of highly skilled technicians, while the improvement of actuarial science made it possible to calculate risks, fees, and benefits. This impressive achievement of administrative technique was possible because the state could provide the most effective administrative and organisational structure.

Social health insurance systems in Western welfare states have become impressive machineries; they managed to improve access to health care, to institutionalise solidarity, and to dramatically reduce social exclusion[15]. But a price was paid for these impressive achievements. The complexity and technical nature of decisions justified increasing specialisation and centralisation of decision-making, but at the same time contributed to increase the gap between people's contributions on the one hand, and the actual use of that money on the other. The gains in effectiveness and efficiency came at the expense of participation, ownership, and individual responsibility. Health care expenditure faced an explosive growth, without, however, a matching proportional improvement in quality of life. An important increase in inappropriate use of health services took place— due to both provider and consumer moral hazard. People's capacity to take care themselves of a certain number of health problems was undermined in favour of institutionalised and medicalised solutions. Hence, today we have a system with almost total coverage,

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domesticate the rapidly swelling tide of the workers' movement and to secure workers' loyalty. The state subsidies were the price to be paid for more social control (de Swaan 1988).

[15] Elchardus (1994) writes that European social security systems will probably be amongst the greatest achievements in (European) civilisation and that *"our social security system is perhaps the only 20th century artefact that can reasonably face the comparison with the Middle Age cathedrals"*. In Belgium for instance, about 40% of households would live in precarious socio-economic conditions, even outright poverty, in the absence of the social security system. Today, "only" about 6% of the population live in poverty (Kesenne & Evrard 1997).

substantial state intervention, but with little community participation and sense of ownership (see table 1).

Table 1: Comparison of the features of European social health insurance systems at the time of their inception and today

Time of inception	Today
• low coverage	• high coverage
• limited State intervention	• important State intervention
• limited package of benefits*	• comprehensive package of benefits**
• small-scale initiatives with few economies of scale	• nation-wide systems with important economies of scale
• managerial transparency and important community control	• managerially complex with limited community control
• strong feeling of ownership by the community	• weak feeling of ownership by the community

* Confined to the protection of family assets and income in case of loss of work, illness, or death

** Including health care costs

The Value Framework Underlying European Social Health Insurance Systems: The Issue Of Solidarity

Social health insurance, even if perceived today as a large bureaucratic machinery, has its roots in face-to-face solidarity. That value of solidarity has been of critical importance in the development of social health insurance. The concept is, nevertheless, poorly defined.

One way to define it is to follow the logic of de Swaan's argument. The process of collectivisation of health care—the result of a mixture of both self-interest of the elite and the booming social and political dynamics of mutual aid in a rapidly changing environment—eventually led to the creation of a 'social consciousness' in European society: *"an awareness of the generalisation of interdependence, coupled with an abstract sense of responsibility which does not impel to personal action, but which expects the needy to be taken care of by the State and out of public tax funds"*. This 'social consciousness' implies a tacit approval of a

high tax pressure by a majority of citizens. It is definitely the expression of a more humane society.

Another definition of solidarity is the one given by a Dutch government report: *"the awareness of unity and a willingness to bear its consequences"* (Dunning 1992). Unity indicates the presence of a group of people with a common history and common convictions and ideals. When applied to the case of health care, solidarity means that people accept that the size of the returns to the investments made may not match the resources (financial or others) they have put *ex ante* into the system. The redistributive effects of insurance are consciously accepted, but the willingness to bear 'the consequences of unity' has limits. A feeling of compassion often triggers spontaneous solidarity; but this solidarity generally does not last very long.

Self-interest—based on the element of insurance—must be complemented by a sense of solidarity rooted in broader cultural and emotional grounds. Elchardus (1994) argues that this sense or feeling of solidarity in European societies is based on three components. The first is of Christian origin: the awareness of a personal duty to charity. The second is linked to the historical period of the *Enlightenment* where the perception grew that diversity is not a threat but a positive and enriching experience. Solidarity is then not reduced to the narrow bond existing between individuals of the same kind, but is a feeling of sympathy for many, making life in community a feasible endeavor. The third component is social-democratic in nature. It is the choice for individual dignity and autonomy, with the awareness that the conditions for individual freedom are of a collective nature. Elchardus pleads for a legitimisation of effective modern social insurance systems that goes beyond mere self-interest. It requires a *cultural* and *emotional* basis. It should rest upon a *feeling* of solidarity.

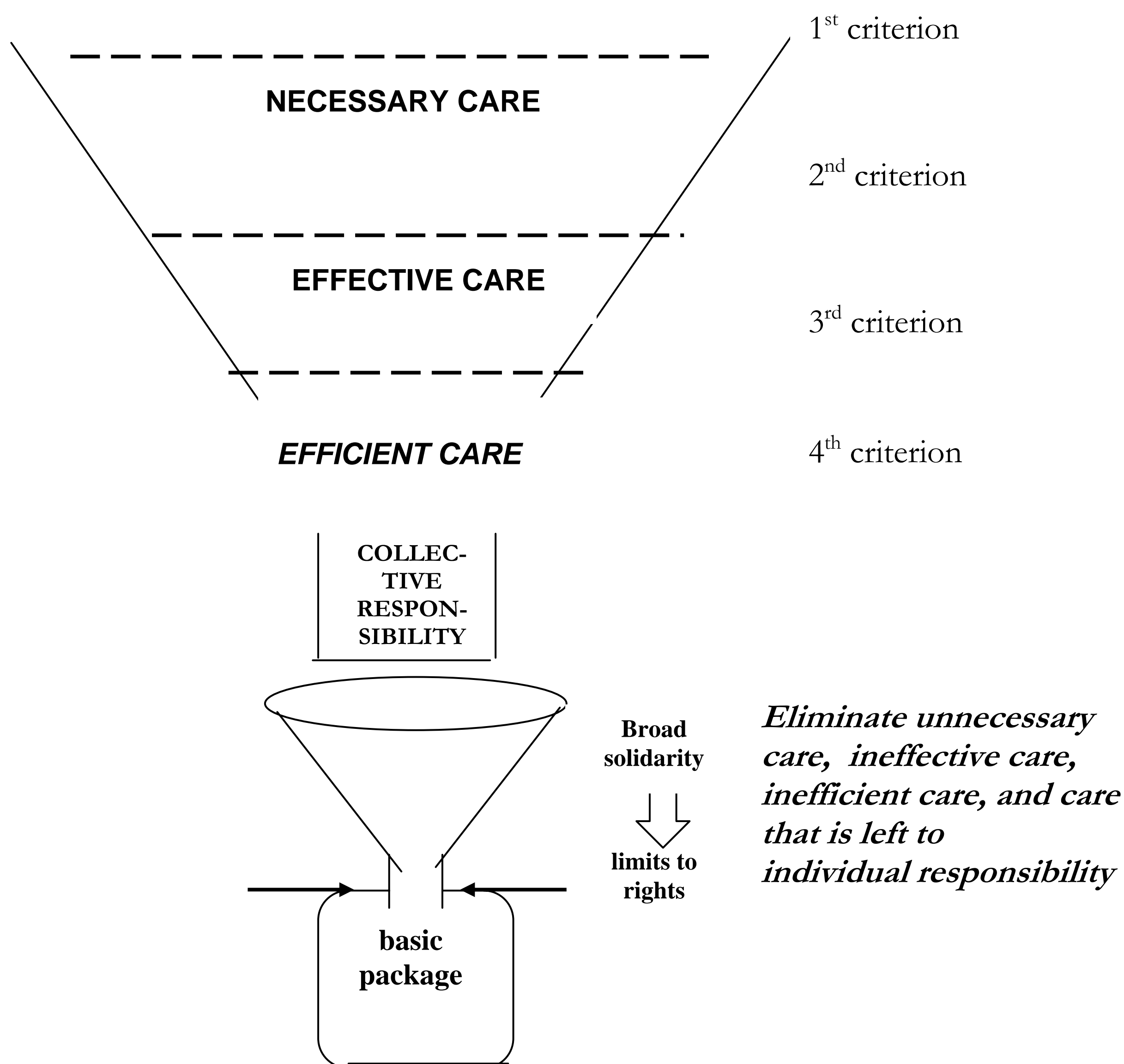
Voluntary health insurance generally builds on self-interest: i.e. economic risk-aversion. It can be blended with different degrees of income- or risk-solidarity. The voluntary character of health insurance carries its own limitations: some people may decide to pull out of the scheme or simply not to engage in it. This occurs when people perceive the potential return as too low: the consequences of the event are not feared (if one is wealthy, one can afford health care when needed) and/or do not warrant the investment (the premiums). Economically this makes sense for the individual, but in societal terms it runs counter to the

principle of solidarity. A situation where low-risk and/or wealthy individuals opt out of insurance is dangerous because it weakens the scheme's financial basis.

In the case of mandatory insurance, the unequal relationship between individual inputs (i.e. the cost for the insured) and eventual return is forced on people by law. Solidarity is then institutionalised, but not, for that matter, cut in stone. Whether and to what extent it is reversed or not depends on the political and social choice society makes. This issue of choices to be made will probably be at the very heart of the debate on European social health insurance in the years and decades to come. In the last few years, there has been a tendency to shrink the package of benefits (or to increase the individual 'out-of-pocket' co-payments—which amounts to the same): this provides an indication of the limits Western European societies wish to set to collective, solidarity-based, financial efforts.

The challenge for these societies will be to make choices on what is to be included in a basic package of care. Which benefits are (still) to be supported by the collectively? And which are not? The Dunning report helped Dutch policy-makers to tackle these questions. The report designed a sieve with four consecutive stages. Is care necessary? Is care effective? Is care efficient? The fourth stage in the Dunning sieve precisely refers to the limit society wishes to set to the collective financing of individual events: is the care to be collectively funded or should it be left to the responsibility of the individual? (see figure 1).

Figure 1. The Dunning sieve



Adapted from Dunning, AJC (1992)

Challenges for European Social Insurance Systems

Today, European social security systems are at best defended with figures and data: human relationships are reduced to financial transfers. This is especially the case amongst people who are marginalised in society, who have become indifferent, and who do no longer participate in community-based social and cultural organisations (Elchardus 1994). "Society has let us down": these people react with mistrust to what they consider as a rupture of contract by society as a whole. The cultural basis of solidarity is gradually being eroded.

On the other hand, the European citizen is ready to give money directly to humanitarian organisations: she/he considers that as being solidarity—which indeed it is. But when she/he pays the (mandatory) contributions for social security in general, and for social insurance in particular, that is perceived as taxes imposed by the State and ***not*** as an expression of solidarity.

The challenge is to make these payments again visible and palpable, so that people can be fully aware of the use of their money but also of the implications of their own behaviour as consumers. It should become clear (again) that through these contributions one does much more than giving to small, meritorious, but often poorly effective charitable organisations.

There is an increasing awareness among the management of e.g. the Belgian social health insurance system of the need to revive the public's sense of ownership of the system. A strategy used by the Belgian national alliance of Christian sickness funds consists of involving its managers in the development of sickness funds overseas—be it in developing countries or in former socialist republics (personal communication, Dominique Evrard, *Alliance Nationale des Mutualités Chrétiennes*). For instance, the sickness fund of the area of Ghent in Belgium (which is one out of the 30 funds that make up the national alliance) is "twinned" with the recently created *Flandria* sickness fund in Poland (Descan 1998). In such countries, sickness funds are developing in a environment where the underlying social dynamic is very lively. Belgian managers offer their specific expertise, but, at the same time, have the opportunity to experience the face to face solidarity and the "social movement" aspect that is at the very core of many of these new initiatives—just as it was in Europe a century ago…

Relevance For Middle Income Countries

Where is the relevance for middle income countries ? What is there to be learned from these, admittedly, broad considerations of Western European social health insurance systems ? There are at least two important issues of interest.

First, there is the need for middle-income countries to be aware that European social health insurance systems are the (provisional) endpoint of a specific and long-lasting social, political, and cultural history. Solidarity, as it is now institutionalised in most of

Western European societies, is a product of that very history. Hence, policy attempts to copy or to 'import' these systems, as they operate today in Europe at the end of the XXth century, ignore this specificity and constitute therefore an a-historical perspective. The solidarity basis—with its specific social and cultural roots—cannot be imported as such. Middle-income countries should, as much as possible, construct their social health insurance systems upon their ***own*** social and cultural roots. One way—not the only one— of doing so is to encourage the development of relatively small-scale bottom-up initiatives.

Second, there is the need to be aware of the other side of the "effectiveness and quasi-total coverage" coin. Effective and relatively efficient social health insurance systems, as they currently exist in Western Europe, often go together with highly centralised and complex decision-making processes, and with strongly reduced community involvement and ownership. Centrally managed social health insurance systems are therefore not necessarily always, nor everywhere, the best solution. One of the important challenges for middle-income countries lies in the design of models of social health insurance which strike an optimal balance between the effectiveness and robustness of large-scale systems on the one hand, and the transparency and sense of community ownership of small-scale mutual aid arrangements on the other.

Acknowledgments

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Universal Coverage of Health Care: Country Experiences

Europe

THE GERMAN

HEALTH CARE SYSTEM

Dr. Jürgen Hohmann

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Introduction

When discussing the German health system it is important to note that it has evolved over a period of more than 100 years. Within the socio-political framework of Germany, the health care system is an integral part of the social security system. The social security system has been designed within the overall concept of developing and maintaining social harmony (Sozialfrieden) as one of the bases of a social market economy.

One of its main characteristics is that within a legal framework set by the state, the statutory health insurance system settles its affairs autonomously and has its own budget separate from the state budget. Insurance carriers are financed from contributions shared equally between employers and employees in contrast to public health schemes funded from general taxes. In such a health insurance scheme based on solidarity financing, contributions are calculated as income-based premiums whereas benefits are granted in line with the medical requirement and are independent of the individual's financial means. By separating the calculation of contributions from the individual's insurance risk, a solidarity balance is guaranteed, implying that the healthy stand by the ill, the young by the elderly, those who are single by families, and the better off by the less well off.

In addition to this solidarity principle (Solidaritätsprinzip), the second major principle governing German social policy in general is the principle of supplementarity (Subsidiaritätsprinzip). It provides for the government to step in as a regulator of private affairs only if the autonomous insurance carriers fail to guarantee efficient social security or overburden the contribution payers.

The autonomy of statutory health insurance is reflected in the fact that its organisation is separate from the state and that those directly involved participate in insurance matters and safeguard their own interests through elected members. The parties involved are the persons insured and the employers who pay contributions. This principle, called "self government", requires the formation of organisations, e.g. employer organisations and associations of the insured to simplify administrative processes. The state determines the legal framework within which the representatives of the insured and their employers settle health insurance matters themselves. Self government in statutory health insurance means subsidarity - the control function of the state should be limited to the supervision

of compliance with legal provisions. The internal organisation of the insurance carriers is a matter for self- government.

In this context, the "Gesellschaft für Versicherungswissenschaft und Gestaltung" (GSV) (Society for Insurance Science and Design) recommends: "Those who decide to establish such a system, should rapidly separate the function and duties of health insurance from the state and transfer them to independent insurance carriers" (Leienbach and Sörensen 1996, 44-46).

Another basic principle ensures free choice of providers as well as access to the same quality of care on equal terms.

One major prerequisite of the system is the obligation of all individuals to participate in the financing of the health care system. Up to a certain income level (DM 75 600 [$39.000] per year) citizens are compulsorily insured in statutory sickness funds; people in higher income groups are not obliged to join a health insurance scheme. Nevertheless in 1997, 86% of the German population were enrolled in the public health care system (either on a voluntary basis or as members of a compulsory health insurance scheme) and 11% are privately insured (Stierle 1997,7).

The German social security system is built upon five pillars:

- statutory health insurance
- nursing care insurance
- accident and disability insurance
- unemployment insurance
- pension funds.

The German health care system, which is discussed below, is an integral part of this structure designed to sustain the development of social harmony.

History Of The German Health Care System

First attempts to develop a health care system can be traced back to the Middle Ages to the so-called "medical edicts" (Medicinal Edikte), which sought to establish generally valid

curricula for pharmacists, doctors and midwives to control diseases and to further public sanitation. In 1725 the Prussian state organised its sanitation by a medical edict. The middle of the 19th century saw the creation of regional schemes of the general local health insurance (AOK) funds as well as company health insurance schemes and special health insurance funds for handicraft workers, students, and pensioners. Introduced with the "Bismarcksche Sozialreform" the parliament passed in 1883 a law obliging blue-collar workers to participate in health insurance. Two-thirds of the contributions were to be paid by workers and one-third by employers. This health insurance provided free medical treatment, free medical drugs, sickness benefits and maternity care. The inclusion of family members was not obligatory but possible. In 1911 the various elements of social security - such as health insurance, pension funds, accident insurance - were merged into the "Reichsversicherungsordnung". At that time more than 23 000 health insurance schemes existed in Germany, of which 70% had no more than 250 enrollees. Health insurance in Germany subsequently experienced a considerable concentration, leading to only 1304 health insurance funds today with an average of 54 000 insured. This concentration process was triggered by several factors, mainly the parallel concentration of companies, changing local structures of the regional funds, and social changes as well as the development of new risks while others were disappearing.

In relation to the introduction of statutory health insurance such as that in Germany, it has been shown that long periods of transition are necessary. Independent professional, local or regional groups and companies can be motivated to set up independent insurance funds. They will eventually establish and consolidate their structures in a system where competition goes along with performance and in accordance with the principle of solidarity which has to remain the *conditio sine qua non* of a sustainable social security system.

The Patients' Perspective

All patients have freedom of choice of doctors and hospitals and the same extent and quality of services guaranteed. Therefore the health system has to provide for the availability of as well as the access to services. This applies to members of both statutory and private health insurance. Privately insured patients get billed and are later reimbursed by the insurance company whereas statutorily insured patients have basically free access to all health care institutions.

The German system distinguishes clearly between ambulatory and hospital care.

Ambulatory care

Doctors who are self employed in their medical practices are mainly responsible for the out-patient care. Since 1994 all patients enjoy free choice of either a general practitioner or a specialist; formerly statutorily insured patients needed a GP referral to see a specialist. Nowadays patients are even allowed to consult several doctors of the same speciality. In 1996 43,380 general practitioners and 65,738 specialists had established medical practices (KBV 1997). The idea behind the offer of specialist out-patient care is to reduce in-patient care. For further investigations doctors consult their out-patient colleagues first; in emergencies or for other needs patients can be referred to hospital.

Before 1987 there was no co-payment in the German health system. To counter a general lack of cost-consciousness, several reforms have been introduced. The ones concerning the patient as a consumer included the introduction of co-payment. At the level of ambulatory care, this applies to pharmaceuticals (lump-sum of DM 9, 11 or 13 per prescription item), aids (such as hearing aids or glasses) and remedies (physiotherapy or massages), false teeth and transport costs. Patients below a certain income are exempted from co-payment; it is generally limited to 2%-4% of gross income per year.

Continuing concerns include the lack of co-operation, co-ordination and communication in ambulatory care resulting in repetition of diagnostic procedures and endless patient histories. Care for the chronically ill and patients with multiple diseases in particular requires more comprehensive and consistently applied concepts in ambulatory care. The patient as a consumer is in a weak position to search for help and advice as well as the best treatment from the provider. Doctors receive their payment based upon the medical service they provide; therefore they have little economic incentive to refer patients. This might increase the patient's uncertainty regarding the appropriateness of care. Remedying this unfortunate situation while keeping the independence of patients and doctors requires ideally a relationship of confidence between patient and doctor to co-ordinate the patient's needs (Hohmann 1998).

In-patient care

For all patients, hospital admission requires a doctor's referral except in cases of emergency. Statutorily insured patients are entitled to unlimited in-patient treatment in authorised hospitals if the illness calls for such treatment and the purpose of such treatment cannot be achieved through out-patient care (Federal Ministry of Health 1994, 41). The hospital service includes medical and nursing assistance as well as room and meals. Co-payment is limited to 14 days of in-patient stay; within that period the patients paid DM 25 per day in 1998.

Hospitals are classified according to the type of care they provide: basic, standard, specialised or centralised care. Normally doctors have to refer their patients to a local hospital offering the service required.

Rehabilitation

Rehabilitation can be divided into medical, vocational and social components. The legal basis for rehabilitation in Germany is incorporated in the Social Code §10 of Book One according to which "any person who is physically, mentally or psychologically disabled, or who is threatened by such a disability, has a 'social right' independent of the cause of the disability, to the assistance which is necessary to

- avert, eliminate, or ease the disability, prevent its aggravation or reduce its effects and
- to secure a place in the community, in particular in working life, in accordance with his or her inclinations and abilities.

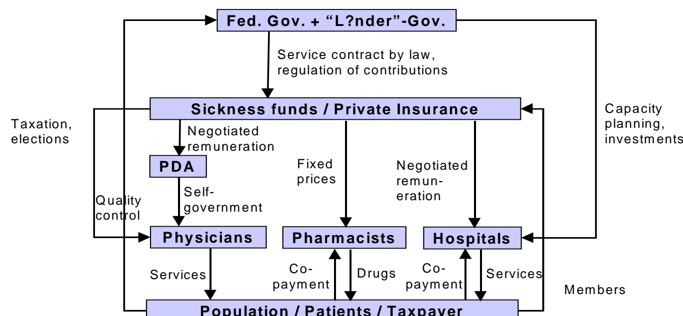
Usually the rehabilitation process develops from medical to vocational and social rehabilitation. Statutory health insurance, pension funds and statutory social insurance share the responsibility and financing of rehabilitation schemes. The motivation for the pension fund to finance rehabilitation is to keep and further the patient's earning capacity. Therefore the patient has to undertake the obligation to co-operate. Moreover the patient's individual rehabilitation scheme must hold out the prospect of vocational reintegration.

The patient, supported by his/her General Practitioner, applies for rehabilitation to the responsible pension fund. The application is reviewed by the medical service considering medical conditions as well as age, social and cultural aspects. Statutory health insurance

funds require a referral from the GP similar to hospital referrals. Their clients are mostly recruited from the non-employed, such as children, students or pensioners.

Integrated rehabilitation is usually performed in specialised hospitals; the accepted length of stay is three to six weeks. Special centres offer the opportunity for vocational and social rehabilitation lasting between six months and three years.

Figure 1: Key Participants in the Health Care System



The Structural Background: Relationship Between Benefit Providers And Health Insurance Funds

The partners negotiating health care in Germany (see Figure 1) are the sickness funds and health care providers - doctors' associations for ambulatory care and hospitals for in-patient care, pharmacists, public health services and home-nursing services. The role of the state is limited to the legal framework within which providers and insurance funds organise their relationship. They regulate their relationship through contracts which create structures of joint self-government. The negotiations take place under the guidelines of the Concerted Action Committee, consisting of representatives of interested parties. The Committee meets twice a year to set maximum rates of increase in health expenditure and to suggest improvements to increase efficiency and profitability of the health care system. The benefits-package to which insured patients are entitled is fundamentally regulated by law.

The contracts regulate

- the type, package, economic efficiency and quality of the benefits provided
- the type and dimensions of remuneration
- settlements and controls
- guarantee of a nation-wide provision of health care benefits (Leienbach and Sörensen 1997, 54).

Statutory health insurance

Statutory sickness funds can be separated into Statutory Insurance Funds (covering 86% of the population in 1996). 11% of the population are privately insured. In 1998 membership was compulsory for workers earning less than 75 600 D-Marks per year. Contributions are income related and the funds are free to determine their contribution rates within a limit laid down by law (the average rate in 1998 was 13.4 %). As the contributions are shared between employers and employees, both are members in the assembly of representatives constructing the basis of the health insurance administration. Contributions for state-pensioners, the unemployed and the disabled are made from social security funds (data KBV 1997 and AOK 1998).

Two main reforms in the 1990s should be mentioned that aimed at balancing the risk structure between health funds, and strengthening competition.

To compensate for the unequal numbers of unemployed and elderly members in the different health insurance funds, which produced decreasing contributions, in 1994 risk structure compensation was introduced as a compulsory measure for all funds. Following an analysis of the demographic variables of the insured within a fund according to income, age, gender and family, funds with high cost membership are subsidised by other funds. This is meant to create more equal starting positions for all funds and should lead to a harmonisation of contribution rates and a more balanced risk structure.

In order to strengthen the role of the individual enrolee, the German legislature introduced in 1996 the free choice of health insurance fund. At the same time, remaining differences in the treatment of workers and employees were abolished. This also led to competition between health insurance funds.

Out-patient care

At the end of 1996, 112 660 doctors had established medical practices. 98% of the doctors provide services for almost 90% of the German population covered by the health insurance system. Due to the high degree of training and the equipment of their practices, the doctors provide comprehensive services for their patients. As the GVG puts it :"as much out-patient care as possible and as little in-patient care as necessary... Dental care is in principle also provided, by dentists who have established their own medical practices. Their structure of self government corresponds to the structure of medical care." (Leienbach and Sörensen 1996, 55). Meaning that what applies for medical care basically also applies for dental care.

Self government - structures and competencies:

Following the federal structure, medical doctors with a contractual relationship with the sickness funds have formed two structures:

The Medical Board: The function and competencies of the Länders Medical Boards are regulated by law. They have the status of public law associations. Membership is compulsory and is based only upon professional qualification. The Boards' functions are mainly the support and regulation of training, the control of compliance with a code of practice, and to serve as an arbitrator between doctors and patients. The "Länder Medical Boards" form the "Federal Medical Board" (Bundesärztekammer, BÄK).

Panel Doctors Associations: The "Panel Doctors Associations" (Kassenärztliche Vereinigungen der Bundesländer) are organized at Länder level only. In contrast to the medical boards, all self-employed doctors are members of a Panel Doctors Association (PDA). The panel doctor association is also a public law association serving as a counterpart to the health insurance funds.

A PDA has four main tasks:

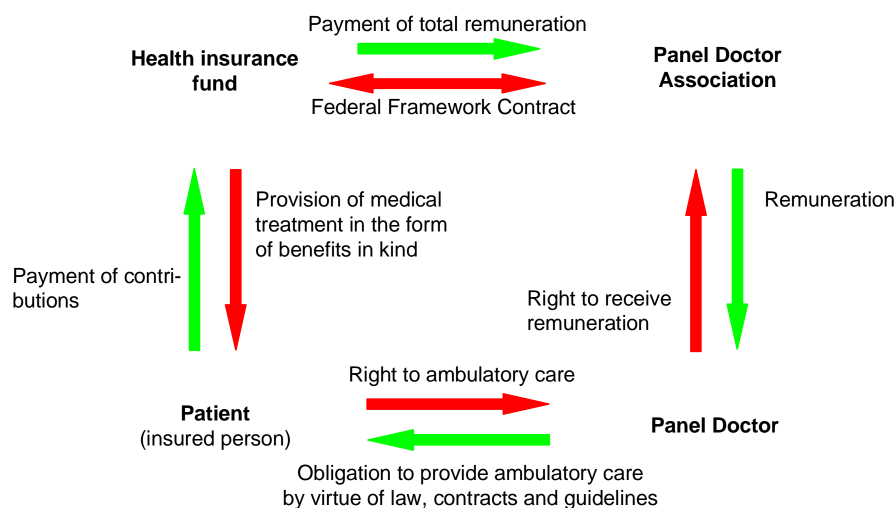
1. Ensure services in terms of quality and quantity including sufficient emergency services
2. Guarantee the implementation of services
3. Act as a special interest association representing doctors' rights vis-à-vis statutory health insurance funds and political authorities
4. Capacity to contract.

86 percent of the German population that is covered by health insurance receives out-patient care based on contracts concluded between the providers and health insurance funds. All decisions drawn up by the PDA are controlled by an arbitration board. They are based upon consensus and follow the principle that no existing contract may expire before a new contract has been concluded. State control is limited to monitoring the legality of administrative acts and provision of services and autonomous self government is assured.

Remuneration of the panel doctors is organised according to the principle "money follows the patient". The relationship and money-flows between patient, panel doctor, health insurance funds, and panel doctor associations, are described in Figure 2. The individual doctor is paid for his individual services, and remunerated according to the fee schedule agreed in the contract between the PDA and the health insurance fund. After accepting the agreement, the sickness funds pay a prospective lump sum to the PDA which distributes the sums to the individual doctors.

Capacity to contract is the core task when discussing the structure of the German health care system, because it is the basis for self-government. It enables providers and health care funds to manage their affairs autonomously, and at the same time guarantees a system of checks and balances preventing the excesses of an uncontrolled free market system.

Figure 2: Cash Flow in Out-patient Care



Provision of services in hospital - in patient care

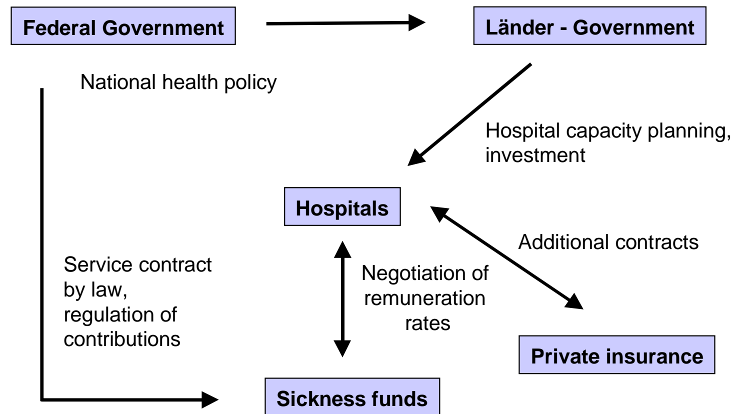
There are three main types of hospital in Germany:

- public hospitals, accounting for 51% of the beds, operated by local or district governments
- private voluntary hospitals, accounting for 35% of the beds, operated by charitable financing authorities

- private for-profit hospitals, accounting for 14% of the beds, usually owned by for-profit organisations.

The Länder have the responsibility for Hospital Planning which is usually performed by planning committees whose members include representatives of hospital financing authorities and statutory health insurance funds. Remuneration is negotiated between hospital financing authorities and sickness funds. Figure 3 shows the legal framework for inpatient care.

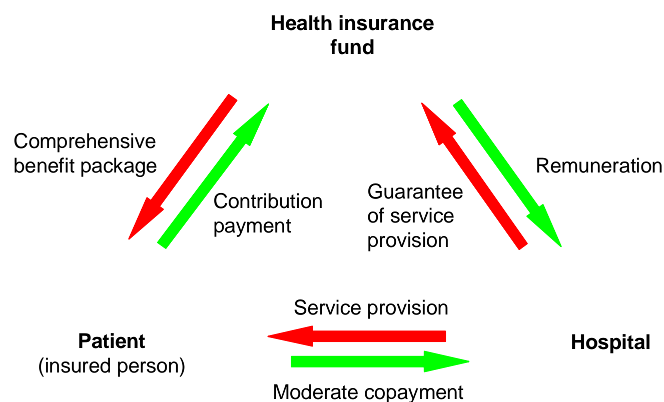
Figure 3: Legal Framework - In-patient Care



Payments to hospitals are made on a dual basis:

- operating costs coming from sickness funds and private insurance and
- investment costs provided by public funding.

Figure 4: Cash Flow in In-patient Care



Since 1996, hospitals have been paid according to services provided (Figure 4). The Land-level federations of health insurance funds enter into service contracts for annual budgets directly with the individual hospitals. In contrast to outpatient care, there are no group negotiations. The service contracts stipulate the rates for care which in principle cover the costs incurred for inpatient care and for other staff costs and services. In addition, the German Federal Care Rate Ordinance (Bundespflegesatzverordnung) sets out flat-rate and special payments for special hospital services. Hospital remuneration is divided into four elements:

Lump-sum payments per case

1. *Flat rates* (taking up 15% of the budget) cover surgical and obstetric services. They include operations as well as pre- and post-operative treatment and were designed to shorten the length of hospitalisation. The flat rates are mainly applied for major surgical procedures, i.e. deliveries, caesareans, appendectomy, hip- or knee-replacements.

Hospital specific rates

2. *Basic rates* cover the non-medical in-patient costs. These are costs for accommodation, meals, capital and maintenance costs (16% of the hospital budget).
3. *Departmental rates* cover the general medical costs of hospital wards. They differ by type of ward (64% of the budget).
4. *Special payments* (5% of the budget) apply for defined medical procedures (i.e. transplantation or surgical procedures which are not covered by flat rates).

The usual hospital remuneration consists of basic and departmental rates. Sometimes special payments have to be added. A flat-rate payment replaces all other elements of remuneration for the specific service.

The joint self-government of hospitals and statutory health funds is responsible for future development of flat-rate and special payment schedules. The main idea behind reforms is to increase economic management and by that to cut costs in general. Any further development of the present payment procedures will remain a mixture of different remuneration elements. A single payment structure through Diagnosis Related

Groups alone, for example, implies a total reform of the underlying ideas and is therefore unlikely.

In 1994, the average hospital in Germany had one bed for 131.4 residents, took care of 17.9 patients per 100 residents with an average stay of 12.7 days. The bed utilisation rate was 82% and out of the 81 500 000 residents, 1 058 545 were hospital employees. In the years 1990-1994 the number of hospitals decreased by 110 while the number of patients undergoing in-patient care rose by some 850 000 (Leienbach and Sörensen 1997, 69).

Private Insurance

In contrast to statutory health insurance, membership in private health insurance is voluntary. Citizens who are not compulsorily insured by the statutory sick funds (those exceeding the compulsory insurance income limit, self-employed persons, members of the liberal professions) are offered another possibility to protect themselves against health risks. Additionally they introduce an element of competition helping to ensure that all insurance providers develop adequate care for their members and avoid mismanagement. All citizens can buy supplementary private insurance to improve their statutory provision, e.g. treatment by a consultant or single rooms during in-patient stays.

Two main principles distinguish private from statutory insurance:

1. They work on the cost reimbursement principle
2. They offer different benefit packages, so that members can choose the ones suiting their needs.

Conclusion

Within a framework set by the government, the German health system is based upon the principles of

- solidarity financing
- supplementarity
- self-governing of funds and providers
- free choice of providers and access to the same quality of care on equal terms.

However, a financial crisis has developed with rising expenditures and falling contributions. Key contributory factors include:

1. *Demographic and epidemiological changes*

   With increasing life expectancy, the number of chronically ill and patients with multiple diseases rise; at the same time low birth rates are the reason for fewer young people living in and working for society.
2. *System factors*

   The lack of co-operation and co-ordination within and between ambulatory care and in-patient care results in higher costs for diagnostic and therapeutic procedures.
3. *State insurance regulation*

   The risk-structure compensation considers the demographic differences between insurance funds but neglects the morbidity status. At the same time the ability of the better-off to leave the statutory health insurance system enables young, working and paying members to leave the statutory insurance funds.
4. *"Cost explosion" in benefits provided*

   More sophisticated diagnostic and therapeutic procedures cause higher expenditures in the health system.

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HEALTH CARE FINANCE REFORM IN TURKEY: TRANSITION TO UNIVERSAL COVERAGE

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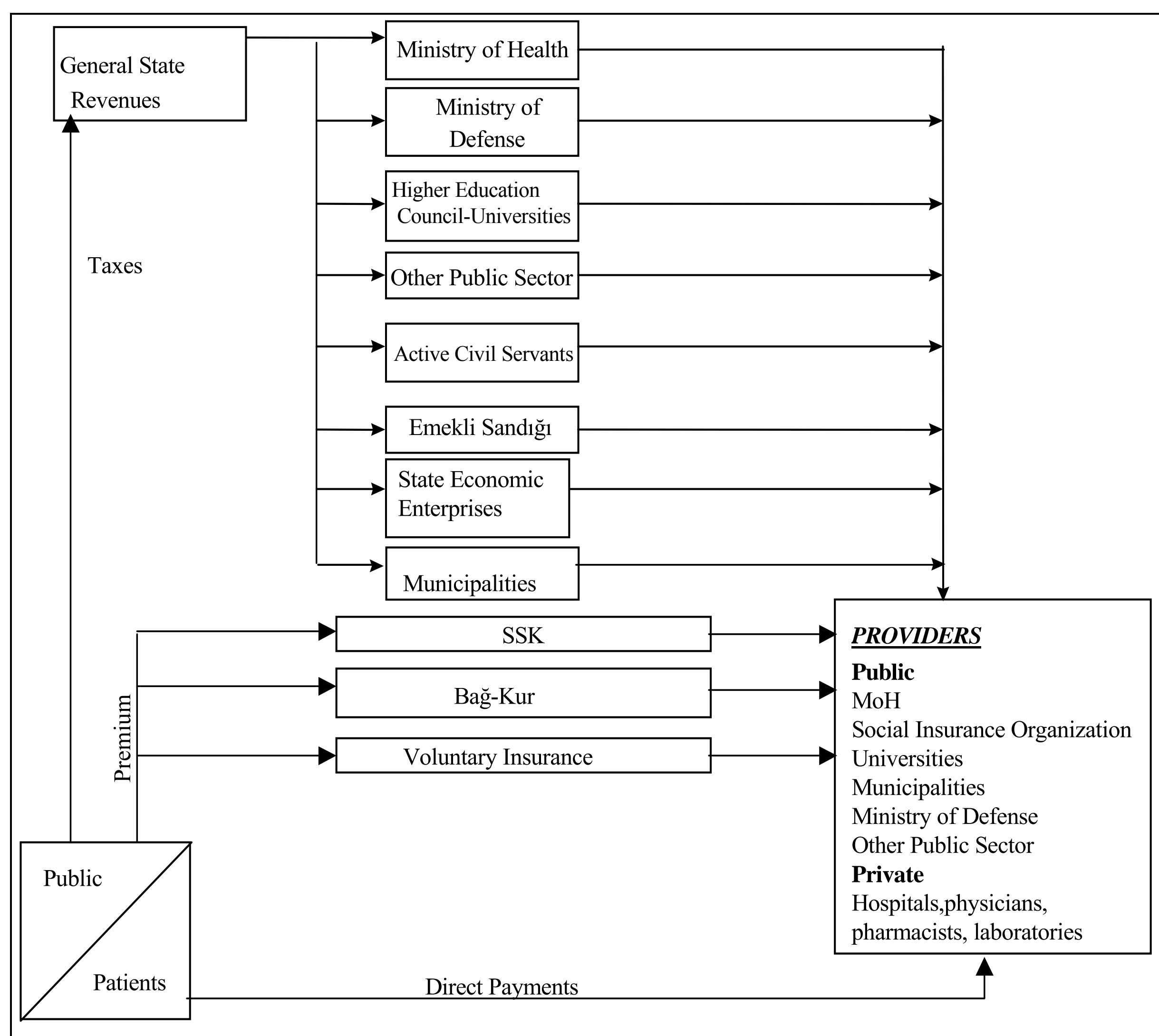
The Health Care Financing and Delivery System

The health care delivery and financing system in Turkey has been consistently characterized as extremely complex and diffuse as there is a large number of institutions involved in the health care system and most of these institutions are performing both service provision and financing (Figure 1).

The Ministry of Health (MOH), Social Insurance Organization (SSK) and the Universities are the main providers in Turkey. Additionally, the Ministry of Defense, private physicians, dentists, pharmacists, nurses and other health professionals provide health care services.

As described in Table 1, tax-based financing is still the major source of health care funds in Turkey. Over the years stated in the table, approximately 45% of the total expenditure is financed by taxation, 25% by social insurance funds through premiums and the remaining 30% by direct out-of-pocket payments (user charges).

Figure 1. THE STRUCTURE OF CURRENT HEALTH CARE FINANCING IN TURKEY



Source: Project Coordination Unit, Ministry of Health

Table 1: Overall Health Expenditures by Source of Funding (Million USD)

	Million $					% Distribution				
	1992	**1993**	**1994**	**1995**	**1996**	**92**	**93**	**94**	**95**	**96**
State Budget	2.776	3.135	2.170	2.457	2.921	46	46	45	43	42
Insurance Funds	1.361	1.472	1.136	1.547	1.708	22	22	24	27	25
User Charges	1.942	2.168	1.464	1.759	2.261	32	32	31	31	33
TOTAL	**6.079**	**6.775**	**4.770**	**5.763**	**6.890**	**100**	**100**	**100**	**100**	**100**

Source: Project Coordination Unit, Ministry of Health

The funds derived from these sources are transferred to the service providers:

- through Ministry of Health, Ministry of Defense, social health security schemes (Social Insurance Organization (SSK), the Government Employees Retirement Fund (Emekli Sandi□i, the Social Insurance Agency of Merchants, Artisans and Self-employed (Ba□-Kur) and active civil servants, Y._.K. (university hospitals), state economic enterprises, municipalities, other public institutions and establishments, special funds, foundations and private health insurance companies;
- directly by users in the form of out-of-pocket payments.

The Ministry of Health

The Ministry of Health currently accounts for the majority of Turkish health care expenditures. Approximately 25% of the total health care expenditure is financed through the Ministry of Health which accounted for 1.9 billion US $ in 1996.

The major sources of funds for the Ministry of Health are (Table 2):

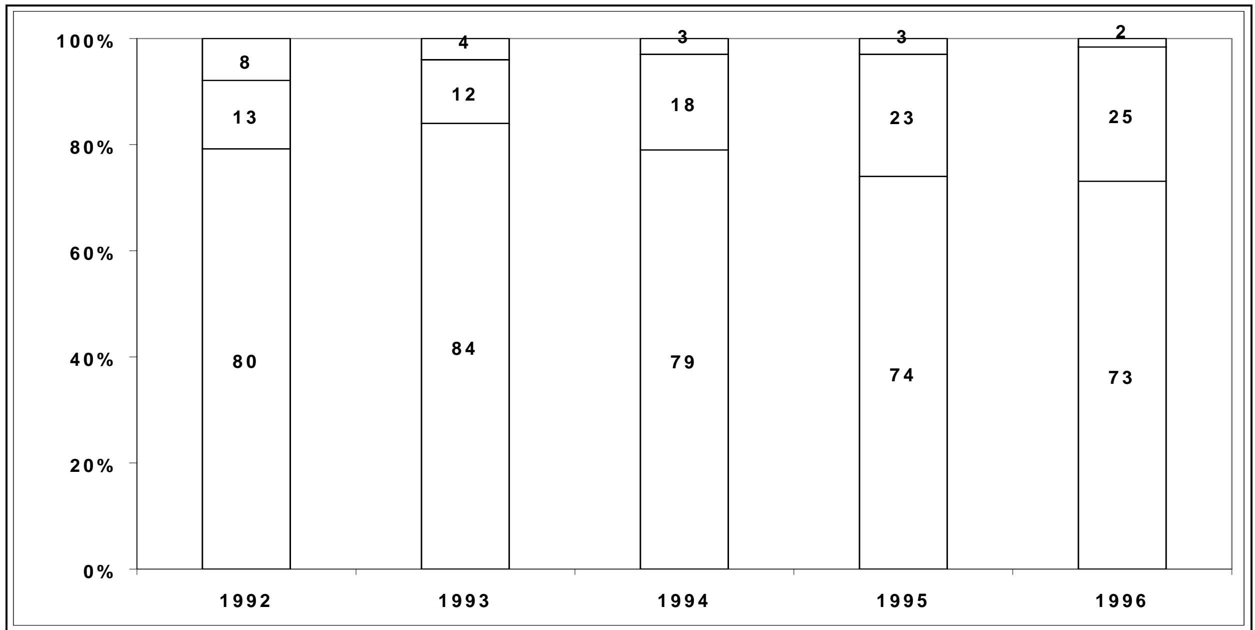
- allocations from the general government revenues (80%)
- fees paid to hospitals by either insurers or individuals (revolving funds) (15%)
- special Funds (5%).

Table 2: The Ministry of Health Funding Sources in Turkey, 1990 – 1995 (Million US$)

	Million $					% Change			
	1992	**1993**	**1994**	**1995**	**1996**	**92/93**	**93/94**	**94/95**	**95/96**
State budget	1.451	1.647	1.022	1.208	1.379	13	-38	18	14
Revolving Funds	231	226	235	376	479	-2	4	60	27
Special Funds	140	88	36	41	29	-37	-59	15	-28
TOTAL	**1.822**	**1.960**	**1.293**	**1.626**	**1.888**	**8**	**-34**	**26**	**16**

Source: Project Coordination Unit, Ministry of Health

FIGURE 2: MINISTRY OF HEALTH FUNDING SOURCES – PERCENTAGE DISTRIBUTION



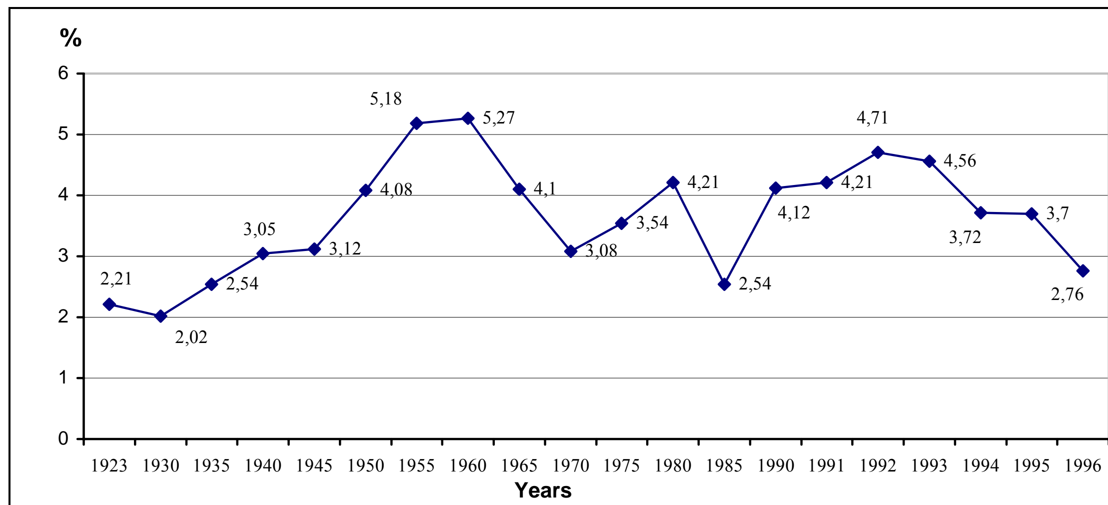
Source: Project Coordination Unit of Ministry of Health

State budget allocations are prepared through simple adjustments by taking the previous year's inflation rates into consideration. In recent years, the inflation rates have constituted a major challenge to efforts to control public expenditure. It has, therefore, become routine to revise the initial general budget allocations during the financial year.

Revolving fund revenues are basically fees paid for services by individuals in the form of out-pocket expenditure or by private and social insurers (Table 2). Fees to be paid (price list for medical procedures) for the health services are determined by a commission consisting of the Ministry of Health and the Ministry of Finance representatives without considering the actual cost of the services, and solely through adjustments according to inflation rates. Since 1988, additional funding has been available from earmarked taxes on fuel, new car sales, and cigarettes.

During the period 1923 – 1996, the share from the state budget allocated to the Ministry of Health fluctuated between 2.02% and 5.27 %. In 1992, a downward trend began and the share fell from 4.71 % in 1992 to 2.76% in 1996 (Figure 3).

FIGURE 3: ALLOCATION OF THE STATE BUDGET TO THE MINISTRY OF HEALTH, TURKEY (%)



Source: Health Statistics Yearbook 1996, Ministry of Health

In 1992, the Green Card Scheme was initiated for Turkish citizens with no capacity to pay for health services. This scheme is providing in-patient hospital health care services, and is financed by the MOH through general budget allocations and special funds. In the period 1992 to 1997, 9 million people applied and 7 million people have been accepted into the Scheme. Approximately 11 % of the total and 33 % of the uncovered population have a Green Card with a US $ 565 million cash expenditure in 1997.

University Hospitals

University hospitals have two main funding sources: the state budget allocations and universities' own revolving funds. The state budget covers both recurrent expenditures and capital expenditures. Through rational pricing policies, the revolving fund revenues have been strengthened considerably in comparison to state hospitals. The expenditures of the university hospitals through the revolving fund are controlled by the Ministry of Finance and the capital expenditures are controlled by the State Planning Organization.

Social Health Insurance Schemes

Health insurance schemes were established in Turkey following the Bismarkian model. They evolved into a complex multi - institutional structure and a fractured pay-as-you-go system, with different legal and regulatory frameworks, out – dated actuarial standards, fiscal indiscipline, and a myriad of exemptions and privileges that have prevented the system from

functioning adequately. For the last 30 years there has been a policy intention to have an integrated and universal health care system. In spite of the intentions and the laws passed to this end, the complex social insurance system has expanded without resolving the issues of adequate financing and quality of provision of health care services. Currently, there is growing intention to institutionalize a new general health insurance scheme and a new health financing institution aiming at fulfilling the ultimate policy goals of integration of the social insurance schemes and of universal health coverage of the population.

Social Insurance Institutions are contributory pension schemes that have expanded to health care over the years, providing health coverage for insured workers and their dependants; government employees and their dependants; and the self employed. 41 million, or 65% of the Turkish population is partially or fully covered under one of these social health insurance schemes.

Social Insurance Organization (SSK)

SSK is a social security organization having a history going back to 1946, originating with the first maternal insurance and professional work accident insurance. The pilot health insurance scheme started in 1951 and expanded to the whole country in 10 years. The present SSK Law instituted benefits for employees in public and private enterprises, and seasonal agricultural workers (since 1982) within the Ministry of Labor. SSK has the status of a state enterprise and is both an insurer and a health care provider through facilities of its own, directly providing health care services through its hospitals, clinics and dispensaries: about two-thirds of the services required by its members. Additionally, SSK members have access to health care services purchased by SSK from the university hospitals and the MOH, and in some cases from private hospitals (for instance for cardiovascular medicine and surgery).

SSK provides coverage to 24 million people, which is 39% of the total population. Sources of funding are as follows:

1. insurance premium paid by employers and employees (11% of the salary-5% paid by employees and 6% paid by the employer);
2. fees paid on behalf of non-members using SSK facilities such as the Social Insurance Agency of Merchants, Artisans and the Self-Employed (Ba□-Kur) members;

3. income obtained through co-payments of drug costs for outpatients (10 percent for retired and 20 percent for active workers).

The coverage of SSK includes pre-paid short-term medical and maternal benefits, employment-related accident and occupational disease benefits; and long-term benefits for old age, disability and survivor pensions. SSK does not provide or pay for preventive services, and therefore is not a fully comprehensive health care insurance scheme. One of the major problems faced by SSK management today is the over emphasis on cost containment policies at the expense of quality. Most SSK clients complain about the quality of health care and accessibility to SSK health facilities.

The Social Insurance Agency of Merchants, Artisans and the Self-Employed (Bag-Kur)

Bağ-Kur is the Social Insurance Agency for Merchants, Artists, and the Self-employed established in 1971 as a contributory pension system within the Ministry of Labor; it is a compulsory scheme for those individuals. Since 1987, its coverage has included health benefits at the same level of SSK. The contributors have access to the same entitlements covering all out-patient and in-patient diagnosis and treatment. Bağ-Kur does not own its health care facilities, and it purchases the necessary services required from the contracted MoH hospitals, SSK facilities; other public hospitals (municipality owned) and from private pharmacies. Reimbursement is made on the basis of standard fees. Drug purchases require a 20% co-payment for active members and 10% from retired members. It covers approximately 9 million people, 14% of the Turkish population.

The main problem of Bağ-Kur is the low compliance rate of its members leading to many dropouts from the system. Today, amongst the 9 million Bağ-Kur members, only 4.8 million members pay premiums and are entitled to utilize health care services.

Government Employees Retirement Fund (Emekli Sandigi)

Emekli Sandiği (ES), established in 1950 as a pension fund for retired civil servants, also provides social health benefits. It is attached to the Ministry of Finance. Retired civil servants and their dependants receive free medical care. It is mainly a pension paying body but additionally handles the health benefits of retired civil servants and their dependants. This Government Employees Retirement Fund finances all health care needs of the retired

government employees with only a 10 percent drug co-payment. Scheme members have to utilize public services for their health care needs except for some special cases such as the absence of required equipments for medical analysis or treatment, where private sector services can be utilized.

Contributions are paid only during working life but they are not in the form of a health insurance premium. The health coverage is actually an element of retirement benefits and it is impossible to split the amounts which active civil servants pay between the two functions. Entitlements are not linked to the existing contributions but rather to budgetary offsets for the government's obligations to retired employees. Therefore, it is possible not to consider ES as a proper health insurance organization. The Government Employees Retirement Fund has no control over its rapidly growing health expenditures and basically pays invoices issued by the health facilities and pharmacies for its members. No technical analysis is done within the Fund about service expenses or utilization rates. There are about 2 million retired civil servants and their dependants.

Active Civil Servants

The health care expenditures of all active civil servants are covered by their public employers through the earmarked state budget allocations. When these budgetary allocations are insufficient, new allocations are issued. There is no contribution from salary in the form of a premium. Additionally, the budget of each ministry or public institution includes earmarked funds to cover these health care benefits. This covers about 6 million people or 10% of the population. Active civil servants, like the scheme of the Government Employees Retirement Fund, have to utilise public services for their health care needs except in some special cases.

Total Health Expenditures of Social Health Security Schemes

As seen in Table 3, SSK accounts for the majority of the total health expenditures of social health security schemes. Scheme expenditures have fluctuated between the period of 1992-1996 except for Ba□-Kur, which saw a continuously increasing trend in the same period. Another point which must be emphasized is that all expenditures peaked in 1996.

Table 3: Total Health Expenditures of Social Health Security Schemes

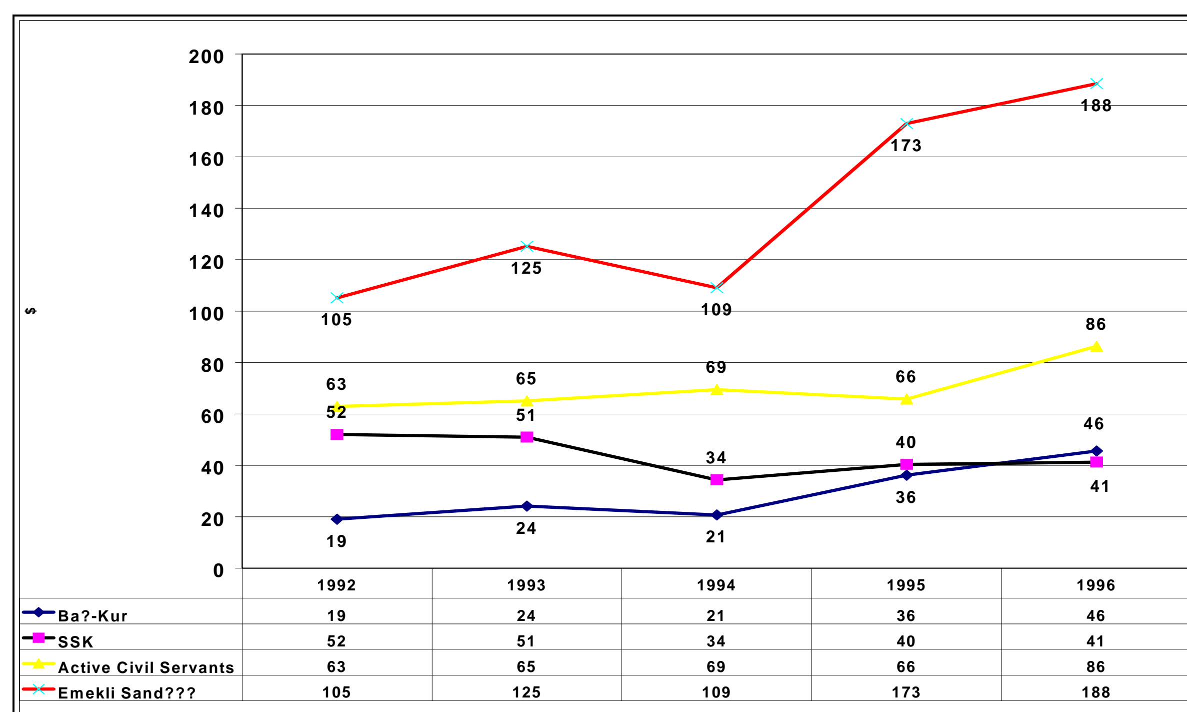
	Million $	**% change**

	1992	1993	1994	1995	1996	92/3	93/4	94/5	95/6
SSK	1.062	1.098	789	980	1.060	3	-28	24	8
Emekli Sandigi think I	223	277	247	391	426	24	-11	59	9
Bag-Kur	76	97	101	176	222	27	4	75	26
Active Civil Servants	421	435	465	440	578	3	7	-5	31

Per capita Expenditures of Social Health Security Schemes

Figure 4 shows that the per capita expenditures of the social health security have increased between 1992 - 1996 except for SSK; and Emekli Sandi-i proves to be the most generous.

FIGURE 4: PER CAPITA EXPENDITURES OF SOCIAL HEALTH SECURITY SCHEMES



Source: Project Coordination Unit, Ministry of Health

The Number of Beneficiaries of the Social Health Security Schemes

Table 4 summarizes the distribution of beneficiaries between the schemes, indicating that SSK is the by far the largest.

Table 4: The Number of Beneficiaries of The Social Health Security Schemes

	Million	(%)
SSK	24.00	38.5
Emekli Sandi□I	2.00	3.2
Active Civil Servants	6.00	9.6
BA□-KUR	9.00	14.4
Uninsured including Green Card	21.4	34.3
Total Population	62.4	100.0

Universal Coverage

Policy development

The Integrated Health Insurance Policy was stressed in the 1961 Basic Health Law, whose intention was to introduce an Integrated Health Service Scheme to unify the services provided by the different and separate social insurance institutions under the same delivery system, and to increase health care coverage in rural areas including community health and maternal child health and family planning. The Law had a target of 15 years to reach universal health care coverage but the objective was never actually achieved. Currently, approximately 41 million people (66% of the Turkish population) are eligible for benefits under one of the major social security schemes, the remaining 34% of the population or 21.4 million people pay out-of-pocket for their care or, if poor, receive free health care in MOH facilities which are directly subsidized by the general state budget (Table 4).

The 1982 Constitution declared the right of every citizen to live in a healthy and balanced environment. A constitutional provision of this kind is considered programmatic in nature, to be fulfilled when the political and economic conditions allow resources to be assigned for its implementation. The 1987 Basic Health Law was enacted to address areas where the 1961 Law and the 1982 Constitution had failed to achieve their health sector objectives. The MOH was formally assigned with the responsibility to integrate the administration of the many relatively autonomous institutions providing health services. However, this also could not be accomplished as the Law did not address the underlying structural problems inherent in the institutional complexity of health financing and delivery. This law had little impact on

the current system. Awareness of the strong need for improvement in the health sector has pushed the government to look for alternative models, which initiated studies for a comprehensive health sector reform programme.

In accordance with this objective, the main framework of the new strategy for health sector reform in Turkey has been generated in the Health Sector Master Plan Study commissioned by the State Planning Organization (SPO). The Master Plan Study has defined, in a comprehensive report, the current situation of the main aspects of the health sector and has produced four main strategy options for its development.

- Improvements in the status quo,
- The Free Market Strategy,
- The National Health Service Strategy and
- The Intermediate Option.

The main characteristic of all four strategies is the extension of health insurance to cover the entire population not enrolled in existing insurance schemes. Additionally, those insured shall pay premiums according to their ability to pay, supplemented by general budget subsidies.

The Status Quo Option: Under this option, the existing health care delivery system would be broadly retained in its present form, except for achieving universal coverage. Nothing would be materially changed in the managerial culture, and the heavy reliance of the MOH and SSK on direct provision of services would continue.

National Health Service Option: This relies heavily on tax funding, and all public sector health facilities would be combined in one provider system, absorbing SSK and university hospitals. The Ministry of Health would become the focus for strategic planning of the health sector, and develop investment and manpower planning capacity.

The Free Market Option: This is based on competition in insurance and provider markets. It would be very expensive, both for insurance contributors and for the tax payer. The provider system would eventually consist of competing independent enterprises charging full cost fees.

The Intermediate Option: This is based on collective financing and competition in provider markets. It is constructed around the concept of meeting the total needs of a defined population, and relies on a mixture of planning and market forces to ensure the supply of appropriate services. The strategy would encourage the provincial health authority to favour preventive and primary care services, and allow the integration of personal preventive and curative services. It mainly calls for a public system in preventive and primary care, and a managed/competitive market in curative care.

For its combination of responsiveness to population needs, low costs, and incentives to effective management, the "Intermediate Option" has been selected by the SPO and approved by the government and the former president Turgut _zal. The main areas of reform and the strategic targets for increasing effectiveness and improving health status were subsequently defined in the Master Plan Study. As portrayed in this report, for the implementation of comprehensive reforms in the health system, there is need for a long-term, consistent, and stable National Health Policy that will not be influenced by different government policies. For this reason, the Turkish Ministry of Health has conducted a deliberate process of policy development. It began with the First National Health Congress in 1992, at which health related subjects were discussed in 34 working groups with 500 participants from all relevant institutions, sectors, universities, professional associations and the press. Each group prepared a report at the end of the Congress. After the Congress, all group reports were published as a book and a health policy draft document was assembled by a group of editors. The draft document was opened to public discussion and sent to the participants of the Congress as well as to all relevant individuals and institutions and to the World Health Organization, and the comments received were published. The draft document was revised and the National Health Policy Document was developed. The final document was presented at the Second National Health Congress in 1993.

The Turkish Government, in this National Policy Document, exposed the following key problems with its current health system:

- The health indicators in Turkey are not satisfactory given its level of socioeconomic development. The most common causes of mortality are preventable or controllable.
- The health care system experiences equity problems. Although all MOH hospitals are subsidized up to the amount of 75 percent of the actual costs,

only insured people are entitled to free access at the point of use. Equity problems occur in the utilization of health services as well, because the distribution of hospital beds and health professionals favor urban and western areas of the country. Correspondingly, people living in urban settlements of a western province utilize more health services than people living in rural areas in the eastern part of Turkey.

- There are major problems with the organization of current health services. Highly centralized decision-making along programmatic lines and rigid control of service providers make effective coordination and the delivery of services difficult. A Personnel Directorate within the Ministry of Health carries out recruitment and placement of staff for all state facilities. Remuneration is in accordance with the Law of Civil Servants, which establishes a pay scale based mainly on education, duration of public service and job title. There are automatic cost-of-living increases during the year, but the basic salary is not supplemented by incentives for good performance. Public employees are granted lifetime employment. Individual hospitals or provincial health managers have little autonomy to recruit or manage their own staff.
- There is no effective referral system operating between primary care and hospitals. Patients bypass health centers and health posts and use hospital out-patient clinics and accident and emergency facilities as first contact for non-emergency services while cost-effective primary care is under-utilised.

In response to this need for change, the Government has embarked on an ambitious health reform programme, which is strongly supported by the World Bank. Considerable amount of time and effort has been devoted to the promotion of Health Reforms both to the public and the politicians after the Second Health Congress. In the period since 1993, major rectification and corrections have been made to the draft design. Major research has been undertaken since 1994 regarding the model; the subsequent opinions of related institutions and health organizations have been fully reflected in proposals; and the Health Reform Model has been made a part of the country's general reform and development plans.

The proposed health care reform adopts a problem-oriented approach, with the aim of improving health status in Turkey. The reform programme consists of the following main headings:

- Health Financing Reform
- Hospital and Health Enterprises Reform
- Family Physician and Primary Care Reform
- Health Information Systems
- Organization and Management Reform
- Human Resources Reform

The reforms are intended to provide people with better health services according to their needs by extending social insurance coverage to the whole population through the principles of equity, quality, efficiency and effectiveness. At present, there are great variations in health status associated with differences in geographic and financial access to services. Therefore, the greatest gains in average health status will come from improving accessibility to services for those people who have least access at present. These are generally low-income people, people without existing social health insurance coverage, and people living in rural areas. The National Health Policy Document (1993) and subsequent Turkish Government documents outline the strategy of the Turkish Health Reform Programme. The Programme has multi-party support, and is supported by health insurers and health sector personnel.

Reforming Health Care Financing: The Personal Health Insurance System (PHI) and Health Insurance Administration (HIA)

The preliminary model has been generated by the Project Coordination Unit of the Ministry of Health and revised through discussions with the Health Insurance Administration Standing Committee including members from related ministries such as the Ministry of Finance, the Ministry of Labor, the State Planning Organization and institutions such as Social Insurance Institutions. The characteristics of the uninsured population have been analyzed through a "Health Services Utilization Study" and several other statistical resources have been used to gather information on demographic aspects. A crucial element of the design process was to be able to utilize a working instrument for the determination of the income levels of the potential members of the HIA. The Income/asset Ownership Study

undertaken by the State Institute of Statistics, which evaluates the productive assets of a household, has been used for this purpose.

The health care finance model proposed by the "Draft Law on the Personal Health Insurance System and the Establishment and Operation of The Health Insurance Administration" aims at providing social health security for the 21.4 million Turkish citizens who are not covered by any social health security scheme. The Health Insurance Administration (HIA) shall be the establishment to cover the necessary finance and costs and expenses in order to ensure the provision of health care services for the uninsured people. After the establishment of this institution, green card holders shall be covered under the HIA scheme.

The end target is to harmonize and gradually integrate all health insurance schemes into the HIA in a universal health financing system. Efficiency and equity in health care provision and finance are the guiding principles of the HIA. It will enhance the welfare of its members by giving access to quality health services on an affordable basis. With the establishment of the HIA, the financing of health care services shall be separated from the service provision. This separation is expected to promote efficiency in utilization of funds spent for health through consciousness of costs and control of expenses from the insurance point of view, and promote quality through competition in service provision. The Personal Health Insurance System is based on the principles of actuarially balanced social insurance through premiums payable on income.

Membership

Membership shall be compulsory for all Turkish citizens who are not covered by any current social insurance scheme.

Registration

The potential members shall be asked to enroll in a period of one month after the initiation of the new scheme. The registration shall be implemented by private insurance companies to be contracted with the HIA, and other organizations and institutions to be determined by the HIA. Those who do not apply for registration could be registered by HIA on their behalf.

Premium calculations and financial flow of the HIA

The insured persons shall pay premiums in order to benefit from the health services in the Basic Benefits Package stated in Law and determined by the Council of Ministers on the basis of the proposal made by the HIA. The amount of premium shall be adjusted every year in relation to the health expenditures of the scheme. The premium shall be calculated by dividing the projected overall cost of the system by the number of beneficiaries.

Premium collection

The premiums shall be collected by the private health insurance organizations under contract, tax offices, and other organizations and institutions which are authorized to collect premiums by Law or which are to be determined by the Administration. They can be paid through Banks which have contracts with the authorized institutions, post, telegram, and telephone offices, private health insurance organizations, or other organizations and institutions.

Premium contribution rate calculation

The entire cost of the health insurance benefits will be met by the premium income calculated on an actuarial basis. However, the size of individual premiums shall be determined according to the net aggregate monthly income of the insured persons liable to pay and his/her dependants. The amount of the monthly premium shall not exceed twenty-five percent of the gross minimum wage determined for workers over 16 years of age working in industry in accordance with the Labour Law No 1475. The premium structure will be based on five categories calculated according to multiples of the gross minimum wage, which will attract differing levels of subsidy (see Table 5 and Figure 6).

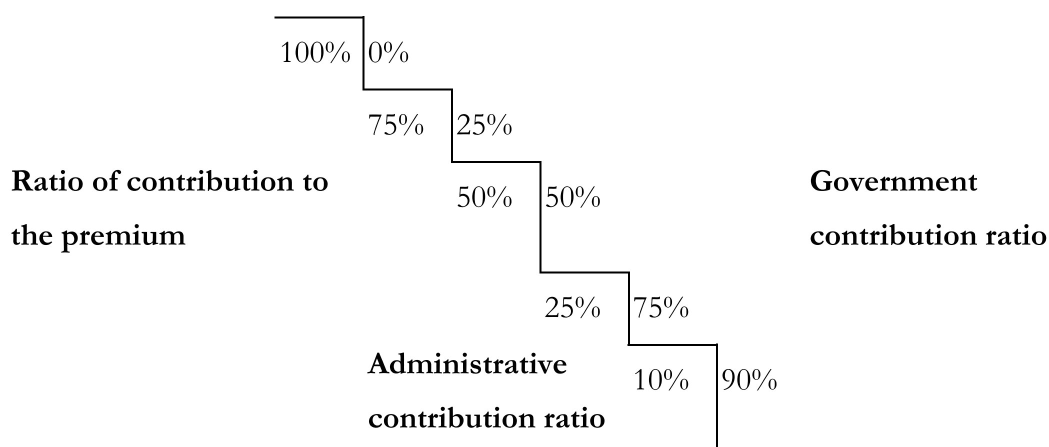
Table 5: Income levels of the 21.4 Million uncovered population and government subsidy

Household Income According to Minimum Wage	Population	Households	% of Uncovered	Government Subsidy
1.2 times and below	7,220,360	1,144,072	33.7	90% of premiums
1.2 - 1.6 times	2,983,160	596,632	13.9	Partial
1.6 - 2.0 times	2,694,260	538,852	12.6	Partial
2.0 - 2.4 times	2,129,300	1,274,584	10.0	Partial

2.4 times and more	6,372,920	1,274,584	29.8	No subsidy

The premium shares of the insured persons without capacity to pay their premiums fully or partially shall be subsidized by transfers from the General State Budget. There shall be a 90 percent subsidy for approximately 1/3 of the targeted population and 1/3 of them shall require no subsidy. The state shall subsidize only the premiums of the poor.

FIGURE 6: PREMIUM PAYMENT LEVELS



Therefore, the state shall be subsidizing needy individuals rather than the service, and every insured person shall benefit from the health benefits included in the Basic Benefits Package regardless of the premium they actually paid.

The estimated cost of the HIA Scheme and the net cost to the state budget

The estimated cost of the HIA is 1.070 million $ if the premium is $50 premium per capita and 1.605 million $ at $75 (Table 6). Even though it is calculated that the expenditure to be realized for the provision of the health care services determined in the basic benefits package can be met by collecting a $50 premium, the calculations regarding the $75 level have also been made as per capita public health expenditure in Turkey accounts for approximately the same figure. The share of the gross state subsidy in aggregate premium revenue is estimated at 49.6 % with a $50 premium, and 60 % at a $75 premium. The additional financial burden to be undertaken by the state after deducting General State Budget transfers for the "Green Card", personnel expenditure of public hospitals planned to be turned into "Autonomous Health Enterprises" (their health personnel shall be outside the civil service

payroll), and health expenditure realized according to the Social Assistance and Solidarity Encouragement Law No: 3294, shall be approximately 10 % of the total value of premiums collected by the HIA at the $50 premium level.

Table 6: The Financial burden of the HIA on the General State Budget

Actuarial Premium	**50$**		**75$**	
TOTAL HEALTH EXPENDITURE OF HIA	**1.070**	***Million $***	**1.605**	***Million $***
TOTAL INCOME OF HIA	**1.070**	***Million $***	**1.605**	***Million $***
The amount of premium to be collected	**539**	***Million $***	**642**	***Million $***
Gross Gvernment Subsidy	**53**	***Million $***	**963**	***Million $***
(-) The expenditure to be saved by Operational Reforms (Health Enterprises – Competitive Social Market)	**427**	***Million $***	**427**	***Million $***
General State Budget transfers for the "Green Card"	**127**	***Million $***	**127**	***Million $***
Personnel expenditure of public hospitals to be turned into "Autonomous Health Enterprises"	**279**	***Million $***	**279**	***Million $***
Health expenditure realized according to the Social Assistance and Solidarity Encouragement Law No: 3294	**21**	***Million $***	**21**	***Million $***
Additional burden to be undertaken by the State	**104**	***Million $***	**536**	***Million $***

Source: Project Coordination Unit, Ministry of Health

Responsibilities of the HIA

To attain the intended social objectives, the Health Insurance Administration will be attached to the Ministry of Health but will be autonomous in terms of finance and administration. It shall:

- make annual calculations relating to the amount of the annual actuarial premium,

- prepare the content of the Basic Benefits Package to be submitted to MOH and the government for approval,
- utilize financial resources effectively,
- sign the contracts stated in the Law.

Benefits Package

The Benefits Package contains primary, secondary, and tertiary health services locally provided for persons benefiting from social health security, medicine and treatment materials, prostheses and similar insurance benefits, and travel expenses and necessary allowances paid to those who travel to another place for such benefits. Patient co-payment shares for outpatient treatment are a maximum of 50% of the fees paid for medicines. The Board of Directors of the Institution determines this rate in terms of the kinds and features of the drugs. However, no co-payment rates are applied for a treatment of long term duration and medicines of vital importance.

Contractual relations

The reform proposals in the health sector should be considered and regarded as a whole. Along with the proposed HIA scheme, which is a financing arrangement, the planning, regulation and provision of services are envisaged to change their shape and form also. In this context and under the principle of separation of financing and delivery of services, HIA shall not provide health care services directly but purchase them via Provincial Health Directorates (PHD) and /or the private health insurance organizations or other organizations and institutions. HIA may enter into contracts with private and autonomous health care service providers directly when necessary.

In order to provide insurance benefits included in the benefits package in accordance with the law, the following contracts shall be entered into:

1. *Health Services Delivery Contracts*: shall be signed between the HIA and the health service providers (private and/or autonomous), and
2. *Contract for Transfer of Provincial Health Insurance Expenditure Share*: shall be signed between the HIA and private health insurance organizations, other organizations and institutions, or Provincial Health Directorates for providing services in the scope of the benefits package according to this Law.

Payments

The Provincial health insurance expenditure share, which shall be determined by the number of members living nearby each Provincial Health Directorate and the contracts signed between the above stated parties, shall be transferred to the related institutions and/or organizations in four installments annually, each for one quarter. The transferred provincial health insurance expenditure share shall be transferred to health service providers according to the contracts agreed between these providers and the Health Insurance Administration and/or the private health insurance organizations or the other organizations and institutions or Provincial Health Directorates, for the provision of the allowances for the insured ensured by the contracts. With the advent of this new model, health care services shall be purchased by block contracts which shall replace fee-for-service payments.

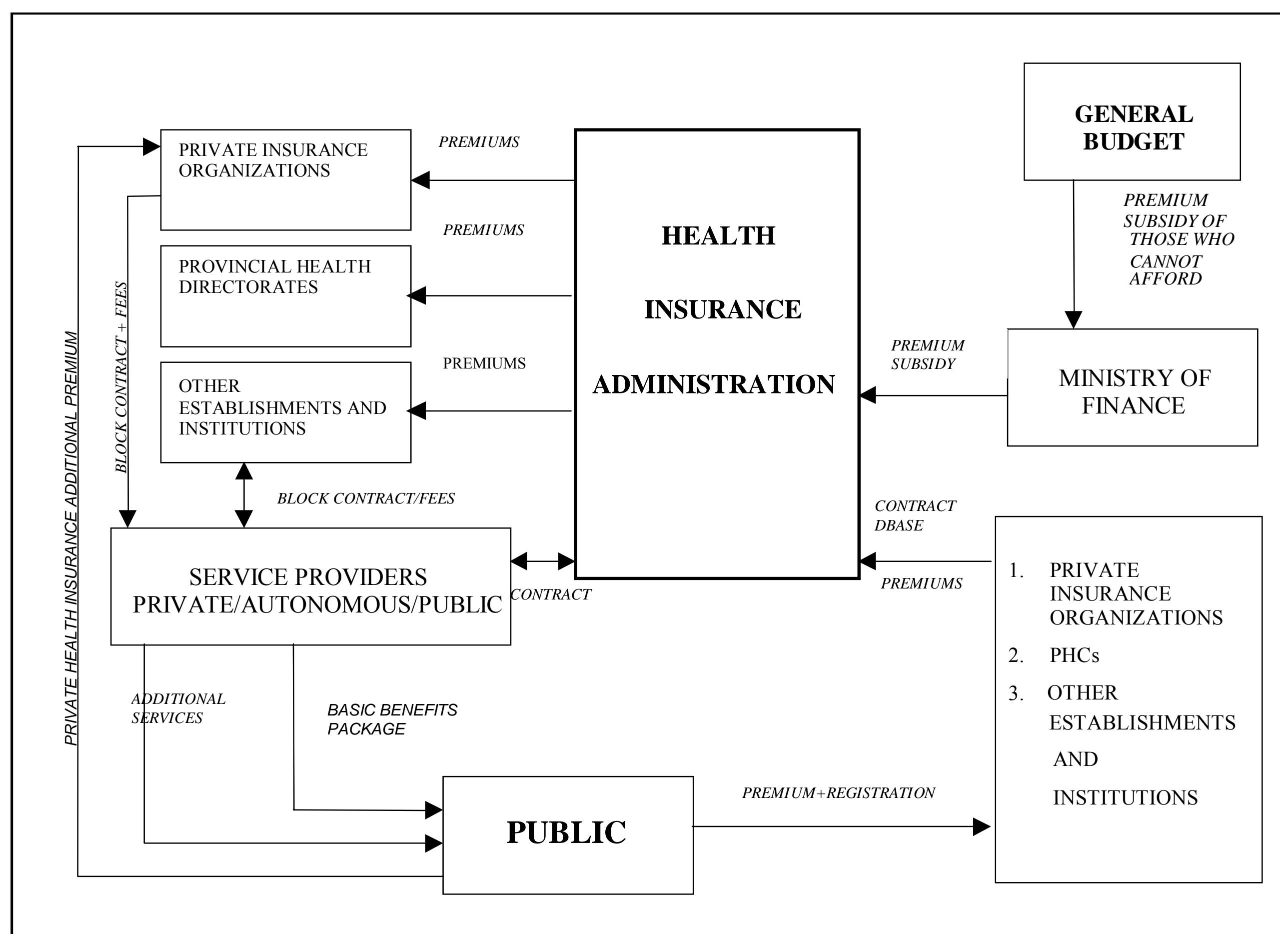
Roles of Private Insurance Companies

The private health insurance companies under contract shall undertake key operational roles in the implementation of the PHI system. They shall be liable for ensuring the registration of insured persons, collecting the premiums from the insured and making contracts with health care providers for the population registered with them in order to provide the benefits within the scope of this Law. Additionally, they will be able to present their supplementary benefit packages to these individuals.

Through cooperation between the HIA and private health insurance companies, the cost of health care services provided to the insured and the insurance risk arising from the HIA scheme shall be shared. Therefore, the efforts for minimizing costs and accordingly the actuarial premium shall be exerted cooperatively, in the most rational manner. Moreover, compulsory health insurance under public supervision will stimulate the private insurance sector by improving insurance consciousness.

The operation of the new model is shown in the flow chart in Figure 7.

FIGURE 7: FLOW CHART OF THE FINANCING MODEL PROPOSED IN THE LEGISLATION



Source: Project Coordination Unit, Ministry of Health

Implementation stages

The design of the PHI system has been revised during the last two years. The system has been integrated within a broader "Social Insurance Reform Package" and the implementation strategy determined as follows:

- *Step 1*

  Introduce health insurance to the 21.4 million who are uncovered

- *Step 2*

  Rationalize the overall pension systems through separating the health and pension plans of the existing social security schemes

- *Step 3*

  Transition to General Health Insurance through bringing social health plans under a single standard.

Conclusion

As 66 % of the Turkish population is covered under current social health schemes, the PHI system is expected to cover the remaining 34 %. In this targeted population, the state shall be subsidizing the poor and the partially poor; thus, it is expected that universal coverage shall be achieved through the rational behavior (also enforced by compulsory measures) of people who should choose to join the PHI as opposed to being faced with continued out-of-pocket expenditures for their health care.

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Latin America

HEALTH INSURANCE REFORM AND NEO-LIBERALISM IN ARGENTINA

Peter Lloyd-Sherlock

Introduction

Health care financing reforms are now being implemented across much of Latin America, as well as in many other regions. The twin goals of these reforms are, in theory, to promote both the equity and efficiency of health care delivery systems (Frenk 1994; Londoño and Frenk 1997; Berman 1995). Whilst the reforms being developed in individual countries are quite varied, there are some general features, including decentralisation and increased private sector involvement. Less explicit reference is made to measures directed at extending health insurance coverage. This paper argues that, although such reforms may have some beneficial impact, they do not resolve the key weaknesses of health care systems in Latin America. These include an over-emphasis on high-cost curative services and fragmented, socially exclusive institutional structures. Rather than improving access to health services, it is argued that Argentina's reforms represent the adaptation of long-standing structures to the new social and economic order imposed by neo-liberalism.

This paper provides a brief examination of the health care system which had evolved in Argentina up to the early 1990s. It shows that institutional structures had changed remarkably little throughout the 20th Century and that these reflected a political logic rather than the health needs of the population as a whole. The paper then gives a short account of the Menem administration's health reforms and speculates on their impact both as an extension of the current neo-liberal project and in terms of health itself.

Argentina: General Background

Argentina is the second largest country in Latin America but its 1991 population was only 32.6 million. The country's population continues to grow slowly and is projected to reach around 37 million people by the end of the century. Life expectancy is high by Latin American standards (72 years, 1990-1995) and this partly accounts for an aged population structure (8.9 per cent aged 65 years old or more in 1991). Despite population ageing, Argentina has a relatively low demographic dependency ratio, due to a small number of young children.

Argentina's demographic structure is a consequence of its relative prosperity over the past century. In 1947 it was claimed that the country was amongst the wealthiest nations in the world. Whilst this prosperity has not been sustained, Argentina remains

considerably ahead of most of its Latin American neighbours (in 1995, per capita GDP was US$8,030). Structural adjustment, rigorous exchange rate controls and neo-liberal policies led to rapid economic growth in the early 1990s (5 per cent annually, between 1991 and 1997). However, this economic success has been achieved at a major social cost. Unemployment and underemployment reached historic levels (open unemployment was 14 per cent in October 1997) and there was a rapid expansion of the urban informal sector (this accounted for 34 per cent of urban employment by 1992 and has since risen). As such, Argentina's health care system faces a number of challenges, including the demands of a rapidly-ageing population and the exclusion of increasing numbers of workers from the salaried formal labour force. The following sections will assess the success of health care reforms in meeting these challenges and in universalising health insurance.

General Characteristics Of The Health Care System Before The Reform

When studying health care systems in Argentina as in much of Latin America, it is vital to recognise that they do not form unified administrative structures but consist of almost entirely separate, parallel systems. Publicly-financed services are essentially non-contributory (although the increased incidence of user fees may be undermining this); they are financed by general revenue and aim to provide universal, basic coverage. In practice, however, a significant proportion of the population of most Latin American countries, mainly the rural poor, receive little or no protection. Mesa-Lago (1992) estimated that 130 million poor people in Latin America and the Caribbean had no access to health care whatsoever. Secondly, a range of often obligatory occupation-specific health insurance funds provide exclusive protection to the formal urban labour force and their dependants. These funds may be administered by the public sector (by a separate ministry from the ministry of health) or, as is the case in Argentina, by organisations such as trade unions. Finally, complementary private health insurance has become increasingly significant in the region, although its coverage remains largely confined to a relatively privileged minority.

The structure of the Argentine health care system has its roots in the late nineteenth century (Katz and Muñoz 1988; Belmartino et al 1991). Despite advances in medical

technology and social and economic development, the main institutional and financial structures have been surprisingly durable. Health insurance funds began to appear in significant numbers from the 1880s. These were initially organised along lines of common ethnic descent among immigrant workers, but by the 1920s this had been supplanted by union affiliation and occupational group. These funds rarely provided services themselves but contracted out to private sector operators. In 1946 the funds were nominally brought under the *aegis* of the Secretary of Labour and Welfare, but they were able to retain most of their operational autonomy.

Several constant trends can be identified in health insurance from the late 19th century through to the 1990s:
1) The great majority of funds remained administered by unions. The only exception was during the military administrations of 1976-83, when funds were taken over by military councils.
2) Funds had monopolistic rights over demarcated sectors of the labour force. Workers were not entitled to chose which fund they affiliated to.
3) Funds were very varied in terms of size and the quality of services they offered. For example, in 1994 it was calculated that average revenue per beneficiary ranged from under US$5 a month in the poorest funds to US$80 in the richest (World Bank 1997). Most continued to contract out and there was a widespread practice of dumping expensive or chronic cases on public sector hospitals.
4) State regulation was virtually absent. Despite considerable legislation, state agencies even lacked basic information about numbers of affiliates and financial records.
5) There was a series of unsuccessful reforms. Key reasons for failure were the low priority afforded health care in national politics and the opposition of interest groups such as unions, pharmaceutical companies and physicians.

Less continuity is observable in the development of non-insurance public health. Other than basic sanitation and civic works programmes, very little priority was given to this before the 1940s. During the Peronist administrations a network of provincial hospitals was established and there was some discussion of developing an embracing national health service, into which the insurance funds could be absorbed. However, this fell foul of the unions, for whom occupational health funds were a major source of finance and political influence. From the 1960s, financing for the public health sector went into

decline. *Ad hoc* efforts were made to decentralise health care and to introduce direct user fees, but these initiatives largely served to increase disruption and disorganisation. The main outcome was a marked deterioration in the quality of services provided by the public health sector. This reached crisis proportions in the wake of the 1980s debt crisis: between 1980 and 1985 per capita spending on public health care fell from US$ 28 to just US$ 12. Spending was subsequently increased but this has not been enough to make up for long-standing shortfalls.

The health system which was in place for much of the 20th century was more a reflection of larger social, economic and political structures than of the population's real health needs. It was a health service geared towards satisfying key urban working and middle class groups and maintaining relative privilege and stratification, rather than maximising health for all. The system was defended by a powerful range of actors, including the unions, pharmaceutical companies, physicians and health administrators. It emphasised urban curative health care to a remarkable degree, instead of more cost-effective promotion and basic health services. In relation to its GDP, Argentina has more doctors than any other country in the world (nearly 30 doctors per 10,000 inhabitants by the early 1990s). There was also a marked imbalance in the numbers of doctors and nurses (in 1987 there were almost five doctors to every nurse). The health care system was extremely fragmented. Administrative structures were often over-staffed and highly inefficient, and regional disparities were emphatic. For example, in one poor municipal district in the northern province of Jujuy infant mortality rates were more than treble the national average in 1996 (*Página 12*, 1 July 1997). As a result, health outcomes were poor given the overall amount of expenditure: despite devoting larger sums to health, infant mortality rates were higher than those in Chile and Costa Rica by the 1990s.

Health insurance coverage

Given the lack of regulation, reliable data on health insurance coverage are not easy to obtain and estimates sometimes vary wildly. For example, the Finance Ministry estimated coverage to be 75 per cent of the total population in 1994 (Flood et al 1995), whereas an agency of the Ministry of Health put it at only 47 per cent (INDEC 1996). Table 1 summarises data from the 1991 national census, which can be taken to be relatively reliable. This shows that 62 per cent of the population were covered by some form of health insurance, of whom the great majority was accounted for by social security. It also

shows that there was considerable over-lap between the private and social insurance sectors.

Table 1. Health insurance cover estimates, 1991 (percentage)

Total insurance cover	Just social security	Social security and private	Just private	Uninsured	Do not know
62	40	17	5	37	1

Source: INDEC (1995).

The 1991 census also reveals sharp geographical disparities in health insurance cover, with levels varying from 80 per cent in Buenos Aires city to only 43 per cent in the province of Formosa (respectively the richest and poorest parts of the country). Poorer and more remote parts of the country are also at a large disadvantage in terms of access to health care services. In many provinces health insurance service providers are located only in the capital cities. As such, many people with nominal insurance entitlements are unable to mobilise them. It might be hoped that public health care spending be targeted in order to compensate for these disparities. There is, however, little evidence of this occurring. Indeed in the early 1980s, per capita public health care spending in Buenos Aires city was more than twice that of Formosa.

Although the data are of poor quality, there are strong indications that insurance coverage has fallen significantly over recent years. ANSSAL, the official health insurance regulator, calculates that between 1990 and 1995 the total number with protection declined from 17,973,986 (55 per cent of the population) to 16,270,660 (47 per cent). The causes for this decline lie largely with trends in the labour market. During the 1980s, poor economic performance led to a sharp contraction in manufacturing employment and a surge in the informal sector. However, this effect was largely off-set by large increases in public sector employment at the level of provincial government. As a result, affiliation to provincial government health insurance funds roughly doubled (from three to six million) between 1980 and 1990. The economic growth of the 1990s failed to generate formal sector employment. Indeed, many workers lost insurance protection through a policy of "flexibilising" the workforce (promoting short-term contracts and

part-time employment). At the same time, structural adjustment saw massive reductions in provincial public sector employment and a consequent fall in health insurance affiliation.

Official policy towards extending health insurance is extremely vague. According to a recent World Bank publication:

> “...the [Argentine] Government’s long-term vision of health insurance -shared by the World Bank- is one of universal coverage of the population; a standard benefits package with a generous set of preventive and health services for every Argentine citizen.” (World Bank 1997, p.22).

How long this long-term vision might be was not specified here, although a later section of the same World Bank report was less than sanguine about any immediate progress:

> “The problems of transition to a full demand subsidy, giving the poor the same choice of insurer and provider as the already insured, are formidable. However, this could have great potential impact on the neediest part of the population.” (World Bank 1997, p.44).

Given the close relationship of the World Bank and the Argentine government in developing health care reforms (see below), this cautious view was likely to be influential.

The Menem Administration’s Reforms

The imposition by the Menem administrations (1989 to 1995; 1995 to present) of neo-liberal reforms are impressive and well-documented. These range from dramatic reorientations of macro-economic policy, to privatisation and labour market deregulation. The first major reforms in the field of social welfare were directed at the state pension system and by 1995 these had been largely implemented. The pension reforms clearly fit within the regime’s broader neo-liberal philosophy. First, they promote the involvement of private insurance companies, which were seen as inherently more efficient than public funds and an effective stimulus to local capital markets. The reforms ended employer contributions and facilitated the movement of workers between private funds. It was argued that this would reduce labour market rigidities and facilitate consumer choice. The pension reforms have been widely heralded as a success, encouraging the government to apply similar principles in other areas of welfare. By the mid-1990s it was apparent that the next target for major reforms was the country’s health care system.

Above it was mentioned that previous regimes had attempted to carry out health care reforms but that these had usually proved unsuccessful in the face of powerful opposition lobbies. However, the Menem reforms differed from past experiences, both in terms of their content and the context in which they have been implemented. De-industrialisation and several years of neo-liberal adjustment had greatly reduced the political influence of unions and had also weakened rank and file public sector workers as an interest group. At the same time, these trends had called into question the view that health insurance cover would continue to expand over time. As such, the political and social certainties which had under-pinned the old health care system were less in evidence by the 1990s.

The reform content is original in several respects. First, no attempt was made to unite the union insurance funds and the publicly financed sector. Instead, the principle thrust of change has been an attempt to introduce private sector competition against the union funds. This has occurred in a number of phases. In November 1996 the government defined a minimum set of health services (with an estimated cost of US$ 40 per person per month), which all funds are obliged to provide. From the following January all insurance affiliates were given the right to select their funds and from January 1998 private medical firms were to be permitted to compete for these affiliates on an even footing. The privatisation of health insurance did not appear to threaten the interests of groups such as the pharmaceutical industry and physicians. Resistance from weakened unions was largely overcome through an overt policy of divide and rule. Selected government-friendly unions benefited through the US$ 150 million from the World Bank and US$ 120 from the Treasury, which had been made available for pushing through the insurance reforms.

In late 1997 it became apparent that the final stage of the health insurance reform would be delayed and possibly modified. First, it became clear that even those union funds which had benefited from substantial grants would be in no position to compete with private insurers. Also, serious defeats for the Menemist alliance in mid-term elections strengthened the position of potential opponents to the change, including anti-government unions. As yet, two bills (one opening the union funds to private competition and the other submitting the private funds to a regulatory framework) are

still to be ratified by the National Congress. In January 1998 the World Bank admitted that it may require at least another two years before the final phase of the reform will be implemented. Despite these setbacks, those Menem reforms which have already been implemented are more significant than anything which had been achieved over the preceding five decades.

A small number of reforms have been implemented in the publicly-financed sector. These seek to promote decentralisation to hospital trusts and to up-grade primary health care services. These initiatives have the potential to improve significantly the performance of the publicly financed sector but to date have been implemented only on a relatively limited basis. For example, the trust hospital programme involves just 15 facilities located in two cities. Likewise, a programme to develop GP fund-holding has been implemented only in selected parts of Buenos Aires and by June 1997 only 10,000 people (out of a total uninsured population of 500,000 in the city) had been registered with the scheme. Those reforms implemented to date will have little impact on the main problem of this sector: accumulated years of under-funding and an extreme curative bias.

It is clear that the current health care reforms fit well within a neo-liberal development model: weakening the unions, enabling further deregulation of the labour market and promoting private insurance operators. An emerging alliance between pro-government unions and private insurers is a particularly interesting development. In the new regime these two operators have a common interest in collaboration: to gain access to the existing "client bases" of the old union funds and to benefit from the commercial experience of the private sector. Although it is theoretically illegal, several of the more "progressive" union funds are now working very closely with private insurers, and this is giving rise to a new insurance hybrid which may well dominate the market in the near future. These new alliances may have significant ramifications for industrial relations and the Argentine labour movement as a whole. Also, the emerging private health insurance industry will bolster local capital markets which are already expanding rapidly in the wake of the pensions' privatisations.

The impact of the reforms (both those already implemented and those being proposed) on health care financing are less apparent. It is to be expected that introducing competition between the union funds will increase efficiency. By 1999 the number of

funds had fallen from 320 to around 200 and most of those which disappeared had low levels of affiliation and high administrative costs. However, the experiences of the USA and other countries show that competition between insurers does not guarantee efficiency in terms of cost control. Health services are highly complex, consumers have insufficient information and the risks of profiteering either through over-servicing or the minimalisation of care are considerable. Apparent efficiency gains through competition may be more than cancelled out by sales and marketing expenditure, not to mention profit margins. Also, privatisation will reinforce the previous arrangement of separate insurance funds for high and lower income groups. It is already apparent that the new private insurers are developing niche marketing strategies and making particular efforts to attract richer clients. Whilst the Argentine reforms seek to establish a regulatory framework, it is fair to question why this should work properly when all previous attempts to regulate the union-run funds were such abject failures.

Despite having fewer financial resources than the insurance sector, the public health care system probably exerts a greater potential impact on the population's overall health status. As such, the limited nature of reforms in this area and the lack of urgency with which they are being implemented is a major obstacle to real health improvements. Several pressing issues are simply not addressed in the reforms. For example, user fees are now widely utilised in the sector but virtually no information is available about them. Anecdotal reports claim that the system is widely abused to the detriment of lower income groups. Likewise, little is being done to improve hospital management or to promote community participation: two measures which have been demonstrated elsewhere to play a central role in improving performance. Finally, other than a small number of under-funded short-term emergency schemes, nothing is being done to address the marked regional disparities in health care infrastructure.

The reforms do nothing to redress the balance away from over-sophisticated hospital and doctor-based curative services towards more cost-effective approaches. Within the existing legislation, funds are entitled to charge higher levies if they provide services beyond the basic health package established in 1996. It is therefore likely that relatively superfluous services will be the major source of market differentiation and profits. No efforts have been made to reduce numbers being trained by the medical schools - a measure which would effectively resolve the problem of over-supply of physicians but

which would also prove very unpopular with key middle class constituencies. Although overall levels of recruitment to medical schools have fallen in recent years, a sharp increase in the graduation rate has led to an overall rise in numbers of newly-qualified doctors. This effect has been compounded by the appearance of several new private medical schools since the early 1990s.

Finally, it is clear that Argentina's health care reforms make no attempt to break down the long-standing dualism between the insurance and public health care sectors or to facilitate the inclusion of groups who remain without protection. Indeed, if current labour market trends continue, it is likely that overall health insurance coverage will continue to fall significantly. There are no signs that private insurers, either working alone or linked with union funds, are taking an interest in attracting affiliates from beyond high income groups. The lowest private premia are currently US$ 100 a month – well beyond the means of most Argentines. Rather than blaming this failure on the actual contents of the reform (which were, after all, primarily concerned with efficiency gains), attention must be paid to the reform process and the debates which preceded policy formulation. It is apparent that, other than vague official statements, no attempt was made to put universal health insurance on the national policy agenda. To a large extent, this reflected the overall lack of attention paid to health care by politicians, the media and academics, as well as a general consensus around the government's broader neo-liberal project. By contrast, reforms of the country's social insurance pension programme had been the object of considerable controversy and were repeatedly postponed and modified. After this experience, the Argentine government must have been reluctant to promote debate about other areas of reform. A further consideration is that Menem's political party had successfully blocked proposals made by the previous government to develop a unified health care system. Any sign of returning to this strategy might have been interpreted as an act of political weakness or double-standards.

Conclusions

Argentina's recent health care reforms have been a success in terms of extending neo-liberalism but will fail in terms of improving the population's health and promoting equity. Nevertheless, the fact that the first stages of a sweeping health reform, whatever its features, have actually been implemented largely as planned is in itself an impressive

achievement. Previous governments sought to impose a variety of reforms, some laudable others less so, none of which even reached the initial stages of implementation.

The ability of the Menem administration to partly buck past trends suggests that the current reforms have been a missed opportunity to develop a health care system which both fits within new economic and social structures and effectively delivers health to the entire population. Given the weakness of the union movement, the advice and financial support of the World Bank and the general strength and stability of the Menemist alliance, much more could have been done to improve health for all. In other Latin American countries, notably Colombia, health sector reforms are currently attempting to create unified systems which will embrace both insured and non-insured sectors of their populations. Whether these reforms are ultimately successful is still unclear. However, it must be asked why in Argentina, where health insurance cover and per capita wealth are relatively high, the creation of a unified system was not even debated in public. Such a system could have been a first step towards universal coverage and emphasising those health services which have the greatest impact on health itself. This could have done much to counter the present government's image of doing too little for the poor and abetting social exclusion. Instead, the Menem administration opted for a reform package which satisfies the political demands of certain sections of the middle class, along with the pharmaceutical and financial services industries.

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Asia

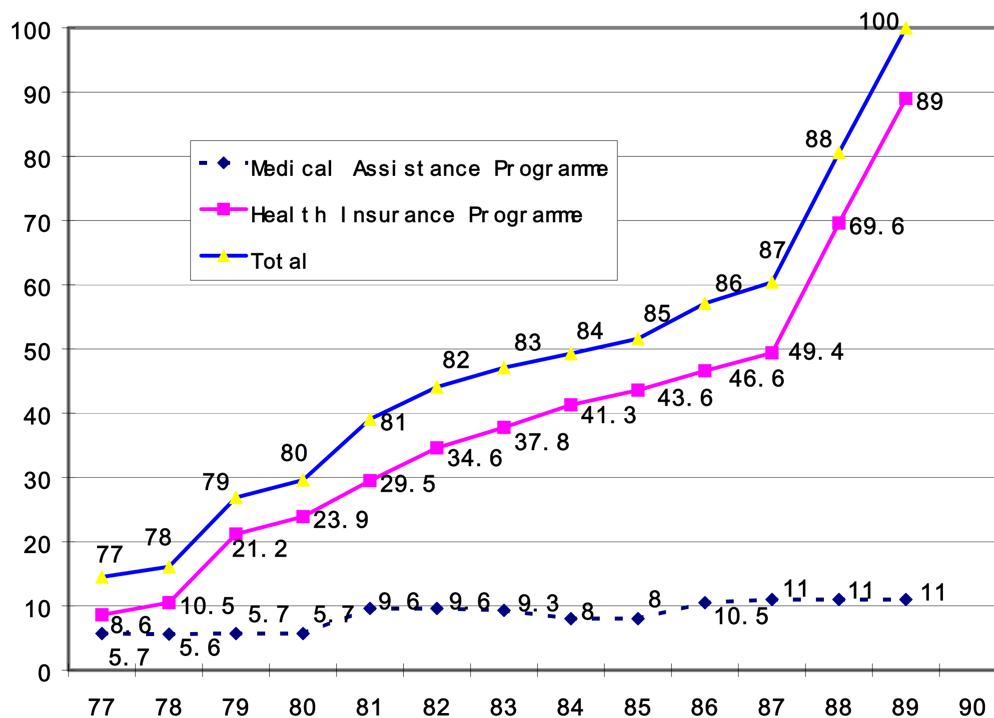
THE KOREAN HEALTH INSURANCE PROGRAMME

Ok Ryun Moon

Current Health Insurance Policy on Universal Coverage

Though Korea was a late comer in the health insurance business, she achieved universal population coverage fairly early in 1989. It has taken 26 years to achieve it since the inception of the statutory health insurance law, and only 12 years since the implementation of social insurance programmes (see Figure 1).

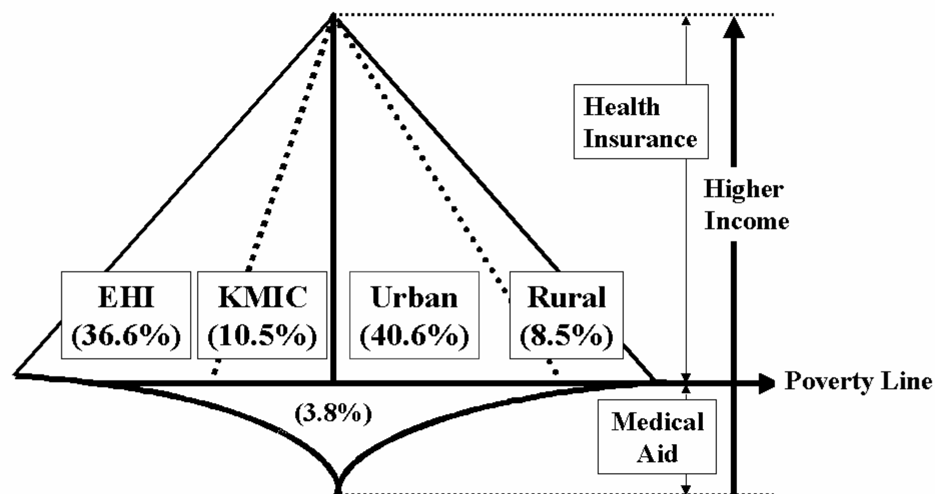
Figure 1: Percentage of Population Coverage by Social Security Medical Care Programme, 1977-1989



The Korean Medical Security Programme consists of two different entities: 1) Medical Aid Programme for the poor or those unable to pay their contributions and 2) Health Insurance Programme for those who are able to pay them. As of December 1997, about 3.6% (1.7 million) of the total population (46.4 million) belong to the former, and the rest 96.4% (44.4 million) to the latter (see Figure 2). The Medical Aid Programme is financed mainly by the central government (80%), and partially by local government (20%), but it is managed by local government. A rather strict means test and income test is applied to determine eligibility. The Health Insurance Programme consists of three different components: 1) the employees' health insurance scheme for industrial workers and their dependants (36.7%), 2) a special categorical health insurance scheme for public

officials and private school teachers and their dependants (10.5%), 3) self-employed health insurance scheme (49.0%).

Figure 2: Composition of Health Security Programme by Income Level



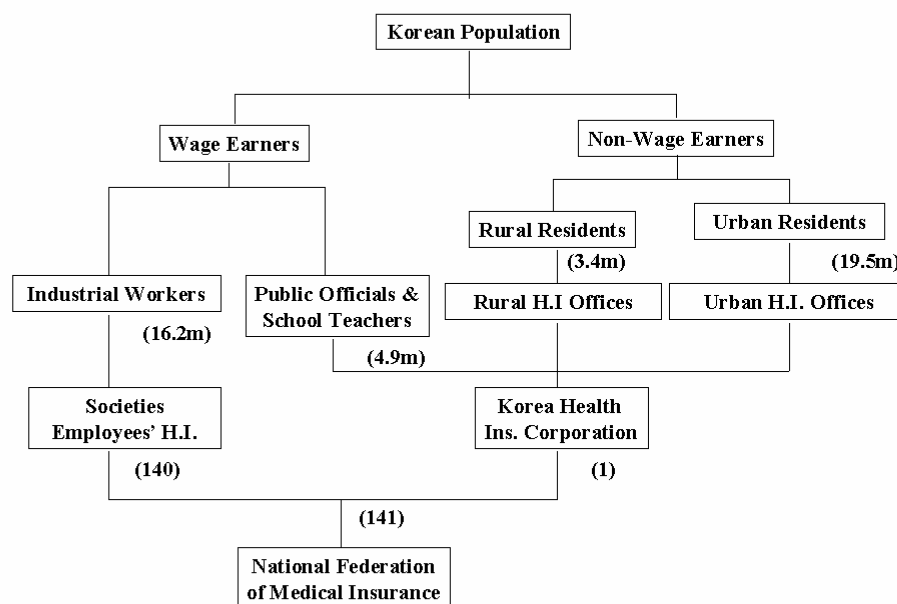
The industrial workers' health insurance scheme is managed by 140 employees' health insurance societies. Of these, 58 societies are organised by large individual companies, and the remaining 82 societies by independent legal entities based on areas. All of them are financed from contributions levied on their payroll, equally shared by both employees and employers. On average, a half of 3.24% of their salary and wages are levied as employee contributions.

The Korea Medical Insurance Corporation (KMIC), a special non-profit public organisation, was established for the employees of the government and the private schools, military servicemen, and their dependants. It is the largest insurer covering about 4.9 million beneficiaries, and is run by a unified national organisation with its 19 regional and local offices located in provinces and metropolitan cities. The contribution rate is 3.8% of the insured person's standard monthly remuneration, and that for military servicemen is 3.0%, both of them shared equally by both the insured and government. However, as for private school employees, the government subsidises one fifth of the

contribution rate (which is 3.8%). This is to help relieve the financial burden of school foundations or managers. The government allocates a yearly budget for its employees' insurance benefits and pays the KMIC quarterly. As of July 1998, KMIC was renamed the Korea Health Insurance Corporation (KHIC), and KHIC has integrated both the regional health insurance programme for the self-employed (see below) and the old KMIC.

The self-employed health insurance programmes cover non-wage earners, semi-urban and rural and urban areas separately. Residents in semi-urban and rural areas (3.4 million) are organised by 103 semi-urban and rural regional health insurance societies, and those in urban areas (19.5 million) by 52 urban regional health insurance societies (see Figure 3). The finance of the self-insured programme is composed of a contribution determined by their household income and property and a basic contribution determined by the size of the family. The government subsidises a part of the contribution for low-income groups as well as all administrative costs of the programme operation, providing some proportion of the total revenue income, ranging from 25% to 30%.

Figure 3: Current Korean Health Insurance System



Benefits are payable to the insured and their dependants in cases of sickness, injury, childbirth and death. Benefits are granted both in cash and in kind. Medical care benefits currently are provided for 330 days a year. Benefits-in-kind include medical care consultations, pharmaceuticals, surgery, other treatments, hospitalisation, nursing care, traditional oriental medicines and transportation. Maternity benefits are payable when the insured or dependent woman gives birth to a child at health care facilities. Continued health care and maternity benefits even after disqualification are guaranteed for a certain period, for example maternity benefits provided for 6 months after disqualification. Benefits-in-cash consist of medical care allowances and maternity allowances if birth occurs at a place other than health care facilities. Funeral allowances are given to the person who is in charge of the funeral rites. The amount of cash benefits differs by type of health insurance. Otherwise there are no differences in statutory benefits among kinds of health insurance, except that general physical check-ups are included only in the benefit packages of industrial workers and public officials and private school teachers' insurance.

Heavy cost sharing formulae have been in use since the start of the programme. The insured or their dependants are required to share 20% of inpatient costs. Cost sharing for

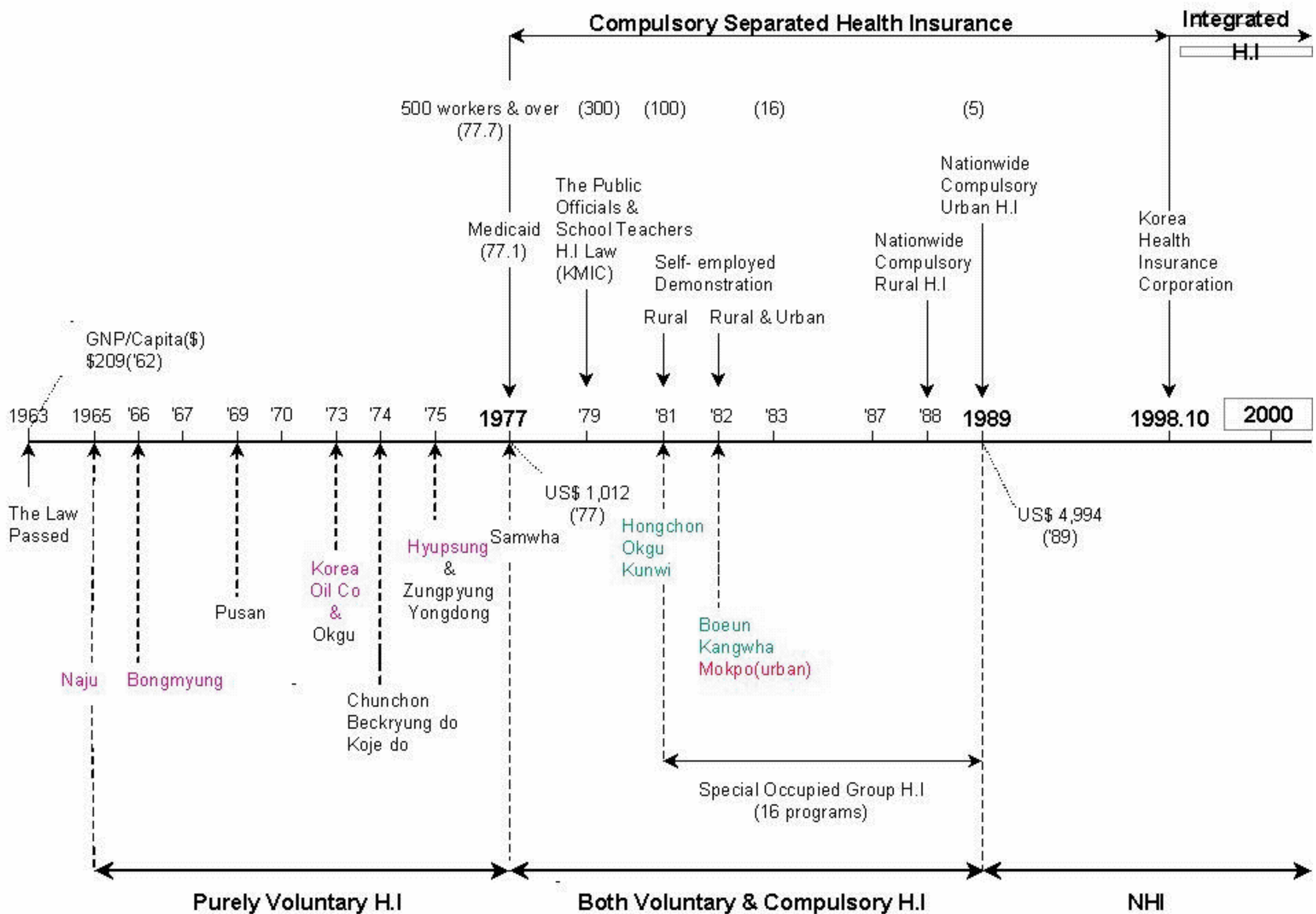
out-patient treatment varies widely according to medical facilities and amount of expenses. The insured pay up to 55% of the total outpatient charges.

All health care facilities are compulsorily designated as insurance care facilities. They are not allowed by law to avoid providing health care without justifiable reasons. Medical services are provided predominantly by private sector health facilities and purchased by health insurance societies and the KHIC. However, multiple providers interact with a single payer, the National Federation of Medical Insurance (NFMI). NFMI is a special public corporation established by Article 27 of the Health Insurance Act. NFMI aims at contributing to the enhancement of national health and NFMI pays the claims filed by all medical care facilities for both employees and self-employed programmes. It has 140 health insurance society members and the KHIC under its umbrella. Low fee schedules have been maintained throughout the process of social insurance implementation.

Historical Development of Health Insurance Policy

As mentioned above, the process of health insurance expansion has been extremely rapid in terms of its population coverage. The Health Insurance Act was enacted in 1963. The entire process of development can be divided into three periods: 1) voluntary programme period (1965-1977), 2) compulsory programme period (1977-1989), 3) universal health insurance period (1989 to date). The voluntary programme period started when the first voluntary health insurance society was organised in 1965. After that, eleven additional voluntary societies were organised on a pilot basis. About 0.2% of the total population at most were covered by the twelve voluntary insurance societies (see Figure 4).

Figure 4: Diagram on History of the Korean Health Insurance



The employees' health insurance programme was compulsorily organised for employees and their dependants at companies with 500 employees and above in 1977. Then the coverage requirement was lowered to include firms with at least 300 workers in 1979, with 100 workers in 1981, and 16 workers in 1983. Another law was promulgated to include government officials and private school teachers in 1979. It was amended to include families of military servicemen and employees of private school foundations in 1980, and to include managerial functions of the Medical Aid Programme in 1990. As a matter of fact, both NFMI and KMIC competed vigorously to extend their population coverage. The expansion based on employment status resulted in side effects. The jobless, the poor, farmers and most of the self-employed workers were medical care sufferers before universal coverage.

The third stage of universal population coverage started when the 1988 rural self-employed health insurance programme was followed by the urban self-employed programme nation wide in July 1, 1989. This expansion was based on the result of a demonstration programme, three rural and three urban compulsory self-employed health insurance projects, for the period from 1981 to 1988. Already nine years have elapsed since universal coverage was achieved.

Insurance fee schedules were set, at the outset, at approximately half the price of customary charges. As the demand for health services has increased a great deal since the implementation of health insurance, it could compensate medical providers for the loss incurred from the reduced fees. While the insured persons enjoyed relatively low insurance fee schedules, the poor and the self-employed persons without health insurance paid higher prices for the same medical procedures at the same medical facility. This problem of price discrimination between the insured employees and non-insured self-employed persons got worse as the population coverage became bigger. For example, the average charges for outpatient care for non-insured patients were double those for the insured in the mid 1980s. Many saw this as an example of social injustice (Moon 1989). The insurance low fee policy helped to expand health insurance rapidly, but it has brought about undesirable effects. There would be no option but to expand the health insurance universally if the inequalities were to be eliminated.

Politically, in comparison with the free health care system in the Democratic Peoples' Republic of Korea (DPRK), the capitalistic Republic of Korea (ROK) had lagged far behind in providing health care to the people. It was only in 1969 that the economy of the ROK exceeded that of the DPRK in terms of per capita GNP. The ROK government adopted the social insurance policy as a means of generating financial resources for health for the purpose of overcoming its weaknesses. This policy was in accordance with the basic direction of the Fourth Economic Development Plan of the ROK (1977-1981), which was the strategic promotion of social development and equity. It is also acknowledged that the military regime in the early 1960s, lacking legitimacy in the process of gaining political power, tried vigorously to obtain its popularity by implementing the social health insurance policy (Shin, Moon and Kim 1996). In any case, the role of the state was essential to introduce the compulsory scheme.

Economically, its rapid growth allowed the ROK to expand employment and job opportunities. The average annual growth rate had been fluctuating around 10% in each five-year Economic Development Plan period. It is fair to say that without economic development and urbanisation, such a rapid expansion of social insurance coverage would have not been possible at all in Korea.

In addition, the pool of trained human resources was indispensable for its rapid expansion. The fact that the ROK owned an enormous pool of manpower resources, including middle management workers as well as devoted, hardworking elite bureaucrats, has helped the ROK greatly to develop a social health insurance programme. It might have been impossible to launch the national health insurance programme without establishing basic management units like health insurance societies for membership registration, levying contributions and their collection, and benefit management, etc.

Applying health insurance on the basis of employment and of region has made it possible to expand rapidly. Both manual workers and white-collar employees, and their dependants, were insured alike. This was further prompted by the compulsory designation of all medical care facilities as the source of insurance medical care. A substantial fine has to be paid by law in case of denial of the compulsory designation of a medical facility.

The benefit package has been enriched as the coverage has increased, though the scope of insurance benefits was rather limited. For example, high cost medical technologies like MRI were exempted. The period of benefits has been extended gradually, starting from 180 days a year to 365 days in the year 2000. Still a rather lengthy list of excluded items is in place.

The single most dominant issue during the past 20 years was related to the unitary approach versus separate approach in administration of the programme. Problems of different financial solvency among health insurance societies have arisen as the coverage has increased. This is particularly the case for the self-employed health insurance programme. The proponents of the unitary approach criticised different level of benefits and contribution rates between insurance societies. They stressed the law of large numbers in pooling of the funds and spreading their risks, and the principle of income redistribution. Meanwhile, the advocates of the separate approach argued that the

method of levying contributions equitably be developed for both employees and the self-employed before integration. They stressed that the separate approach was a good match for the concept of local autonomy and of competition (Normand and Weber 1994) and it was relatively easy to assess and levy contributions (Moon 1989). The confrontation has been continuing for the last 20 years. However, the new government has a new health insurance law that aims to unify the former 373 health insurance societies into a single insurer by January 2000. The process of integration is rapidly going on.

Financing of Universal Coverage

Despite the substantial amount of subsidisation by the government, the coverage of voluntary health insurance was found to be severely limited to those persons who were able to pay their contributions. In 1977, the government adopted the Bismarck style social health insurance policy with minimum state financial involvement. Early statistics tell us that public spending amounted to far less than 10% of the total health insurance revenue income (see Table 1). The employees' health insurance was geared to a minimal financial input from the government. In contrast, contributions payable by public officials and private school employees were not uniform. The government, as the legal employer of public officials, paid 50% of the contribution. However, the government subsidised 20% of the contribution of private school employees (the school owners paid the remaining 30%).

Table 1: Proportion of National Subsidy to the Total Health Insurance Expenditure

Year	Total Expenditure (A)	Amount of Subsidy (B)	B/A(%)
1977	5,117	307	6.00%
1979	80,574	1,749	2.17%
1981	209,606	1,942	0.93%
1983	437,621	2,142	0.49%
1985	647,957	1,761	0.27%
1987	752,523	2,238	0.30%
1989	1,585,109	220,716	13.92%
1990	2,308,057	363,901	15.77%
1991	2,615,969	586,790	22.43%
1992	3,163,200	592,440	18.73%
1993	3,680,235	638,149	17.34%
1994	4,229,802	629,460	14.88%

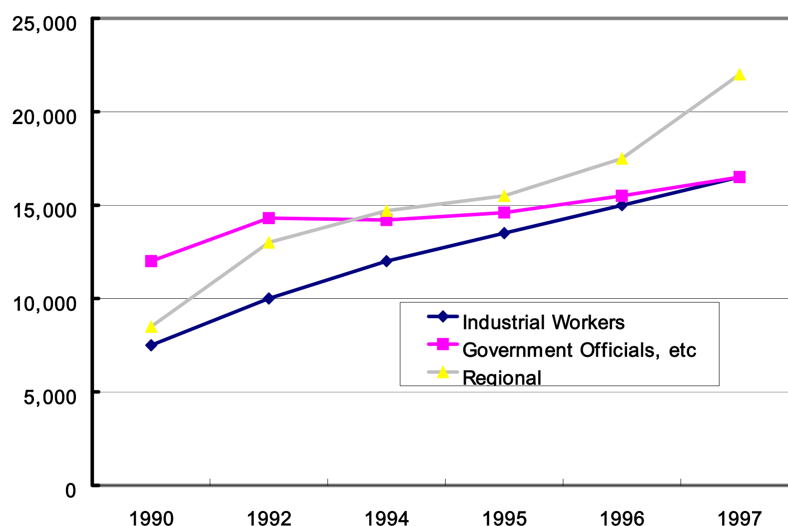
Then came the six pilot schemes for the self-employed including rural farmers in 1981 through 1987. The multiple pilot schemes indicated that public financing could not be avoided in the operation of regional insurance. About one third of the total programme expenditure was subsidised by the government. The tax subsidy consisted of a part of the contribution and the entire cost of administration. Heavy co-payment was inevitable for reasons of both minimum tax subsidy and minimum level of contributions.

The crux of the matter was how to levy the contributions of the self-employed. Two principles were applied: the ability-to-pay principle and the basic benefit principle. The former refers to the grading of 30 classes according to both their income and assets/property. The latter refers to the calculation of a fixed amount of contribution per household and per family member. And the last factor was car- or ship-owning status (the number and the type of cars or ships owned). The above five factors are all considered in the calculation of the contribution of a self-employed person.

As the government subsidy decreased from the initial 50% to the recent 25%, the average amount of direct contribution by the self-employed farmer began to exceed that by the employee. This has caused health insurance a serious problem of inequities. For example, if the employer's contribution for industrial workers and the public subsidy for the self-employed would be excluded, the actual contribution by an average rural self-employed

person per month was about US$ 20 (17,918 won in 1996), which was 20.8% more than that of an average industrial worker in 1996 (see Figure 5).

Figure 5: Amount of self-paid Contribution per Household per Month by Scheme



Raising the contributions of the self-employed programme, particularly of farmers, every year has encountered enormous difficulties. A serious insurance resistance has faced Korea. In order to mitigate the burden of the self-employed health insurance, the financial stabilisation fund was established in 1991. This is a cross-subsidisation programme that has aimed at reducing financial differences among health insurance societies. The fund is charged by member societies for large medical bills which exceeded about US$ 1,100 in 1995. The stabilisation programme was further extended to cover inpatient expenses of the elderly above 65 years old in 1995. NFMI has been in charge of running the subsidisation programme for more balanced financial development. In fact, tax subsidies and subsidisation from the financial stabilisation fund comprised 33% of the total urban self-employed programme budget and 51% of the rural self-employed budget in 1995 (see Table 2).

Table 2: Amount of Transfer for the Regional Health Insurance Scheme (billion won)

		1990	1993	1995
Rural	National Subsidy	128	195	185
	Stabilisation Fund	-	14	44
	Total	128	209	229

	(% of Total Revenues)	(39%)	(46%)	(51%)
Urban	National Subsidy	236	443	571
	Stabilisation Fund	-	19	70
	Total	236	462	641
	(% of Total Revenues)	(35%)	(39%)	(33%)

The new government is facing the problem of integrating the substantial amounts of reserve funds, about US$ 2.6 billion as of 1998, which are separately owned by each health insurance society. The Labour Union argues that, as most of the reserve funds belong to employees, a deposit of an equivalent amount of reserve is required for the self-employed programme for the merger of all member societies into a unified programme. In addition, a new method of levying contributions needs to be designed for the unified programme.

Provision of Services and Payment of Providers

As stated earlier, health services are predominantly provided by the private medical sector. No insurance society owns their health facilities except KHIC. Particularly for health care in rural areas, government-run public health centres, subcentres and primary health posts have been established throughout the nation. There are pharmacies, dental hospitals and clinics, and oriental medicine hospitals and clinics, and midwifery clinics. The near poor and indigent people are likely to choose to use public health centres and subcentres.

A nation-wide patient referral system was implemented from July 1989 to ensure that insured patients see a primary care physician first and then, if necessary, are referred to specialists or hospitals. This is to increase efficiency in the use of scarce health resources by discouraging patients with minor sickness from direct visits to secondary/tertiary hospitals. The nation is divided into 138 Small-scale Medical Service Regions (or Primary Health Services Regions) and 8 Large-scale Medical Service Regions (or Tertiary Health Service Regions). These regions were created on the basis of administrative jurisdiction and natural borders. Patients need a physician's approval of referral to use health facilities located outside the Primary Health Service Regions (KIHSM 1994). The same referral

system is applied for dental and oriental medicine services. But for childbirth and emergencies, they can visit any facilities without a referral letter.

Providers have customarily been paid for their services on the basis of an itemised fee for each medical service rendered. The National Health Insurance programme has followed this traditional practice. Submitted claims are reviewed by the Medical Fees Review Committee at NFMI. The committee consists of ten full-time and 500 part-time members who are medical specialists. It is divided into a central committee and local committees. Pharmacists, nurses, medical engineers, and administrative staff are assigned to assist the committees. They examine individual claims against the standard fee-guidelines published by the Ministry of Health and Welfare. Providers are normally reimbursed within 30 days from the date of claims submission, if nothing is wrong. The fee schedules are updated periodically, once or twice a year, by the National Health Insurance Deliberation Committee.

In the Korean setting, problems regarding the fee-for-service (FFS) payment system are as follows:

1) FFS reimbursement leads to an expansion of the volume of services. It provides providers of care with financial incentives to generate more revenues. This has resulted in the increase of unnecessary services in terms of both quality and quantity.

2) The fee schedules are neither reflecting real cost nor balanced across the departmental services. Some services are either under- or over-valued in the context of low fee schedules.

3) The unit fee schedules are tightly regulated as a cost containment measure. This has created financial hardship for providers. It has forced physicians to see as many patients as possible in a short period of time. The low fee schedule policy has distorted the allocation of health care resources and diminished the level of quality of care (Suh 1997).

A single payer, NFMI, asks each member society to deposit a certain amount in advance on the basis of the following formula: (average amount paid for the society during the last 3 months) X 4/3 – (balance remaining after adjusted settlement of the previous month). All member societies receive their payment through designated payment agencies (NFMI 1997). Practically all banking institutions and post offices are designated nation-wide. Payments of medical care fees are regularly made 12 or 13 times a month.

Unfortunately, as the population coverage became universal, health expenditures exploded rapidly and gaps in physician incomes among medical specialities widened. Thus, two measures were taken: one was to adjust uneven fee schedules among different medical specialities. This was done by adopting the idea of a resource-based relative value scale (RBRVS). The final report on the RBRVS payment has recently been published. The other was related to the change of payment method from the existing fee-for-service to DRG payment. A pilot project was organised two years ago. According to the previous two evaluation reports, the project has proved to be successful in terms of volume of services, administration cost and provider satisfaction. The pilot project was intended to cover more health facilities and to broaden the scope of DRG coverage in 1999.

Specifying and Assuring Benefits

As stated earlier, In the event of sickness, injury, maternity, and/or death, the insured persons and their dependants are entitled to health insurance benefits, consisting of benefits-in-kind and cash. Benefits are now fairly broad in the sense that the scheme covers the cost of CT scanning, major surgery, bone marrow transplantation, and various laboratory tests, etc., though MRI services have not yet been included. The period of benefit coverage was 330 days in 1999 except for pulmonary tuberculosis. The elderly aged over 65 years are given 365 days of benefits without any limit. For the initial 17 years the benefit period was limited to 180 days a year, and it was gradually extended by 30 days a year from 1995. Limits on the benefit period will be terminated in the year 2000, meaning that a full year service will be available in the 21 century.

The list of benefit exclusion items is rather long: cosmetic surgery, unauthorised treatment, specially arranged consultations, room charges beyond the standard room of six beds, bodily harm caused by criminal acts or intentional accidents by the insured person, expenses compensated by benefits from other sources, direct visits to tertiary care hospitals, dental prostheses and preventive scaling, aid devices such as artificial limbs, hearing aids, and high cost technologies such as MRI and Laser treatment. Benefits are suspended while in military service, during travel abroad or when in the care of correctional institutions. Benefits may be withheld in whole or in part for disobedience

to institutions of the insurer or health care providers. Benefits would be suspended for three months if false claims were made.

The KMIC has included health examinations and preventive services for all the insured and their dependants once every two years. This is to ensure the early detection and treatment of chronic degenerative diseases. Many employee schemes have followed the KMIC to cover various vaccinations like hepatitis B and Lyrugen, pap smear, mammography and so on (KMIC 1997). These services were further extended to the self-employed in regional health insurance, but they were limited to high risk groups like those aged over 40.

As mentioned, heavy cost sharing formulae are practised. The insured or their dependants are required to share a part of their medical expenses at the point of services. They pay 20% of total costs in the case of hospitalisation and a specific amount of money for outpatient care. But if the outpatient cost exceeds 10,000 won per medical visit or 12,000 won per dental visit, 40% or 55% of the coinsurance rate is applied for hospital care, respectively, and 30% for both medical and dental care at clinics according to regions. A similar cost sharing formula is applied for the Pharmaceutical Benefit Programme according to doctor's prescription and total cost amount. Co-payment is a vital component of social health insurance in Korea. Despite such high cost sharing, the volume of services has risen very steeply. This indicates that Korea is not successful in containing the national health insurance expenditures.

Other Implementation Experiences

Despite this weakness, the Korean health insurance programme has achieved many good points within a short period of time. The following are some examples:

1) The level of contribution is only 3.2% of wages and salaries, which is ranked as the lowest among universal health insurance programmes in the world. Before the IMF crisis in Korea, the average level of industrial workers' contribution had declined for 5 years since the inception of universal health insurance in 1989.

2) The process of expansion has been extremely rapid. It has taken only 12 years from the beginning of social insurance in 1977 to universal population coverage in 1989.

3) The benefit scheme is fairly broad in the light of its low contribution level.

4) Access to care has greatly improved. For example, the number of physician visits has increased from 1.1 in 1977 to 6.4 in 1989, which is equivalent to an increase of 5.8 times during 12 years.

However, problems of containing national health expenditure (NHE) are serious. There is a danger that if the current rate of increase in NHE continues at approximately 19% per year, Korea will be in danger of massively exploding health expenditures in the early 2000s like the US. The percent growth during the period 1987-1992 was an annual 21.8%. With the NHE growing faster than the Korean economy, the future of health insurance cannot be bright at all (Moon 1994).

A DRG based payment system is a strong possibility. According to the interim evaluation report, the total volume of medical services decreased by 11%, average length of stay by 3%, and the average cost of antibiotics used per inpatient case by 40.3%. These are all good signs for it. Of providers who joined the pilot project, 52% were satisfied with it, and 75% answered that they would continue in the second phase of the project. However, it is too optimistic to expect a complete success since the Korean Hospital Association is still reluctant to accept DRG reimbursement. But the government has succeeded in extending the scope of the initial coverage from 29 DRGs to 41 DRGs in the third phase of the experiment this year.

National Health Insurance has been the most epoch-making event in the history of health services in Korea. It was an innovation as well as a breakthrough as it grants a right to health services for all Koreans. Still the most difficult task has been to devise a fair working formula in levying the contributions of self-employed persons. This becomes even more difficult as the new Korean government is trying to integrate all health insurance societies into a unified scheme. Korean health insurance stands indeed at the crossroads.

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ACHIEVING UNIVERSAL COVERAGE FOR HEALTH CARE: EXPERIENCES FROM THE PHILIPPINES

Jaime Galvez Tan

Introduction

The majority of health problems faced by Filipinos face today is rooted in the inability of the majority to access basic health care services. In response to this, Republic Act No. 7875 or the National Health Insurance (NHI) Act was signed into law on February 14, 1995. It envisions to provide health insurance coverage and ensure affordable, acceptable, available, and accessible health care services for all citizens of the Philippines.

The NHI Act was not, however, the country's first attempt at universal health care coverage. The first programme was the Philippine Medical Care Plan (Medicare) established through the Republic Act No. 6111 in August 1969.

Assessment Of The Medicare Programme

Though legislated in 1969, the Medicare Programme was not implemented until January 1, 1972 with the creation of the Philippine Medical Care Commission (PMCC). The following is a brief assessment of Medicare's 25 years of implementation.

Organization

The overall management of Medicare nominally rested with the PMCC with the Social Security System (SSS)[16] and the Government Service Insurance System (GSIS)[17] acting as financial intermediaries. As the two systems also managed the Health Insurance Funds (HIFs) as mandated by law, the PMCC was left with little power to manage the funds.

Programme design

Medicare was committed to providing comprehensive medical care to all Filipinos in a gradual and evolutionary manner. Hence, it was designed to be implemented in two phases: Programme I covered all those formally employed in the public and private sectors, while Programme II should have covered all those not part of Programme I. However, in its more than 25 years of existence, the Medicare failed to implement Programme II fully. When the NHI law was passed in 1995, the Medicare was still pilot testing Programme II in several provinces.

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[16] The Social Security System (SSS) administered (until August 1, 1998), the Medicare program for those working in the private sector.

[17] The GSIS used to administer the Medical Program for those working in the government.

The benefits under Programme I were limited to inpatient care. Medicare was financed through compulsory contributions collected through a payroll tax. Each employee contributed 2.5% of his/her salary base and the employer and employee shared equally in the cost. Beyond the salary base ceiling, contributions remained constant in absolute terms.

Coverage and membership base

The Medicare Programme covered about 24.21 million Filipinos (members and their dependents) or 38% of the total population. Table 1 shows the growth of the membership of Medicare from 1972 to 1991.

Table 1: Medicare Coverage in Absolute Numbers and as Percentage of Population; 1972-1995

Year	Coverage (in millions)	% of Population	% SSS	% GSIS
1972	5.59	14.40	90.90	9.10
1976	12.42	28.60	73.80	26.20
1981	18.40	37.10	76.10	23.90
1986	29.77	53.20	75.90	24.10
1991	23.50	37.40	70.10	29.20
1995	24.21	38.5	71.60	28.40

Source PMCC 1997

The decline in Medicare coverage from a high of 29.77% million in 1986 to 23.5 million in 1991 was due to the purging of inactive files.

Support value

Medicare envisioned supporting 70% of its members' hospitalization costs. However, the Support Value of Medicare or the percentage of the amount covered by Medicare as a percentage of total hospitalization costs, was far below the target (see Table 2).

Table 2: Medicare Support Value; 1972-1989

Year	Support Value
1981	39.8
1985	31.5
1987	33.4
1989	48.9

Source : PMCC 1997

Financial performance

The management of both health insurance funds (HIFs) also varied to a large extent. For example, the reserve capacity of the SSS was strong at six years compared to less than two years for the GSIS. This resulted in a better benefit package for SSS members despite the fact that members of both systems paid equal amounts of premiums.

The macroeconomic conditions of the Philippines have important implications for health sector financing. First, the slow growth of household incomes and continued high poverty rates meant a reduced capacity of households to finance health expenditures. Household income for Filipinos grew by only an average of 2% in the 1970s - 1980s while that in other Southeast Asian countries leaped by 4% to 6% (Herrin 1992)

Second, since the Medicare Programme covered only the formal sector employees in government and private sectors, the slow shift in the proportion of employment from agriculture to modern industry meant also only a slow expansion of the population that could be covered by Medicare. The percentage of the population in industry remained stagnant at 20% until the first part of the 90s (Herrin 1992).

Third, the slow economic growth also meant a slow growth of government resources. This placed a limit on government resources for health. And lastly, the high rates of inflation eroded the purchasing power of the peso particularly for health services, making much more insignificant the meagre resources allotted for health services. The average annual inflation rate from 1980 - 1990 was about 12% and inflation for pharmaceutical and medical supplies reached as high as 15% (Solon and Herrin 1991).

National Health Insurance Act Of 1995

The National Health Insurance Programme (NHIP), which seeks to cover all Filipinos within a period of 15 years, is an improved and enhanced version of its predecessor, the Medicare Programme. To implement the programme, the Philippine Health Insurance Corporation (PhilHealth) was established in 1995.

Programme components

To date, PhilHealth is administering the health insurance programme for workers in both the government and private sectors.

An important component of the NHIP is the Indigent Programme. Through this, the indigents who were not previously covered by Medicare, can be covered. To implement the Programme, PhilHealth entered into Memoranda of Agreement (MOA) with 31 Local Government Units (LGUs)[18] nationwide. Of this number, only 10 LGUs are currently implementing the Programme covering over 350,000 indigent families. This is about 9.3% of the estimated 3,750,000 indigent households nationwide. By the end of 1999, the Programme will be introduced to an additional 60 LGUs with an indigent population of about 600,000.

The 21 other LGUs are in the process of conducting the Means Test. The Means Test is a protocol administered by PhilHealth at the barangay level to identify the indigent.

Benefit Package

PhilHealth still retains the benefit package provided by the former Medicare Programme, which is basically inpatient care. The law specifies the provision of the following benefit package:

Inpatient Hospital Care:

- Room and Board
- Services of health care professionals;

[18] Local Government Units (LGUs) are the political subdivisions of the country. There are four levels of governance below the national government: province, city, municipality and barangay.

- Diagnostic, laboratory, and other medical examination services;
- Use of surgical or medical equipment and facilities;
- Prescription drugs and biologicals;
- Inpatient health education package.

Outpatient Care:

- Services of health care professionals;
- Diagnostic, laboratory, and other medical examination services;
- Personal preventive services;
- Prescription drugs and biologicals;
- Emergency and transfer services;
- Other health care services as determined necessary by the Corporation.

For hospital services, there are maximum peso allowances that depend on the type of hospital service (e.g. room and board, medical expenses, operating room fees, etc.) as well as on the category of hospital (primary, secondary or tertiary). Professional services are compensated through fees-for-services based on a Relative Unit Value (RUV) Scale[19].

PhilHealth is now in the process of developing a phased implementation of the benefit package as envisioned in the law. It is likewise upgrading the RUV Scale, which had been left unchanged since its adoption in 1972.

Organizational structure

PhilHealth is a government-owned and controlled tax-exempt corporation attached to the Department of Health (DOH) for policy supervision. It has 18 Local Health Insurance Offices (LHIOs), one in each of the country's fifteen regions and three in Metro Manila.

Financing

The law provides for the following sources of funds for the NHI Programme:

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[19] The Relative Unit Value (RUV) Scale is a measure of the relative complexity of a medical procedure, and is multiplied by a peso conversion factor to obtain the fees

1. Payroll contributions of those in formal salaried employment in the government and private sectors;
2. For those who cannot afford their premiums, their contributions will be subsidized by the national and local governments; and,
3. Additional appropriations will come from twenty-five percent of the increment in revenues from Republic Act No. 7660 (Documentary Stamp Tax) and from Republic Act No. 7654 (Sin Tax Law).

Payroll contributions

For those in the formal salaried sector, the law provides that the premium should not exceed 3% of an employee's salary. The employer and the employee equally share in the premium. At present, premium contribution is pegged at 2.5% of the member's salary base not exceeding P3,000 (US $75)[20]. With the present salary cap, the maximum monthly premium is P75 (US $1.88).

The salary cap is a very regressive feature of the Programme as higher salaried employees pay less for Medicare as a proportion of their salary.

Premium subsidy

The national and local governments subsidize those who cannot afford to pay their premium contributions. First to third class local government units (LGUs) equally share the premium with the national government[21]. Fourth to sixth class LGUs initially shoulder only 10% of the premium, progressively increasing until such time that their share equals to that of the national government.

The devolution of health services, as mandated by Republic Act No. 7160 of 1991, transferred health service delivery to the LGUs. Of the agencies that were devolved, the Department of Health (DOH) transferred the most resources. The DOH accounted for 65.5% of the total cost of devolved functions. It likewise transferred more than half of its personnel to the LGUs. Like any other change of this magnitude, devolution has

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[20] RP P40 = US $ 1

[21] Local Government Units are classified into six categories, first to sixth, depending on their income.

spawned a host of problems including political, administrative and management issues. The most compelling however, are financial in nature.

The precarious financial condition of the LGUs is further burdened by a number of unfunded mandates from the national government. These are:

1. Magna Carta for Public Health Workers (Republic Act No. 7305). In recognition of the important role of public health workers in the delivery of health services, the Magna Carta for Public Health Workers was passed in 1992. Amongst other things, the law provides for public health workers a comprehensive package of financial benefits that includes hazard pay, subsistence, laundry, and remote assignment allowances and longevity pay. The full implementation of the law would cost about P1.239 billion ($ 30.98m). Since its implementation, the national government has provided LGUs with a subsidy for the provision of these benefits as the LGUs alone cannot afford to shoulder them.

2. Salary Standardization Law. An across the board salary increase was given to national employees in 1994. As devolved health workers are no longer with the national government, they are not included in the increase. However, a provision in the Magna Carta states that local employees shall receive the same salary as their national counterparts. The salary increases further drained the resources of the LGUs.

3. Barangay Health Workers' Law. Barangay Health Workers numbering about 200,000 are the country's barefoot doctors. In 1995, the Barangay Health Workers' (BHW) Benefits and Incentives Act was passed providing BHW with a mechanism for training, accreditation, and a package of benefits and incentives including hazard and subsistence allowances. After more than two years, the majority of LGUs have not yet given these benefits to the BHWs due to lack of funds.

Additional appropriations

The law provides that 25% of the increment in revenues of the Sin Tax Law will go to the NHIP. Such a law not only discourages people from engaging in hazardous activities (eg smoking) through increased taxation but will also ultimately help cover the costs incurred by the government as a result of these activities or behavior. The same 25%

increment from the Documentary Stamp Tax should go to the Programme. Despite clear provisions in the laws, none has been allocated to date. For such provision to take effect still needs Congressional action to include it in the General Appropriations Act (GAA) or the annual budget, which unfortunately has not been done. The following table shows the funds that should have been appropriated to the Programme.

Table 3: Expected revenues for the NHIP from additional appropriations (Million Pesos)

SOURCES	1995	1996	TOTAL
Sin Taxes	1,000 ($25.00m)	1,330 ($33.25m)	2,330 ($58.25m)
Documentary Stamp tax	37 ($ 0.93m)	26 ($ 0.65m)	63 ($ 1.58m)
TOTAL	1,037 ($25.93m)	1,356 ($33.90m)	2,393 ($59.83m)

Source: Department of Finance May 1997

Provision of services

Accredited providers

To be able to participate in the Programme, a health care provider should be accredited by PhilHealth. Under the law, the following providers can be accredited:

- Health care institutions, whether government or private;
- Health Care Professionals (doctor of medicine, nurse, midwife, dentist, or other practitioner duly licensed to practice in the Philippines);
- Health Maintenance Organizations;
- Community-Based Health Care Organizations.

Health care institutions

After a little more than three years of implementation, the most serious debate on the NHIP has concentrated on the so-called "three-year accreditation rule". Under this rule, a health care institution should be operating for at least three years before it can be accredited into the Programme. This was to ensure primarily the financial viability of the health care institution for it was reasoned that a financially secure institution would not resort to fraud. However, many contend that financial viability is not a safeguard against fraud and that in a country where hospitals are lacking, the three-year rule is detrimental.

Health Maintenance Organizations

Managed health care is still a relatively new way of providing health services in the Philippines. To date, there are about 30 health maintenance organizations (HMOs) in the country, the majority of which are investor-based or for-profit. HMOs currently cover less than 2% of the total population, a dramatic increase from five years ago when HMOs covered less than 1% of the population.

The considerable growth of the HMO industry over the past few years and its potential for future development argues for some form of regulation. The Department of Health (DOH) issues HMOs with only a Clearance to Operate. A pending bill in Congress seeks to clarify the issue of regulation. There is also the debate of whether HMOs are indeed "health care providers" or simply "brokers" of health care.

Coordination is now going on between PhilHealth and HMO groups for the development of a suitable and acceptable accreditation guideline for HMOs. PhilHealth contends that HMOs should only provide benefits over and above those PhilHealth provides to its members[22]. HMO members who are not yet members of PhilHealth should automatically be made members of the NHIP and the corresponding premium paid to PhilHealth. This would not only pave the way for the accreditation of HMOs but also move forward universal coverage.

Community-Based Organizations

Recent years have shown the tremendous growth of community-based organizations in the country. Many of them provide some form of health insurance programmes to their members. There are about 30 community based organizations with a membership of less than 100,000 households that have a health insurance component in their programmes.

Community-based schemes provide a wealth of information for the full implementation of the NHIP. Some of them have innovative premium collection schemes and a number have started providing outpatient benefits and pay their providers on a capitation basis. Given this diversity, the accreditation of community-based programmes indeed poses a

[22] Most HMOs provide their members with options for better room accommodation, hospitalization costs for catastrophic cases, etc.

serious challenge to the NHIP and is definitely a big step towards the realization of universal coverage.

Provider payment mechanisms

Accredited providers are presently compensated on a fee-for-service basis. Although there has been no formal study that would support the contention that fee-for-service payment increases utilization, the use of fee-for-service may not be efficient if outpatient services are to be provided.

Studies are currently being made to include other provider payment mechanisms, which are allowed under the law. These include:

1. Capitation;
2. Combination of fee for service and capitation;
3. Any or all of the above subject to a global budget.

Quality assurance

Quality assurance is one of the three main pillars of the Programme together with universal coverage and cost containment. As a financial intermediary, the NHIP ensures that the services rendered and paid for on behalf of the members are acceptable, adequate, appropriate and of the right quality.

Providers are accredited into the Programme after passing the accreditation standards set by PhilHealth. A performance monitoring system is being established to safeguard against:

1. Over and under-utilization of services;
2. Unnecessary diagnostic and therapeutic procedures and interventions;
3. Irrational drug use;
4. Inappropriate referral practices;
5. Gross, unjustified deviations from currently accepted standards of practice;
6. Use of fake, adulterated, or misbranded pharmaceuticals, unregistered drugs or parallel imports;
7. Use of drugs other than those recognized in the National Drug Formulary.

Together with the DOH, PhilHealth has formed a Committee of Peers to evaluate questionable claims based on the standards enumerated above. The Committee is composed of respected medical practitioners from different specialty groups. PhilHealth has also collaborated with medical groups for the formulation of Treatment Protocols and Diagnostic Related Groups (DRGs).

Implementation Experience

Making the NHIP a success cannot be the work of PhilHealth alone. It needs the concerted efforts of organizations, both government and private, within and outside of the health sector.

The most crucial issues in the full implementation of the National Health Insurance Programme in the Philippines are as follows.

National Government Support: As previously pointed out, the increments of the revenues for the Sin and Documentary Laws have yet to be given to the Programme. The Department of Budget and Management (DBM) still owes the Programme more than P1B (US$24.8 M) representing arrears in premium contributions of government employees. The organizational structure of the new organization was only approved in September 1997, more than two years after the promulgation of the law.

Local Government Support: LGUs will be shouldering from 10% to 50% of the total premium contribution of its indigent constituents. Many LGUs see this as additional expenses and have set it aside in favor of the more tangible and politically popular infrastructure projects. The financial condition of LGUs is further exacerbated by the passage of unfunded legislative mandates and dwindling collections.

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ACHIEVING UNIVERSAL COVERAGE FOR HEALTH CARE THROUGH HEALTH INSURANCE THE THAI SITUATION

Sanguan Nitayarumphong

Supasit Pannarunothai

Introduction

Thailand is a constitutional monarchy with a population of 60 million in 1998. Its population size is similar to that of the United Kingdom (UK), however the population density is one half that of the UK. Thailand has 76 provinces including Bangkok, with 31% of the population living in urban areas. In the last decade, Thailand has seen rapid economic growth, averaging 6% growth of GNP in real terms each year, and in some years (1988 to 1990) two-digit growth. The economic growth has caused a rise in the private health sector and increased health expenditure. Unfortunately, the recent economic crisis has hit Thailand very hard; the updated figure of 1998 economic growth will be zero or even negative at the worst.

The social and economic developments in Thailand have changed the economy rapidly from agricultural-based to industrialised production. This is apparent from the increasing share of GDP from industry and manufacturing sectors at the expense of the share of the agricultural sector. This has a significant impact on labour structure, population migration, urbanisation, lifestyles as well as disease patterns. Thailand is facing an epidemiological transition: while communicable diseases are gradually decreasing, the non-communicable diseases related to lifestyles and behaviours are becoming important causes of deaths. A peculiar situation is an inequality of income distribution which has widened as a result of unhealthy economic growth. The corollary is that unequal income distribution produces inequalities in the health care financing and health care delivery systems.

This paper presents the historical background on health benefit coverage, health care system, and health related inequalities, in order to provide the basis as to why Thailand should develop a universal coverage policy. The paper outlines a plan of how to finance this policy, how to provide the specified basic health package to the population, and how to assure quality of the services provided.

Historical Development Of Universal Coverage Policy

The coverage of health benefit

The first national survey on health benefit coverage was carried out at the household level by the National Statistical Office in 1991. At that time, only one-third of the population was covered by any kind of health benefit schemes. The total coverage rates were no different amongst people in urban and rural areas, but the types of benefits differed (see table 1). The main benefit scheme for urban people was the civil servant medical benefit scheme (CSMBS), but the main protection for rural people was provided by the low income and public welfare schemes (NSO 1993). Additional protection in rural areas was provided by the health card scheme, a voluntary insurance scheme. In 1993, two years after the enactment of the Social Security Act, 7% of the population were protected by the compulsory insurance scheme. Furthermore, the first Chuan Government at that time expanded the public welfare scheme to cover the elderly and children from 0-5 years old. This increased coverage from one-third to one-half of the total population (Pannarunothai and Tangcharoensathien 1993).

Table 1 Health benefit coverage (% of total population) from 1991 to 1997

	1991		***1993***		***1995***	***1996***		***1997***	
Schemes	***Total***	***Urban***	***Rural***	***Total***	***Total***	***Total***	***Urban***	***Rural***	***Total***
CSMBS & state enterprise	10	23	7	11	11	10	18	8	11
Social Security	*	*	*	7	7	6	13	4	7
Low income & public welfare	17	2	20	27	44	30	19	32	41
Health card scheme	2	0	2	5	8	15	2	19	**9
Private employee benefits	2	7	1	na	na	-	-	-	na
Private insurance and others	1	0	1	1	2	2	3	2	na
Not covered	68	68	68	49	28	37	45	35	32
Total	100	100	100	100	100	100	100	100	100

Sources: 1991 - National Statistical Office, Health and Welfare Survey (1993); 1993 - Pannarunothai and Tangcharoensathien (1993); 1995 - Health Insurance Office (MOPH 1995); 1996 - Adjusted from NSO, Health and Welfare Survey (1998); 1997 - The Budget Bureau (1997) calculations at the beginning of the year for budget allocation;

* The Social Security Scheme was established only in 1991

** In 1997, the Health Insurance Office reported that 16% of the population purchased the card

na : not available or not taken into account

The Government's policy to expand health benefit coverage has gone further to cover children from 6-12 years of age. According to the Health Insurance Office of the Ministry of Public Health, 1995 saw the highest coverage rate of 72% of the population, as the result of targeting 44% of the population under the low income and public welfare schemes. The second national survey on health benefit coverage in 1996 revealed that the coverage was not as high as the MOPH's figures, after adjusting for the public welfare coverage which provides benefit to the elderly and children under 12 years. By 1996, the coverage rates were different between urban and rural areas. High coverage of the low income and public welfare schemes and the voluntary health card amongst rural people made the total coverage of rural areas 10% more than that of urban areas, even though urban people were protected by better schemes (ie schemes with greater protection and more generous benefits) such as the CSMBS and the Social Security scheme.

However, the Budget Bureau, which scrutinises budget allocations to all government sectors, argued that many people were counted twice; e.g. the elderly were counted under the public welfare scheme and may be covered by the CSMBS. After removing this double-counting, the Budget Bureau accepted that in 1997, the public welfare schemes would cover 41% of the total population. This caused a slight drop of the coverage rate in 1997. But if the latest figures of the Health Insurance Office were taken into account, 16% of the population bought Health Cards (confirmed by the NSO survey in 1996), including the unemployed that resulted from the economic crisis in 1997. This would mean that only about 25% of the population were not covered by any health benefit schemes in 1997.

The health care system

It has been government policy for many years to extend health services to remote areas, especially during the era of Health For All since 1983. Table 2 shows that from 1981 to 1993, the beds per 1,000 population had increased from 1.5 to 1.9. But the relative distribution did not change when comparing the discrepancy between Bangkok and the Northeast (the poorest region). The explanation is that although the government may intervene by expanding public hospital bed capacity in the poorest areas, the private sector does not expand where people are unable to pay for the care, and instead builds capacity in the richer areas, notably Bangkok. The growth of private hospitals has encouraged doctors to stay in urban areas (Nittayaramphong and Tangcharoensathien 1994).

Table 2 Distribution of hospital beds from 1981 to 1993 (beds/1,000 population)

	1981	1986	1993	*Public*	*Private*
Bangkok	3.3	2.9	4.1	*2.4*	*1.7*
Central	2.1	2.2	2.1	*1.6*	*0.4*
North	1.2	1.3	1.5	*1.3*	*0.2*
Northeast	0.8	0.9	1.0	*0.9*	*0.1*
South	1.4	1.7	1.7	*1.5*	*0.2*
Total	1.5	1.6	1.9	*1.5*	*0.4*

Sources: 1981-1986 - The Thai Government (1988); 1993 - Pannarunothai (1994)

Hospital bed is the core for other health resources to accumulate. However, the distribution of health personnel was not evenly according to number of beds. There were more doctors in Bangkok; therefore each doctor looked after only half the number of inpatients than doctors in the provinces. The work load was also lower for doctors who worked in other ministry hospitals or private hospitals rather than in the MOPH hospitals. This is one of the structural indicators of quality of care. However, the workload was not very different in terms of the nurses' distribution (see table 3).

Table 3 Inpatient workload of doctors and nurses in 1992

		Bed/Dr	***IP/Dr/day***	***Bed/RN***	***IP/RN/day***
MOPH	Provinces	11.48	9.99	2.32	2.02
	Bangkok	6.53	5.17	2.26	1.79
Other Ministries	Provinces	5.83	3.13	2.37	1.27
	Bangkok	2.85	1.19	1.40	0.59
Private	Provinces	8.08	3.13	4.50	1.74
	Bangkok	3.65	1.86	2.12	1.08

Source: Health Policy and Plan Bureau (1994) in Pannarunothai (1996)

RN = registered nurse

In terms of ambulatory care, the MOPH has successfully expanded health centres (without medical doctors or beds) and community hospitals to all villages and districts. The ambulatory visits at health centres had increased 23% per year during 1977 to 1985, and 26% per year during 1985 to 1995, while the visits at community hospitals increased faster in the

first period (35% per year) and then slowed down to 15% per year. This increased the share of ambulatory visits made by rural people at health centres and district hospitals from 54% of the total visits at all public health services outside Bangkok in 1977 to 80% in 1995 (Bureau of Health Policy and Planning 1997).

Health-related inequalities

Different health benefit schemes target different groups of population and provide different benefit packages (see table 4). The low income and public welfare schemes provide free care at the public designated facilities (of the MOPH, and some other ministries) for nearly all conditions, with no copayment. The CSMBS, the fringe benefit for civil servants and their dependents, provides freer choice of health facilities with access to inpatient services at private hospitals, with some copayments for treatments in private hospitals but not in public hospitals. The Social Security Scheme (SSS), comprehensive compulsory health insurance, limits the choice of health care to a contracted hospital (public or private) with no copayment, while the Workmen's Compensation Scheme (WCS), a work-related compulsory insurance scheme, provides freer access but with copayments if the total charge is higher than the set ceiling. The Health Card (HC), a voluntary scheme managed by the MOPH, provides access to only MOPH facilities with referral networks and has no copayment.

Table 5 shows inequality in terms of health expenditure per capita amongst selected health benefit schemes. The low income scheme is financed by an annual global budget with no copayment at the point of delivery. In 1995, it was estimated that the expenditure for the low income scheme was at least 225 baht per capita. The SSS is financed by tripartite contributions to the Social Security Fund for other benefits as well as health. The expenditure per capita for health in 1993 was about 712 baht, or 3 times higher than expenditure of the low income scheme (though different years were compared). The most advantaged group in terms of expenditure per capita was the CSMBS because the discrepancy index was a a factor of 8 (Supachutikul 1996) (Table 5).

Table 4 Benefit package and financing characteristics of the health benefit schemes

Scheme characteristics	Low income and public welfare	CSMBS	SSS	WCS	Health Card	Private insurance
Benefit package						

• Ambulatory services	Only public designated	Public only	Public & private	Public & privat	Public (MOPH)	Public & private
• Inpatient services	Public only	Public & private	Public & private	Public & privat	Public (MOPH)	Public & private
• Choice of provider	Referral line	Free	Contractual basis	Free	Referral line	Free
• Cash benefits	No	No	Yes	Yes	No	Usually no
• Inclusive conditions	All	All	Non-work related illness, injuries, except 15 conditions	Work-related illness and injuries	All	As stated in the contracts
• Maternity benefit	Yes	Yes	Yes	No	Yes	Varies
• Annual physical checkup	No	Yes	No	No	Possible	Varies
• Promotion & prevention	Very limited	Yes	Health education and immunisation	No	Possible	Varies
• Services not covered	Private bed, special nurse, eye glasses	Special nurse	Private bed, special nurse	No	Private bed	Varies
Financing						
• Source of funds	General tax	General tax	Tripartite contributions, 1.5% of payroll	Employer, 0.2-2% of payroll with experience rating	Household purchase 500 baht + tax subsidy 500	Premium
• Financing body	MOPH	Ministry of Finance	Ministry of Labour	Ministry of Labour	MOPH	Competitive companies
• Payment mechanism	Global budget	Fee-for-service reimburse	Prospective capitation	Fee-for-service reimburse	Limited fee-for-service	Fee-for-service reimburse
• Copayment	No	Yes, for IP at private hospital	Maternity and emergency services	Yes, if beyond the ceiling of 30,000 baht	No	Almost none

Source: Pannarunothai and Tangcharoensathien (1993), Supachutikul (1996) and Tangcharoensathien and Supachutikul (1997)

Table 5 Total expenditure per capita of selected health benefit schemes

Schemes	Private contributions (million baht)	Government budget (million baht)	Expenditure per capita (baht)	Discrepancy index*
1. Public welfare				
• Low income, elderly (1995)	0	4,143.1	>225	1.0
• Primary school (1995)	0	161.1	>30	0.1
2. Fringe benefit				
• CSMBS (1994)	0	9,954.0	>1,780.7	8.0
3. Compulsory insurance				
• SSS (1993)	5,553.5	3,803.7	711.9	3.0
• WCS (1993)	921.4	0	96.1	0.4
4. Voluntary insurance				
• Health card (1994)	807.4	400	>190	0.8

Source: Supachutikul (1996)

* ratio between expenditure per capita of each scheme and the low income scheme

Unequal benefits set by different insurers produce inequality in health care utilisation; especially the not covered group had only half the hospitalisation rates of other health benefit groups in a study of a large urban area (Pannarunothai and Mills 1997a). Health benefit scheme was an important variable in influencing self-reported health status and the probability of hospitalisation of an individual. Furthermore, the not covered group, who tended to be poorer, paid for health care out-of-pocket a higher percentage of household income than the covered groups (Pannarunothai and Mills 1997a). Recent studies confirm that the Thai health care system is inequitable: in terms of the Kakwani index, the financing system for health care was regressive to income (Rehnberg and Pannarunothai 1998), and in terms of the concentration index, the health delivery system favoured the rich (Pannarunothai and Rehnberg 1998).

Such evidence has raised awareness amongst policy makers and the Budget Bureau of inequalities within the Thai health care system. One approach, in the long term, to this problem is to move towards a universal access health care system. The big question to be

solved is whether the system be financed by general taxation or the amalgamation of the existing insurance systems (Pannarunothai and Mills 1997a).

Policy On Universal Coverage

Since Thailand has already achieved high coverage of health care for the majority of the population, a policy of achieving universal coverage has been greatly welcomed and is currently under consideration to formulate explicit policy. One approach, learned from international experiences, is to enact a law. The National Health Insurance Act has been drafted and is being scrutinised by many parties, including political and government bodies as well as NGOs.

The timetable for implementing universal coverage

The time frame for achieving universal coverage of health care was stated as policy under the 8th National Health Plan (1997-2001), and the initial plan was that this would be at the end of 2001. However, due to the current economic crisis, the proposed time frame is likely to be somewhat delayed. If the economic crisis is used as the opportunity to improve the efficiency of the Thai health care system, the policy on universal coverage should be implemented as soon as the economy recovers.

Single or multiple organisations

There are 2 options of how to expand health coverage to all: one is to set up a ***National Health Security Fund*** as a single agency to manage the universal coverage policy. The other is to set up a ***National Commission on Health Security*** to coordinate the policy of universal coverage through multiple health insurance organisations (Pannarunothai and Tangcharoensathien 1993, Nitayarumphong 1996).

Setting up the National Health Security Fund requires radical reforms of all health benefit schemes, to be managed under a single agency. Funds from existing schemes would be pooled together, in addition to new tax raising schemes e.g. general taxes, earmarked taxes for health from cigarettes, tobacco, etc. Under this option, all citizens would have a right to choose their contracted health facility which would be accessible and would provide the specified essential health package. If they required anything not included in the package, they would have to pay for the service themselves or through a private insurance scheme. This option would equalise benefits to all citizens (see figure 1).

The alternative to the radical reform, the National Commission on Health Security, is proposed to be a coordinating body to bridge the gaps amongst existing health benefit schemes. This national commission would have the duty to advise the government on how to expand health coverage to the unprotected groups. Management of each scheme would be maintained (see figure 2).

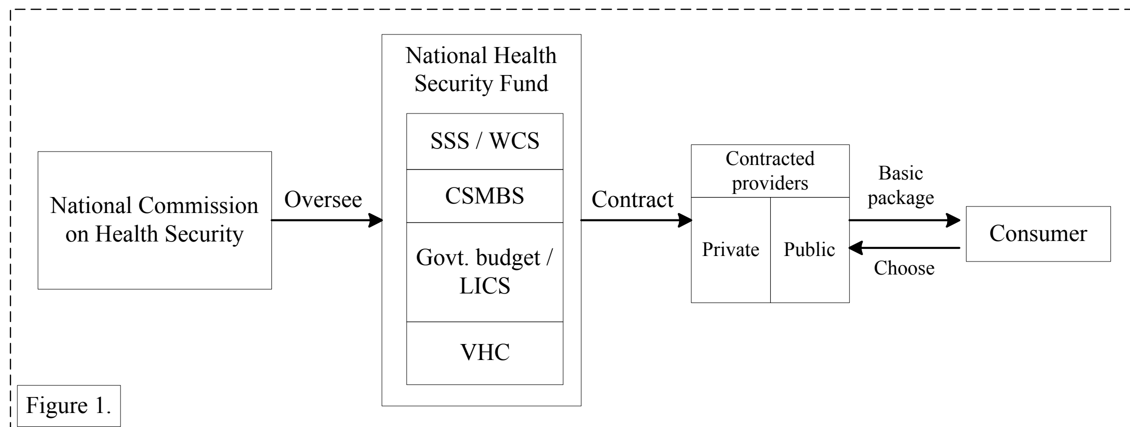

Figure 1.

SSS = Social Security Scheme
CSMBS = Civil Servant Medical Benefit Scheme
WCS = Workmen Compensation Scheme
VHC = Voluntary Health Card Programe

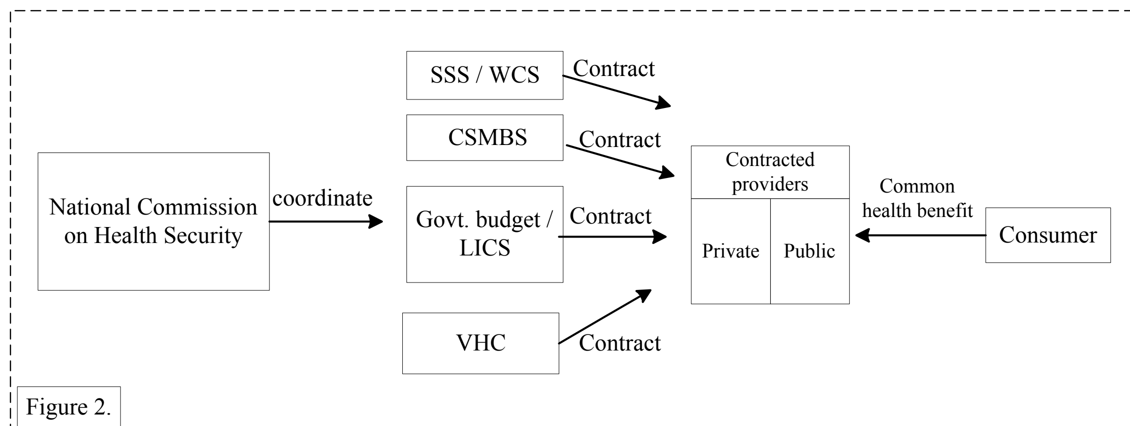

Figure 2.

Financing Of Universal Coverage

There is no answer as yet to how the universal coverage policy would be financed in Thailand. It is likely to be financed by insurance contributions from those who earn higher than the poverty line. There would be exemptions for those who need public assistance such as the elderly, children under 12 years old and the handicapped. Copayments would be an additional source of finance raised from certain kinds of services and from the bypassing of the referral line. Details on premium contributions and copayments have to be carefully designed: several studies are being conducted to shed light on these areas. In principle,

universal coverage should be accomplished through a mix of financing sources, i.e. general taxation, compulsory insurance and copayment at the point of delivery. This section discusses the main possible sources of finance based on studies and recent policy developments.

Arguments for a tax-financed health care system

The trends in health benefit coverage in table 1 show that only the low income and public welfare schemes have significantly expanded the coverage of the population. The CSMBS has been faced with cost containment problems and the number of civil servants have been kept constant for years as part of civil service reforms. The SSS will be expected to have decreased in size if the economy gets worse because workers become unemployed. The Health Card scheme, a MOPH-run voluntary health insurance scheme, has increased its popularity in recent years because of strong publicity and public relations. However, the scheme cannot reach high coverage in many provinces, and puts MOPH health personnel under pressure to sell the cards each year to voluntary subscribers (Pannarunothai et al 1997). On the other hand, a sound policy discussion between the MOPH and the Budget Bureau on public subsidy to attain equity and efficiency objectives in health care financing has significantly increased the budget for the low income and public welfare schemes.

A study by Pannarunothai and Wongkanaratanakul (1997) estimated the burden on the government budget, if the not covered group were put under the same benefit packages as the public welfare schemes with copayment of 5-20% of total charges. This policy would cost the government around 44-79 billion baht in 1995, while the total government health budgets in all ministries for all activities were already 46 billion baht. However, all the estimates on health care financing in Thailand have to be scrutinised because the latest study on national health accounts by Laixuthai et al (1997) has disapproved the previous perceptions of health care financing in Thailand. The previous projection by the National Economic and Social Development Board (NESDB) of 1991 national per capita expenditure was 40% too high, and the public share was higher than had been thought: the public share was 49%, up from the previous estimate ot 25% (Laixuthai et al 1997). The new estimates support the position that the government can be the major purchaser of health care for its population with only marginal investment, but through drastic health sector reforms.

Arguments to retain the existing insurance schemes

As Thailand has to comply with the bail-out package of the International Monetary Fund (IMF) to control public spending at a level not higher than government income, therefore, existing sources of finance for health care must not be abandoned. Each year, at least 3% of public health spending comes from the SSS. Moreover, the SSS is operating with a surplus: its fund has accumulated over 50 billion baht. Its stability is maintained as the SSS is a compulsory scheme.

The government voluntary insurance scheme the Health Card, on the other hand, is operating a negative balance. Even though the scheme has received a matching subsidy from general taxation for each card sold, the actual expenditure per card was almost double the income of the scheme (revenue plus subsidy). This may be the result of adverse selection of the card subscribers and the price not indexed to inflation. However, the revenue raised in 1997 of one billion baht (about 20% of the low income budget in 1997) may be significant enough that the MOPH would not want to lose it.

Community-based funds for health insurance

A few community-based funds, which operate at village level and make a surplus from giving loans to members, have moved to provide health benefits to their members. An example of a community-based fund in the south of Thailand has operated for more than 10 years: the accumulated fund is over 50 million baht. The fund started to provide health benefits 3 years ago for reimbursing a part of medical bills at public health facilities. The proportion of reimbursement to the total charges has increased each year. The community considers this activity as a community welfare scheme comparable to the welfare that the government provides to civil servants. The community-based fund can be one mechanism to raise premiums from people in the informal sector in rural areas. However, it is very difficult to generalise this to other communities on a voluntary basis.

Introducing copayment at an affordable level

About 20% of the expenditure of government hospitals is financed by user fees at the point of delivery (Pannarunothai et al 1994, Pannarunothai and Mills 1998). Many health benefit schemes provide exemptions from user fees, so the not covered group have to pay high fees which are regressive to income (Rehnberg and Pannarunothai 1998). The universal coverage policy will change this pattern and certainly will face resistance. The CSMBS is introducing

copayment for fees on private room and board if stays are lengthy in public hospitals (Tangcharoensathien 1997); however, there are hot debates about this introduction.

Provision Of Services And Payment Of Providers

According to the National Health Insurance Act, a comprehensive health care package will be made available. Family physicians will be assigned to every family member to make health care accessible to all. Health care providers must include both public and private sectors, and the public sector should not be limited to the MOPH only. The SSS has been successful in cost containment because the SSS contracts with both public and private hospitals on a prepaid capitation basis. In areas where there are many public and private hospitals, competition amongst them to get a higher number of contracted workers is claimed to ensure that hospitals provide high satisfaction to consumers.

As far as the cost of care is concerned, private ambulatory services appear to be cheaper than public facilities especially in urban areas (Pannarunothai and Mills 1997b, Pannarunothai et al 1998), and also for some diagnosis related groups (DRGs), private hospitals treated them more cheaply than public hospitals in terms of total costs (Kunaratanapruk et al 1996). Competition amongst private hospitals alone, especially in Bangkok, tends to drive costs up because of information asymmetry between consumers and providers and weak regulation by the MOPH (Bennett 1997). Policy implications can be drawn that public and private hospitals should put less emphasis on providing ambulatory care; at the same time hospitalisation should be paid for on a case-mix basis, and where possible with a global budget cap, to regulate prices and contain costs. The package for medium-term reform of the CSMBS contains two strong components of paying for ambulatory care on a capitation basis and paying for hospital care on a case-mix basis with a budget cap. Consumers would have to copay for both ambulatory and hospital care (Tangcharoensathien 1997). However, the private sector will argue for different copayment rates for different 'perceived' quality. The CSMBS short-term measures to contain cost by inhibiting access to private hospitals will make them more receptive to the payment scheme of case-mix with budget cap.

The relationship between purchasers and providers

Under the new arrangements (according to the second option above), the likely purchasers of health care are the Civil Servant's Health Fund, the Social Security Fund, the Fund for the Low Income and the Public Welfare Groups, as well as the Budget Bureau. These

purchasers would contract for comprehensive health services with public or/and private health networks according to consumers' choices. People would have the right to choose their family physicians, and family physicians from the network would provide comprehensive health services for their registered population. Family physicians would refer cases to hospitals (public and private), if they cannot handle those cases, and may pay the hospitals on the patients' behalf at negotiated prices.

Specifying And Assuring Benefits

Guaranteeing all people access to the specified benefit packages is a difficult task. Strong financing mechanisms have to be made to shift over-supply of resources in Bangkok and urban cities to rural areas. The resource allocation mechanism will be used to ration limited resources to only cost-effective services by putting these services into the resource allocation formula to the provinces. However, people would have to face higher copayment if the referral line is not followed.

Quality assurance is an important mechanism to achieve the specified goal of good health at reasonable cost. The SSS has implemented a hospital accreditation process with the contracted hospitals. This activity has raised awareness amongst health providers because those who get certification of good quality may be exempted from the annual accreditation procedure whilst the borderline providers have to be re-accredited every year (Chayasrivong 1997). On-going developments on total quality management (TQM), hospital accreditation and clinical audit, both internal and external to hospitals, are intended to improve the quality of care in both public and private sectors. These developments support the provision of health security to the citizens (Health Systems Research Institute 1996).

Conclusion

This paper has reviewed the key issues facing the Thai government in moving to universal coverage. Legislation is one approach to provide effective universal coverage to all Thai citizens. Key questions are on how and how much to finance this policy and whether it is feasible under the current economic crisis. The implementation of the law is yet a difficult task as the country has to decide on politically and economically sensitive issues, e.g. why let the non-poor use health care without paying; or what should be included in the basic essential health packages. Mixed sources of finance are the most likely solution with a major component of a public welfare scheme and small portion of copayments. There needs to be

a committee at the national level to put this policy into practice. It is envisaged that the committee would be the purchaser of health care for all citizens by making contracts with networks of health care providers. Family physicians and hospitals would act as providers winning different contracts: e.g. family physicians would win a capitation contract for providing comprehensive ambulatory care; hospitals would get contracts for referral cases or hospitalisations.

The Thai health care system has faced equity problems which have meant that it cannot deliver good quality care to all citizens regardless of socio-economic status. About one third of the population remains unprotected by any health benefit schemes, and the share of the population uncovered is higher in urban areas. Universal coverage is both a means and an end to reduce inequalities in health and in access to and use of services.

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Universal Coverage of Health Care Synthesis

The Route to Universal Coverage

Anne Mills

Introduction

One of the most striking differences in the health systems of countries at different levels of development is that of the share of the population who have adequate access to health services and who are protected from the financial consequences of illness. High income countries, with the notable exception of the United States, have health systems that guarantee universal access to health care regardless of a person's income or social status. There are of course differences in the degree to which countries are successful in achieving an equitable system; nonetheless the principle of universal coverage is unquestioned.

In contrast, the health systems of poorer countries demonstrate both absolute lack of access, and very different degrees of access for different population groups. Where compulsory social health insurance schemes exist, they tend to offer much higher quality and quantity of care than that available to those not in formal employment, who must rely on often under-funded and poorly distributed Ministry of Health-run services. Thus dual and even triple health systems can co-exist, institutionalising inequity in access to health care.

A notable feature of health policy trends in the last few years has been the interest in a number of countries and regions of the world in achieving universal coverage. In South East Asia this has been fuelled by economic growth, and by an awareness that improvements in access to health care and protection against income losses due to illness are both some of the fruits of economic growth that can be shared widely in the population, and an important contributor to a flourishing economy. In Latin America, institutionalised inequalities in access to care are finally being tackled in some countries, as countries liberalise their economic systems and open up their political systems.

However, while the principle and desirability of universal coverage is unquestioned – at least for those countries sufficiently wealthy for it to be a feasible prospect in the not too distant future – the means of achieving it are the subject of considerable controversy. Health sector reforms are being discussed in many parts of the world, and there is argument over the desirability of different forms of finance; of the nature of the financial institutions which transfer funds to providers; and of the ownership and organisation of the providers themselves (Mills 1999). These arguments increase in complexity when

they have to deal with the reality of the systems currently in place in countries, and what changes are both feasible and acceptable.

The papers in this volume share in common a focus on analysing and explaining how particular countries have achieved universal coverage, or are planning to achieve it. They are intended to help policy makers in countries wishing to plan a course towards universal coverage to understand the key issues and the options that face them. This final paper therefore seeks to:

- highlight key themes emerging from the country papers
- identify how those countries which have achieved universal coverage did so
- identify key options and choices for countries seeking to move towards universal coverage
- pose some key policy questions for those countries still seeking a route to universal coverage.

The Objective Of Universal Coverage

First, however, there is the question of what is the target. The paper by Kutzin defines the objective as "achieving universal coverage with effective risk protection at the least cost possible". He acknowledges that key issues are the depth of coverage - the range of services available to people without out-of-pocket payment; and the breadth of coverage - the proportion of the population that has effective health care risk protection. The objective of universal coverage is unambiguous with regard to the latter: it must be 100%. However, with regard to the former, there is no absolute standard that can be specified. Even the richest countries acknowledge that resources set limits on the amount of care to which the state can feasibly guarantee access; for middle income countries this is even more of a problem. Hence it must be acknowledged that there is not an unambiguous target for countries aiming at universal coverage.

We also should not assume that the desirability of achieving universal coverage goes without question. As an illustration, it is noteworthy that the paper on Argentina in this volume highlights that despite extensive discussion and even implementation of health sector reforms, the question of universal coverage has not been on the policy agenda. In contrast to some other Latin American countries, notably Colombia and Mexico, where health sector reforms are attempting to create unified systems which will embrace both insured and uninsured sectors of their populations, the creation of a unified system in Argentina, one of

the richest countries in Latin America, has not even been debated. The paper points out that the government opted for a reform package which satisfied the political demands of certain sections of the middle class, along with the pharmaceutical and financial services industries. Hence, the political context sets limits on what is feasible, and will dictate the extent to which the government is concerned about the poorest: those who usually have most to gain from universal coverage. It may also be the case that widespread acknowledgement of the need for reform to existing schemes of protection – for example the compulsory social insurance schemes of Colombia and Mexico - provide the opportunity to extend the coverage of the poor. This then avoids extension of coverage being the sole purpose of the reform, and hence one with few political gains where the poor have little political influence. Reform instead brings together a coalition of supportive interests.

Elements Of The System

While political factors will always have a powerful influence on the goals and means of reform, it is helpful in considering the options for moving to universal coverage to abstract from these issues, and consider the options from a more technical point of view. In so doing, it is important to disentangle the various elements of the health system. Six elements are considered here:

Sources of finance

- Allocation to financial intermediaries
- Nature of financial intermediaries
- Payment to service providers
- Nature of service providers
- Regulation of the system as a whole.

Sources of finance

One clear message from the papers presented in this volume is that countries have not used any one source of finance, but rather a mix of sources. This is very clearly the case in Japan with a combination of payroll taxes and general tax revenues, and also in the Philippines which is in addition using earmarked taxes. Other sources used by countries include voluntary contributions and copayments. A new source of additional funds, not mentioned in this volume but currently attracting considerable interest, is medical savings accounts. These compulsory household based savings, to be used for specified aspects of medical care, are in use in Singapore (Nichols, Prescott and Phua 1997) and the subject of experiments in cities in China.

It is note-worthy that the core of funding for many countries moving towards universal coverage is compulsory social insurance, not general tax revenues. In recent years, increased general tax revenues for health has not been seen as an attractive option, and compulsory payroll contributions seem to be considered to have greater political acceptance, as well as greater acceptability to workers.

Given this reliance on compulsory social insurance, which is best suited for covering those in salaried employment in the formal sector, a key issue facing countries seeking to extend coverage has been how to finance the extension of cover to self-employed and low income workers. A number of possibilities are apparent in the papers in this volume and from experience elsewhere:

- the cost of insurance premiums can be kept low by providing highly subsidised public hospital care (Thai health card, Singapore)
- social insurance funds can be used to cross-subsidise care for low income workers (Mexico, Costa Rica)
- all compulsory health insurance premiums can be subsidised by public funds (Thailand), or only those of the low income employed and self-employed, identified through some form of a means test (Korea, Turkey)
- innovative ways can be found of incorporating farmers, who usually make up the bulk of the self-employed (payment at the time of harvest; payment related to assets as well as or in place of income: Korea)
- the government can encourage voluntary schemes which in time can become compulsory (Philippines and Thailand).

A related issue is how to finance the extension of cover to those without a steady income, namely many of the aged, the unemployed, and the disabled. A considerable number of the elderly as well as children can be covered as the dependants of those in formal sector employment: this, for example, is being recommended as the next stage in the extension of the Thai social health insurance scheme. In Europe, rights to health care have often been added to cash benefits given within social security schemes (for example for those who become unemployed), and those on social assistance may have their contributions paid for them.

A key issue in this extension of cover is whether separate arrangements are made for the various population groups not in formal employment: for example a separate and self-contained insurance arrangement created for the self employed; or whether government funding is used to bring them under the umbrella of the compulsory insurance scheme. The experience of countries in Asia suggests that the latter is the preferred or most feasible option in the first instance: for example Japan, Korea and Taiwan all have had historical experience of separate arrangements for different population groups. Over time the different schemes are standardised and made more compatible, one of the key issues being at what point it is affordable to the government to bring the benefits for lower income groups up to the level of those in formal employment.

In general, co-payments have been given only a very limited role in Europe. In contrast, co-payments feature quite prominently in some of the experiences in this volume. Key attractions of rather sizeable co-payments are that they can permit the contribution rate to be set at a level that is affordable and acceptable (Korea, Philippines), and that they may help to constrain demand in the early (or even later) years of extension of coverage (Korea, Philippines, Germany). They may also be seen as a symbol of family responsibility for their own health care (Korea, Singapore). Their main disadvantage is that they are regressive, and reduce the level of risk protection.

Allocation to financial intermediaries

Funds raised from various sources (with the exception of direct payments by patients) pass through financial intermediaries who then channel funds to providers. Major issues concern the nature and role of these financial intermediaries; however before exploring the options,

mention needs to be made of the basis for premium payment. In general, the principles of equity demand that premiums be income related. However, in countries with weak capacity to collect information and monitor payments, flat rate payments may be seen as administratively simpler and providing less incentive to under-report incomes. For example, flat rate payments have figured in the compulsory insurance plans of both Jamaica and Nigeria.

A key question in the design of financial intermediaries is whether there should be one ('single payer') or many ('multi-payer'). The German model of sickness funds which are firm or industry related was followed in Japan and Korea, resulting in large numbers of financial intermediaries. While this has the attraction of giving the insured a greater sense of involvement and ownership, there can be problems when individual funds are small relative to their risk-pooling function; and when the risk profile of members differs between funds, rendering some very solvent and leaving others in financial difficulties, and resulting in different premium levels. Further issues are that administrative costs may be higher than with a smaller number of larger funds; and the purchasing function may not be carried out as effectively. As noted in the paper in this volume, Germany has seen many mergers of sickness funds to create a smaller number of larger funds; and both Germany and Korea have introduced arrangements to compensate funds if they have an insured population with higher than average risks.

The problem of differing risk profiles between funds becomes much more of a problem when the insured are given choice of fund. Originally, since the fund was related to a firm or geographical area, workers had no choice. In order to try and make schemes more responsive to the insured, some countries have introduced choice of fund (eg Argentina, Columbia, Germany). In order that funds do not have an incentive to avoid enrolling higher risk groups, they must be compensated adequately – hence the need for risk equalisation payments. However, there is as yet inadequate information on whether such payments are successful in eliminating undesirable practices such as cream-skimming, and some considerable scepticism of their likely success (Saltman and Figueras 1997)

A separate but related question is the ownership of the financial intermediaries – ie whether they are part of central government, parastatals, private for profit, or private not

for profit; and whether private bodies are given a role in a compulsory system. The paper on Germany in this volume emphases how important is considered the fact that the arrangements in Germany are not government owned and run, but rather involve autonomous, self-governing associations of sickness funds and providers, within a framework of state regulation. This contrasts with traditional arrangements for compulsory social insurance in many countries in Latin America and elsewhere, where the main social insurance agencies have been very large and centralised parastatals. Given that they are not seen to have performed well, there has been considerable interest in the potential role of private insurers as administrators of compulsory arrangements. Turkey is allowing private insurers a role in its plans for extending compulsory insurance cover to those outside formal sector and to lower income groups (see the paper in this volume); and South Africa, in its discussion of introducing compulsory health insurance, envisages a role for the numerous medical schemes that exist in South Africa (van den Heever 1997).

While the purchasing role of financial intermediaries is much mentioned, there has been little exploration of how this might work in practice. A key question is whether the money follows the patient or the patient follows the money – in other words, is patient choice constrained by the contractual arrangements made by the financial intermediary (as it was in the UK GP fundholding scheme: Hunter and Stockford 1997); or is the patient allowed free or relatively free choice of provider and the purchaser simply channels funds to the selected provider (as in many social insurance schemes). In either case there is a role for prior negotiation of prices, but the power of the purchaser is likely to be more limited where it is paying for a more fragmented set of services.

Provider payment

Provider payment has become one of the key issues in the design of compulsory insurance arrangements, and is of fundamental importance in the process of achieving universal coverage since it can greatly affects the cost of cover and hence how quickly it is feasible to offer the whole population the same level of benefits. Traditional payment arrangements, for the indirect form of social insurance provision where the financial intermediary and the provider are separate bodies, are based on fee-for-service. However, such payment systems have been shown to encourage cost inflation through increasing the volume of services (as in Korea and Taiwan). This tendency is aggravated

when prices are set well below normal charges as they were in Korea, for example, and creates the further problem that providers may raise charges to the uninsured as a further means of compensating for low prices for the insured.

Payment methods which offer greater control over total costs include case-based methods, capitation, global budgets and block contracts. All have their advantages and disadvantages, which relate to the nature of the incentives they provide for over or under provision. The Thai experience of capitation shows that it can be a very effective means to contain costs and simplify administration, though there have been concerns that this has been at the expense of the quantity and quality of services (Mills et al in press). A number of countries, for example Korea, Taiwan and Thailand, are experimenting with case payment based on DRGs. Turkey proposes using block contracts in its planned extension of insurance to achieve universal coverage.

Service providers

There are a number of key issues to do with service provision, most notably whether or not there is a limited list of providers that those covered can use; whether access is given to private as well as public providers and if so, on an equal basis or not; and how to encourage care to be given at the most appropriate level.

The paper on Korea in this volume emphases that the decision was taken that all health care providers should be required to give care to the insured. In Thailand, because the arrangements involved a capitation payment for all care, criteria were set on what facilities were necessary for a hospital to act as a contractor to the social insurance scheme. In the Philippines, facilities are required to have been in existence for three years before they can be used by the insured, to ensure they are financially stable.

Whereas some years ago, it was still possible to debate whether or not those included in compulsory social insurance should have access to private sector facilities (Mills 1983), now this is expected by those covered, not least because of the rapid growth of private facilities in most countries. However, it is still an issue for separate schemes that may be established for the low income groups, where access may be limited to public facilities both to help keep costs down and because these groups live mainly in rural areas where availability of private facilities is more limited.

It is generally accepted that care should be given at the lowest appropriate level; however in practice, the pattern of care is often dominated by hospitals. This is the case with the compulsory social insurance scheme in Thailand, for example, although it might have been expected that the capitation payment for all care, paid to a hospital, should have encouraged the hospitals to contract out much of their primary care to lower level clinics. In the public welfare schemes in Thailand, there is a requirement that patients follow a referral channel, and this is also required in Korea.

Regulation of the whole system

Regulation of the system as a whole is vital in the movement towards universal coverage, since countries will usually have a diverse set of different arrangements which need over time to be brought together. One key question is what body or agency should have the responsibility for overall regulation. This might appear to be the appropriate role of the Ministry of Health, but often its power is limited, especially when compulsory social insurance is the responsibility of another Ministry, as is usually the case. There is then a need to establish a higher level body, as Thailand is considering.

A particularly important question for a regulatory agency is the specification of the benefit package. Such specification is rightly seen to be key in the process towards universal coverage, since it determines its affordability, especially for the government which will need to subsidise the participation of poorer groups. However, there is little clarity over how best to limit the benefit package: whether by specifying services to be excluded or the reverse - specifying services to be included; whether by clinical practice guidelines; or whether by setting a minimum package, leaving those who can afford it to purchase additional cover privately, or by attempting to cover a total package. Even the criteria for establishing the package is not clear: should it be a package based on criteria of cost-effectiveness, in which case primary care should feature prominently in it; or should the focus be on risk protection, in which case the priority should be to cover the more expensive hospital care.

Key Policy Questions

On the basis of the papers presented in this volume, and the comments and discussion at the conference, some key questions can be posed in conclusion.

- At what level of compulsory insurance coverage (or tax funding) does it become feasible to extend a standard level of benefits to the whole population? Behind this question lies the problem that the greater the proportion of the population who must rely on the government to finance their care, the more unaffordable will it be to extend the same level of benefits to everyone.
- Is progress inevitably dependent on the growth of formal sector employment, or are there ways to speed up the process of expanding coverage?

- At what point does it become feasible to compel coverage of those outside the formal sector (as in Korea, and intended in Turkey)? Many countries have started with voluntary schemes of insurance or prepayment for the self-employed, though these often have rather low rates of enrolment. Compulsory schemes have many attractions but are both politically and administratively difficult to impose.
- Are the gains from competing financial intermediaries really worth the risks and the additional administrative costs? There is as yet inadequate evidence on which to base a judgement.
- What mixture of public and private bodies is appropriate in the administration of universal coverage? Is there a useful role for private insurers as administrators of schemes, or is this best kept as a public function?
- Can definition of the 'minimum package' really make universal coverage financially feasible for poorer countries? There is a tendency to see specification of a minimum package as a solution to affordability problems; yet how best to specify such a package is still unclear.
- Is catastrophic insurance cover only desirable, feasible, acceptable? If the concern is financial risk protection, catastrophic cover has many attractions. However, it is not clear whether it is desirable (since it may skew care provided towards that which is covered); feasible (since the conditions to be covered have to be clearly specified); and acceptable to people (if they pay regularly but benefit rarely).
- Should primary care cover be included as well as hospital cover? On the one hand such care is inexpensive and hence can be paid by out-of-pocket arrangements; on the other hand excluding primary care risks skewing care provided to that which is covered by insurance, and weakens the possibilities for structuring the whole system of care provision and ensuring it is primary care led.
- How comprehensively can risks be pooled? Many countries, like Thailand, have developed over time a patchwork of different arrangements for different population groups. This limits risk pooling to within each group, and restricts the possibilities for cross-subsidies from richer groups to poorer groups. Bringing together at least some of these different arrangements is an important step towards universal coverage. Amalgamating the special schemes for government workers with compulsory insurance for the private sector is an important step, as achieved recently in some countries in South-East and East Asia.

Apart from these technical questions, there are many issues to do with the process of agreeing and implementing universal coverage. Existing arrangements can be seen as social institutions, which have embedded within them sets of relationships which are not easy to change. The circumstances most conducive to reform still need to be identified. Most importantly, in the case of Thailand, is the question of whether the economic crisis represents a set back, or an opportunity to make radical changes that otherwise might not be possible.

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'Enhancing the insurance function can be described as deepening and/or broadening effective protection. Because efficiency in the use of resources is also a policy objective, the overall objective for countries can be summarized as: 'achieving universal coverage with effective health care risk protection at the least cost possible.'

Joseph Kutzin
j World Health Organization

During the policy formulation phase, the design of the reform needs to consider both the financing and service delivery aspects. Without access to health services, legislation that mandates universal financing is little more than a paper law.

Alexander S.Preker
World Bank

Today we have a system with almost total coverage, substantial state intervention, but with little community participation and sense of ownership.

Bart Criel
Institute of Tropical Medicine, Belgium