SOCIAL HEALTH INSURANCE
A guidebook for planning

CHARLES NORMAND & AXEL WEBER

Second Edition





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with

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Foreword

This second edition of the Guidebook on social health insurance development is a joint initiative of the ADB, ILO, WHO and GTZ (GTZ acting on behalf of the German Federal Ministry for Economic Cooperation and Development, BMZ). The Guidebook has been part of the activities of the GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries which has now evolved into a new initiative on Social Health Protection - Providing for Health (P4H). P4H is a new partnership between France, Germany, ILO, WHO and World Bank that aims to support developing countries in their development of social health protection systems. Most people in such countries do not have effective access to affordable health care. A principal avenue therefore to overcome the access deficits and the risk associated with catastrophic health expenditure is the creation and extension of sustainable systems of social health protection, based on values of universality, equity and solidarity. This is the principal focus of P4H.

Developing countries are working on different national or regional models of sustainable and equitable health care financing to provide affordable access to quality services for all. The International Conference on Social Health Insurance in Developing Countries, held in Berlin on 5–7 December 2005, provided a forum in which the experiences of different countries and regions were shared and discussed. One of the conclusions of this conference was that in implementing viable and sustainable health financing systems the context of the country is preponderant and that there are no ready-made blueprint methods to reach universal coverage. The most suitable financing and organizational options have to be chosen from a broad menu of choices that essentially ranges from tax-based health financing, social health insurance, private financing options and mixed health financing systems. Historical, economic and social choices determine which type of system is most suitable at country level. In fact, most national health financing systems are de facto conceived as mixed systems. The particular organizational mechanisms that form part of such systems are secondary to the primary goal, namely to achieve and guarantee social and financial protection for all households.

There are many possible paths towards the goal of universal social health protection, and social health insurance is one of them. This Guidebook is aimed particularly at the needs of countries that choose social health insurance as the main component of their systems, or that are interested in exploring this option, as it details the various prerequisites for a successful implementation. The Guidebook also intends to make clear that the implementation will be accompanied by various challenges of a political, organizational and financial nature. Thus this guidebook is also a companion for policy-makers and their advisers in managing those challenges.

We would like to thank the principal authors, Charles Normand and Axel Weber for their endless efforts and patience to have made this joint publication possible. Finally, we would like to extend our thanks to Ralf-Matthias Mohs, Director for Poverty Reduction and Social Protection (BMZ) for his support in this joint project.

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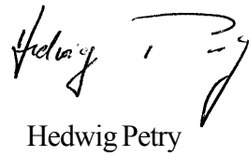

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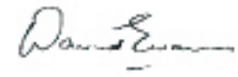

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Acknowledgements

This guidebook has been developed as a cooperative initiative of the Asian Development Bank (ADB), International Labour Organisation (ILO), German Technical Cooperation (GTZ) and the World Health Organization (WHO). This book is a revised edition of the book that was originally published in 1994. Meanwhile, more than 10 years have passed and the discussion and experience of health insurance – especially in developing countries worldwide – has grown. Schemes have been created and reformed. Conferences and a huge number of publications have contributed. The Internet has added to the debate with more information available to everybody at low cost. So the question arises: why add another publication to the existing ones?

The organizations that published the first edition, and the authors who wrote it, received a lot of feedback. Many policy-makers, experts and stakeholders, especially in transition countries but increasingly also in developing countries, used the book. It was translated into various languages. Apparently it was well received by our target groups and we felt that a stocktaking exercise would be useful to contribute to the worldwide discussion of health insurance and to support those who are interested or involved in its development.

We received many positive reactions, lauding not only the conciseness and practical approach of the book but also its comprehensibility and accessibility for non-experts. We also received critiques, which ranged from experts pointing out that we did not take into account the depth of the scientific contributions available at the time, to others who felt that we were too critical, especially of health care providers. Medical professions for their part said they missed health issues and arguments in the book.

We all know that whatever we produce will represent our view alone, which is by its nature subjective and limited. It is the view of economists who have worked a long time in the health sector and in the areas of health insurance and social protection. We also are not claiming to write a scientific contribution but rather a tool that is based on many years of practical experience and on a large number of reactions and contributions from others. We apologize if we do not quote or include all major contributions that have been made. This does not indicate a disregard for them but, given the never-ending flood of contributions, many of them very justified and good, it would exceed our time and budget to evaluate and discuss all valuable and important work that has been done. To do so would require a large study by itself. It would also make the present book very difficult to read and to understand. Nevertheless, we have reviewed a large number of publications and documents, which are listed in the annex. Many important scientists have said that whenever you have a new thought or proudly invent something, at least parts of it were already there before. We are sure that this applies to many of the ideas in this book.

Finally we should like to acknowledge those who have contributed to the overall design and contents of this guidebook, namely the members of the editorial team (Guy Carrin, Ole Doetinchem, Inke Mathauer, Xenia Scheil-Adlung and Jean-Olivier Schmidt), those whose input benefited specific sections (Sara Allin, Sebastian Baine, Andreas Grüb, Rolf Korte, Markus Löwe and Sarah Thomson), and those who provided significant comments on earlier versions of this guidebook – in particular Joe Kutzin, Dorjsuren Bayarsaikhan and Zine Eddine Elidrissi. We are also very grateful to David Bramley who did a most profound job at improving the readability and enhancing the overall coherence of the guidebook. Last but not least, a special word of thanks to Franziska Fuerst, Elizabeth Amelung-Roest and Hans Schimpf for the capable management and facilitating the overall production of this guidebook.

Charles Normand *Axel Weber*





SECTION I.

How to use the guidebook

CHAPTER 1.
Introduction

This guidebook is designed to be used by planners, policy-makers and stakeholders in countries that are considering the introduction social health insurance (SHI) as a replacement for or to supplement to existing financing mechanisms for health care. This book is not meant to be an advocacy tool but a technical guide for those who are interested in the issues and techniques of SHI.

The first law leading to a comprehensive SHI system was introduced in Germany more than 100 years ago. Over time, health-financing systems are changing in order to provide better access for whole populations to health care that is affordable, appropriate and of high quality – while maintaining control over costs.

Countries use different financing approaches to achieve universal coverage – including varieties of health insurance, tax-funded systems and combinations of the two. A close look at the range of health financing systems shows that there are advantages and disadvantages with each. Nevertheless, depending on a country's specific circumstances, some methods may be more appropriate than others.

The focus of this guidebook is on one particular financing approach – social health insurance – and not on the relative merits of different mechanisms. It has both technical and policy objectives.

The technical objective is to lead policy-makers and programme planners through the process of successfully establishing a SHI system. This includes:

- evaluating the usefulness and feasibility of SHI in the context of existing political, sociocultural and economic circumstances;
- providing detailed planning advice for the design of a SHI system;
- offering insight into the process of improving the chances for successful implementation.

The policy objective is to contribute to attaining universal coverage with affordable access to health care services. Both aspects of social health insurance are explained clearly and in detail.

CHAPTER 2.
Health, health systems, financing and insurance

2.1. Achieving system goals

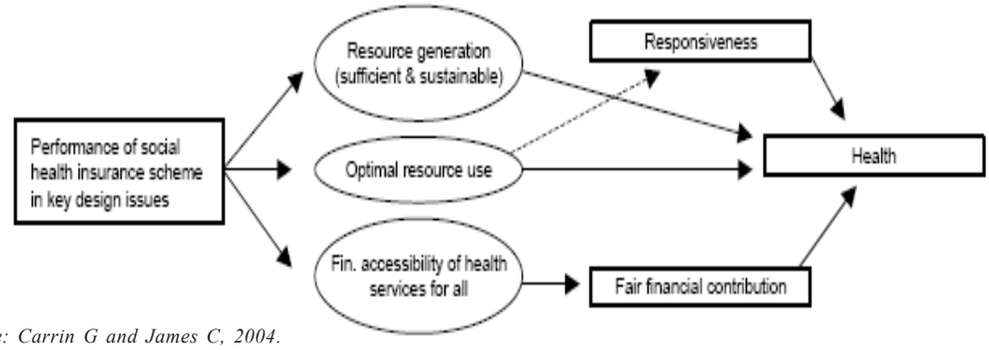
Health financing is an important health system function and should contribute to the overall goals of health systems. *Health* is the primary or defining goal of a health system, and both the overall health status of the population and the distribution of health among the population are important. However, nonhealth outcomes are also important. *Responsiveness to people's (non-medical) expectations* and the *fairness in financial contribution* are also recognized as important final goals of the health system.

Thus, any assessment (and design) of health-financing schemes must ultimately relate to the health system goals. Most directly, a well-designed health financing scheme should be an effective way of realizing the goal of fairness in financial contribution, where risks are pooled and shared and resources are acquired according to ability to pay. But a health financing scheme also impacts on both the distribution and overall health status of a population, by providing resources for health and shaping how these resources are used. Finally, a good health financing scheme can have a positive effect on the responsiveness goal, by altering the incentives faced by health-care providers.

2.2. Mobilizing funds for the health system

The specific purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, in order to ensure that everyone has access to effective public health and personal health care. Thus, a well performing health financing system – and therefore a well performing SHI – should have the following targets: (i) to generate sufficient and sustainable resources for health, (ii) to use these resources optimally (by modifying incentives and through appropriate use of these resources), and (iii) to ensure that everyone has financial accessibility to health services. When assessing the performance (and design) of health financing schemes, it is important to do this with respect to these health financing targets. Figure 1 outlines how performance of health financing design issues is related to health financing targets and final health system goals.

Figure 1: **Health financing targets and final health system goals**



Source: Carrin G and James C, 2004.

Performance in relation to these targets is assessed against the three broad functions of health financing: (i) revenue collection, (ii) pooling, and (iii) purchasing. For each function, key design issues can be specified (see further below).

Revenue collection can be defined as the process by which the health system receives money from households, enterprises, government and other organizations, including donors. It is related not only to resource generation, but also to the target of universal financial accessibility of health services. This is because the way revenues are collected affects financial accessibility. The key design issues for revenue collection are population coverage and method of finance.

2.3. Sharing and managing risk

Pooling is the accumulation and management of revenues in order to limit individuals' payments for health care, so that they no longer bear their risk alone. It is closely related to universal financial accessibility of health services. It is also associated with resource generation. The key design issues of pooling are the level of fragmentation or risk pooling and risk equalization.

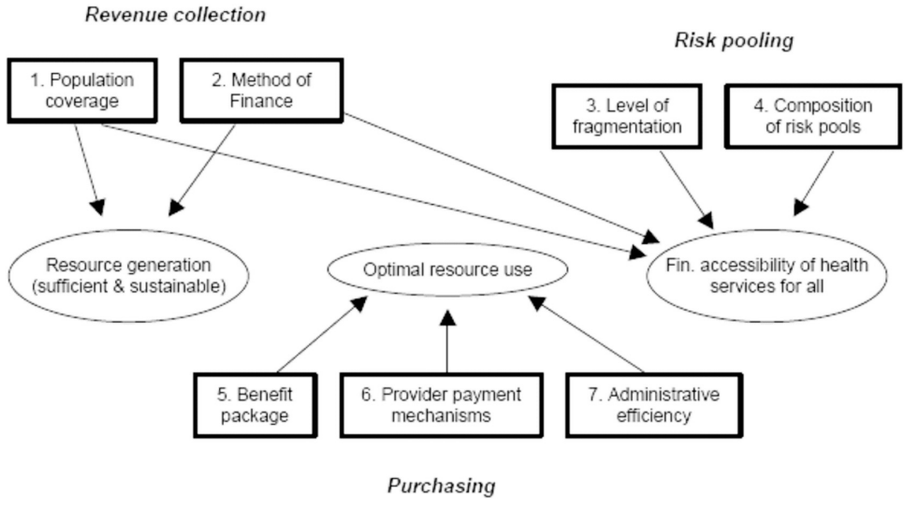
2.4. Purchasing services from providers

Purchasing is the process by which pooled contributions are used to pay providers to deliver a set of health interventions. Purchasing can be either passive or strategic, with passive purchasing simply following predetermined budgets or paying bills when presented. Strategic purchasing is generally preferred, as it involves a continuous search for the best purchase method and source for health services. The key design issues for purchasing are benefit package, organization of services, provider payment mechanisms and operational / administrative efficiency.

2.5. Design issues

There are number of key design issues to be considered and design choices to be taken that determine the performance of the above health financing functions. Figure 2 summarizes the relationship between key design issues within the health financing functions and the health financing targets.

Figure 2: **Key design issues in health financing**



Source: Carrin G and James C, 2004.

These design issues and choices are briefly explained below.

Revenue collection

Method of finance

Level and type of funding
The type of funding must generate both sufficient and sustainable revenues so that he healthfinancing system, as well as the specific schemes, can operate effectively.
This is further described in chapter 4.

Progressivity and solidarity
An important pillar of a health financing system – or specifically of an SHI scheme – is progressivity and solidarity, namely the aim to link contributions to ability to pay. This is achieved through income-related contributions rather than through a flat contribution rate which is regressive. This, as well as population coverage, is further described in chapter 11.

Risk protection
In order for the health financing system to improve the financial accessibility of health services, it should ensure that financing methods enable adequate financial protection against health care costs. Hence, prepayment levels should be high, and the number of households facing catastrophic health expenditure should approach 0. Risk protection is further described in chapter 10.

Population coverage
If a country has chosen the pathway of SHI to move towards universal coverage of health care, a key design issue is the level of population covered by the SHI scheme. This is important for enabling greater financial accessibility to those covered by SHI, as well as generating resources for health. Higher percentages obtained through time are associated with better performance, everything else being equal.

Risk pooling

Composition of risk pools
In universal coverage schemes such as SHI and tax-funded schemes, prepayment is combined with spreading risk among members of a pool. This offers greater protection against high-cost health expenditure and thus improves financial accessibility. Although an SHI scheme by definition pools risks, the actual extent of risk pooling between schemes in different countries can vary greatly since complete risk pooling does not always take place. This is further described in chapter 10.

Level of fragmentation
Complete risk pooling not only depends on the extent of prepayment, but also on the level of fragmentation of risk pooling. Fragmentation is associated with too many small risk pools.

If there are several funds, risk equalization mechanisms help to ensure that all funds can spend the same amount per risk unit, so that similar if not equal benefit packages can be offered. Thus, funds with many high-risk members receive additional financial resources to cover these high risks. Fragmentation and risk equalization are further described in chapter 10.

Purchasing

Benefit package
It is important that patients receive required health services, and there must be adequate capacity to allow this. The pooled funds are used to purchase a set of health interventions and, in an SHI scheme, all insured members are entitled to a specified package of health benefits. This benefit package should cover the requirements as comprehensively as possible, subject to the overall funds available. The definition of the benefit package and related aspects are further dealt with in chapter 12.

Organization of health services
The way service provision is organized has important implications for the purchasing functions. Services can be provided in-house, or contracted and purchased from separate entities. In the case of public providers, their degree of autonomy also affects the way incentives work through provider payment mechanisms. These aspects are further dealt with in chapter 13.

Provider payment mechanisms
How health care providers (both individuals and facilities) are paid and remunerated can significantly affect both the cost and the quality of care. Hence, appropriate provider payment mechanisms are instrumental in affecting use of resources. Each provider payment mechanism has relative strengths and weaknesses and the challenge is to design provider payment mechanisms that set the right incentives for quality and optimal use of resources. These aspects are further dealt with in chapter 14.

Administrative efficiency
Administrative costs arise from planning, management, regulation and collection of funds, as well as the handling of claims. Moreover, some funds are usually kept in reserve to meet unexpected costs, as well as fluctuations in revenue and expenditure. Fund managers need incentives to enhance their management of funding pools and to contain costs. These aspects are further dealt with in chapter 15.

A related but crucial issue is the overall organization of SHI. How independent should SHI be? How should SHI be regulated and controlled, and who should run SHI? The latter questions are addressed in chapter 16.

CHAPTER 3.
Overview of the guidebook

3.1. Preparation

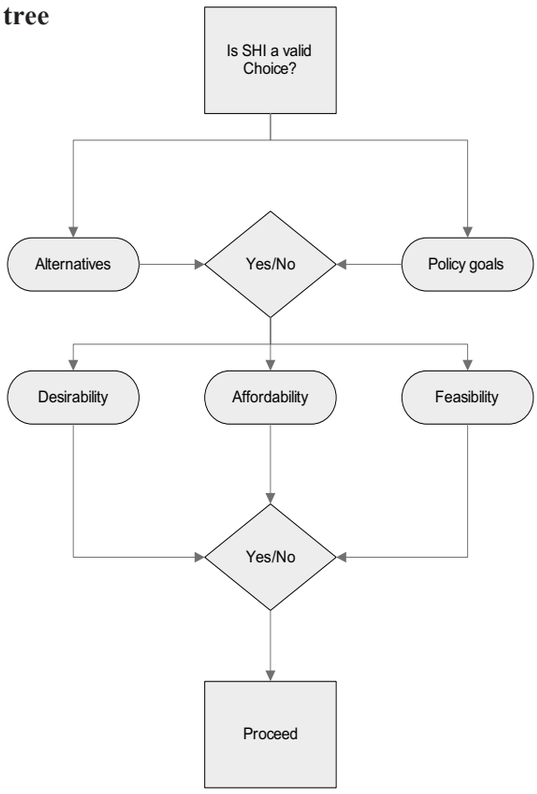
The book starts with a definitions section and material to support decision-making. The purpose is to define SHI in the context of health care financing and to identify advantages and disadvantages. The section then asks the question, whether a country is ready for SHI and whether to proceed or not with planning and preparing health insurance. The result often may be that although not all prerequisites are there it is still possible to prepare for SHI.

SHI can only be successfully introduced if certain conditions are suitable. It must make a contribution to the achievement of health policy goals, and it must serve to improve access to care for the population. This means that the goals of health policy must be clear, so that the new funding arrangements can be seen to help to meet them. This guidebook therefore covers the process of identifying health policy objectives as well as the constraints on achieving those objectives.

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

Figure 3 depicts the sequence of steps outlined in section II. The figure is not intended to represent the only possible sequence of thought and preparation, nor does it provide an exhaustive list of issues that must be considered. Rather, the figure is intended to highlight the importance of ensuring that relevant issues have been considered before resources are devoted to design and further planning. A country should move on to the actual design of an SHI system only if it can successfully progress through the steps in the figure.

Figure 3: **Decision tree**



3.2. Key design issues

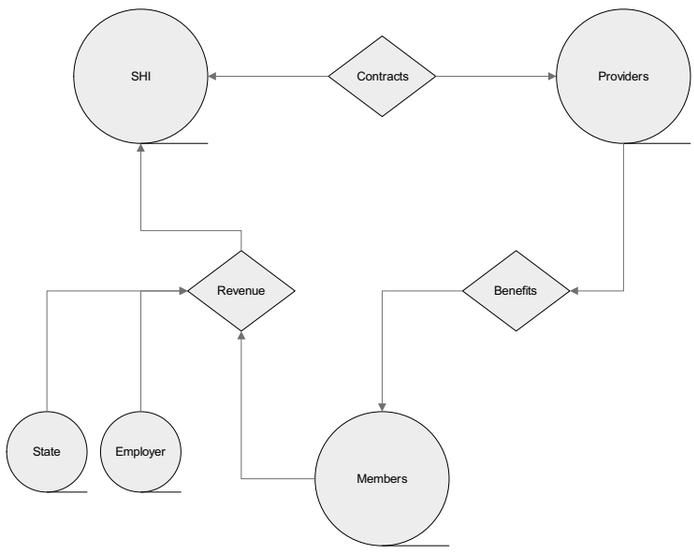
If a decision is taken to proceed with the introduction of SHI, the next step is the detailed design of the system. Section III provides an overview of some fundamental issues related to design. The section illustrates that a country's history, culture and existing political and economic systems must be taken into account in the design process. The overall theme of section III is that a SHI system should be designed to suit the particular needs and circumstances of an individual country, and not be simply imported from abroad. In this context, it has to be remembered that this design phase is part of a process, as is the subsequent development of the SHI. Even mature systems constantly improve and adapt to change.

There are a number of key design issues and design choices to be taken that determine the performance of the above health financing functions. These design issues can be put in a framework. It is important to see that, in contrast to normal market systems where a provider faces a consumer, in health insurance we have a triangular structure. Purchasing is done by SHI, services are provided by health-care providers, and funding comes from insured people or on their behalf from other bodies such as employers or the state. Figure 4 illustrates this system.

Key functions exercised in this scheme are:

- revenue collection, which mainly involves the State, employers and the members;
- protection of the members, which includes definition of membership rules and provision of services to these members;
- purchasing, which entails the payment and, ideally, price negotiation and quality assurance (contracting) of services needed for the protection function;
- administration, which basically means good governance of the health insurance fund.

Figure 4: **Structure of health insurance schemes**



During preparation and planning of a health financing scheme, this framework helps us to think through the relevant design issues critically. At the same time, with this framework, performance of the health-financing functions can be evaluated through easily measurable indicators. It can help policy-makers to ascertain current performance and to monitor progress over time. In other words, static and dynamic features of health financing schemes can be captured. The actual key design issues and design choices, questions and indicators are outlined in Table 1.

Table 1: **Key design features in developing social health insurance systems**

Design features	Issues	Chapter
Revenue collection		
Method of finance	*Level and type of funding* • Why is the existence of user charges and out-of-pocket payments a prerequisite for the establishment of health insurance? • What is the financial capacity of the country? • What are the options for raising funds and what are their advantages or disadvantages? • What level of co-payments can people can afford to pay? *Progressivity and solidarity* • What is the link between contributions and ability to pay? • Are contributions income-related? *Risk protection* • Do financing methods enable adequate financial protection against health care costs? • What is the level of prepayment? • What is the number of households facing catastrophic expenditure?	10 12 11
Population coverage	• Which population groups should be covered by SHI? • What technical problems must be overcome when covering the population? • How can we overcome the problems of covering the informal sector? • What should the membership eligibility rules be? • Should there be compulsory or voluntary membership? • How should dependants be covered?	12
Risk pooling		
Composition of risk pools	• What are the different risks people are confronted with and which ones are priorities for SHI coverage?	11
Level of fragmentation	• What does risk pooling mean and why is it important? • Why have multiple risk pools developed in some countries? • What are the advantages of one central risk pool versus multiple competing pools? • How is it possible to ensure equity and a universal level of protection if there are various funds and not only one?	11
Purchasing		
Benefit package	*Benefit package definition* • Which services should be included in the benefit package? • Should there be coverage of prevention and health promotion services? *Organization of health services* • What are the different ways to provide services? • How does contracting of providers work?	13 14
Provider payment mechanisms	• How should providers be paid? • What are the effects of different payment mechanisms? • Which surveillance mechanisms are feasible? • What are the incentives and mechanisms for quality assurance?	15
Administrative efficiency	*Efficient administration and cost control* • How can costs be controlled? • What are the elements of the administration of a health insurance? • What are the requirements for efficient and effective administration of SHI?	16
	Organizational embedding • How independent should SHI be? • How should SHI be regulated and controlled? • Who should run SHI? • What is the role of public–private partnerships?	17

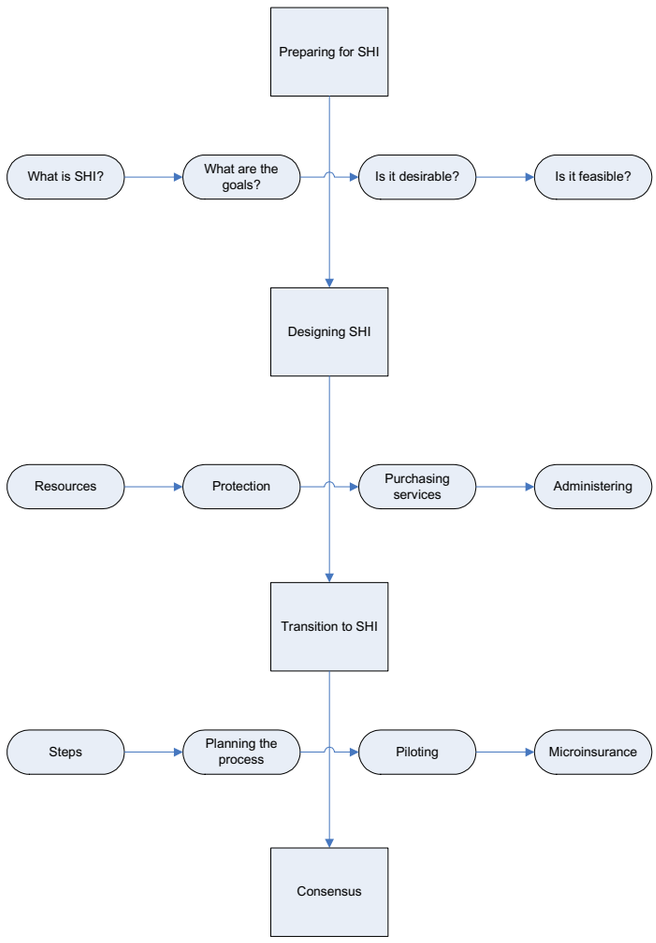
Section IV continues the design process, with an emphasis on the dynamics of creating health insurance. What should be the process of implementing health insurance? Can development and implementation be a phased process if all problems cannot be solved at the same time? The section also considers how to create consensus among stakeholders and how to support social dialogue. SHI will be effective and efficient only if it has the support of the majority of citizens. The guidebook helps in finding the right pathway to consensus.

Section V looks at experiences with SHI in several countries. The country examples provide insight into how varying circumstances can lead to the development of alternative forms of SHI financing. Section IV also emphasizes the importance of ensuring that SHI will be acceptable to those who will use it. Advice is provided on how to build consensus and support for the new system.

Sections II and III are thus concerned with the design phase of an SHI system, whereas Section IV deals with the implementation phase (though there are overlaps). Section V helps to broaden understanding of alternatives and design features.

The best way to use this guidebook is to follow the flow of argument and to go through the questions that are raised after each chapter.

Figure 5: **Flow of the argument**







SECTION II.

Preparing and planning for pocial health insurance

CHAPTER 4.
How to finance health care services

4.1. Introduction

Health insurance is one of several methods of health care financing. This chapter is concerned with the concepts and options health financing and puts health insurance in the broader context of health-services financing. The chapter briefly outlines health financing targets, discusses market failures and the need for government interventions in the health "market", outlines various health financing alternatives, addresses the advantages and disadvantages of SHI and reflects on the need to consider alternatives and complementary options to SHI.

4.2. Health financing targets

Health financing systems in general should follow three targets:

- to generate sufficient and sustainable resources for a health care system (revenue collection);
- to use these resources optimally (by appropriate incentives for patients, providers and administrators, i.e. optimal purchasing);
- to ensure that everyone has financial access to health services (pooling).

Revenue collection can be defined as the process by which the health system receives money from households, enterprises, government and other organizations, including donors. It is related not only to resource generation but also to the target of universal access to health services. This is because the way revenues are collected affects financial accessibility. Chapter 5 discusses what this means. The key design issues for revenue collection are population coverage and method of finance.

Purchasing is the process by which financial resources are used to pay providers to deliver a set of health interventions. Purchasing can be either passive or strategic. Passive purchasing simply follows predetermined budgets for paying bills when presented. Strategic purchasing is generally preferred, as it involves a continuous search for the best payment method, incentive structure and provider pool for health services. The key design issues for purchasing are the benefit package, organization of services, provider payment mechanisms, and operational/administrative efficiency. Co-payments may also be used to influence patients' decisions if appropriate and possible.

Pooling is the accumulation and management of revenues in order to limit a person's payments for health care, so that he or she no longer bears the risk alone. It is closely related to universal financial accessibility of health services. It is also associated with resource generation.

4.3. Market failure of the health sector

Experience in countries that have comprehensive health services shows that health policy goals cannot be met without some level of government involvement. There is agreement among all experts that market solutions alone, as are common and effective in other sectors of the economy, do not work well in the health sector because of a number of special circumstances in that sector. Above all, this is because health is considered to be a human right and everyone should therefore be supported in the objective of enjoying good health. Health services are necessary to help people to achieve the objective of good health.

Features of certain health goods and services, which make it difficult to produce and distribute them through a market mechanism, include the following:

- Some elements of preventive primary health care (PPHC) and health promotion constitute pure public goods (e.g. vector control and health education) which are non-excludable and non-rival. This means that once they are produced, nobody can be excluded from their benefits. At the same time, if one person consumes them, this does not influence either the quantity or quality available for others. This has the effect that people are not willing to pay for them and therefore markets will not provide them. In contrast, curative services constitute a private – i.e. excludable and rival – good which people are (at least in principle) willing to pay for.
- Certain PPHC activities, such as immunization and family planning, are excludable and rival goods, but have very strong positive externalities and merits. This means that not only the people consuming these goods, but also others, benefit from them, so the market will typically produce too little of them.
- PPHC services with future benefits are often little valued, so that people are again less willing to consume them and pay for them.
- In most developing countries services are not provided in sufficient quantities or in sufficient quality due to very low purchasing power, lack of transparency, monopolies and other market imperfections. This leads again to market failures.
- Outcomes of health care are sometimes hard to measure, and can be rather intangible. Few people are willing to pay for intangible results.
- Information asymmetries between the provider and the patient make it difficult for the latter to assess the appropriateness and quality of the activities of the provider. Despite efforts to improve public understanding of health-care issues, providers sometimes offer unnecessary services and may deliver poor quality services at higher prices than would be charged in a perfectly competitive and transparent market.
- Exclusion and unequal access for those unable to pay out-of-pocket for services or for insurance premiums can lead to inequity of health outcomes.
- Weak regulatory frameworks in health care markets may also aggravate market failures, especially in developing countries.

The result of these market imperfections is either under-supply or supplier-induced inefficiency.

It is generally agreed that, in the event of market failure, governments need to develop structures and policies to counter its effects, or other nonmarket instruments have to be developed. Government intervention in health care markets takes four main forms:

- Market failures and imperfections must be addressed to improve market functioning and to raise welfare.
- Public goods and goods with large positive externalities require intervention because the market is typically unable to provide them, or because it fails to provide sufficient quantities.
- As health is considered to be a “merit good” – i.e. a good that is desirable to be consumed from the general public’s point of view – government intervention (public financing or other forms of ensuring financing and/or provision) is needed.
- Access to health services is a fundamental right and it is therefore necessary to provide this access – especially to the poor who could otherwise not afford them.

However, the benefits of government interventions to overcome market failure can be lost due to problems such as bad governance, inefficiency and corruption. This has led to scepticism, especially by market economists. It is important, therefore, that policies to overcome market imperfections are implemented in the context of strong governance arrangements around government services. Governance issues are dealt with specifically in chapter 16. A key objective of this guide is to support the development of effective and efficient government interventions to ensure financial access to health services.

The next partprovides an overview of health financing options and definitions, before going into further detail on SHI as one strategy to ensure financial accessibility and to achieve universal coverage.

4.4. Health care financing alternatives

It is important to recognize that SHI is only one option out of several for financing health care services, and that in practice different models – including combinations of various methods – can be found. In principle, the four main categories of funding for health services are:

- direct payment for services by patients (so-called out-of-pocket payments);
- commercial (private for-profit) health insurance;
- government financing raised through taxes;
- SHI, including micro-insurance.

With the exception of the first, services are provided for "free" or in combination with co-payments or user fees on the basis of rights derived from prior payments. These systems are based on prepayment and contain an element of risk pooling (see Box 1) and solidarity (between healthier and less healthy individuals, younger and older), although to different degrees. There is, therefore, protection (or partial protection) against the financial risk of ill-health and related health expenditure.

Box 1. Risk pooling

Imagine there is no health insurance and no public health service and you suffer a serious illness which leads to high costs. You may have to use your savings or even sell your assets to pay the bill. At the same time, all your neighbours are healthy and have no diseases. During a certain period, maybe a year, you face high health costs which may affect you seriously while your neighbours have none. However, next year it may be your next-door neighbour who falls ill.

Many diseases and accidents are not predictable. This is why they constitute a financial risk for everyone. Risk pooling is a method of alleviating this problem by creating a community – a pool – which agrees to split the risk among all members once it occurs. This has the effect that all pay a small and bearable amount regularly instead of some paying a large amount once the risk occurs. Empirical studies show that health care costs can ruin families and lead to poverty where there is no risk pooling, so pooling the risk is a form of social protection.

Government-financed schemes and SHI may also provide an element of mutual support, depending on the membership and contribution rules: Those at higher risk, those with more dependants and those on lower incomes may be supported by people with high incomes, low risk and few or no dependants. Given the correlation in all countries between low income and high risk of ill-health, there is a case for providing this support.

Direct payment by patients at the point of delivery involves neither prepayment nor mutual support. Patients are charged according to a set tariff for the services they use. These may be the full costs of services and items or part of it (co-payments). If people rely only on direct payments to access health care, they have no financial risk protection, which may constrain access to essential care or may lead to catastrophic expenditure and subsequent loss of all assets and poverty. There are many experiences around the world of poverty being caused by lack of financial protection against health risks.

Commercial health insurance is usually voluntary, and premiums are not related to ability to pay but are risk-related (or "actuarial") – i.e. people pay premiums based on the expected average cost of providing services for them which in turn is based on their health risks. Risk factors include age, sex, or pre-existing and chronic illnesses. Hence, in a commercial actuarial insurance, people who are in high-risk groups pay more, and those with low risks pay less.

Risk-related premiums tend to deter or exclude people who have high risks and low incomes. For such people, who are typically elderly or sick, the risk-related premium is unaffordable. But without risk-related premiums it is difficult for commercial health insurance to be viable, and those attracted to take out insurance would be typically those at higher risks. Assessing risk is expensive, and in many cases commercial health insurance organizations choose to exclude broad groups of the population and focus instead on easy-to-assess and low-risk groups. Often the products provided by commercial health insurance give no real protection to, or are not affordable for, sick and poorer groups. In many countries, commercial health insurance schemes have emerged, offering services especially for the better-income groups, though recently there are examples where commercial insurance providers have offered special products for poorer groups[1].

Common risk management practices of insurers are:

- exclusion of chronic diseases;
- age limits (e.g. 65 years) after which prolongation of contract is either refused completely or offered at a substantially higher premium;
- life-long, annual or claim-related maximum amounts beyond which the insured bears the complete risk;
- annual contracts, where the insurer reserves the right to cancel the contract or increase the premium according to claim history.

Services covered by the commercial health insurance may vary both between companies and across different insured persons. There are also large differences depending on the legal framework, traditions, and consumer awareness and know-how. In some countries, for example, commercial health insurance firms are not allowed to discontinue people's membership when they grow older or develop chronic illnesses. There are also models where premiums are higher for younger people and the surplus is used to subsidize premiums for older people.

Tax-funded systems pay for health services out of general government revenue. In addition to general direct and indirect taxes there may also be some special health taxes (e.g. on health-damaging goods or activities). Decisions about the overall funding of health care are made as part of the overall planning of government expenditure. In tax-based health financing, entitlement to services is usually related to citizenship or to other general categories – such as being poor or belonging to certain population groups – and is paid out of the general tax revenue. There is no link between payment and entitlements.

Social health insurance systems pay for health services through earmarked contributions to a health fund, which may be voluntary in a transition stage, but are made on a compulsory basis in a mature stage. A common basis for contributions is an income or payroll tax, which may entail contributions from both employer and employee based on salary. The key difference from tax-funded health financing is that entitlement to services is based on payment of contributions which are earmarked, pooled and administered in a separate budget.

SHI contributions are usually based on ability to pay and are not risk-related, whereas access to services is based on need. Other features are the absence of risk-related premium scaling (no higher premiums for the elderly or chronically ill) and hence the no risk assessment on joining, and free coverage of dependants without income. In an SHI scheme, entitlements to services are usually universal and not differentiated, and contribution rates are set at a level intended to ensure that these entitlements can be afforded. SHI is targeted at making health care affordable.

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[1] See for example the insurance offered by ADAMJEE in Punjab (Pakistan) in cooperation with the rural support programme.

The health fund (or funds) is usually independent from government, but works within a tight framework of regulations. Hence, SHI funds can be owned or run by private commercial (profit-making), private (non-profit), quasi-public or public organizations. SHI itself is neither a public nor a private domain. However, the establishment, administration and supervision of SHI are generally seen as public tasks and most SHI organizations around the world are public or semi-public organizations. There are examples where partnership between government and private institutions has proven to be an alternative. This in most cases means that the state regulates the terms and conditions and that the administration of the health insurance is left to private insurance companies or nongovernmental organizations (NGOs), possibly in a competitive environment. In any case, a clearly defined policy framework is necessary for the fund(s) to operate effectively.

Community-based health insurance, which is common in many developing countries, may be considered as a mix of elements of commercial health insurance and SHI. Although private, voluntary and based on premiums, they often do not charge premiums based on risk.

Often, we do not find "pure" schemes as described above but hybrid schemes, which consist of various characteristics of the schemes mentioned (e.g. tax-funded national health services might apply out-of-pocket payments and SHI schemes may be co-funded by taxes). Further, in countries with tax-funded national health services we also find health insurance schemes – both public and private.

There is hardly any country where one finds health financing systems based on only one financing mechanism. A combination of coexisting mechanisms is common. However, pluralistic financing mechanisms are often uncoordinated and result in gaps in coverage and access to health services.

It is part of the strategy of the ILO to coordinate existing schemes and thus to extend coverage. Introducing and extending SHI is one possible option for filling the gaps (ILO, 2007).

4.5. Advantages and disadvantages of social health insurance

SHI is thus one method of financing health services. It may be the main funding mechanism or a supplementary one. Countries may wish to introduce or scale up an SHI scheme for a number of reasons. In any case it is useful to consider the advantages and disadvantages of SHI.

SHI has a number of advantages:

- SHI helps prevent people from falling into poverty due to health care costs – i.e. catastrophic expenditure due to accidents or disease – since SHI combines prepayment and risk pooling with mutual support.
- SHI may be more acceptable than tax funding in some countries as a framework for developing risk pooling and social solidarity. This may be the case particularly in countries with a high current dependence on user fees. This is due to the more transparent flows of funds and the link between payments and entitlements. It therefore seems more compatible than tax funding in terms of personal responsibility and compatibility with the wider market economy.
- SHI can mobilize additional resources for the health system, such as funding from employers.
- SHI can provide a stable source of funding for health care, which is separated from the general government budget and independent of budget provision.
- SHI does not compete directly for a share of the public budget.
- SHI is more just and more equitable than out-of-pocket spending and commercial insurance.
- SHI can help to strengthen patients' rights as customers of health care providers.
- SHI can improve transparency of prices, costs and expenditure.
- The SHI framework encourages the development of explicit purchasing arrangements and greater

provider autonomy, which can increase efficiency in health care.

- Employers and employee representatives have incentives to monitor spending if they are part of the social insurance management setup.

Although risk pooling and purchasing are not exclusive to SHI, the need to provide services to which people are entitled and to be accountable for costs encourages good practice. The extent to which the potential advantages are realized depends on the details of how the SHI is designed and developed.

On the other hand, SHI has a number of disadvantages:

- SHI constitutes an administrative challenge, requiring capacities and infrastructure that may be in short supply.
- People may not understand and accept the concept of health insurance. Thus health insurance needs to be explained to many people, especially in developing countries and among poorer and less educated communities.
- There may be limited enthusiasm for solidarity and mutual support.
- It may require more administrative effort to register workers in the informal sector and to collect contributions from them.
- Functional responsibilities for pooling and purchasing may be duplicated, unless there are synergies with other schemes and mechanisms.
- The capacity to provide services of appropriate quality is required.
- SHI schemes may worsen existing inequalities in financial protection, especially during their initial development, if formal-sector employees are covered first.
- Special mechanisms may be needed to cover the poor who are unable to pay contributions.

These challenges, and how they can be addressed, are further discussed in section III. Specific historical or cultural conditions may make the introduction of a comprehensive system of SHI very difficult. However, these factors are unlikely to represent a long-term constraint on its introduction. It is advisable to consider them at an early stage when designing a new scheme or extending an existing one. There is extensive experience around the world on setting up SHI schemes. Developing SHI has typically been demanding, but techniques and technologies are improving, and administration is becoming easier and cheaper.

4.6. Pluralistic health financing mechanisms

Few countries rely exclusively on SHI to finance health services. In most countries, there are pluralistic financing mechanisms in health care and prevention. There are good reasons for this:

- Although basic health care should be covered by SHI, there is room for extra services, not covered by SHI, to be financed by other means such as out-of-pocket payments and commercial health insurance. These extra services may include some types of elective surgery, spectacles, special accommodation, consultation and treatment by facilities and professionals not contracted by SHI, or treatment methods not covered.
- It is more difficult to fund prevention and health promotion through insurance. Government funding and selected user fees may be easier to use to fund disease prevention and health promotion activities.
- If the highest priority is to expand primary health care coverage among scattered rural populations, with an emphasis on basic care and health promotion, it is unlikely that SHI will help to achieve this. The transfer of skilled health professionals to the curative services covered by insurance may even hinder it.

- Public health tasks such as health surveillance, screening and monitoring, as well as public awareness campaigns, are not typical tasks of SHI and in most countries these tasks are carried out by public authorities.
- In most countries, occupational health and safety is handled by specific agencies, as well as by employers, and not by SHI.
- In many countries, cash benefits, especially sick pay, are handled by separate agencies as they require different types of administration.

There are also good reasons to be cautious about multiple sources of funds in a health system. Experience suggests that there can be unintended consequences from the interactions between the different mechanisms. For example, private insurance or private services provided from user fees may divert scarce skilled professionals away from provision of services under the SHI. A careful assessment of alternative and complementary financing mechanisms and their interactions is therefore necessary. These may include tax-financing, community-based or micro-insurance, private health insurance, and also equity funds. It is important to assess the advantages of these various mechanisms (e.g. in the form of a coverage plan), as these mechanisms may either replace or complement SHI or constitute a step on the way to SHI and to achieving universal coverage.

4.7. Questions raised

- What are health financing targets and how can they be met?
- Why do market mechanisms fail in the health sector and what can be the solution?
- What are alternative mechanisms of health care financing and what are the advantages and disadvantages of SHI?
- How high is the risk of people facing a financial crisis following a major health event?
- Would SHI help to reach those currently not covered by affordable health care services (coverage)?
- Would a change to SHI, with its greater visibility of resources for health services, lead to more acceptability and political support for needed health care spending?
- How can SHI be combined with other financing mechanisms?

CHAPTER 5.
Health policy

5.1. Introduction

Chapter 5 starts with a discussion of health policy goals – specifically the objectives of social protection, universal coverage, equity and fair financing with respect to health care. It also looks at the challenges – including economic challenges – in meeting health policy goals and objectives.

5.2. Health policy goals and objectives

The overarching goal of health systems and health policy is good health for everyone. Many important influences on health – such as those relating to the environment, lifestyle, occupation, and socioeconomic and genetic influences – are outside the control of health services. Health policy may therefore be properly seen as the policy of a government as a whole, rather than a single ministry of health.

Progress towards health policy goals, measured by indicators such as life expectancy and health status, can be hard to monitor. The effects of interventions are often seen only after a long time, and it can be difficult to assign any given effect to a specific intervention. Hence, the health policy intended to achieve

these goals is normally expressed in terms of measures to protect the population from avoidable disease and to provide efficient health care services for those who need them.

There are several objectives that help to achieve the overarching goal of good health. These include choice, quality, appropriateness of facilities and equipment, and other factors that affect the quality of services for patients. Furthermore, social protection, universal coverage and equity in financing are objectives of health systems that ultimately contribute to the goal of good health. These will be outlined in further detail below.

Before plans for SHI are developed in detail, health-policy goals and objectives should be clearly stated. The SHI plan must be compatible with policy goals. Therefore, an overall focus on the health financing system – and not merely on one scheme – is critical. As such, SHI needs to be understood as a policy instrument, a means of achieving health goals and objectives. However, since in many countries the policy goals are articulated only in very general terms, the development of SHI can provide an opportunity to make these more detailed and specific.

In this context, it should be mentioned that SHI is not only a tool to meet health policy goals and objectives, but can make significant contributions to other policy goals such as poverty reduction, rural development and safety.

5.3. Social health insurance and social protection

Social protection is the set of policies and programmes targeted at vulnerable groups that enable these groups to prevent, reduce and/or cope with risks. Social protection involves cash or in-kind transfers[3].
Health policy in general and health care financing in particular are parts of social protection. Both are tools and prerequisites for poverty reduction, economic growth and development. The overwhelming importance of addressing health and poverty is also reflected by the Millennium Development Goals (MDG) adopted by the international community in 2000.
The principle of financial risk protection ensures that the costs of care do not put people at risk of financial catastrophe. Extension of social protection in health is the key strategy in reducing financial barriers to access to health care and in moving towards universal coverage (i.e. universal health protection).
In a time of globalization, social protection has become a major issue. Policy-makers have become aware that globalization, with its undoubted advantages, must be accompanied by measures to mitigate its negative impacts – a lesson learned during previous structural changes in history, such as the industrial revolution (ILO, 2004). There is general agreement that SHI can be a key element of social protection. Given the importance of good health for all human activity – be it economic, social or cultural – it can be argued that health care and its financing deserve first priority as pillars of social protection. Thus, it is an area that should be addressed first when countries think of improving social protection, though it must be understood that health care alone cannot alleviate poverty.

5.4. Universal coverage

One of the main policy challenges in health and social protection is the lack of access to health care. In many countries, access to health care, especially for the poor, is blocked by financial barriers.

Universal coverage is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at affordable cost, thereby achieving equity in access. It is important to note that universal coverage has two dimensions: (i) population coverage, which means covering every citizen with access to necessary care, and (ii) service coverage of the essential services needed. As such, universal coverage implies financial risk protection and a guarantee of quality services.

[3] See definitions of social protection in the strategies of The World Bank and The Asian Development Bank. (World Bank, 1999; Asian Development Bank, 2001)

5.5. Equity and fair financing

A related objective of health financing policy is equity in financing, which is again closely related to universal coverage. It is based on the notion that people contribute on the basis of ability pay rather than according to their health status or risk.

Fair financing means that every household should pay a fair share of the cost of providing health services. What constitutes a fair share depends on people's ability to pay and on normative perspectives in each country. Nevertheless, in all countries, fairness in financing embraces two critical aspects – healthy people supporting sick people, and wealthier people supporting poorer people. Risk pooling has the effect that contributions of those who are healthy help to pay for the care of those who are sick, so that individuals who become sick are not struck by a double burden of sickness and financial costs of health care. Fair contributions require that those with more resources pay more than those with fewer resources. In practical terms, fair financing helps prevent the financial impoverishment of households when one of the members becomes ill. A large part of health funding should come from prepaid and pooled contributions. Also, in the context of SHI, this means that those who cannot afford insurance are covered, thus ensuring social justice and solidarity.

The above objectives increasingly gain consensus around the world. They are also laid down in key policy documents of ILO and WHO (Boxes 2 and 3).

Box 2. ILO Convention No. 102

ILO conventions recommend SHI. The Social Security (Minimum Standards) Convention, 1952 (No. 102) is the flagship of all ILO social security conventions. It is the only international instrument, based on basic social security principles, that establishes worldwide-agreed minimum standards for all nine branches of social security, namely:

- medical care;
- sickness benefit;
- unemployment benefit;
- old-age benefit;
- employment injury benefit;
- family benefit;
- maternity benefit;
- invalidity benefit;
- survivor's benefit.

For all the nine branches, the minimum objectives of the convention relate to the percentage of the population protected by social security schemes, the level of the minimum benefit to be secured to protected persons, the conditions for entitlement, and the period of entitlement to benefits.

Box 3. World Health Assembly (WHA) Resolution 58:33, May 2005 on Sustainable Health Financing, Universal Coverage and Social Health Insurance

The 58th WHA urges Member States, *inter alia*:

- to ensure that health financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health care expenditure and impoverishment of individuals as a result of seeking care;
- to ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole;
- to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to those contained in the United Nations Millennium Declaration, and to achieving health for all.

The WHA requests WHO to provide technical support, information and guidance, tools, as well as capacity-strengthening for the development of health financing systems, in response to requests from member states as they move towards universal coverage.

5.6. Economic effects of social health insurance

Some economic issues linked to health care financing and health insurance may support or hamper the achievement of health objectives.

Although there may be considerable public pressure for higher spending on health services, this alone does not necessarily lead to great gains in terms of the main health-policy goal of longer life and better health. There might be cost drivers such as supplier-induced demand, higher inflation in the health sector, technology-driven cost increases and patients' expectations. These cost drivers may increase spending without additional health gains. As resources are scarce, it is very important that they are not spent on care that has little effect on the achievement of the main goals of health policy. In addition to mobilizing more resources, there need to be effective mechanisms to control costs and ensure quality of care.

There are particular risks in increasing the financial resources for health care where there is very limited capacity to deliver care. In such cases the main effect of increased funding may be higher cost of care without any significant increase in services and health gain.

Also, it is sometimes argued that further payroll taxes are likely to discourage employers from retaining or taking on staff, with the consequence of higher unemployment. Although there is little evidence to support this fear, it is important to consider the effects of increased payroll taxes and charges on employment and wages.

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There are strong positive effects of SHI. The Commission on Macroeconomic and Health has shown that investments in health are important for economic growth and development. As SHI provides financial risk protection from illness and better access to services – resulting in a healthier population – the outcome is higher productivity and economic growth. Economic growth is certainly conducive to introducing SHI as it may balance out any possible effect on unemployment.

Social protection in general (and SHI in particular) helps countries become more competitive by ensuring human capital development and by increasing productivity. Investments in social protection reduce risks for the whole population covered and not only for the poor. Social protection allows risk-taking and entrepreneurial activity, can help to retain the value of existing human capital, and prevents the risk of impoverishment following serious health events.

Social protection increases social cohesion and thus paves the way for social and economic stability. Social cohesion, peace and security are crucial environmental factors for economic development and growth.

CHAPTER 6.
Desirability of health insurance

6.1. Introduction

In considering whether SHI is desirable for a country, there are several questions to be asked:

- Is there popular support for SHI? This will depend in part on the level of awareness and understanding of the existing systems and the feasible alternatives?
- Is SHI desirable from the perspective of overarching policy goals?
- Is SHI desirable from the point of view of specific population and interest groups?

6.2. Who wants social health insurance?

The question as to who wants health insurance is not easy to answer. The authors had many discussions with policy-makers and individuals. The result is that, in countries where there is a tradition of having health insurance, its existence is not questioned. In countries, where there is no such tradition, the need is often not recognized. This may be because a functioning tax-financed system is in place that people can access free of charge at the point of use and because health insurance is purchased only by those who would like to have better or additional benefits. Another reason, however, may be lack of awareness of benefits and options. Lack of trust in health insurance also explains low demand for health insurance, even in cases where there is no such comprehensive free service.

Yet, where there is no health care service that is free at the point of use, most people need social protection, mainly to protect themselves from financial catastrophe. There are many examples around the world where even relatively well-off people and their families are impoverished by the catastrophic financial impact of a serious disease, a complicated delivery, or a serious accident. So the answer to the question of who needs health insurance is that almost everyone needs it unless there are free services of adequate quality available for the whole population in the country.

For an individual, the main purpose of health insurance is to have health care costs covered. Hence, people will demand health insurance and be motivated to pay contributions, even in a compulsory scheme, only if they currently have to pay for their health services or if user fees are high. If health care and drugs are provided free or nearly free, people do not want to pay contributions. Thus, the existence of user fees and prices is a prerequisite for the development of health insurance and, moreover, these fees and prices must be official, transparent and monitorable.

In order to increase desirability of SHI and to promote and advocate it, one must understand not only the contribution of SHI to health policy but also how SHI affects specific interest groups – or how they expect to be affected – and how they are likely to try to influence the design of SHI. This is outlined in more detail in the following two sections.

6.3. The contribution of social health insurance to meeting health-policy objectives

When considering the contribution of SHI, the question is whether it can provide additional, secure funding for the provision of services that help to meet health policy goals and objectives. In other words, health insurance schemes that supply only low-priority services in terms of health policy goals and objectives should be treated like any other private supply, needing no specific government involvement. It is important to consider any mechanisms for the financing and provision of health services in terms of the extent to which they help to meet policy goals. Therefore, there is a need for a clear statement of policy at an early stage.

Social insurance can help to meet health policy goals and objectives if these require additional funding which is not (or not easily) available from other sources, or if it leads to better use and fairer distribution of existing spending on health. Additional spending is justified only if it yields greater benefits than spending on other goods or services. Health insurance funding may help to ensure that the wishes of the population for higher spending on health services are met. It can also improve risk-sharing where this is inadequate.

Most importantly, SHI can improve access for some groups of the population and may widen coverage by bringing additional resources into the health sector. Financial protection is enhanced through risk pooling and risk-sharing, as well as through fair financing and prepayment. To ensure that health care costs are affordable to all, insurance for those with low incomes must be subsidized either by higher premiums for richer people or by another source such as government funding.

If well designed and implemented, SHI can meet the objectives of health financing – increasing resource mobilization, ensuring financial accessibility, making better use of resources, and thus ultimately contributing to better and equally distributed health outcomes, responsiveness and fair financing.

6.4. Social health insurance and interest groups

The introduction or extension of SHI may affect the interests of many groups in the population. Any country that is planning to develop SHI should be aware of these interests and the underlying political economy. This issue is dealt with in detail in chapter 19. Here we analyse how SHI affects interest groups and how these in turn can affect the development of SHI. We distinguish the following groups:

- *Employers:* They may have to pay contributions for their employees and therefore argue that increased labour costs endanger employment. On the other hand, they may also see productivity gains due to their employees' improved health status. Employers may be interested to have a sector-wide and compulsory solution in order to avoid distortions of competition.
- *Employees:* Membership may be compulsory and contributions may be deducted from their income. The insurance conditions and package for those who were previously insured privately may change. On the other hand, many employees will enjoy better access to health care.
- *Trade unions:* The interests of their members are affected, and in general they will not want to lose their influence over any labour issue.
- *Health care providers:* They may be subject to new provider payment schemes and quality control. This may affect their incomes. It can be argued that the majority will be better off under SHI because greater financial resources will be available. Moreover, they may obtain their remuneration directly from the health funds, thus increasing reliability.
- *Existing health insurance schemes for certain population groups or private health insurance schemes:* They may fear abolition, loss of income or loss of customers, depending on whether SHI will become the predominant scheme that is compulsory.
- *Government ministries:* The roles and influence of various government ministries may change with the introduction of SHI. These may include support for particular population groups such as farmers, collection of taxes and charges, planning and provision of services, and control of public-

sector employment. SHI organizations may take over some roles, transferring employment from ministries to the new agencies, and ministries may lose control of health care providers. Additional resources for health may lead to higher employment in public or quasi-public organizations.

- *Provincial and local governments:* SHI development may be of particular interest in poorer regions that might experience large increases in financial resources and the accompanying infrastructure.

Hence, there are specific benefits to be gained by relevant interest groups. It is useful to identify these benefits in order to ensure that the SHI scheme receives broad support.

On the other hand, since some interest groups may see themselves losing out from SHI, they may attempt to influence the development of SHI in the following ways:

Employers and employer associations: They may advocate for employer contributions to social health insurance to be as low as possible in order to keep labour costs down.

Employees: The healthy and wealthy employees with private insurance coverage may advocate keeping their private health insurance and having an option to opt out of SHI, particularly if private health insurance offers them a better benefit package at reasonable costs. Also, those with higher incomes may want to set the contribution cap as low as possible.

Trade unions: They may advocate for a high employer share of the SHI contributions. Also, they may wish to participate in supervision of fund management.

Health care providers and professional associations: They may advocate for a fee-for-service provider remuneration scheme with high rates, as this leaves the total health expenditure risk with the insurer, while not limiting incentives for over-production.

Private health insurance schemes: They may strongly advocate for the continuation of their customers' contracts as well as for options to opt out.

Government ministries: Each of these may wish to maintain and increase its level of power and responsibilities, while possibly trying to shed those tasks and responsibilities that are problematic or difficult.

Civil society organizations and others: Depending on the country's context and history, there may be strong resistance to a national public enterprise or large fund-holder, particularly when corruption is widespread.

Community-based health insurance schemes: These schemes may fear the loss of donor support (technical and financial), and competition with SHI, especially for the poorer informal sector.

6.5. Social dialogue, decision-making and building consensus

Sections 6.1–6.4 discuss the different interested parties in the process of design and development of SHI. SHI has worked best in circumstances where the different social partners have been active participants in the evolution and management of the system. Thus, it is important that there should be a process of engagement and dialogue at all stages – from the diagnosis of the health-system problems for which SHI may provide some solutions, to the decision to implement SHI and the process of implementation.

Participation of stakeholders in the process of design and development of SHI must take place before final decisions have been made. The process will do more harm than good if people perceive that they are being invited simply to endorse choices that have already been made. As has been discussed above, a shift to SHI may leave some groups worse off (if only because they will pay more) and will involve a period of change and disruption, which can be challenging and at times harmful. Some providers of care will be better off but some may face a decline in demand, more competition or higher expectations from patients. If SHI changes entitlement to access treatments, this may change the patterns of services that

are needed. It is particularly important that the concerns of those who may be disadvantaged by SHI can be clearly heard.

Social dialogue in the decision-making and consensus-building stages has a number of distinct if related objectives. First, it can be a useful part of the process of agreeing the health policy objectives, the priorities for improvement in the health sector and the feasible steps. As is pointed out in several places in this book, the development of SHI funding often comes in response to perceived deficiencies in current availability of services and resources. However, such dissatisfaction is often poorly articulated and may not include a clear vision of what level of access to care is feasible and desirable in current circumstances. This may mean that there is no realistic set of developments that will be seen as satisfactory. Effective social dialogue therefore should include individuals and organizations that have been critics of the current arrangements, and there must be a process to agree realistic goals in both the short term and the longer term.

SHI is a long-term project, and its success will depend crucially on a stable policy environment. There is good evidence that rapid and frequent changes in policies and organizational structures can be damaging and wasteful so it is important to create a policy environment that allows the more difficult changes to bed down and work effectively. Even in countries with frequent changes in government and political control it may be possible to develop a consensus that the introduction of SHI is a long-term goal agreed by the main political groups, and one that must not be jeopardized by changes in direction. It is particularly important to ensure there is agreement on retaining some of the key principles of solidarity, effective risk-sharing and equity in access. To a significant extent, the objective may be to take the health-policy debate out of the usual political arena.

Social dialogue is a set of attitudes and an approach as much as it is a process. The most important partners may be those who have typically been critics, and effective dialogue should include both those who have official and formal roles in policy debates and those who have a strong voice without being elected or appointed to formal roles. For example, there have been recent examples of informal voices emerging in some countries in support of improved access to care for older people, and there is a need to engage with such movements as well as with formally representative bodies. While resources for social dialogue are limited, as they are for all parts of the development process, it is wise at this stage in the process to err on the side of being more, rather than less, inclusive.

While not an exhaustive list, some of the organizations with whom it is wise to develop effective social dialogue are listed below. It should be noted that it is important for there to be follow-up dialogue with many of these bodies in the development and implementation phase of SHI (see chapter 19).

- central government – both ministries with direct responsibility for public health and health services, and others that are likely to be affected by SHI (such as economy and employment ministries);
- local government at state, provincial, regional, district and village levels; employers' organizations;
- large individual employers;
- employees, through both formal representative bodies and other fora;
- health care providers;
- existing health insurance schemes and organizations, including community-based health insurance schemes;
- NGOs with an interest in health;
- patient representatives and organizations.

It is not easy to generalize about the tools for social dialogue at the decision-making and consensus-building stages. However, they will typically include formal meetings, opportunistic discussions in meetings of relevant organizations, surveys and focus groups, conferences, and increasing the use of electronic media to encourage participation.

While it is always tempting to focus on the technical issues in the development of SHI (and indeed these can require extensive skills and energy), experience suggests that failure to engage the population and the key stakeholders early in the process of decision-making can delay progress and possibly lead to failure to achieve the intended goals of SHI development.

CHAPTER 7.
Affordability of social health insurance

Resources for the provision of health care are limited by the level of a country's income. SHI may provide a mechanism for making resources available and accessible, but it does not, in itself, increase affordability of a country's health care. It is therefore important to consider the ability of the country to afford health services, and also the possibility of health insurance having an effect on affordability through cost control.

Health care costs do not necessarily correlate with a country's income level. While in theory one could argue that health care costs depend largely on local providers' and producers' tariffs and prices and that these correlate with a country's general level of income, this is not true in practice. In fact, costs and prices of service providers vary widely between countries and do not necessarily reflect the income levels of their populations. Additionally, goods such as drugs, supplies and equipment often have a market price that depends on the world market and not on the country's income (though there are certain correlations in practice).

Thus, health care costs may absorb different resources in different countries. The fact that the share of GDP spent on health care is lower in low-income countries than in high-income countries shows that disparities in prices play a large role when explaining low levels of care. Low spending levels coupled with prices that are often relatively high reflect the fact that a large part of the population simply cannot afford health services. In this context, health insurance may be very desirable, pooling scarce resources and at the same time having an influence on cost control and thus on affordability. See chapter 15 for a discussion of cost control.

Resource shortages may result from a failure to mobilize resources for health. A gap between the resources that a country can afford to devote to health services and the funds it can mobilize may be due to several factors. Political constraints on tax funding (sometimes imposed from outside) may limit the state budget for health. It is therefore important to assess the potential of SHI to mobilize extra resources.

While it may be more difficult to introduce SHI in countries where the level of funding of health services is constrained by low income and where national priority for health is low, a move to a prepayment scheme may still be important. SHI can mobilize resources, and various population groups that may have difficulty obtaining appropriate cover from private or government sources may be willing and able to pay contributions to protect themselves from risk.

CHAPTER 8.
Feasibility of health insurance

8.1. Introduction

A number of factors affect the feasibility of introducing and scaling up SHI. One important factor is the way revenues can be collected. Another critical aspect is the structure of the labour market. Further, it is necessary to identify the administrative needs of an insurance system and decide whether they can be

met. Insurance arrangements tend to be more complex (and often more expensive to administer) than tax funding, and they certainly require considerable administrative skills. Finally, an appropriate health infrastructure must be available.

The following sections outline these factors in more detail and show how they affect the development of SHI. At the same time, measures that might address these factors are identified.

8.2. Options for revenue collection

SHI in the formal sector is funded in most countries through a system of payroll tax that is paid to a health fund. It is typical for the total contribution to be calculated as a percentage of income following the principle of ability to pay. This amount may be split between employer and employee. One reason for having employer contributions is that they encourage employers to seek cost containment, since the employer will benefit from any savings in resources.

An important question is whether payroll contributions are the best source of funds for health care. In formal sectors, the payroll is already a major source of taxation – for income tax, pension contributions, unemployment insurance, and sometimes insurance against loss of earnings due to ill-health. If the deduction rate is already high (i.e. a high proportion of income is taken in compulsory payroll deductions) then it may not be advisable to use this source for additional deductions. Chapter 9 discusses in more detail the implications of payroll deductions. It is necessary to ask three questions in order to assess the feasibility of SHI through payroll deductions:

- What is the current level of deductions from the payroll, and is it politically feasible to introduce further charges?
- Is it possible to communicate to employees and employers that payroll deductions may reduce other costs such as user fees for use of services?
- Is the sector formalized enough to introduce payroll deductions?

If the answer to these questions is “no”, then there may be a problem in considering SHI further at this stage. However, it may become feasible for some workers, or if part of the contributions can be found from another source.

When SHI is funded by payroll taxes, it is important to consider the effect this can have on the overall level of deductions. SHI may reduce the need for or the level of other benefits, it may lead to shifts between employer and employee shares, it may allow for tax reductions, or it may reduce employers’ costs for health care, etc. Governments may try to reduce spending on health from general taxation when SHI is introduced, so it is important to ensure that SHI increases net resources for health and does not lead to a reduction in equity in access to services.

In most developing countries, most people work in the informal sector where other ways of assessing and collecting contributions may be necessary and where there may be no employer’s contribution.

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

- Incomes tend to be very variable, depending on the amount of work available or, in the case of agriculture, on crop yields, prices of produce, and so on.
- Personal and business expenses may be difficult to separate, so that it is genuinely difficult to know whether a cost is incurred by the business or by the individual.

Since it is difficult to assess the income of self-employed people, and because declared incomes tend to be taxed, there are strong incentives for people to understate their income.

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

When planning to include occupational groups with a high proportion of self-employed people (e.g. farmers) into the SHI scheme, it is important to consider which type of contribution base will work best. There are many options, like raising a levy on goods sold at auction, or accepting payment in surplus produce rather than a regular financial contribution. It may take some time to find a suitable mechanism for raising charges on this type of group, but there are examples that have worked, even among poor rural populations. This is discussed in chapter 11.

In order to avoid problems of income assessment, flat-rate premiums are an option. Some countries such as the Republic of Korea have tried to use this approach to cover groups whose income is difficult to assess. However, flat-rate contributions may pose problems of affordability.

Experience shows that the introduction of health insurance may require a shift in, and/or a supplement of, government financing. In most developing countries, many people who are extremely poor, are not able to pay substantial contributions to the costs of health care. This means, that if we want to achieve the objective of universal coverage, we need mechanisms of cross-subsidy either between the better-off population and the poor within the health insurance scheme or beyond the insurance scheme through the general government budget.

There is need to assess and promote willingness for solidarity through cross-subsidies between the better-off and the poor. Also, policy-makers must critically estimate the government provisions available for the funding of health care for the poor.

In conclusion, it is important to assess realistically how much funding can be raised through SHI contributions. This must take into account incomes, levels of other deductions and taxes, the labour market structure, the acceptability of paying contributions, and synergy effects between different taxes and charges.

8.3. Factors in the labour market

The structure of the labour market is important for the feasibility of health insurance from the administrative point of view. There may be problems with revenue collection (see above), with registration, or with benefit administration depending of the situation of the labour market. Specific groups of interest are workers in the formal sector, workers in the informal sector, the unemployed and people who are economically inactive.

Almost all developing countries, and increasingly developed countries, are faced with a rapidly growing informal sector. This has drawn international attention to the concerns of informal-sector workers and their families. The informal sector in many developing countries constitutes up to 80% of the labour market. It is not a homogeneous group, and ranges from domestic workers, subsistence farmers and day labourers to market vendors, shop-owners and taxi drivers.

One of the first questions to be answered in this context is which individuals can be defined as belonging to the informal sector. We consider as part of the informal sector those workers and their families who fulfil most (though not necessarily all) of the following criteria: little or no inclusion in tax and social security systems, absence of standards and measures to enforce labour and social security law and labour standards, little or no continuity of employment, insecurity with respect to the level of income, and no (employer) protection in case of sickness, unemployment, or old age. These criteria make the informal sector a special administrative and financial challenge for SHI with respect to registering and collecting

resources from them, given that their income may be irregular. This is why it is often argued that SHI is not a suitable instrument for covering the informal sector. However, there are good examples of countries where the informal sector was integrated into the SHI scheme (e.g. Ghana, Philippines and Vietnam). Increasing numbers of countries are considering how to include the informal sector in SHI. When SHI is voluntary for workers in the informal sector, they are unlikely to join unless the benefit package is affordable and attractive.

SHI should ideally be funded by deductions from incomes (or salaries), and this depends on there being an agreed measure of income. SHI therefore works best in the context of a relatively large formal sector, with a large proportion of the population working as employees, so that there is little scope for doubt about their incomes (though there are experiences with different contribution schemes and assessment methods). In other words, the bigger the informal sector, the bigger the initial coverage gap (the difference between target group and actual coverage) if no special measures are taken to integrate the informal sector. The bigger the formal sector, the easier it is to collect SHI revenues.

When people move from formal employment to self-employment or quasi-self-employment (mostly home-workers), which is more and more the case, it becomes more difficult to measure income, and the tax base can be eroded. Mechanisms to assess income and to collect tax on it must be appropriate to the type of income earned. It helps if there is an income tax system that is efficient and progressive. Such a system can be used to assess for insurance, charges and contributions. question is not so much "what is optimal?" but rather "what is possible?"

From the administrative perspective, the unemployed and the poor form groups similar to informal-sector workers – except that a special problem associated with them is the low level or even absence of income. In this situation, questions of affordability of SHI and of methods to provide these groups with free access arise.

Persons who are not economically active are mainly children, non-working spouses, disabled people, the sick and the elderly. For these groups it is difficult to assess incomes and collect contributions. In any case, they may not be able to afford to make significant contributions.

Finally, a group that constitutes a special challenge for SHI is migrant workers. These may be workers migrating in the internal labour market or migrating abroad. Internal migrants are difficult to trace and thus constitute an administrative problem. International migrants raise the problem of tracing and reintegration, though the problem is larger in pension schemes than in SHI.

If the informal sector, the number of unemployed, migrants and economically inactive groups is large, this creates a special administrative and financial issue for SHI. Other sources of revenue than contributions from salaries will have to be developed and implemented. These issues are discussed in chapter 9.

8.4. Capacity to run social health insurance

The successful introduction and extension of SHI is dependent on a country's institutional and organizational capacity. This relates to the three subfunctions of collection, pooling and purchasing, which are undertaken by different organizations and actors.

Collection may involve the SHI organization itself or it may be carried out by the revenue authority or other social security organizations such as pension funds. Collection may also be carried out by banks, post offices, professional associations or NGOs, depending on the collection mechanism. Staff should be equipped to manage the collection of contributions and support the process of identifying entitlements.

Some countries have an established system for collecting income tax through payroll deductions or other schemes such as pensions. Under these conditions, it may be possible to introduce or extend SHI

contributions using the same basic procedures but earmarking the money for different funds. This can simplify the operation of SHI and reduce costs.

Similarly, various actors may be involved in strategic purchasing, which entails organizational capacity in defining benefits, selecting providers, contracting (contract formulation and negotiation) and monitoring, claims management and surveillance. Apart from skills in insurance administration, specific know-how will be needed in, for example, business management, actuarial sciences and risk management, epidemiology, health economics, and other health sciences.

Other cross-cutting tasks around SHI include communication, marketing and public relations, accreditation and quality management. Finally, government capacity is crucial, including regulation, information provision, and enforcement. Government bodies should be in charge of these or should delegate them to other organizations.

People with these skills may already be working in government departments, but further training is likely to be necessary. The need to coordinate training policies with the requirements of the health fund and with government health-policy objectives implies that there must be close cooperation with ministries of education throughout the SHI planning process. The skills needed to administer a system of SHI are different from those used in other types of health service management and financing. Training staff to establish and manage the SHI system can take several years, and some of the work needs to be done before the new arrangements are established.

Two types of preparation are needed to ensure a suitable administrative infrastructure – training staff and setting up structures and procedures. Thus, what is required includes inter alia: a legal and regulatory system with clearly defined insurance laws combined with enforcement procedures such as for collection of contributions and government subsidies, trained human resources as well as a communication technology and infrastructure.

The overall level of education within a country can also be important since people need to be able to understand the rules and principles of health insurance. High levels of literacy can help. Education in general, as well as the educational level of the administrative staff, can be significant for the success of SHI, although there are examples of schemes established in communities with a very low educational standard using community structures.

The above factors are intended as examples. However, it is important to assess the overall capacity needed to support SHI, as well as the existing institutional and organizational capacity. Specifically, it is worth asking the following questions:

- Is there a core of well-educated human resources who could be trained at reasonable cost to operate an SHI system?
- Is there a framework of law and enforcement procedures to support an SHI scheme?
- Do existing administrative structures and procedures offer mechanisms for collecting contributions?
- Is there complementary communication and information technology infrastructure?

If the answer to the above questions is “no”, SHI may not to be feasible at this stage or may need extra efforts and specific transitional solutions. These aspects are discussed in chapter 15.

8.5. Availability of health infrastructure

Health insurance gives the insured population an entitlement to health services. It is therefore important that the necessary health infrastructure exists to provide those services and that the services can be accessed. People do not benefit from health insurance if they have no (geographical) access to adequate health care services and infrastructure. The benefits covered can only be those that are on offer and accessible to the people. Early action may be needed to ensure that the services to which insured people are entitled are available and located in places where people can easily access them.

If the health sector is unprepared for an increase in demand for services, additional funds may simply inflate the price of health services without improving access. This does nothing to meet health-policy objectives. To avoid this problem, it may be necessary to develop a transitional plan for health services that remain funded by other mechanisms and to introduce health insurance funding step by step. See also chapter 17.

Health services can be developed directly, with the government building the facilities, buying the equipment and training staff. Or the government can develop the services indirectly by providing incentives and enabling private and nongovernmental organizations to invest. Even in countries where all health services are supplied by private-sector organizations, there is a need for government regulation of service provision and infrastructure development. Furthermore, providers will invest in buildings and equipment only if they see a reasonable chance of recovering their costs. As there are very long lead times between the initial decision to build infrastructure and the eventual provision of services, the government may provide guarantees or incentives, especially in remote areas.

Of particular concern is training of health professionals, which is expensive. Sufficient staff need to be trained in order to be able to contribute to health policy goals.

A growing diversity of health-care provision has implications for health personnel. There is usually little incentive for the private sector to be involved in the cost of training and professional development if it can recruit staff easily from public hospitals. This can mean that providers are not competing on equal terms, since public hospitals bear the cost and disruption of training. On the other hand, teaching hospitals (which are often government-owned) may gain an advantage from employing the most prestigious and/or qualified staff. Hence, there is a growing realization that ways must be found to guarantee equal treatment for all health care providers as far as training costs are concerned, and to ensure that high-priority services are not starved of skilled health professionals.

Before embarking on detailed planning of an insurance system, it is necessary to ask: “Does the necessary health service infrastructure exist to provide the services to which insured people will be entitled?” If the answer to this question is “no”, then SHI may not succeed under current conditions or may need special transitional measures.

8.6. Establishing synergies and partnerships

The development of SHI will affect other areas beyond health policy, such as the feasibility of collection of other taxes and charges, as well as other government objectives, as outlined above. If SHI is to be successful, these effects must be anticipated and taken into account in planning the system.

There are manifold options for establishing synergy effects with a variety of organizations and institutions that provide services related to health insurance. This is not merely limited to the health sector (e.g. synergy effects with public health plans and programmes, enterprise health measures, insurance for work accidents and occupational diseases), but applies also to organizations that can help to administer health insurance plans (like banks, post offices, public administration and employers).

Depending on the focus in cooperation, bilateral and international development partners can provide technical assistance through experts, training, staff secondment and exchange, twinning, facilitation of exchange and discussions, and financial support in the form of grants or loans for establishing health insurance. There is no best way how to do it, but partnership may help.

Many initial obstacles to the development of SHI can be overcome with the right strategy to create synergies and to create partnerships (see also chapter 20).

8.7. To proceed or not with social health insurance

After assessing the various factors and conditions relating to desirability, affordability and feasibility in the country, policy-makers are faced with three options regarding the introduction of SHI:

- If conditions are favourable, the government may decide to start developing the necessary policy, to initiate the necessary political process (see section IV for more discussion on social dialogue and building consensus) and to set up the necessary organizations, institutions, legal framework and respective procedures for SHI.
- If conditions are not suitable, then the choice is between taking steps to overcome the constraints or not proceeding with SHI at this stage.
- A third option is to choose a step-by-step approach, starting for instance with transitional solutions like community-based schemes and then developing comprehensive SHI at a later stage (see Section IV).

If conditions are rather unsuitable or design is poor, introducing SHI could possibly lead to higher expenditure on health care, inefficient allocation of resources, inequitable provision and dissatisfied patients. It can also make it more difficult to realize the potential advantages of SHI.

In countries where SHI already exists with limited population coverage (e.g. for civil servants or employees of large enterprises), the question is whether (and, if yes, how) to cover the remaining groups of the population. Desirability, affordability and feasibility factors equally have to be considered in order to extend population coverage to rural populations and the informal sector successfully. Of particular relevance are feasibility aspects relating to health-care infrastructure and administrative capacity for revenue collection. Countries may decide to postpone the decision because conditions are not yet favourable. However, even under apparently adverse conditions, health insurance may be a viable option, given that its benefits for the target groups are large.

There is no single best way to develop a perfect SHI system. But when establishing a new SHI scheme or extending SHI, it is good to draw on proven experiences and outcomes. The establishment of SHI is a process that tries to combine existing structures and design features and the social and political environments with international experiences and existing technical understanding in order to arrive at a system that meets consensus as far as possible, that achieves universal coverage, and ultimately provides better health for everyone. Whether or not to continue with development of SHI is not simply an analytical question. The decision in the end depends on consensus-building and social dialogue among relevant partners. This is discussed in chapter 19. It should be emphasized that the decision to proceed with SHI may depend as much on success in building national consensus as it does on demonstrating the usefulness of the mechanism.

The next section discusses the relevant design issues in more detail and outlines how and when they function best.

SECTION III.

Designing social health insurance

CHAPTER 9.
Financing social health insurance

9.1. Introduction

This chapter deals with financing sources and funding techniques, in terms of risk protection, benefits, revenue needs and the feasibility of mobilizing adequate funds.

Key questions in choosing the level and source (or sources) of funding include:

- How much funding is needed to provide the envisaged services?
- What are the sources of finance?
- What are the methods of funding?
- What are their impacts and incentives?
- How sustainable are the sources of finance and what are their limits?

We are dealing here with health systems that are financed to a significant extent through SHI. Combinations of different sources of finance are both possible and likely. The discussion below assumes that at least part of the funding comes from insurance contributions.

The following sources of finance can be distinguished:

- insurance contributions;
- government subsidies (e.g. financed from taxes) and tax relief;
- donor funds;
- co-payments, user charges and fines;
- interest on reserves.

Each of these sources of finance can have a different design, different political objectives and a different impact. They are discussed individually below. Before we analyse the different sources of financing, we must look at the issue of what a country can afford and its “fiscal space”.

9.2. Fiscal space

The foremost task of SHI is to share the costs of health services in an equitable and affordable way, through risk pooling and prepayment. In many developing countries however, health spending is arguably too low to achieve good health care for the population. In these instances, SHI can have the additional task of generating further funds (relative to the current situation) for health. Raising additional funds leads to issues of feasibility and desirability. Raising funds must be sustainable and must not jeopardize economic stability. The ability to raise additional funds is termed “fiscal space”.

Fiscal space is determined largely by the economic performance of a country. Fiscal space increases as the GDP grows per capita. In many developing countries, especially in Asia, GDP growth is strong and sustainable. These countries could consider the introduction of social protection measures, especially SHI, given the fiscal space created by economic growth.

Using fiscal space means raising money from any of the above-mentioned sources, but it also means looking at the consequences of doing so. Receiving donor grants for health spending may create concerns about sustainability and could have effects on inflation of health-care prices. Increasing taxes may jeopardize economic performance. In some cases, people may also object to increases in insurance contributions. There are thus limits to the fiscal space that can be created. The limits differ from country to country.

Fiscal space may also be generated through reduction of costs, synergy effects and improvement in efficiency that increases the cost-effectiveness of care. This includes measures such as introducing effective primary care, focusing on generic drugs, negotiating prices and quality with providers, using economies of scale, getting discounts for bundling orders and so on. All this may free fiscal space, which can be used to extend coverage and subsidize those who have very limited financial means. One other desirable function of SHI apart from risk pooling is cost control.

The range of benefits that can be provided under an insurance scheme depends primarily on the available fiscal space and the availability of appropriate providers of services. The economic resources that can be spent on health will depend on a number of factors, such as:

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

Before planning the benefit package it is necessary to calculate the possible revenue (fiscal space) of the system. The simplest way of doing this is to take the expected number of members and multiply it by the expected average contribution. This requires some basic data, namely:

- the expected number of paying members (which should be taken from population and labour market statistics, if available);
- the expected average contribution (which may be calculated by assuming the contribution rate and taking the average income of the designated members or, in the case of the informal sector, assuming ability to pay and calculating on the basis of a flat rate).

In many countries, however, these data are not available. In this case, the expected revenue will have to be estimated from any available information, such as data from the tax authorities, the turnover of certain sectors, or consumption figures. In addition, a study or pilot project may be carried out (see Chapter 17 for discussion of the transition to SHI).

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

9.3. Contributions

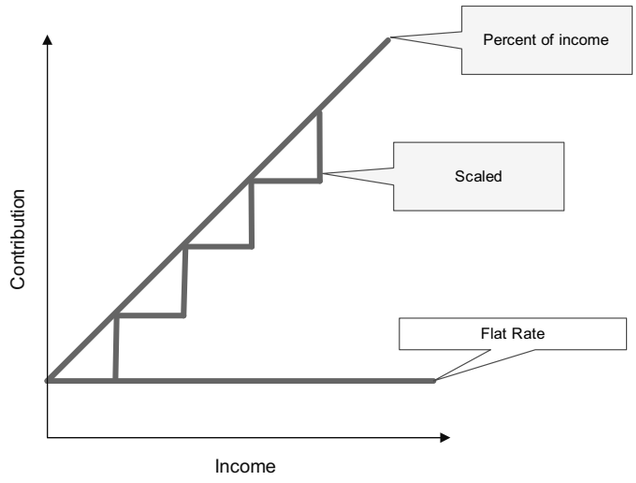
9.3.1. Form of contributions

There are many different ways of calculating contributions. It is important to be aware that each method has a different effect on the distribution between social insurance members.
SHI contributions may be (in increasing order of complexity):

- universal flat rate;
- different for specific groups (e.g. lower premiums for low-income groups, with or without a means test, or different contributions according to the available infrastructure in a geographic region);
- wage-related or income-related (scaled, proportionate, progressive or regressive, with or without a minimum premium or an upper limit).

Figure 6 shows the different types of contributions.

Figure 6:. **Types**



Any of the contribution methods listed above may include dependants, or may require that dependants have to pay their own contributions (which may be the same as or lower than those of the employed person).

Contributions that are entirely risk-related, taking into account the member's sex, age and previous history of disease, are not used in settings since such contributions are not based on ability to pay but on probability of falling ill. In most cases, such an insurance arrangement benefits wealthy and younger people and is not affordable for poorer and older people.

Contributions may be paid exclusively by insured persons, or may be paid in part by the employer or by other institutions such as the pension fund. In the latter case, the contribution is often split 50:50, but in some countries employer and employee pay different shares.

9.3.2. The impact of different types of contribution

The main difference between types of contribution is the effect on the distribution of health costs among the members (so-called solidarity effect). Table 2 shows the solidarity effects of each type of contribution. It also shows which forms of contribution must be combined with compulsory membership (or similar safeguards). Compulsory membership may be necessary to avoid negative risk selection. For example, if flat rate contributions (e.g. $10 per person) are not combined with compulsory membership, many people might only register when their health care costs are likely to be higher than the contribution (when they get older, for example). The alternative to compulsory membership is restricted access to social health insurance, which allows people to join only if they are below a certain age. In France, some mutuals work this way, charging wage-related contributions and at the same time allowing voluntary access up to a specified age only. However, this conflicts with the objective of universal coverage.

An additional possibility for avoiding a high-risk mix is to introduce a qualifying period before an individual is allowed access to benefits and to exclude people with existing diseases or chronic illnesses. To achieve universal coverage, any such exclusions make necessary alternative services for those excluded.

In many countries, contributions – at least in the formal sector – are in some way wage-related. They may be a percentage of the wage, or scaled, which means a fixed amount for people whose wage falls within a certain range (which is easier to administer in countries where there are problems with the exact assessment of wages or incomes). The advantage of wage-related or income-related contributions is

that they take into account the ability to pay of each individual, so that everybody can afford SHI. This point is particularly important in countries with very unequal distribution of income.

Wage-related contributions result in differences in the absolute amount of contributions paid by different individuals for the same benefits. These differences are larger the bigger the differences in incomes, and the wealthiest people in a society may end up paying much more than the value of health services they use. If this is deemed to be unfair, an upper limit or ceiling can be applied to contributions. This means that only the wage up to the specified ceiling is taken into account in calculating the contribution, and no contribution is payable on income above the ceiling. Some countries have such ceilings (e.g. Germany and Philippines), while others do not (e.g. France). However, a contribution ceiling means that contributions are regressive – i.e. people on higher incomes pay a lower proportion of their income in contributions whereas poorer people have to pay a larger share of their earnings, which runs counter to the principle of ability to pay. Which option is chosen depends on the understanding of fairness within the society to which it is being applied, and may also depend on the extent to which the tax system reduces income disparities. There is no inherently right or wrong way.

Table 2: **Effects and prerequisites of different types of contributions**

Type of contribution	Effects on distribution	Impact on administration	Prerequisites
Flat-rate premium	Limited distribution from healthy to sick; from young to elderly; from regions with weak infrastructure to regions with strong infrastructure[1]	Easy to handle and to calculate; may be collection problems due to inability to pay of some groups	Compulsory membership required
Wage-related premium	From healthy to sick; from young to elderly; from regions with weak infrastructure to regions with strong infrastructure	Relatively easy to handle and calculate; assessment of wages may be difficult	Compulsory membership required
Income-related	See wage-related	See above. Assessment of income may be difficult, especially for self-employed people	Compulsory membership required
Related to region (may be added to the above options)	Counteracts the distribution from regions with weak infrastructure to regions with strong infrastructure, mentioned above	Determining the different levels of infrastructure and their impact on health care costs may be difficult	Compulsory membership required

1 Low-income groups' ability to pay may be a problem.

There is also a rationale for introducing a minimum premium in income-related schemes as it is not very cost-effective to administer very small premiums and almost all people have some kind of income. For those who are really without income or with an income below subsistence level, means-tested free membership can be considered and/or contributions may be paid from public funds.

This guidebook does not describe in detail how each type of premium is calculated. However, the calculation of a wage-related premium is shown below, since it is frequently used. The contribution rate (CR) equals the total cost of the benefit package (plus any change in reserves and administration costs) multiplied by 100 and divided by that part of the salary that forms the contribution base.

$$CR = \frac{(Cb + Ca + cR) * 100}{W}$$

Cb = cost of benefits
Ca = administration costs
cR = change in reserves
W = total assessment base (sum of salaries)

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

The policy value, and the major advantage, of employer contributions is their important role in cost containment. Employers receive little or no direct benefit from social health insurance, apart from healthy and productive staff, so it is in their interests to keep contribution rates low and constant.

The distinction between employer and employee premium may cause a problem when assessing contributions for self-employed people. As self-employed people get no employer contribution the question arises as to whether they should pay both shares (the employee share and the employer share) or only the employee share.

9.3.3. Pay-as-you-go versus capitalization

Capitalization is normally used for the provision of long-term benefits. The individual pays contributions, which are accumulated in a technical reserve and then paid out after a number of years, together with a guaranteed amount of interest. One typical example is life insurance. Health insurance also provides long-term benefits, given that around 70% of health expenses during an average person's life occur in later years. For this reason, commercial health insurance companies build up technical reserves charging actuarial premiums that are higher than the age-related costs for younger people and lower than the age-related costs for elderly people. That way, they have sufficient funds left for each individual when they reach an older, and often less healthy, age.

However, SHI does not link individual contributions to individual benefits. It normally uses the "pay-as-you-go" method. This means that the health fund does not have a technical reserve (except the small reserve mentioned above to cover unexpected fluctuations in expenditure). All revenue collected from current contributions serves to purchase the health services currently needed by the covered population. Accumulating capital from the contributions lowers the populations' disposable income for no additional benefit and this may be considered an inappropriate use of contributions. If revenues exceed expenses, the SHI must either lower contribution rates or offer better benefits. Conversely, if expenses exceed revenue, additional finance must be found (e.g. increased contributions, new or more effectively enforced co-payments, etc.). The intergenerational solidarity in SHI is achieved through mandatory membership combined with redistribution.

9.3.4. Targeting and means-testing

As contributions to SHI are based on ability to pay, there needs to be a way of determining the income of members. This is also necessary if the poorest are offered further benefits such as fee waivers or exemption from paying the contribution altogether (free coverage). Establishing income in the formal sector is fairly straightforward, but becomes much more difficult for the informal sector (including the self-employed, those without any work, and other poor people). Individual means tests are administratively challenging and almost always expensive. As an alternative to traditional means tests, proxy means tests

and the involvement of communities have proven to be effective. Proxy means tests use certain indicators instead of assessing the whole income. In the Philippines for example the electricity bills of people are taken as indicator of income. In other places, a person's assets may be used as an approximation of wealth (or lack of it). Once those qualifying for exemptions have been targeted, a system of identification needs to be in place so that the benefit can be claimed, or the exemption can be granted at the point of use. In some cases photo identity cards or computer-readable cards may be used, though any potentially costly investment in advanced computer systems must be weighed carefully against the benefits it provides. Recently, biometric systems of identification have emerged, which are easy to handle, falsification-proof and effective.

9.4. Co-payments

9.4.1. Form of co-payments

Co-payments are a type of user charge. Co-payments influence benefits and benefit schemes. They are discussed here as they have an impact on financing of benefits. Co-payments may take various forms, such as:

- flat rate (per day, per item, per prescription);
- percentage co-payment (a certain percentage of the price or fee);
- excess payment, meaning that the insurance pays up to a limit only, with the patient paying any amount charged by the provider in excess of the maximum amount (price or fee) reimbursed by the health insurance;
- any of the above options subject to a maximum amount per year (stop-loss), beyond which the insurance covers the costs.

Table 3 shows how these different co-payment forms can be applied to a range of health benefits. It is important to recognize that a variety of co-payment combinations are possible.

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

It is understood that the patient has to pay 100% of the costs for services and goods that are excluded from coverage.

Table 3: **Co-payments for different categories of care**

Type of co-payment	**Category of care**			
	Outpatient care	**Inpatient care**	**Drugs**	**Medical aids and prostheses**
Flat rate	Per visit or per treatment	Per day or per stay	Per item or per prescription	Per item or per prescription
Percentage of costs	% of fee	% of fee	% of price	% of price
Excess	Cost of treatment exceeding a fixed amount	Cost of treatment exceeding a fixed amount	Price of drugs exceeding a fixed amount	Cost of treatment exceeding a fixed amount
Stop-loss	Total costs (accumulated)	Total costs (accumulated)	Total costs (accumulated)	Total costs (accumulated)
Payment for services excluded from the insurance benefit package	Particular treatments	e.g. single bedroom	Less important medications or too expensive ones	e.g. dentures and spectacles
Combinations are possible				

9.4.2. The Impact of co-Payments

It is worth considering the impact of co-payments on consumer behaviour and on the distribution of health care costs. Co-payments may have the effect of:

- making insured people more aware of the cost of health care and containing consumption;
- reinforcing certain types of behaviour (especially preventive) and discouraging others (those that negatively affect health); it is also supposed to discourage people from excessive and unnecessary utilization of services;
- gaining access to additional sources of financing;
- redistributing the cost of health care from the healthy to the sick, which may or may not be intended.

Studies of the effects of prices and charges on the utilization of health care show that demand for health care is generally price-inelastic (i.e. an increase in prices has a less than proportionate effect on demand). However, the evidence also shows that this is not the case for people on low incomes. Co-payments are likely to deter the poor from using health services and may exacerbate inequity. It is therefore important to calculate how the financing rules are likely to affect the amount that different population groups pay for health care, and put in place adequate exemption mechanisms. In general, an insurance-funded scheme will be less expensive at the point of use than one where patients fully pay for services out-of-pocket, because insurance members have already (pre-) paid for their health-care utilization. A newly introduced insurance system may thus be expected to lead to higher utilization among poorer groups if they are covered (and can afford any co-payments that they may be charged).

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

9.5. Government subsidies

9.5.1. Sources of government subsidies

Experience shows that SHI schemes are rarely, if ever, the sole revenue-raising and revenue-spending entities in a health system. Funds from government budgets almost always play a part. In some cases this takes the form of parallel systems where SHI operates the health spending for one group of the population and the state for another (e.g. in Colombia). In other cases, government funds go directly as subsidies into the SHI fund, leaving the insurance to cater for all population groups (as in the Philippines). As this book is concerned with SHI as such and not with systems that may exist in parallel with SHI, this text will deal with the latter form – government subsidies as additional revenue for SHI.

Government subsidies come from the government budget, which in turn is financed mostly from taxes. The decision to use some of those funds to subsidize health insurance needs to be taken by the political decision-makers. It may simply be an amount out of the general budget as determined by the Ministry of Finance.

This can, however, be further refined by linking the tax itself to its spending – i.e. earmarking certain tax income to be spent on health, or more specifically on subsidizing SHI. A popular way of earmarking taxes for health is to use so-called “sin taxes”. A variety of consumption behaviours and many kinds of human activities are hazardous to health. Billions of dollars are spent each year on the consequences of tobacco and alcohol consumption, traffic accidents and hazardous sports. It is frequently suggested that it would be appropriate to make people pay for the consequences of their lifestyle. Some countries have already put this principle into practice (e.g. France, where vehicle insurance premiums are subject to a special tax which is transferred to the health insurance budget). Likewise, the revenue from taxes on tobacco products may be earmarked to go towards health services.

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

- to discourage people from engaging in hazardous activities or behaviours (although effects on behaviour may be modest when price sensitivity of demand is modest);
- to cover the costs incurred by the health fund as a result of hazardous activities or behaviours (though one problem here is the difficulty of calculating the real costs of these types of behaviour in order to set the tax at an appropriate level).

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

9.5.2. Usage of government subsidies

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

- subsidies to cover deficits;
- subsidies to cover contributions (partly or entirely) on behalf of certain groups;
- general subsidies covering a certain percentage or a fixed amount of the overall costs;
- subsidies to cover the cost of certain services provided by SHI;
- subsidies to cover initial investment or start-up costs of SHI.

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

Subsidies to cover the contributions on behalf of certain groups are a way of achieving greater population coverage. This means that people who cannot afford regular contributions because they are poor are nevertheless included in SHI, the costs being covered by the state. There are different ways of managing this. The easiest way is to assess contributions for the people concerned in the usual way and let the state pay them. In the Philippines, Phil Health (Philippine Health Insurance Corporation) is doing this. The advantage is that the contributions paid by the state cannot be manipulated since they are defined in advance. If the state undertakes to reimburse treatment costs for these groups without such constraints, there may be room for manipulation, either by the state or by the health fund itself.

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

The state may subsidize certain services purchased by SHI (e.g. immunization, preventive services) that would otherwise be underprovided (see chapter 9). Additionally, subsidies may be provided for services that are not really health services, such as maternity grants.

Subsidies for one-off investment costs can be useful to ensure that the contributions paid in by members are used solely to purchase health services for them whereas infrastructure or other one-off investments (and the decision whether to make them) are kept with the state. In many countries large infrastructure investments (e.g. the construction of hospitals) remain as government spending and are not undertaken by health insurance. Given the fact that the up investment of SHI is quite expensive and mostly does not coincide with corresponding revenues, the state can subsidize these costs until the revenue from contributions is sufficient to cover them.

In addition to direct subsidies to the health fund, there are indirect ways of financing SHI out of the state budget. If SHI contributions are paid from pre-tax income, then the revenue to the insurance will be

higher and government tax revenue will be lower. SHI bodies may also be exempted from many kinds of taxes, such as corporation tax, taxes on assets, or value-added tax.

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

9.5.3. Impact of government subsidies

State subsidies have both advantages and disadvantages. One important feature of an SHI fund is a degree of independence. Its budget may be less subject to politically motivated interventions, manipulation and policy changes than the government budget. In general, this improves acceptability and people's willingness to pay. If a major part of health insurance is financed by state subsidies, health insurance loses some of this advantage unless the state gives unconditional grants. The only way to prevent this is to define the amount of subsidy and the modalities of payment clearly and unambiguously.

To limit outside influence, it is advisable for state subsidies to represent no more than half of the health fund budget. The larger the state's financial commitment, the less independence the health fund has and the greater the danger that SHI will lose one of its major advantages – independence from the state budget. In general, indirect subsidies have less influence on the autonomy of SHI than direct subsidies.

Concern about equity may arise if health insurance does not cover the whole population but is financed to a significant extent by taxes, which in turn are paid by the whole population.

9.6. Interest on reserves

Another source of income is interest on the reserves that health funds are obliged – or choose – to hold. The amount of interest income depends on the amount of reserves and the quality of the health fund's financial management. This point is considered in more detail in chapter 15. If a health fund's mandatory reserve equals two months' expenditure in a pay-as-you-go system, interest income would amount to 1.7% of annual revenue at an interest rate of 10%.

9.7. Donor funding

In developing countries donor, funding may play an important role, especially during the period of building up SHI. Donors may fund technical assistance, training, equipment, and a start-up fund. During the past decade, the interest of bilateral and multilateral donors in SHI has increased substantially and there are many examples of donor funds helping to set up an SHI scheme (e.g. Philippines, Viet Nam).

Donor contributions are a source of income not only in developing countries. In almost all countries there are foundations and associations that spend donor and charitable funds on health. In some countries, donors have provided grants in the form of equity funds, which finance health care for people who are needy. International donors have shown in the past that support for health systems in developing countries is one of their priorities. Such funds can also be paid into SHI in the same way as the different government subsidies described above. However, it may be difficult to measure the precise impact of such funds, which may make SHI less attractive for donor subsidies. This can be helped by linking such funds to specific SHI expenditures that are certain and foreseeable, such as treatment for chronic diseases, HIV, or preventive or maternity services. The caveat for accepting donor funds to subsidize SHI is that they are potentially unsustainable. Most donor funds are time-limited. They will also always depend on the

willingness of the donor to continue payment, leaving the health of a population potentially dependent on the goodwill of the donor. At the same time, domestic sources may also be volatile, depending on political stability and economic performance.

In this context it should be mentioned in general there is no advantage in taking loans to finance the benefits of health insurance, even in the start-up phase. However, it may be useful to finance capacity-building and equipment from loans.

9.8. Other sources of income

There may be additional sources of income for the health fund, although they will represent only a small part of total revenue. Some examples are fines for late payment, self-referral fees, payments for services provided on behalf of other authorities, indemnities (e.g. those paid by other insurance organizations for health services, notably accident insurance companies), and revenue from the sale of goods and services by the health fund.

9.9. Questions raised

- What are the political constraints and responsibilities that affect the financing of health care?
- What is the population's ability to pay?
- To what kinds of payment systems are patients accustomed?
- Has there been a careful examination of the relationship between the proposed benefit scheme, the costs, and the sources of finance?
- How can equity be guaranteed in a system with various funds?

CHAPTER 10.
Risk pooling and risk protection

10.1. Risk pooling

10.1.1. Financing and risk pooling

Risk pooling is the accumulation and management of health insurance premiums so as to ensure that the risk of having to pay for health services is borne by all members of the pool rather than by each affected individual. In other words, individuals share the financial risk associated with health services for which the need is uncertain.

SHI is an important option in health financing that can undertake such risk pooling. The health insurance premiums or contributions paid by its members to the SHI fund should in principle be enough to finance the expected health-care expenses of all of its members. Risk pooling is not uniquely linked to SHI with its traditional revenue collection method (whereby members pay regular health insurance contributions). It is also possible to "insure" health risks via taxes, with the government ensuring that people receive the health services they need. To understand this better, one can say that members of SHI insure themselves in an "explicit" way (with members knowingly contributing and making a direct link with the health services to be received in case of need). In cases where the tax system protects individuals, the insurance can be called "implicit". Increasingly one sees hybrid forms of SHI schemes whereby, apart from members' contributions, their revenues consist of subsidies transferred by the government. These subsidies may help to ensure that vulnerable groups such as the poor, the elderly and the unemployed can retain their membership in SHI and remain financially protected against health care costs.

10.1.2. Fragmentation of the risk pool

SHI can be organized via one large risk pool or single fund, or via several smaller pools or funds. There are advantages and disadvantages to having several funds versus a single fund.

A single fund with a large pool can realize economies of scale in administration. This means that the administrative cost per member decreases with the size of membership. A further advantage of a single fund is that there is less uncertainty about the occurrence of illnesses (especially epidemics). This contrasts with the uncertainty involved when smaller population groups are insured in a fragmented system with different insurance funds. Because of this reduced uncertainty, a larger fund needs fewer reserves.

On the other hand, there may well be reasons for establishing (or keeping) a multitude of health insurance funds. For instance, historical and political reasons might include the existence of insurance funds covering certain parts of the population. The acceptability of a new system, such as an SHI system aiming at universal coverage, may be increased if these funds are allowed to continue. There are also financial reasons: efficiency and flexibility of administration may be increased when the insured population has the right to choose between several health funds. There may be an advantage in giving members the choice between various funds. This encourages competition, which may stimulate funds to improve their administrative services.

It needs to be highlighted that, unless strongly regulated, a multiple, fragmented fund system might turn out to be inefficient. Fragmented risk pools may result in certain segments of the population, especially the low-income groups, having less financial protection against health expenditures than others. The risk pools they are associated with would then receive a lower overall level of contributions, leading to a more limited benefit package and restrictions on access. However, fragmentation can be avoided through an appropriate regulatory framework, including in particular the establishment of compensatory mechanisms.

10.1.3. Risk equalization mechanisms

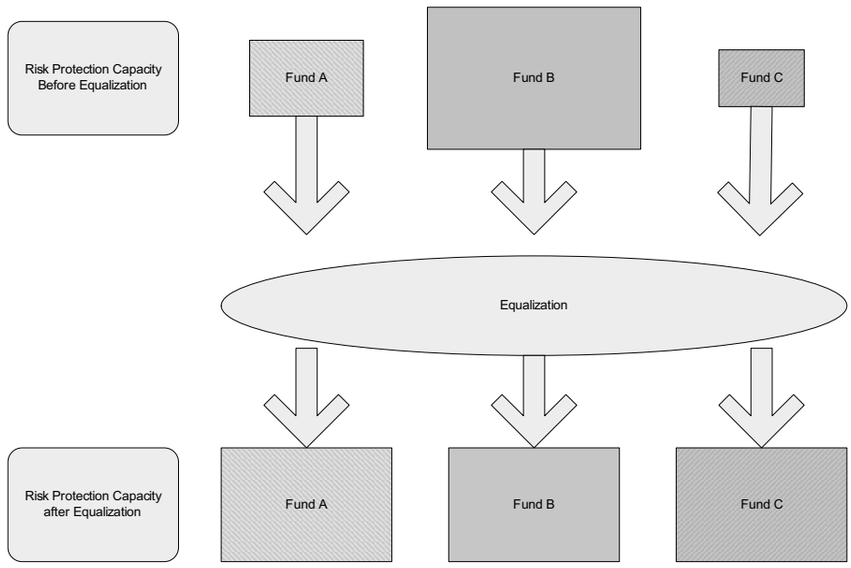
If a health financing system is fragmented into several funds, its risk protection capacity may be reduced. Risk protection capacity is determined by two elements:

- levels of income per capita (if contributions are income-related);
- risk structures (the mix between healthy and sick members in the pool) impacting on per capita expenditure.

A pool with only high-risk members leads to higher health expenditure and hence could imply higher contributions given constant benefits and/or lower benefits given constant contributions. This is critical if members do not have a choice between funds. If the political will is to maintain several funds, these differences can be compensated through transfers between the different funds. It may be politically desirable to maintain several funds in order to have competition, to give certain population groups the possibility of having their own funds, or just in order to maintain historical structures for political and social consensus reasons.

The purpose of compensatory mechanisms, also called risk equalization or risk compensation schemes, is to adjust the available resources of the different insurance funds, taking account of the health risk and contributory capacity of their members. Transfers will flow to those funds that have especially high-risk and low-income individuals as members. These transfers can be financed via a risk equalization fund (or solidarity fund) with net contributions from those health insurance funds whose membership is dominated by individuals with relatively low health risks and relatively high incomes. This has the effect that the risk protection capacity of all funds becomes similar. It is similar re-insurance. Figure 7 shows the basic functioning of such equalization.

Figure 7: **Equalization of capacity for risk protection**



In these circumstances, the objective of one benefit package for all insured persons can be more easily achieved using a risk equalization scheme. It will also help, in the case of free choice of funds, to ensure that health insurance funds accept all categories of members, including those with high risk, by providing these funds with the necessary financial resources to cover these high risks. Thus, equalization of risk is a means to guarantee equity.

Two forms of risk equalization are distinguished: risk adjusters and ex-post risk-sharing. Risk adjusters are characteristics used to estimate likely health expenditures, with typical adjusters in developed SHI systems (such as those of Belgium, Germany, Israel, Netherlands and Switzerland) including age, gender, disability, income, employment status, region (epidemiological profile and whether it is predominantly rural or urban), prior year expenditures, and prior utilization (using diagnostic information). For those health insurance funds with an expected greater proportion of high-risk individuals, subsidies can be given through the risk equalization scheme from those health insurance funds with (expected) lower-risk individuals. This helps equalize the impact of different risk profiles, albeit imperfectly because such adjusters are only estimations of likely health expenditures for different individuals. Certain characteristics are easier to obtain information on than others. An SHI scheme with multiple funds that is in the early stage of development should use risk adjusters that are not too costly to obtain, while still being good predictors of future health expenditures for different individuals. Box 4 shows an example of risk equalization through risk adjusters.

Ex-post risk-sharing involves retrospective reimbursement by the solidarity fund for some part of each fund's costs. This can be designed, for instance, to cover the costs of those individuals whose costs are exceptionally high. It is interesting to note that the extreme of complete retrospective reimbursement is effectively a single fund system with fragmented administration.

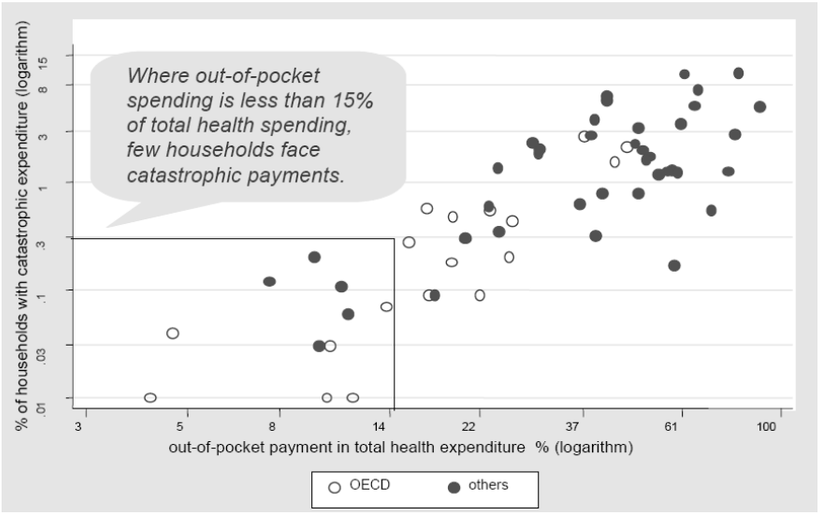
Box 4. Risk equalization in Colombia

One example of risk equalization between risk pools can be found in the Colombian universal health insurance. Insured persons contribute 12% of their salary (the Regimen Contributivo), unless their contributions are waived if their income is insufficient (the *Regimen Subsidiado*). All insured can affiliate themselves with a health insurance fund (*Entitad Promotora de Salud*, or EPS) of their choice. The payroll contributions are paid directly to these health insurance funds. Yet, at the same time, the government has determined the level of health insurance revenues to which a fund is entitled. This revenue equals a flat amount per person (*Unidad de Pago por capitación*, or UPC) adjusted for age and sex times the affiliates of the fund. The schedule of flat amounts is set in such a way that the total amount of revenue of a particular fund covers the cost of health services used by the members of that fund. The risk equalization is thus as follows: those health insurance funds that receive an amount of payroll contributions that exceeds the revenue that is due to them pay the excess amount to a solidarity fund (*Fondo de Solidaridad y Garantía*, or FOSYGA), and the FOSYGA then distributes the net amounts it receives to those health insurance funds whose contributions are below the revenue due.

10.2. Risk protection

To determine the degree of risk protection of the health financing system, the proportion of prepayment of the total health expenditure (found in the national health accounts) and the percentage of households incurring catastrophic expenditure can be used as indicators. Following the WHO definition, catastrophic expenditure occurs when a household's health expenditure is greater than or equal to 40% of its nonsubsistence income (i.e. income available after basic needs have been met). Using this definition, WHO estimates that every year some 44 million households worldwide incur catastrophic expenditure, and about 25 million households are pushed into poverty by the need to pay for health services. As can be seen in the Figure 8, the proportion of households with catastrophic expenditure rises as the share of out-of-pocket spending in total health expenditure increases. Below a threshold of out-of-pocket spending of 15% of total health spending, only a few households face catastrophic payments.

Figure 8: **Catastrophic expenditures and of out-of-pocket payment**



Source: Xu et al., 2005.

There is an ongoing discussion as to whether SHI is primarily insurance or a financing vehicle for health care costs. This may not appear to be a contradiction, but in practice those services that are most cost-effective may not be ones that meet the needs that are of greatest concern even to poorer people. Since the Declaration of Alma Ata (WHO/UNICEF, 1978), primary health care has been regarded as the most cost-effective way to provide health care, and such services should be given priority in the benefit package. However, from the point of view of the individual, the most threatening risk to be protected against is that of a complicated illness requiring expensive treatment. For poorer people such treatment can easily lead to catastrophic expenditure. This includes serious accidents, complicated deliveries, diseases that require long hospitalization, and surgery or expensive drug treatments. Without proper risk protection such cases have ruined families and have led to the loss of land and other productive assets, as well as homes, if not lives. These cases occur rarely and unpredictably but are expensive, so they can only adequately be dealt with by sharing the risk and protecting against the financial burden through an insurance mechanism.

What risks constitute the threat of catastrophic expenditure depends very much on what people can afford. For very poor people, even minor treatment may be too expensive, so it is sometimes difficult to judge what constitutes a catastrophic risk. Nevertheless, there are several methods for making such a judgment for the purpose of defining health insurance benefit packages. One method is to define specific treatments (e.g. all inpatient care) as catastrophic and requiring risk protection. However, there are always likely to be cases falling outside such a benefit package that may lead to catastrophic expenditure. Another method is to have "stop-loss" insurance. This kind of insurance leaves a certain amount of health costs to the patient (e.g. US$ 50 per year), and the insurance cover steps in only when costs exceed this amount. The advantage is that all potentially catastrophic cases are covered but it poses a larger administrative challenge.

Depending on the wealth of a population, stop-loss thresholds or limits on benefit coverage must be considered carefully in order to provide financial risk protection and to avoid impoverishment from health-care payments of already poor populations. Including low-cost health services, and not only expensive treatments, in insurance reduces that risk. Although the need for these services may be regular and predictable, in most countries people seem to prefer them to be included in insurance. Even though this amounts to the SHI performing a financing function without any particular insurance benefit, it does help to share the overall financial burden more equitably. Studies in Africa and India among poor and even illiterate people have shown that, given the choice, most people desire to be protected against regular and catastrophic cases, even if they have to pay a higher premium (Dror et al., 2006).

10.3. Questions raised

- Should there be one SHI fund to achieve economies of scale and efficient risk pooling, or multiple funds to allow choice and competition?
- Is it feasible to introduce risk equalization between competing funds?
- Is the proposed SHI primarily a financing mechanism or a protection against catastrophic costs to families?

CHAPTER 11.
Population coverage

11.1. Introduction

An overarching objective in health financing and health systems policy is to achieve universal access for the population, which means access for all to essential preventive, curative and rehabilitative health interventions at an affordable cost.[4] This chapter is about how to achieve universal access through a social health insurance scheme.

Universal access can be achieved in many ways. from the general objective of achieving universal coverage at affordable cost there is no general rule about the proportion of the population which best should be covered by a social health insurance system. One obvious solution is to cover the whole population. Nevertheless, there are arguments for not doing so, and these carry more or less weight depending on the situation in the country concerned. In chapter 20, a pluralistic health financing and delivery system is described using the example of Thailand where a social insurance scheme, a major occupational system and a tax-based system coexist with private health insurance.

Most countries with SHI started by protecting population subgroups such as employees in large enterprises. Over time, coverage has been extended to other groups. This is why in this book we give special attention to the question of how to extend coverage. In the Republic of Korea, for example, coverage started with the employees of big firms; later, smaller firms were included, followed by other population groups such as the self-employed.Korea also moved from multiple funds to one single fund. Other countries such as the Netherlands had a system where persons could opt out but changed it to a comprehensive compulsory system.

Full protection of the whole population is a long-term objective in the process of establishing SHI. But given the fact that coverage of separate population groups is quite different in terms of technical feasibility, acceptance and financial impact, experience shows that to start with those groups that are less technically demanding and financially less controversial has proven to be a feasible way towards comprehensive coverage. However, that groups that are easiest to cover may vary from country to country.

In addition to the situation prevailing when a health insurance system is being built up, there may be historical, technical or political reasons for not covering the whole population. There are many examples of countries with established SHI systems that do not include certain groups. In Germany, for example, self-employed people, civil servants, military personnel and priests may opt out of SHI coverage or are not included.

It is useful to consider the possible target groups of population coverage. A number of population groups can be distinguished, whose characteristics, size, needs, technical requirements and political influence may be different in different countries. Table 4 gives a brief overview of a possible set of target groups in order to give some idea of the complexity of the issues involved. It should be remembered that, if the system does not provide free coverage for dependants, spouses and children will have to be considered

[4] Universal access is consistent with WHO's concepts of health for all and primary health care. See: WHO, 2005.

Table 4: **Possible groups for social health insurance coverage**

Group		Technical and administrative issues
Employees	Industrial workers	No specific technical or administrative problem
	White collar workers	Acceptability problem with high-income groups
	Workers in agriculture	Registration, income assessment
	Seafarers	Evasion, high-risk jobs
	Miners	No technical or administrative problem, but high-risk jobs
	Casual workers	Registration, income assessment, contribution collection
Self-employed	Craftspeople	Registration, income assessment
	Farmers	Registration, income assessment, contribution payment
	Owners of small businesses	Registration, income assessment, contribution collection
	Other independent workers	Registration, income assessment, large income differences
Special groups	Civil servants	No real technical and administrative problem
	Military personnel	No real technical and administrative problem
Non-working population	Pensioners	Ability to pay
	Unemployed people	Ability to pay, registration
	Disabled people	Ability to pay, registration
	Welfare recipients	Ability to pay
	Students	Ability to pay
	People in training	Ability to pay
	Dependants	Registration, ability to pay

Given the variety of potential target groups, several issues need to be considered in the development of a policy for population coverage.

- *Political*: What is the political impact of including or excluding certain groups or finding separate solutions for them? Political considerations may be influenced by the fact that in most countries which plan to establish an SHI system, some protection schemes already exist for certain population groups. These groups may resist incorporation into a larger scheme and pooling contributions and sharing risks with them. There may also be financial, territorial or ethnic considerations.
- *Technical*: What kind of risk mix is needed to ensure a functioning health insurance system? If mainly elderly and sick people are joining the scheme, perhaps because membership rules allow voluntary membership without measures against negative risk selection, SHI will be likely to fail as costs may be higher than revenues.
- *Equity*: What is the impact on equity objectives of choosing a certain pattern of population coverage? Any consideration of equity and risk mix requires low-income, high-income and zero-income groups to be identified and pooled. A scheme insuring mainly zero-income or low-income groups will not be sustainable unless there are substantial revenues in addition to contributions or the benefits are very basic (see chapter 18 on micro-insurance).
- *Feasibility*: Is it feasible to cover a large number of different population groups in one scheme? There may be challenges to establishing universal coverage, such as difficulties in registering certain groups, or in assessing and gathering contributions, or ethnic and political considerations.
- *Membership*: Should the system be compulsory or voluntary? What are the practical problems associated with voluntary membership and what can be done to ensure a balanced risk mix?

Each of these issues is considered in more detail in the following sections.

11.2. Political aspects of population coverage

For various reasons, SHI schemes sometimes exclude particular population groups or allow them to opt out, or envisage separate schemes for them. This may apply, for example, to persons who can easily afford to make their own prepayment arrangements, either through savings or private insurance. Instead, they may be obliged to seek their own private insurance arrangements or to pay for health services directly. However, taking out these contributions from a SHI fund generally harms the equity and sustainability of the system since in general they contribute more and cost less than average.

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

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

- employed persons, with the exception of certain groups (such as public servants, seafarers, casual employees, family members of the employee, other groups not exceeding 10% of the rest of the employed population);
- at least 75% of the economically active population or at least 75% of all residents;
- the non-income earning spouses and children of insured persons.

When envisaging comprehensive population coverage and whether to apply different risk-pool schemes, another consideration may be ethnically or territorially distinct groups. Though umbrella arrangements in terms of risk-sharing (see chapter 10) may be in place, separate schemes and arrangements may be politically opportune.

11.3. Technical aspects of population coverage

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

If the objective of SHI is to provide a certain level of health protection for a reasonable contribution, it is very important to find a "mix" of risks that guarantees sufficient financial resources. Some groups of the population might be regarded as low risks and others may be characterized as high risks in insurance terms. It is important to stress that these are strictly technical terms and have no implied judgement, moral or otherwise. Table 5 shows some of these groups.

From the perspective of the insurance, the average costs for services per year for a "low risk" person are lower than for a "high risk" person. If the system is funded by *wage-related contributions*, the risk depends on two parameters – the costs per year and the wage of the individual. In a system with *flat rate contributions*, there is only one parameter – the health costs per person.

Experience shows that the lowest risks are young wage earners without families or with small families. The chronic sick and the elderly, as well as large families (if dependants are covered free), are the largest high-risk groups; other high-risk groups include women of childbearing age and workers in hazardous professions. Also, very poor people are considered to be high risks given their very limited resources and their often heightened exposure to health hazards.

Table 5: **Population groups and "risk mix"**

Low risks	High risks
Healthy people	Sick and disabled people
People with no work stress or feelings of certainty regarding their future income	People with work stress or feelings of uncertainty regarding their future income
People with few or no dependants (in a system where dependants are covered for free)	People with many dependants (in a system where dependants are covered for free)
Young people	Elderly people
People in safe working environments	People in hazardous jobs

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

Commercial insurance companies have to differentiate between various risk groups by charging risk-related premiums. They attract low risks by offering them low premiums, and reject high risks, or accept them only in return for high premiums. In some countries, commercial insurance laws allow companies to exclude members as soon as they turn out to be a high risk. The result may be that the high risks either have to be covered by public health services as far as available or they are exposed to severe financial risks. a set-up systematically puts the poor at a disadvantage and risks exacerbating poverty through catastrophic health costs. In the long run, such systems inevitably result in differential access and treatment according to economic well-being – one system for poorer people and one for richer people.

SHI tries to counter that. SHI does not exclude anyone who belongs to a group that qualifies for coverage and it does not charge risk-related premiums. With premiums that are not risk-related but perhaps wage-related or flat rate, an insurance fund has to ensure that it gets the right risk mix. This is possible only if membership is compulsory or if voluntary membership is coupled with precautions against a high-risk mix. Otherwise, people who are low risks will choose to opt out and/or join SHI only when they become high risks. This would result in a pool of poor and/or unhealthy people who need costly treatment, driving contributions up and further exacerbating the problem.

This issue becomes clearer when we consider solidarity (mutual support) between different groups in SHI and commercial health insurance.

Table 6: **Mutual support between population groups in health insurance**

Form of solidarity	Social health insurance	Commercial health insurance
The healthy with the sick	Yes	Yes (limited if pre-existing conditions or chronic diseases result in higher premiums)
The young with the old	Yes	No
High income earners with low-income earners	Yes	No
Singles with families	Yes (in systems with free or below-cost coverage of dependants)	No

Compulsory membership in SHI schemes can be justified for two reasons. Firstly, it is a "contract between generations". At some stage in life, people expect to become a high risk; for instance, if they have a large family or when they become older. Therefore, single and young people who pay high contributions are making an investment for future coverage of their health costs. These points are considered further in 11.6 below. Secondly, compulsory membership is based on experience showing that people underestimate the risk of health care costs and their impact on their subsistence. Thus, affordable health insurance based on ability to pay and no risk selection is likely to fail without risk-sharing. One risk-sharing measure is compulsory membership.

11.4. Equity considerations

In many SHI systems, contributions are split between employer and employee. For certain groups, such as pensioners, the unemployed, welfare recipients, disabled people and the very poor, other social security branches or the state play the role of the employer and pay the employer's share of the contribution (or even the entire contribution). But for self-employed people there is no such surrogate "employer". Compulsory membership for this group raises problems of equity, as they would either be obliged to pay the whole contribution themselves or, if their contribution would be limited to the individual's part, their contribution would be much smaller than that of average employees. In case they have to pay both shares, this discourages compulsory and even voluntary coverage of self-employed people, because for them the visible costs of membership are much higher than for employed members. Even though, economically speaking, the employer's contributions may be regarded as a hidden part of the employed person's wage, it is usually not perceived that way. If their contribution is limited to the calculated "employee's share" then their contribution is likely to be less than the average health care costs and the shortfall would need to be covered by a subsidy or from the formal sector contributions.

Equity problems may also arise in insurance schemes where fraud involving wage-related contributions is not effectively combated. For example, jobs with artificially low wages can allow access to the full range of insurance benefits in return for very low contributions. This type of fraud can be avoided by effective income assessment, means tests and/or setting a lower limit on the amount of income required to establish insurance coverage. The lower limit may be set at, for example, 20% of the average income or at the national income poverty level.

High-wage earners may consider a wage-related contribution system to be unfair, because their contributions will be a multiple of those of low-wage earners while they receive the same benefits. For this reason, high-wage earners sometimes opt out of SHI schemes (if opting out is allowed). It is important to note, however, that empirically people with higher incomes have a lower illness risk, so excluding them from the fund can be detrimental to the development of a low-risk mix. This is why there are schemes which include cash benefits like sick pay and maternity pay (which can be wage-related) into the benefits so that higher-wage earners have higher benefits to some extent. In some countries there are also schemes that give those members with higher contributions extra benefits such as single bedrooms in hospitals.

As SHI coverage is unlikely to be extended to all target groups immediately, there is also the issue of transitional inequity while SHI coverage is introduced. Because the coverage is administratively easier to achieve, many schemes start by covering the working population in the formal sector. In many poorer countries, these people are better-off than the majority of the population, mainly owing to their regular and dependable salary income. Giving these relatively better-off segments of the population the coverage and access to the benefit package of SHI, while offering no improvement to the informal sector and the poor, can exacerbate existing inequalities. From an economic perspective, putting some people in a better position than before without making anyone else worse-off is a positive development. However, widening the gap between rich and poor can be socially and politically unacceptable. If it is not done from the beginning, then there needs to be a clear pathway to extending coverage to these disadvantaged populations, and possibly some interim measures to improve their access to health services (e.g. increased investment in provision and infrastructure, reduction of direct payments).

Another issue that may have equity implications is whether to establish one scheme or several. The reason for allowing several schemes may be that systems already exist for certain groups at the time when SHI is introduced. Another reason may be that the infrastructure varies greatly within a country. Urban areas often have the best infrastructure, with the highest rates of hospitals and physicians per inhabitant. In rural areas, the infrastructure can be quite poor. Incomes in urban areas are also generally higher than in rural areas. If the rural and urban populations belong to the same system and pay the same contributions, the rural population may be financing part of the urban infrastructure, since it does not have access to comparable services. This will cause equity problems. Other considerations relate to ethnic, political and territorial boundaries.

11.5. Feasibility of universal coverage

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

In their early stages, most health insurance systems in industrialized countries covered only employees in industrial enterprises or the formal sector. This was for technical rather than policy reasons. These employees formed the biggest group with regular wages from which contributions could be deducted. Some countries distinguished between small/medium-sized and large enterprises, and started with the larger ones. Registration and monitoring of the collection of contributions is much easier in bigger enterprises. Also, in many countries these groups were better organized than others and the enterprises constituted an administrative environment that was favourable to the introduction of compulsory health insurance schemes.

In a country with a significant number of self-employed people in small or informal businesses – such as market traders, small shopkeepers, agricultural smallholders or taxi drivers – it may be difficult to include all in a compulsory social insurance scheme within a short time because of the administrative challenges. However, in some countries these groups and their families represent more than 50% of the population. Developing countries in particular often have a small industrial or formal sector and a large rural sector. Coverage of large rural populations raises many technical problems.

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

Casual workers represent another group that is more difficult to register, and to keep track of, and whose income cannot be easily assessed. To overcome the problem, coverage may be organized with the help of technologies of identification and tracking of incomes. The registration of family members (i.e. dependants) constitutes another administrative task.

Some countries have developed and implemented community-based health insurance schemes instead of, or in addition to, formal-sector insurance. These small, local schemes are often initiated together with NGOs and development partners, and they have spread fast in many developing countries. These are dealt with extensively in chapter 18.

11.6. Membership: compulsory or voluntary?

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

Compulsory membership can also be limited, for example, to individual groups of people such as formal-sector employees, cooperatives, associations or even villages. This form of compulsory membership leverages existing organizational and administrative structures for the health insurance.

Offering voluntary membership may entice certain population groups to join, particularly those groups who are not presently covered by an insurance scheme and may be dissatisfied with the existing quality of health care services. However, it would be likely to attract in particular high-risk groups and would result in a high-risk mix. Adverse selection may occur if high-earning persons choose commercial health insurance as long as their premiums are lower than the contribution to SHI (this normally means as long as they are young and do not have dependants) but as soon as their premiums rise (i.e. as soon as they become older and high risks), such people may switch to SHI. Adverse selection would also occur if people do not choose insurance as long as they are healthy but, as soon as they fall seriously ill, they apply for membership in the SHI fund.

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

- qualifying conditions (e.g. pensioners may be allowed to participate in SHI only if they have already been members for a minimum period such as 50% of their working life or for a certain number of years before retirement);
- voluntary membership may have a qualifying period (e.g. of six months) to prevent people joining only when they fall ill (which means that voluntary members have to pay contributions for the duration of the qualifying period without any entitlement to benefits);
- limited voluntary access, which would give people only limited opportunities to enrol in SHI relatively early in life while they are still low risks – e.g. during the first year of professional activity – and people who do not join then or who withdraw from SHI because of a change of status (e.g. from employee to self-employed, or by passing the upper income threshold) are not allowed to re-enter.

In summary, voluntary membership has a variety of advantages and disadvantages, which must be considered in the planning process. In terms of ensuring a low risk mix and contributing to mutual support, compulsory membership is preferable. However, in particular situations compulsory membership may be problematic. The following table provides a comparison of the two membership options.

Table 7: **Advantages and disadvantages of voluntary and compulsory membership**

Type of membership	Advantages	Disadvantages
Voluntary membership	Better acceptability Technical feasibility	Adverse risk mix Underestimation of health risks and subsequent risk of high costs May raise equity problems
Compulsory membership	Risk mix Possibility to establish mutual support Full coverage of groups possible	Evasion Political resistance

Whatever decision is taken, the exclusion of people from compulsory or voluntary membership may pose problems and hardships, which may not be acceptable from an equity point of view given the objective of universal coverage. There is a trade-off between fraud prevention and administrative efficiency on one side and social protection objectives on the other.

11.7. Covering dependants

It is common for a comprehensive SHI scheme with universal coverage to cover some people who are not able to pay contributions. These include dependants, such as children or others without an income who are part of a household. To cover the costs of their health services there are basically three solutions:

- to charge the contributing member for each member of the household, which may make the contribution burden for members with large families unbearable;
- to include the family members free of charge, which means that the community of contributors bears the costs of dependants, whether the individual contributor has dependants or not;
- to pay the dependants' contributions from other sources, such as tax-funded subsidies to the insurance.

The second solution is an element of mutual support between members with and without dependants. Both members pay the same contribution, but the one with more dependants uses more services.

In the second and third solutions it must be very clearly defined and verifiable who qualifies as a dependant. If a country decides to allow free coverage for dependants, the concept of a dependant must be carefully defined according to prevailing custom. Does it include a spouse or spouses, children (how many?), parents, grandparents, grandchildren, adopted children, dependant siblings? The registration of dependants can be simplified if there is a reliable population registration system in place. Otherwise, documents such as birth certificates may be needed but may not always be available.

11.8. Covering the informal sector

The formal sector and the informal sector relate to categories of the working population. The informal sector is best defined as consisting of those persons in the working population who are not in the formal sector. Those in the formal sector are all those people who have formalized, contractual, salaried working relationships and conditions. Employment in the formal sector means inclusion in tax collection systems, social security systems (if they exist), coverage by protection standards relating to working conditions, access to health care, and access to schemes of income replacement in case of incapacity to work. The typical formal-sector worker works in an enterprise or institution with which he or she has a formal contract, subject to certain standards and including certain rights and obligations.

The formal sector also includes self-employed workers as far as they are included in a system of obligations, rights and standards like the tax system, protection mechanisms in case of sickness, accident, old age and so on. Importantly for health insurance, it is known who the formal-sector employees are, how many there are and what they earn. For the informal sector, this information is often missing or incomplete. In most developing countries, the majority of the working population is in the informal sector.

Why is this distinction so important in this context? First, most people in the informal sector face large financial risks if they have no affordable access to health care. Those in the formal sector in most countries are to some extend covered by work-related protection mechanisms, they have an employer who is to some extent interested in their well-being (if only to keep them productive), and they can at least rely on a regular salary. Second, precisely because of this absence of formalized working relationships and environments, it is administratively very difficult to include informal sector workers in an SHI system. Possibilities for covering informal-sector workers in SHI include:

- compulsory membership (which is preferable and possible if there is a link to cooperatives or other communities but which is administratively not easy; voluntary membership, combined with awareness campaigns, is easier but less effective);
- flat rate contributions and free membership for those who are not able to pay (if there are state or other subsidies, and combined with a means test);
- offering a basic benefit package;

- cooperation with communities and community-based organizations in registration and contribution collection (communities have good access to informal-sector workers);
- bundling SHI with other products such as membership in organizations or micro finance;
- increasing audit and control of small and medium enterprises in order to improve the possibility of achieving compulsory membership and to improve information about target groups;
- information-sharing across government agencies in order to improve information about identity and situation of possible target groups. (check PhilHealth et al., 2007)

There are synergy effects between formal-sector and informal-sector insurance in terms of administration and purchasing of services.

11.9. Questions raised

- What are the target groups of SHI? The different population groups should be identified, showing who (and how many) should be covered by SHI and whether some groups need a different health financing system to achieve universal coverage.
- Will there be problems with including all of the identified groups in the health insurance system? The feasibility of registering and collecting contributions from each group should be checked.
- What are the risk patterns of each of the groups to be covered by the health insurance system and how able are they to pay? This is a crucial question for the financing of the system. There may be a need to adjust either the target groups, or the benefits, or the contributions.
- Which are the first groups to be included? Will partial coverage exacerbate inequity and can this be mitigated? A phased plan for extending coverage to other target groups should be drawn up.
- What are the specific challenges of covering the informal sector, which represents the majority of the workers in most developing countries, and what are the possibilities for covering these workers?

CHAPTER 12.
Benefit packages

12.1. Introduction

The benefit package specifies the entitlements of insured persons and determines the costs of a health insurance scheme. Its two objectives are to give access to necessary services of adequate quality while covering financial risks, and to contain costs.

The definition of a benefit package is an important task. It is important for the members since it describes their entitlements, and it is important for the insurance organization as it determines its risk. Thus, a benefit package has to be precisely defined in order to create appropriate entitlements and to limit risks. This chapter deals with issues that must be taken into account when defining benefit packages. It also gives criteria for cost-effective benefit packages.

In a world with unlimited resources and excellent health services, the health benefit package should include the full range of services determined by current medical knowledge and patient needs (comprehensive benefit package, or CBP). In the industrialized world, considerations of cost-efficiencies entered the scientific and public debate in the 1970s when the gap widened between what was technically feasible and what could be financed.

In tax-financed systems, the overall benefit package is primarily determined by the health budget. In systems based on contributions to SHI schemes, limitations to the benefit package are determined by the contributions of members and the level of subsidies from taxes.

Financial limitations lead to implicit or explicit exclusion or rationing of services through user charges, co-payments, waiting lists, explicit policies not to provide specific services or, particularly in resource poor countries, the lack of services, and geographical and financial obstacles to access.

A benefit package should deliver the kind and level of health care services that people are accustomed to, but considerations of cost-effectiveness in the delivery of health care services, as well as the financial risk for the individual, must be part of the planning process. A major guiding principle should be that health services should not contribute to increased poverty.

The range of benefits or specific health care services that can be covered under an insurance scheme or a tax-financed health system varies between countries and even between different population groups within the same country. In poor countries, planning for the most suitable and cost-efficient services to be provided has a long tradition, but in rich, industrialized countries such processes are more recent [5].

The benefit package of a specific country or region will depend on several considerations and will differ between countries with differing health financing schemes. Entitlements must be planned carefully in the context of the socioeconomic and demographic circumstances of the insured population. Some considerations relevant to planning of entitlements and benefit packages are discussed in more detail in the following paragraphs.

While this chapter concentrates on the definition of benefit packages in developing countries, examples and experiences from industrialized countries are highlighted. The fundamental issues of priority-setting are in principle the same – i.e. to reach societal consensus on limiting the tension between the technically feasible and desired and the financial resources available. Even the problem of ageing populations is increasingly becoming an issue in developing countries.

Defining a benefit package is never a one-off process. It needs continuous commitment to review priorities at various levels. Rational treatment guidelines can help to limit expenditures and to free funds for essential services, thus reducing the pressure to exclude elements from an essential package. These difficult decisions have to be made within a consistent ethical framework. Several criteria should be considered in the decision processes. Some of the most important issues are discussed below.

12.2. Issues to be considered in planning benefit packages

12.2.1. The epidemiological perspective

Epidemiological analysis helps to identify the most common illnesses and causes of death. For developing countries these are shown in Table 8.

[5] One of the best known examples being the Oregon Health Priorities for the 1990s in which public participation was sought to determine priorities in the MEDICAID programme. Other countries have undergone similar exercises.

Table 8: **Priority diseases in low-income countries**

Low-income countries	Deaths in millions	% of deaths
Coronary heart disease	3.10	10.8
Lower respiratory infections	2.86	10.0
HIV/AIDS	2.14	7.5
Perinatal conditions	1.83	6.4
Stroke and other cerebrovascular diseases	1.72	6.0
Diarrhoeal diseases	1.54	5.4
Malaria	1.24	4.4
Tuberculosis	1.10	3.8
Chronic obstructive pulmonary disease	0.88	3.1
Road traffic accidents	0.53	1.9

Source: WHO data

This list may serve as a template for priority-setting but does not address debilitating diseases and common illnesses that rarely lead to death. Similarly, a ranking of disease burden by DALYs[6] identifies the most serious health problems. This approach, however, neglects many chronic, disabling diseases or rare conditions that may lead to major expenditure. On the other hand, it includes expensive interventions as a consequence of vascular and pulmonary diseases as well as the costly sequelae of severe road traffic accidents. The disease priorities implicitly set within the MDGs should be considered in the design of an essential benefit package based on epidemiological considerations. Nevertheless, such a list will not meet the expectations and needs of the population.

12.2.2. The cost-effectiveness perspective

With the publication of the *World Development Report 1993, Investing in Health* (World Bank, 1993), the concept of an essential public health package was developed. A minimum package of public health and clinical interventions, which are highly cost-effective and deal with major sources of disease burden, could be provided in low-income countries for about US$ 12 per person per year, and in middle-income countries for about US$ 22. Properly delivered, this package could eliminate 21–38% of the burden of premature mortality and disability in children under 15 years and 10–18% of the burden in adults. Just 10 disease conditions cause 71% of the loss of DALYs. Except for congenital malformations, all these causes correspond to very cost-effective interventions, at less than US $100 per DALY.

Such programmes would include immunizations and micronutrient supplementation, school health programmes to treat worm infections, and health education. AIDS prevention, alcohol consumption and tobacco control would also be elements of this approach. The clinical package would comprise short-course chemotherapy for tuberculosis, the integrated management of childhood illnesses, prenatal and delivery care, family planning, treatment of sexually transmitted diseases, and other limited care interventions costing a total of US$ 350. In 1993, AIDS treatment was not available at reasonable cost. More recently the Commission on Macroeconomics and Health presented estimates of approximately US$ 40 for the provision of minimal services (WHO, 2001). This reasonable estimate is, however, far above the amount currently available in many poor countries.

Given a fixed budget, a package of services comprising only the most cost-effective interventions would ensure the maximum possible health benefit for the population concerned.

Such cost-effectiveness analyses are also increasingly used in industrialized countries to make decisions on inclusion in or exclusion from benefit (e.g. the British NICE and the German Institute for Quality and Efficiency in Health Care).

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[6] Disability-adjusted life years. DALYs for a disease are the sum of the years of life lost due to premature mortality in the population and the years lost due to disability for incident cases of the health condition. The DALY includes equivalent years of healthy life lost in states of less than full health, broadly termed disability. One DALY represents the loss of one year of equivalent full health (WHO, XXX).

It is obvious that this list of benefits excludes many effective interventions, yet it can serve as a basis for specifying the benefit package. Since estimates of cost-effectiveness are not precise, it is common to categorize cost-effectiveness of interventions into, for example, low, medium and high. Other factors such as external impacts (spillovers such as the benefit of TB or AIDS treatment to the larger community beyond the benefit to the individual) of a disease and nonhealth outcomes may also affect decisions.

12.2.3. The equity perspective

Again, in a well developed health system, equal treatment should be available for equal needs (horizontal equity). In practical terms, however, this is a challenge as geographic access to health services in rural areas may be difficult (e.g. travel to treatment centres for AIDS or simply institutional professional care for childbirth that can also offer caesarean sections). Urban populations generally have better geographic access.

Even if only moderate co-payments are charged, these may be too high for the poorest and thus may impede access to services. In fact, there is often a real need for travel and fee subsidies, which are difficult to administer.

The health-care strategy should aim to reduce inequity in the longer run. The ultimate aim should be to reduce inequalities in health status between individuals by favouring the disadvantaged. This requires a societal consensus. Benefit packages should also be acceptable to the better-off section of the population in order to encourage participation in a solidarity-based financing system.

It is plausible that priority should be given to providing rescue for acute, life-threatening conditions (usually referred to as the rule of rescue). However, provision of such services may be expensive and should not lead to the exclusion of services that are much more cost-effective in reducing mortality and improving health. Similarly important are considerations of inclusion of services for severe and chronic health conditions and illnesses that contribute to poverty (vertical equity). Furthermore, some services, such as heart surgery and dialysis, are demonstratively useful to the individuals who receive them, but they do not normally represent good value for money in low-income settings. As resources become more available, such services may be cost-effective for at least some groups of patients.

In a well functioning tax-financed or SHI system, the rich subsidize the poor. Usually, however, these cross-subsidies do not reach the poor effectively, so health service providers may consider a specially designed package of services for the poor (e.g. deliveries, or care of the under-fives).

More difficult to address is the provision of long-term, life-prolonging treatment for chronic conditions (e.g. diabetes, asthma, hypertension). Yet, if people have to pay out-of-pocket for these, it may also lead to catastrophic health expenditures and ultimately to impoverishment of individuals and families, as explained in section 10.2.

It is important to consider inclusion of such conditions to prevent individuals and families from being driven into poverty. Careful estimation of cost is needed to avoid political commitments that are financially untenable and may in fact lead to depriving the poorest people of essential services.

12.2.4. Benefit package and providers

When designing the benefit package, the relationship between patient, health insurance and provider plays a crucial role. Basically there are three possibilities:

- Health insurance defines broad categories of costs that are reimbursed. The provider defines what is necessary and the health insurance pays the bill (this gives significant freedom to providers and patients but is the most expensive solution).
- Health insurance establishes a detailed positive list of which goods and services are covered (this gives better opportunities for cost-containment).

- Health insurance establishes a negative list of what is not paid.

Combinations of these are possible. The most common approach is for health insurance to establish a positive list of goods and services that are covered and at the same time to exclude certain items. It is possible to put in place mechanisms to contain costs in such circumstances, but it may be difficult to do so.

If SHI establishes a list of what is covered, there are various ways to arrange payment:

- The SHI fund pays the provider directly on the basis of agreed fee levels for all services within the benefit package. This allows patients a choice of provider, it offers the best control of costs, and the SHI can monitor directly the cost and quality of care. It also allows the SHI to use different payment mechanisms. It is sometimes argued that this has a disadvantage in that patients are not aware of the costs of the care they receive.
- Patients pay for services at rates agreed between the providers and the SHI, and then reclaim the costs (less any deductible amounts or co-payment) from the SHI. This has the advantage that patients are aware of costs, but it may be more expensive to administer and it may exclude patients who cannot find the funds to pay the bills.
- Patients pay for services at rates determined by providers, and reclaim from the SHI at rates determined by the SHI. This effectively leaves risk and responsibility for bargaining to the patient and can allow costs to increase significantly. This method is used in schemes where it is difficult to establish contracts with providers.

These options can be combined with insurance benefit payments according to diagnosis, type of service or category of provider. Table 9 shows the options. See also chapter 14 on provider payment.

Table 9: **Alternative methods for determining benefit packages**

	According to type of diagnosis	**Based on type of services**	**Based on category of providers**
Direct payment of provider (see also chapter on provider payment)	DRG payment systems based on a list of diagnoses	Fee for service Essential drug list	Capitation fee Budget Salary
Payment of maximum amount to patient	$100 for malaria $150 for delivery	List of drugs with maximum prices List of surgical interventions with maximum prices	Inpatient Outpatient
Reimbursement of cost to patient	Fees for malaria treatment Fees for complicated delivery	Surgery per item based on bill Drugs per item based on bill	Inpatient Outpatient

12.2.5. The concept of support value

Support value is the value of the benefit package in relation to the total burden of unavoidable costs individuals are confronted with. It is a concept that is applicable if the benefits paid by SHI leave a share of the costs to the patient. It is especially relevant for developing countries, in contexts where there is no elaborate system of provider payment and contracts. The support value of a health insurance can be determined as a percentage of the total cost burden, where the support value ideally should increase according to the degree to which an event is catastrophic. It should be an objective of health insurance to maximize the support value without forgetting that people have a certain responsibility to bear costs they can afford. All the costs people have to bear outside the support value constitute a risk and are a form of co-payment if these are essential services.

The support value SHI gives to people can have various forms:

- SHI can pay a maximum amount based on a list of essential services to the patient. This is an approach which, for example, the Philippine Health Insurance has chosen. This means that, if a patient does not find a provider who offers the services for this price, the patient must bear the additional cost. The support value is determined by the level of payment and its relation to the prices of available services. It is a method of limiting the risk for the insurance.
- SHI can pay a percentage of the total costs and/or defined services, leaving a part to the patient (possibly scaled according to the severity of the condition). This requires an out-of-pocket payment by the insured. The support value is determined by the relationship between payment of the insurance to the insured and the total costs.
- SHI can pay the providers based on a contract and fees agreed. The support value will be higher if the SHI achieves more cost-effective purchasing. Cost-effective contracting is a way of maximizing the support value.

Combinations of these methods are possible, especially in transitional arrangements. For example, Table 10 shows the benefit package of the Philippine Health Insurance. It can be seen that the support consists of maximum amounts paid according to severity of cases and level of care. The support increases with the severity of cases. Studies show that the support value in this system is about 60%.

Table 10: **Benefit package of the Philippine Health Insurance (PHILHEALTH)**

Level 1 Hospitals (Primary)			Level 2 Hospitals (secondary)			Level 3 and 4 Hospitals (Tertiary)			
Benefit Item	**Case Type**		**Case Type**			**Case Type**			
	A	**B**	**A**	**B**	**C**	**A**	**B**	**C**	**D**
Room and Board (max 45 days a year)	P300/Day	P300/Day	P400/Day	P400/Day	P600/Day	P500/Day	P500/Day	P800/Day	P1.100/Day
Drugs and Medicine (per single period of confinement)	P2.700	P9.000	P3.360	P11.200	P22.400	P4.200	P14.000	P28.000	P40.000
X-Ray, Laboratory and Others (per single period if confinement)	P1.600	P5.000	P2.240	P7.350	P14.700	P3.200	P10.500	P21.000	P30.000
Operating Room	P500		For Procedures with RVU 30 and below=P750			For Procedures with RVU 30 and below=P1.200			
			For Procedures with RVU 31 to 80=P1.200			For Procedures with RVU 31 and below=P1.500			
			For Procedures with RVU 81 to 600: RVUxPCF 15 (Min P2.200 and Max 7.500)			For Procedures with RVU 81 to 600: RVUxPCF 20 (Min P3.500)			
Professional Fees									
a.	*Daily visits*								
	General Practitioner (Groups 1,5 and 6)								
	Per Day	P300	P400	P300	P400	P500	P300	P400	P500	P600
	Max per confinement	P1.200	P2.400	P1.200	P2.400	P4.000	P1.200	P2.400	P4.000	P6.000
	Specialist (Groups 2,3 and 4)									
	Per Day	P500	P600	P500	P600	P700	P500	P600	P700	P800
	Max per confinement	P2.000	P3.600	P2.000	P3.600	P5.600	P2.000	P3.600	P5.600	P8.000
b.	*Surgery (for Case Types A and B)*	Surgeon	Anaesthesiologist	Surgeon	Anaesthesiologist		For RVU 500 and Below		For RVU 501 and Above	
							Surgeon	Anaesthesiologist	Surgeon	Anaesthesiologist
	General Practitioner 1st Tier (Group 1)	RVUxPCF 40=PF1	40% of surgeon's fee	RVUxPCF 40=PF1 Max of P3.200	40% of surgeon's fee (PF1) Max P1.280		RVUxPCF 40=PF1 Max of P3.200	40% of surgeon's fee (PF1) Max P1.280	RVUxPCF 40=PF1 Max of P3.200	40% of surgeon's fee (PF1) Max P1.280
	With Training 2nd Tier	RVUxPCF 48=PF2	48% of surgeon's fee	RVUxPCF 48=PF2	48% of surgeon's fee		RVUxPCF 48=PF12	48% of surgeon's fee	RVUxPCF 48=PF12	48% of surgeon's fee
	Diplomate/Fellow 3rd Tier	RVUxPCF 56=PF3	56% of surgeon's fee	RVUxPCF 56=PF3	56% of surgeon's fee		RVUxPCF 48=PF12	56% of surgeon's fee	RVUxPCF 48=PF12	56% of surgeon's fee
		Max 2.000 per confinement	Max Fee Computed as % of P2.000							

RVU is the Relative Value Unit and it is the measure of the relative complexity of a case, the higher the value of the RVU, the more complex is the procedure and hence, the higher pay. The RVU is multiplied with a factor known as the PCF of the Peso Conversion Factor. The PCF is a constant multiplier and is in peso terms. The PCF multiplied by the RVU gives us the amount to be paid to the provider. Am not sure if the PF refers to the primary physician and support doctors.

RVU is the relative value unit.

12.3. Designing the benefit package

12.3.1. Assessing the status quo

Taking into account the issues mentioned above, the design of a benefit package should follow a certain method. First, the current service provision and the capabilities of the existing health-care infrastructure should be assessed. One possible classification of health-care benefits may be the following:

- primary care services in the community;
- physician services in individual practices, polyclinics or outpatient departments, hospital inpatient care;
- provision of drugs;
- diagnostic services;
- ancillary services (e.g. x-rays, computerized tomography, laboratory tests), sight tests;
- basic dental maintenance;
- restorative dentistry and dental prostheses;
- prostheses and appliances;
- services related to HIV/AIDS;
- transport to and from hospital;
- services offered by other authorities, such as public health administrations or other insurance branches (e.g. immunization, birth control and abortion, long-term care;
- inpatient and outpatient treatment of mental illness;
- rehabilitation, vocational rehabilitation.

The assessment should start with the services that are most relevant from a public health point of view, but may also review the established practice of expensive and less cost-effective procedures. These existing services should be costed – including the assessment of unit costs. This analysis should also include a cost-effectiveness assessment. This may serve as a basis for ranking services by priority.

12.3.2. Assessing the utilization of services

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

Data on the utilization of health services may be obtained from existing schemes covering specific groups, from other countries with similar social and economic patterns, from a pilot project covering a specific area or population group, or from survey data.

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

The utilization rates of health services are influenced significantly by morbidity patterns, clinical practice, the existing infrastructure, current financing mechanisms, co-payments, cultural influences and the habits of patients.

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

12.3.3. Setting strategic objectives and priorities

As it is unrealistic to address all health services simultaneously, priorities will have to be politically determined. Ideally, this should be done through a guided consensus-building process with many stakeholders – including private health care providers, patients, and potential customers for the insurance. Studies have shown that poor and illiterate people make rational choices once they are asked for their preferences (Dror et al., 2006). The most common and catastrophic conditions for which cost-effective interventions or preventive services are available should rank high on the list. A limited number of high-priority interventions and services may be selected from this list to serve as a nucleus – a "starter pack" around which the basis package can be built. This incremental approach avoids the difficult issue of exclusion from an essential package. Current services will continue, while some priority elements are selected for inclusion in an improved package. The decision-making process should be guided by ethical principles and should aim to provide a package that is also attractive to better-off people. This may ultimately increase the willingness of the rich to provide cross-subsidies to the poor.

12.3.4. Health promotion and health education

Health insurance schemes are primarily designed to cover unpredictable events. Thus, predictable events such as uncomplicated pregnancy, presbyopia or disease prevention might be excluded if one follows the logic of insurance. In tax-financed systems this should not be an issue since, for example, vaccination may be in the public interest. Some preventive and promotive services should be available free of charge to the population because of the proven public health and economic benefits. Such interventions may be cost-effective, but should not necessarily be included in insurance benefit packages.

Nevertheless, SHI can support activities and tasks of public health authorities as well as arrangements in the field of health education and promotion. This can happen through various tools: SHI can pay providers for fulfilling these tasks. On the other hand, SHI can link co-payments and reimbursements to certain risky behaviours like smoking, hazardous sports, or drug and alcohol abuse. SHI can charge extra premiums to employers with hazardous and unhealthy workplaces and working conditions.

There are many good reasons to provide services for particularly vulnerable groups – such as antenatal care and safe delivery at no cost to the user. This will lead to higher utilization of services and thus reduce maternal and newborn deaths, particularly among the poor. It will benefit groups with a high risk of morbidity and mortality among the poor. It may also offer an opportunity to provide preventive and promotive health services and is likely to contribute directly to attaining the MDGs. It has, however, been debated whether these services should be provided from insurance funds or from public funds.

12.3.5. Standards for diagnosis and treatment

When basic packages of care are defined, standard diagnostic and treatment guidelines and the appropriate drugs must be in place, as must quality assurance mechanisms. An essential generic drug list should be a standard element in any benefit package. Diagnostic services are often absent or lack quality control. Presumptive treatment may at first sight appear cost-effective, but it often involves unnecessary prescriptions or interventions that are burdensome and detrimental to the patient and costly for the health care provider. Referral rules (gatekeeper function) and acceptable waiting or qualifying periods may also be standardized.

12.3.6. Choice of providers

International experience shows that people want to have a free choice of health care provider but that this may not be cost-effective. Models around the world show that limiting the choice to providers that have contracts with the SHI controls costs and ensures quality, especially if the country has no general quality standards or fee schedules. Methods of contracting are discussed in chapter 13.

12.3.7. The basic package

Taking all elements into account, a basic package should fulfil the following criteria:

- The package should not contain too many cheap services that can be paid out-of-pocket. However, a health-financing strategy should ensure that certain services are provided free of charge but not necessarily by the SHI.
- The package should help people to cope with catastrophic cases such as complicated deliveries, accidents and serious conditions, and it should provide a certain support value which can be determined according to the financial capabilities of the scheme.
- The support value can be determined through maximum amounts paid per condition, contributions to actual costs, or benefits contracted with certain providers. Combinations are possible. In countries where there is resistance from providers to enter into contracts and cost-containment arrangements, maximum values are a transitional solution (see also chapter 14).

The basic package can be expanded as the capacity to pay contributions rises and new mechanisms are put in place. It is important to balance the essential benefit package with the possibility of contracting and monitoring providers. The greater the possibility of contracting and monitoring, the broader the possible basic benefit package. An important step towards the basic package is to make an assessment of the services and their costs and to compare this with available financial resources. Only then, it will be possible to design an affordable package.

Co-payments should be defined as part of the package (see chapter 9). Co-payments can be designed to influence behaviour patterns among patients and providers. More specifically, co-payments can be set at levels that encourage or discourage the consumption of particular health care services. For example, if the aim is to discourage excessive prescription and consumption of drugs, patients can be charged relatively high co-payments for drugs that are covered in the benefit package, or drugs and services can even be excluded from the benefit package.

In many developing countries, experience has shown that the level of co-payment may constitute a factor in people's decision whether to join insurance (if there is voluntary membership). People have to learn the concept of insurance and that health insurance primarily exists to protect them against the risks of high-cost treatments. However, people often measure the usefulness of a health insurance system by the fact that, for example, it pays for their paracetamol and they do not see the long-term benefit of high-cost coverage in the (unlikely) event of a near severe accident or illness.

Sometimes people want immediate benefits for their contributions and do not believe in long-term and high-risk benefits. It may take time for people's priorities to change. SHI organizations often find it hard to persuade members to agree to cuts in short-term benefits for the sake of guarantees against high costs in the future.

12.3.8. Assuring the quality of package elements

Once a benefit package has been identified, a quality check on current practice should be performed against national or international guidelines. This refers to quality control of the design of the benefit package as well as quality control of the delivery of the benefit package through providers. If guidelines are not available, they should be developed and should become an essential element of the basic package definition and of the contracts with providers. Quality control and corresponding measures to enforce quality are essential services of health insurance and can be performed effectively only if there are contractual arrangements between health insurance and the provider.

12.3.9. Scaling up

Developing a benefit package is a dynamic process of trial and error. The basic package should be scaled up gradually on the basis of experience and with a prioritized list as a guide. The control of

overuse and cost is a challenge. However, this issue must be considered and regularly adjusted to uphold the principles of cost-effectiveness, public health relevance and equity.

Each step in scaling up needs to be supported by careful cost projections and control. Again, these steps need to be accompanied by a public debate among consumers and service providers to reach at least partial consensus.

12.4. Questions raised

- What is the concept of risk protection and how can SHI help to protect people against risks?
- Which considerations determine the priorities of health services on one side and health insurance benefits on the other?
- With which kind of benefits should a scheme start?
- What are the basic methods for determining an effective benefit package?

Chapter13.
Purchasing health services

13.1. Introduction

The benefits of SHI depend on products and services that are purchased or reimbursed. The successful development of SHI depends on the availability of cost-effective health services for the insured population. If such services are not available, a strategy for developing them must be implemented. This chapter considers ways of ensuring that health services are available for SHI members, and suggests some issues that need to be addressed when developing such services.

The provision of health care services in a country is often a mixture of private, charitable, faith-based and government-provided services. In many developing countries, due to insufficient funding in the tax-financed government sector and poor service provision, there is an uncoordinated growth of other types of service providers aiming at different strata of the population. Unfortunately, the typical result of these developments is a system of health care with marked disparities between urban and rural services, and with geographic and financial obstacles to access. Severe deficiencies in quality and a growing disparity between public, private and faith-based institutions emerge.

The instrument that SHI uses to influence the development of health services is purchasing through contracts. Most important is the change from a supply-driven service to a demand-driven system. Insurance organizations can contract selected service providers and ensure that their members have a choice of accredited and monitored providers. The members are entitled to services and may actually make choices between different service providers.

13.2. Separating purchaser and provider

There are two basic forms of health-care provision under social insurance – the direct method and the indirect method. In the first case, the SHI fund owns/operates health care providers, and in the second the fund enters into contracts with them.

Although it is possible to allow SHI organizations to be responsible for the provision of health care, there are good reasons for discouraging this. The most important reason is that the combined responsibility for financing (purchasing) and service provision may lead to conflicts of interest.

When purchasing and service provision are separated, the purchaser has an incentive to buy the best services for its members' contributions, and can focus on the volume, quality and cost of services. If both functions are within one organization, the members have less choice of provider and the SHI is more likely to be influenced by the interests of its own providers.

It is likely that the introduction of SHI will lead to greater diversity in the provision of health services. Health funds can usually choose to contract with government, private non-profit or commercial providers. The growth of choice and diversity in the provision of health services can lead to more efficient provision of health care and improved quality of care.

Experience around the world shows that the direct method normally leads to quality problems and the indirect method leads to problems of cost control. The indirect method has generated a great deal of interest, particularly since the development of sophisticated cost-control strategies (see chapter 15).

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

13.3. Accrediting and contracting providers

Where purchasing and service provision are organizationally separate, the SHI has the option either to reimburse invoices or to contract with providers directly.

In both cases there may be a precondition that providers are accredited with SHI. This means that after a quality check the insurance organization includes them into a pool of providers. Only accredited providers may issue invoices that are paid by SHI. If there is no undersupply of providers, this accreditation creates a first level of competition which leads to improved quality and competitive prices.

There is a tendency for the professional or economic interests of institutions and providers to prevail over the interests of patients. Access to appropriate care can be partly dependent on factors such as the interest of providers to give certain kinds of treatment, rather than on the identified health needs of the patient. There are two measures that can be taken to avoid this problem.

First, providers may be allowed only a limited role in setting priorities for treatment patterns. The process of identifying priorities, treatment protocols and the need for services should be based on the best available evidence concerning patterns of disease and the cost-effectiveness of services to meet those needs. Specialists and providers' representatives may help to gather information to determine priorities, but responsibility for this should lie with SHI, government or, for example, a committee of disinterested experts.

Second, the best form of agreement between SHI and the providers is a legally binding contract. This has the advantage that the monitoring of quality of care, volume of services and access to services can be enforced (although this is not normally necessary, it is a useful fallback position). Contracts can provide a clear statement of the expectations of all parties and a mechanism for establishing rules for the care management and treatment of patients.

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

Experience shows that solely reimbursing bills is a support to patients but is highly ineffective. Providers are not subject to explicit price and quality controls and they have the incentive to increase prices if they are reimbursed for whatever they ask.

For this reason it is advisable for SHI to exercise price and quality control over health care providers. In some countries this has been faced with resistance from providers, but it is the better choice for reasons of cost-effectiveness.

Contracts with providers may have a number of options, such as:

- contracts with individual providers, or contracts with provider organizations;
- contracts with all providers that are willing to provide services, or contracts with selected providers only;
- contracts for a certain period, or unlimited contracts with regular adjustments, and with or without the possibility to cancel or to exercise sanctions;
- contracts regulating payment, quality of service and service provision details, or contracts that regulate payments only;
- contracts regulated by law, or contracts based on individual agreement;
- contracts with institutions like clinics or hospitals, and/or contracts with individuals.

The type of contract that is applicable depends on the legal framework and regulations. It is important to develop a set of rules and framework legislation that describe procedures and the roles of partners.

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

Once SHI is well established, it will not be necessary for the government to be involved in the ownership of health-care facilities and equipment. However, in the development of services in preparation for SHI, there may be a problem of timing. Individual service providers will be uncertain about obtaining contracts, and will therefore be unwilling to risk investing in facilities. The option of granting contracts in advance has its own risks. One possible solution is for government to undertake some preparatory investment, which can be followed by privatization or franchising of the facilities. It may also be necessary to allow appropriate transition periods to move from grant-financing of service providers to performance-based reimbursement. The most demanding element of change is the autonomy of service providers in recruiting, discharging and remunerating personnel.

13.4. Quality assurance

Quality assurance is essential for any health service provider. In SHI arrangements, quality considerations must be an important element of contracts. Given that the number of contractual partners may be large, it may be advisable to use accreditation of service providers to ensure that they can demonstrate their participation in recognized quality assurance mechanisms, including quality certification schemes.

Quality assurance implies:

- a system of quality standards and indicators;
- a functioning information system;
- monitoring and evaluation of provider services on the basis of indicators using the information system;

- effective accreditation and possible sanctions for accredited providers that do not meet quality standards.

As mentioned above, the two methods of reimbursing providers are the direct method (where providers are contracted and paid by SHI) or the indirect method (where patients pay providers and are then reimbursed by SHI).

The advantage of the direct method is that SHI has better possibilities for quality assurance. SHI pays the provider and is able to negotiate and control fee schedules and quality standards. With this system, health insurance is not only a scheme for covering expenses but also provides consumer protection. The disadvantage of direct payment of providers by the health fund is that patients may get the impression that health-care entitlement is unlimited and they do not realize the costs involved.

If the patient pays for care and claims a reimbursement from the health insurance fund, it is more difficult for the fund to monitor providers. It is the patient, rather than the health insurance fund, which enters into a business contract with the provider. There is not necessarily a direct contact between the provider and the insurance fund. There may be fee schedules, but they will not have the same effect as in the direct system. There is a risk of "erosion" of health insurance benefits if providers do not keep to a fee schedule. The advantage of the patient paying the bill is that he/she sees how expensive health care is. However, this can cause serious problems for patients if providers request immediate payment, or even advance payment. Patients who are not able to advance the money may run into liquidity problems or may be denied the treatment they need.

The indirect method is also administratively more cumbersome: the physician sends a bill to the patient, the patient pays it and then submits a claim to the health insurance fund. The fund then checks the bill and sends a reimbursement to the patient. With direct reimbursement of providers, the physician sends the bill directly to the health fund, which then checks the bill, upon which providers are remunerated. A system with employed providers is cheaper still.

Finally, the indirect method has a certain risk of fraud through manipulations of the bill.

SHI providers may find it easier to contract and monitor inpatient services with hospitals as they usually have at least basic administrative capabilities. Hospital records allow for a check on services actually provided. Contracting and monitoring ambulatory, primary health services is more demanding. The large number of service providers makes quality assurance more challenging. Clients have to be made aware of their entitlements regarding prevention, diagnosis and treatment. Standard treatment guidelines are essential and should be part of the contractual arrangements. The provision of drugs needs to be carefully monitored. The assurance of quality and the prevention of fraud are important. Similarly, rules against overuse of services are essential. Co-payments may be considered, but may deprive poor populations of access to services. Other methods to limit utilization may be the rationing of services. As utilization patterns are not totally predictable, regular adjustments to purchasing arrangements and entitlements may be necessary.

13.5. Balancing care

In preparing the health services for SHI, there is a need to start with a reasonable balance between different levels of care, and between services in different areas. Contracting policies may enable SHI to prevent services from growing further in areas which already have above-average provision, but it is not always possible to ensure that nongovernment providers will set up business where needs are greatest. Government may need to invest directly in new facilities and staff training, or provide guarantees and incentives to encourage nongovernmental providers to establish the services needed. Private investors may need financial guarantees, contracts for the initial period after the services become available, or assurances that competitors will not be allowed to enter the market in the early stages. It is therefore

likely that the government will at least need to be involved in coordinating the establishment of the desired pattern of services.

A major criticism of SHI is that it does not adequately encourage health promotion and disease prevention. Nevertheless, an appropriate balance can be found if such services are contracted together with curative services. In addition, incentives may be offered to clients who use preventive services (e.g. exemption from co-payments).

A critical issue is the commonly practiced self-referral of patients to the highest possible level of care. This may dramatically increase costs. The introduction of a gatekeeper function at the primary-care level is a possible approach, but at times it is more difficult to enforce. In small towns, the hospital is often the major service provider and it would be perceived as unreasonable to force patients to first consult peripheral rural services before being referred to secondary-level care institutions. On the other hand, urban populations with easier access to services are already advantaged over rural populations. This may require the establishment of primary-care providers around a hospital and the limitation of primary-care provision at hospitals. It may, however, be difficult to mobilize political support for such rules. Higher co-payments for self-referrals may be considered in this case.

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

13.6. Questions raised

- Which system will be used to purchase services and goods under the health insurance scheme?
- What is the most cost-effective method of influencing prices and quality of care?
- What should be the framework and content of accreditation of providers and contracts between health insurance and providers?
- What might be the role of competition among providers?

CHAPTER 14.
Provider payment mechanisms

14.1. Introduction

There are many different methods for paying health care providers. Each method has different effects on the quality of health care services, on efficiency and on the costs of services and administration. SHI schemes consist of an insurance body (the health fund) on the one hand and the insured persons on the other. If any insured person needs a service that is included in the entitlements, he or she must consult a provider. Without providers – such as hospitals, physicians, nurses, producers of aids and supplies and the pharmacy – there can be no health care. Providers represent the “cost side” of SHI.

There are two basic methods for providing, and receiving payment for, health care services. The first is when the patient has access to services without paying the provider (although there may be a co-payment), and the second is when the patient pays for the service and receives a refund from the insurance fund, which may cover all or part of the cost.

Both methods may be used with contracted providers or insurance-owned providers. This means that either the health fund contracts with providers (e.g. hospitals or physicians) in order to guarantee services for its members, or the fund runs its own hospitals and employs its own physicians.

Further discussion of these options can be found in previous chapters. In all methods described above, the issue of payment of the provider may arise.

Simply stated, expenditure on health care is determined by the quantity of services and products that are prescribed or consumed, and the prices of these services and products. Both these factors are influenced by the provider payment system. To a certain extent the providers, especially physicians and hospitals, can determine the demand for their own services and products once the patient has taken the first step of contacting them. It is the physician, not the patient, who specifies the kind and quantity of treatment and medication required.

Although motivation of health care providers can be very complex, like other people and organizations they are interested in income. Depending on the payment system, the providers can influence this by:

- providing more treatments than necessary;
- attracting as many patients as possible (e.g. by prescribing drugs, even placebos, since this often reassures patients that they are receiving proper treatment);
- sending patients with financially unattractive or hazardous conditions to other providers, such as hospitals;
- asking patients to come back several times even when it is not necessary;
- unnecessarily using expensive equipment that they have purchased (e.g. x-ray equipment) in order to amortize its cost.

The payment system must allow the providers to achieve a reasonable income. This motivates them to produce services of good quality and (an aspect which is especially important in developing countries) dissuades them from moving to better-paid jobs in other sectors or other countries. In addition, the potential to earn an attractive income can help to ensure a steady supply of qualified staff to provide services for members of the health fund.

A well-designed provider payment system should ideally also prevent waste and unnecessary service provision. Devising the provider payment system is therefore very important. These systems are major instruments of cost containment. There are many different provider payment systems, and various combinations of different mechanisms are possible. The following subsections describe the core types of payment mechanisms and their impacts on quality, cost containment and administration.

14.2. Salary

14.2.1. Description

A salary system is normally based on an employment contract between the provider (staff) and the health fund. Under this agreement, the health fund pays the staff a monthly salary, plus supplementary benefits such as the employer's contributions to the social security system, as far as applicable. The employee works on a time basis, being paid not for the quantity of services provided but for the agreed amount of time to be worked. The amount paid is the same, regardless of the number of patients treated (Table 11). Equipment, materials and additional staff are paid for by the facility or the SHI.

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

Employment can be applicable to all kinds of individual providers who produce services or products – such as family physicians, nurses, pharmacists, physiotherapists, and manufacturers of prostheses. For obvious reasons, this system is not applicable to provider units such as hospitals, health centres or the pharmaceutical industry.

Salary payment exists in all health systems, at least in the relationship between health facilities and their staff. It is not usual for an SHI to employ staff directly (which is the arrangement we primarily look at here). One system where it is practiced is in health maintenance organizations (HMOs).

An SHI may own hospitals, in which case staff are often employed on a salary basis and the health fund takes care of additional outlay such as materials and capital. It also means that the health fund is responsible for organizing the combination of these factors and for guaranteeing quality. The SHI may also employ individual health-care professionals.

Table 11: **Application of salary payment**

Provider	Basis for payment	Unit of service
Family physicians, dentists	Amount according to labour contract	Per month
Specialists	Amount according to labour contract	Per month
Independent hospitals	Not applicable	
Hospitals owned by SHI	Amount according to labour contract	Per month
Pharmacies	Amount according to labour contract	Per month
Drugs	Not applicable	
Ancillary services	Amount according to labour contract	Per month
Prosthesis	Limited application	

The establishment of a provider payment system based on employment consists of several tasks, namely:

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

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

14.2.2. Impact on cost containment, quality, efficiency and administration

It is not possible to say in general whether it is more efficient and less expensive to provide health care by employing providers as staff or by entering into contracts with independent providers. There is some evidence, however, that the cost of providing services may be lower with employed staff than in a system of independent providers. It may also depend on the kind of services required. Services that are required on a regular basis can be purchased by employing competent staff. Services that are needed occasionally and that require special skills and support may be better outsourced. The question as to whether SHI should operate its own facilities is also a political one because, if SHI covers a large share of the market, existing providers may object.

Employed staff may have fewer incentives to perform well and maintain high standards than independent staff. However, employees' motivation depends to a great extent on the quality of management (the level or amount of salaries, promotion prospects, the organization and responsibilities of individual units, the scope for decision-making, and so on). The danger is that the health fund may grow to resemble other semi-public institutions, tending towards bureaucracy, formalism, inflexibility and lack of motivation. Nevertheless, there are many examples of very successful private companies with highly motivated staff who are employed on salaries, so it is clear that it is not always necessary to use direct financial incentives to achieve appropriate and high-quality care.

In a system with providers managed by the health fund, it is not clear that administration costs are higher than in a system using independent providers. However, all the additional costs that are included in the other payment systems have to be borne by the health fund directly.

In a system based on employed providers, the crucial question is whether the health fund can acquire the provider's labour more cheaply, ensure at least the same performance (quantity and quality of work), and guarantee more cost-effective management and better organization than independent providers.

Another consideration is that of creating a monopoly if there is only one large health insurance fund and no real competition.

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

14.3. Budget

14.3.1. Description

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

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

The budget system is applicable to many kinds of providers, as shown in Table 12. Physicians and hospitals may be allocated budgets. Total costs, or only certain costs such as investment costs or drugs, may be budgeted. Some health services – such as drugs, ancillary services or prostheses – can be financed by an indirect budget. This is appropriate because the demand for these services and products depends on prescriptions by physicians, so they should take responsibility for decisions about the use of the budget. In practice, this means that physicians receive a separate budget for drugs, ancillary services and prostheses.

If a physician is allowed to earn a surplus (or incur a deficit) on an indirect budget, there is an incentive to manage the budget in an efficient way. In this case, the budget must be combined with a quality control system (see also flat rate payments and bonus payments). In theory, it is also possible to finance secondary care (specialists and hospitals) using budgets under the control of primary care physicians, because the latter normally decide whether a patient should have access to secondary care. However, this may be difficult in practice because these budgets would be much larger than the physician's own budget and

would constitute a considerable additional responsibility. The National Health Service in the United Kingdom has experimented with such a model, which is called "fund-holding".

Table 12: **Application of budget payment**

Provider	Basis for payment	Unit of service
Family physicians, dentists	Amount payable in total per year or in instalments; fixed sum for prescription of drugs and ancillary services per year	All services for members of SHI in a defined period; per prescription or prescribed item
Specialists	Amount payable in total per year or in instalments; fixed sum for prescription of drugs and ancillary services per year	All services for members of SHI in a defined period; volume of prescribed items
Hospitals	Amount payable in total per year or in instalments	All services for members of SHI in a defined period
Pharmacies	See above under "Family physicians, dentists"	
Ancillary services	See above under "Family physicians, dentists"	
Prosthesis	Not applicable	

14.3.2. Establishment and calculation

The calculation of a budget should take place under a clearly specified set of budgeting regulations and a system of negotiation. The budget calculation may be input-oriented or output-oriented. An input-oriented budget is based on the cost experience of a provider unit. The cost experience may be described as the actual costs of a particular provider unit, or the average costs of all provider units of the same size (number of beds) and kind (specialty).

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

Calculation and negotiation of budgets is not an easy task; it requires detailed information about service provision, and experience in estimating and adjusting variables.

14.3.3. Impact on cost containment, quality, efficiency and administration

In countries where budget systems have been established, especially in the hospital sector (e.g. Canada, France, Germany), the experience with cost containment has been good. In these countries, the budget system has successful controlled costs or has at least achieved a slower rate of increase than in sectors that were not budgeted.

In a budget system, the provider has an incentive to contain costs. In certain cases, this may lead to attempts to save money by avoiding expensive drugs and operations, even when they are necessary, or by substituting expensive treatments with less expensive ones (which of course may be appropriate or inappropriate). It may lead to waiting lists, or to more explicit forms of rationing and priority-setting. This can improve the cost-effectiveness of the treatments given within any budget, but it will mean that some people with treatable conditions will not receive certain services.

This problem may be solved by having a flexible budget which depends to a certain extent on actual (not estimated) morbidity and quality control measures (and which also can handle special cost-intensive cases separately), and by competition for patients between hospitals and other providers.

Administratively, a budget system is likely to be less expensive than a fee-for-service system.

14.4. Fee-for-service (and price-per-item) payment

14.4.1. Description

Fees for specific services and prices per item for drugs and appliances are the most common basis for payment. This payment system is the one closest to a "market" model. Providers are paid for each treatment act or product they provide. For example, a physician is paid for a consultation or for carrying out an examination, or a surgical procedure, and a pharmacist is paid for a packet of drugs or for a certain quantity of pills, liquids or powders. In another example, a hospital is paid for specific treatment acts provided by its physicians and for inpatient accommodation. These fees or prices may be uncontrolled, which means that each provider can charge as much as the market will bear – or as much as the patients, or whoever pays for their treatment, will pay. This system is difficult to control unless payers negotiate prices. However, the possibilities for negotiation depend on the situation of the patient and of the market.

A more controllable alternative to this market solution is a schedule of fees or prices. A fee schedule may be compulsory, or may represent an upper or a lower limit on the prices that may be charged. It may be imposed by law or may be negotiated between providers and the health insurance. In Germany, for instance, physicians who wish to treat SHI patients must adhere to a schedule; they are not allowed to charge fees higher or lower than the fees on the schedule. In Belgium and France, the fee schedule represents a recommended set of prices so that physicians retain the option to charge fees higher than those listed in the schedule. In some countries, physicians are not allowed to charge more, but may charge less than the schedule fees.

Providers themselves may also introduce fee schedules. There are examples of hospitals and other providers around the world which publish their fee schedules and make this kind of transparency a marketing argument.

In general, a fee schedule has two functions:

- to inform people about the treatment acts and services that may be charged to health insurance (the list must be updated frequently to stay abreast of new methods and techniques in medicine and to react to developments in consumption, prescription and epidemiology);
- to inform people of the price of these acts and services (prices may also be adjusted for inflation or to take account of developments in techniques or treatment).

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

However, even the existence of fee schedules does not guarantee cost control. Providers may charge patients extra fees – officially or unofficially – beyond those that the health insurance pays to them. In the Philippines, for example, the health insurance pays fixed tariffs but providers are officially allowed to charge more than these. This may lead to a situation where the support value of the health insurance cover decreases to perhaps 60% or 50%. This means that the patient has to pay the excess cost.

If providers are not obliged to keep to the fee schedule, patients often have to pay a large part of the charges for treatment. From the point of view of both the health fund and the patients, it is an advantage

to have a compulsory fee schedule for all physicians who treat SHI patients. A compulsory schedule leaves no room for doubt about the charges to be expected.

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

The same arguments apply to hospitals and other providers, including pharmacists. Unfortunately, many countries still do not have price lists for essential drugs. In these countries, the pharmaceutical industry and pharmacists are free to charge whatever price they like. This leads to the effect that drug prices may vary enormously between countries. In Asia, differences of several hundred percent may be found for identical drugs of the same brand. Countries like France that have introduced obligatory drug lists have found them useful as cost-containment instruments.

A particular feature of the drug market is the existence of generic drugs. These are legal copies of brand drugs manufactured after the patent period has expired. Generic drugs are normally considerable cheaper than the branded drugs. This is why, in many countries, health insurance schemes encourage the prescription of generic drugs, or the replacement of prescribed branded drugs by generic drugs at the point of sale (either by contract between health insurance and pharmacy or by benefit definition). For example, SHI can specify a lower co-payment for generic drugs in order to encourage patients to ask for them.

Two items of information may figure in a price list for drugs – the product itself and the price. The list of products means that SHI will pay only for those products that are on the list. In France, health insurance invites tenders for the products to be included on the list. It is also possible to issue a list of active ingredients, rather than specific brands or products (this model is found in Germany), which means that the health insurance pays only for certain active ingredients, regardless of the manufacturer. The prices may be listed for specific products (as in France) or for certain active ingredients (as in Germany).

Table 13 identifies the basis for payment and the unit of billable service for a range of providers operating on a fee-for-service basis.

Table 13: **Identifies the basis for payment and the unit of billable service for a range of providers operating on a fee-for-service basis.**

Provider	Basis for payment	Unit of service
Family physicians	Fees (ideally fixed schedule)	Act
Specialists	Fees (ideally fixed schedule)	Act
Hospitals (inpatient and outpatient)	Fees (ideally fixed schedule)	Act/inpatient day
Pharmacies	Prices (ideally fixed list)	Item
Ancillary services	Fees (ideally fixed schedule)	Act
Prosthesis	Prices (ideally fixed list)	Item

14.4.2. Establishment and calculation

A fee-for-service payment should be based on a fee schedule. This schedule may be fixed by the insurance fund in consultation with the Ministry of Health, or it may be the result of negotiations between health funds and providers. A combination of the two is also possible whereby provider federations and health funds negotiate a fee schedule which is then endorsed and supported by the Ministry of Health.

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

- values can easily be adjusted (every provider needs an accurate schedule, and schedules showing actual prices must be reprinted and redistributed in their thousands every time prices change, e.g. because of inflation);
- it is possible to fix or negotiate an overall budget for all services in advance and to fix the point value at the end of the financial period to keep total costs within this budget (in this way, providers cannot increase the overall budget for services);
- in the construction of a fee schedule, planners must consider the assumed income of physicians, the estimated costs of providing specific health services, and the desired incentive structure.

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

Fees for specific acts are calculated on the basis of the factors used (e.g. labour, capital costs, materials), the number (quantity) of units of each factor used, and the price of one unit.

The quantity of each unit is multiplied by the unit price to give the cost of each factor. These are then added together to give the fee for one act (e.g. a vaccination performed by a physician). Table 14 shows one example in detail.

Table 14: **Calculation of the fee for one act**

Factor		**Units**	**Price**	**Factor costs**
Proportional costs	Labour – physician	10 minutes	$0.50/minute	$5.00
	Labour – nurse	10 minutes	$0.20/minute	$2.00
	Materials			$2.00
Subtotal				**$9.00**
Overhead	Rents	10 minutes	$0.18/minute	$1.80
	Capital utilization	10 minutes	$0.05/minute	$0.50
	Administration	10 minutes	$0.05/minute	$0.50
Subtotal				**$2.80**
Total				**$11.80**

Source: Working paper on social health insurance planning, management and financing. International Labour Office, 1993.
Note: The units to be used for each kind of service can be identified by empirical study.

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

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

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

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

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

14.4.3. Impact on cost containment, quality, efficiency and administration

Providers working under a fee schedule system have three ways of influencing their income – by increasing as far as possible the number of acts (i.e. services), by reducing the quality of the services (e.g. by reducing the time per consultation), and by delegating more acts to lower-paid personnel (e.g. nurses, technicians).

Given the method used to calculate the fee, it is obvious that a provider has a certain incentive to produce as many acts as possible. By increasing the number of acts, physicians can increase payments for their own work, and increase the overall surplus by using the overhead factors more than is assumed in the calculation and getting fixed payments for this utilization (which in turn – after passing a break-even point – produces surpluses).

The effect of fee-for-service payments on the costs of the health service is clear: it encourages the production of services (even unnecessary ones) and thus leads to higher costs (unless the total fee volume is budgeted as, for example, in a point system).

The impact on quality is not so clear. There is an incentive to spend as little time as possible on each treatment act in order to maximize the number of acts that may be performed in any one period. Moreover, there is an incentive to delegate work to less qualified personnel in order to increase the total revenue. Both of these may have a negative impact on quality.

On the other hand, under fee-for-service schemes providers have a strong incentive to work and to provide services, even after office hours or on weekends. If there is competition among providers, it will not be easy to retain patients if the quality of the service and the accessibility are inferior.

To sum up, the fee-for-service system tends to encourage overproduction but may also lead to a higher quality of service. To a great extent, the effects of the fee-for-service system depend on the design of the fee schedule – which leaves room for many options. If particular services are to be encouraged, for instance, the fee should be set above the actual cost of the service. If the aim is to prevent physicians from overproducing certain services (especially services that can be delegated) the fee should be set slightly below the actual cost. The total budget to be spent for fees can be capped in a point system leading to the effect that the fees for each single service decrease if there is "overproduction".

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

14.5. Case payment

14.5.1. Description

The case payment system is based on a single case rather than a single treatment act. Each case the physician or the facility treats leads to the payment of a fee. Different systems can be distinguished. A case payment system may be based on

- a single flat rate per case, regardless of diagnosis and specialty;

- a schedule of diagnoses;
- specialty and/or departments and facility types;
- a mix.

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

The second model uses systems of case classification. The most widely known case classification approach is the "diagnosis-related groups" (DRG) system, which classifies patients on the basis of their diagnosis, and assigns them to a group where costs are broadly similar. There are several DRG variants, and these typically have around 500 or more groups. DRG systems are most commonly used to pay hospitals for the treatment of inpatients, although the approach can have other applications. The provider is paid according to the DRG into which the patient's diagnosis falls.

In order for cases to be assigned to the DRG, it is necessary to have a diagnosis. There are obvious advantages to this being done early in the process, since it is then possible to agree the payment in advance of the treatment being carried out. It is often argued that there are important differences between payment systems that are prospective (i.e. the price for the treatment is fixed in advance) and retrospective payment, where the price may change in the light of how things turn out. Put another way, with prospective payment the risk from an overrun on cost is borne by the provider, and with retrospective payment it is borne by the payer.

In practice, the diagnosis is often assigned on discharge of the patient, following the results of tests and interventions. There may be different grades for some diagnoses, and fees vary according to the average cost of treating the condition diagnosed. This description is simplified and there is a very extensive literature on DRG systems and their operation. The key issue for cost control is that it should be impossible for providers to pass on higher costs to the payers, and the earlier the diagnosis is determined the less chance there is for additional charges to be added.

The third model differentiates between different types of specialties (e.g. ophthalmology, gynaecology, orthopaedics) or level of care (primary, secondary or tertiary) or type of care (e.g. intensive, regular, nursing home).

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

Case payment systems may be used for providers whose services can be related to individual cases – such as family physicians, specialists, dentists, physiotherapists, hospitals or health centres (Table 15). Case payment is not suitable for provider units such as pharmacies that sell single-product items.

Table 15: **Application of case payment**

Provider	Basis for payment	Unit of service
Family physicians	Fees (ideally fixed schedule)	Diagnosis
Specialists	Lump sum	Average case
Hospitals (inpatient and outpatient)	Lump sum/fees (ideally fixed schedule)	Average case/diagnosis
Pharmacies	Not applicable	
Ancillary services	Fees (ideally fixed schedule)	Diagnosis
Prosthesis	Not applicable	

14.5.2. Establishment and calculation

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

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

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

14.5.3. Impact on cost containment, quality, efficiency and administration

In theory, case payment systems avoid one disadvantage of fee-for-service systems, namely the incentive to produce as many services as possible. However, as in DRG systems, providers are paid by diagnosis and not for each act. They can attempt to influence their revenue by:

- recording a more complicated diagnosis than the patient actually presented (if the payment schedule contains several different grades for one diagnosis, the provider can simply choose the highest grade – a process sometimes described as "DRG creep");
- submitting claims for nonexistent cases;
- reducing the cost per case (i.e. the time and materials used per case), potentially producing services of inferior quality;
- picking out the cases with the lowest ratio of cost/revenue and sending other (sometimes more complex) cases to other providers, if possible.

To a certain extent these problems may be solved by a detailed specification of each diagnosis group, and by limiting the number of items on the fee schedule – since providers' influence over the diagnosis of a case increases with the number of items on the schedule.

Clearly, there are trade-offs between these two solutions. Therefore, a system based on diagnoses requires monitoring in order to ensure that cases are assigned to the right diagnosis groups, patients are not needlessly transferred from one provider to another, and a certain level of quality is maintained.

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

In general, a case payment system with diagnosis groups is better than a fee-for-service system. The opportunities for fraud are more limited, consisting mainly of manipulation of reported diagnoses.

Unfortunately, experience with case payment systems (specifically DRGs) demonstrates that providers consistently maximize their claims, and the cost of monitoring and validating claims is high.

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

14.6. Daily charge

14.6.1. Description

Per diem fees or daily charges are used to pay providers who treat patients for lengthy periods. They are found only in inpatient payment systems such as hospitals and nursing homes (Table 16). Theoretically, it would also be possible to use them in other situations – for instance, to pay nurses providing long-term care.

Per diem fees cover all services and expenses per patient per day (e.g. medical treatment, drugs and bandages, prostheses, accommodation). The fee is always the same, no matter what treatment is required (although fees may differ among providers and between specialties or departments). Per diem fees might be higher for a university hospital than for a hospital in a rural area, although this is justified only if services are better or there are other costs to cover such as teaching and research. However, there is a good case for paying explicitly for teaching rather than paying for it as part of service costs. Per diem fees may be negotiated between the provider (hospital) and the health fund.

Table 16: **Application of daily charge payment**

Provider	Basis for payment	Unit of service
Family physicians	Not applicable	
Specialists	Not applicable	
Hospitals	Fixed or adjustable rate	Inpatient day
Pharmacies	Not applicable	
Ancillary services	Fixed or adjustable rate	Patient day
Prosthesis	Not applicable	

14.6.2. Establishment and calculation

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

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

It is also possible to fix the daily rate in advance and to exclude any later adjustment. In this case, a surplus or deficit is possible. If no changes to the daily rate are allowed, the provider bears the risk of increased costs due to increases in morbidity or severity of cases. The health insurance fund bears the risks of positive changes to these variables. But, as rates are usually negotiated on a yearly basis, the surpluses/deficits are volatile.

14.6.3. Impact on cost containment, quality, efficiency and administration

With a per diem payment mechanism, the only parameters a hospital can influence are total costs per time period and the number of patient-days.

If the daily rate is fixed, the hospital has an incentive to reduce costs and increase the number of patient-days in order to make a (temporary) profit. If hospitals reduce costs by better management, this is a desirable effect. They may also reduce cost by reducing the quality of the process (or possibly the outcomes). This is less likely to happen if there is a choice of providers, and if there is a well established mechanism for monitoring quality. However, there are limits to this effect as negotiations after a year with surplus may "tax" these away. There may also be legal provisions that hospitals should not make profits or deficits. In this case there is less incentive for the hospital management to save costs.

If the daily rate varies during the year (in the long run all rates are variable), the hospital has no incentive to reduce costs because all recognized costs will be reimbursed anyway. Nevertheless, it still has an incentive to increase the number of patient-days. It is relatively easy for hospitals to keep patients in hospital longer than strictly necessary. A large proportion of costs in a hospital are fixed (i.e. they cannot be changed in the short term). Variable costs can amount to as little as 20% of a hospital's total costs. The hospital will want to ensure that it achieves the utilization rate that is used for calculating the daily rate. It may be possible to do so only by keeping patients in hospital for longer than necessary. This can be particularly attractive to the hospital management since patients tend to cost less in the later part of their stay and are particularly cheap to look after if they no longer really need hospital care.

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

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

14.7. Lump sum payment

14.7.1. Description

Lump sum payments are frequently used to finance specific investments. For instance, providers may receive a fixed budget to buy equipment (Table 17). If this system of financing is used, a basis for the assessment of the budget is required. If physicians are paid by lump sum, the basis might be the specialty of the physician (e.g. family physician, eye physician, radiologist). Under this system, each physician would be allocated a budget for a certain period, generally a year. The budget should cover amortization and interest on the capital needed to buy the equipment.

Nevertheless, it is difficult to finance the capital costs of physicians such as radiologists who work with high-cost equipment, because the lump sum payment will be higher than the physician's income. Lump sum payments are less complicated when used to finance the equipment costs of providers such as family physicians or paediatricians who work with low-cost equipment.

Lump sum payments may also be used to cover other kinds of costs. For example, the physician may be allocated a budget for staff costs. Additionally, lump sum payments may be used as a source of finance for other providers, such as hospitals. In this case, a hospital may receive a lump sum to buy equipment, based on the number of beds.

Table 17: **Application of lump sum payment**

Provider	Basis for payment	Unit of service
Family physicians, dentists	Lump sum	Defined or approved equipment
Specialists	Lump sum	Defined or approved equipment
Hospitals	Lump sum	Defined or approved equipment
Pharmacies	Not applicable	
Ancillary services	Not applicable	
Prosthesis	Not applicable	

14.7.2. Establishment and calculation

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

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

14.7.3. Impact on cost containment, quality, efficiency and administration

The impact on cost containment, quality and administration depends on the way the lump sum payment is handled. In general, there are two methods of lump sum payment – the flexible budget combined with monitoring of financial resources, and the fixed budget combined with quality control.

In the case of a flexible budget, the provider has an incentive to spend all the money, even if that means buying equipment that is not needed. The provider loses any money that is not invested. On the other hand, this method of financing allows the health fund to specify, register and monitor equipment standards. At the same time, certain unnecessary high-cost investments (that would have to be amortized later) are excluded because the investment budget is not large enough. The provider has no incentive to use equipment excessively as there are no amortization costs to recover.

The incentives of a fixed budget are different. If the provider is able to buy equipment at a good price, there may be some money left over to increase his/her personal income or to undertake additional investment. In this case, the provider has an incentive to buy cheap equipment, to wait longer before buying or to buy no equipment at all. For this reason, it is important to establish clear specifications for equipment and other measures that ensure quality control and to monitor standards.

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

14.8. Capitation fee

14.8.1. Description

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

The capitation fee may be paid to a provider chosen by the insured person or to a provider located near to the insured person's residence. In order to encourage competition and high quality service, the insured person should have the right to change the nominated provider on a regular basis, usually annually or per semester.

There are simple systems and more sophisticated systems of capitation payment. In simple systems, the provider receives the same fee for each patient registered. In more sophisticated systems, the fees vary according to parameters such as age and sex of the patient or area of residence. Table 18 shows the example of a system that was developed in Mongolia and which has a total of 10 different classes of capitation payment.

Table 18: **Capitation fee according to patient classes developed in Mongolia**

Needs class	Low income	Other
Age under 1 year	Class 1	Class 6
Age 1 to 15	Class 2	Class 7
Female age 16 to 49	Class 3	Class 8
Age 60 and over	Class 4	Class 9
Other age or sex group	Class 5	Class 10

Capitation fees are suitable as a mechanism for payment to hospitals where, because of the location, patients will inevitably use the one facility. The capitation fee would cover any or all services required at primary and secondary level (Table 19). Sometimes when a hospital is paid a capitation fee it is then held responsible for both primary and secondary care for the insured person. However, it is possible to have a dual capitation whereby the primary-care practitioner chosen by the insured person is paid one capitation fee, and a hospital (either chosen by the insured person or assigned to the insured person because of location) is paid a separate capitation fee to cover secondary-care needs. In this instance, the primary-care practitioner's role of gatekeeper to secondary services is reinforced, thus helping to ration the utilization of secondary-care services.

In the case of individual specialists working alone or in tandem with a small number of specialist colleagues, the capitation payment mechanism is not suitable, although it may be practical to fund access to a collection of specialist services using this mechanism. For individual specialists, other payment systems such as case payment or even fee-for-service are more practical. In addition, capitation fees are not applicable to pharmacies.

Table 19: **Application of capitation payment**

Provider	Basis for payment	Unit of service
Family physicians, dentists	Fixed rate per registered patient	All health services provided during a certain period
Specialists	Application facilitated when specialists work within a capitation-paid facility	
Hospitals	Fixed rate per registered patient	All health services provided during a certain period
Pharmacies	Not generally applicable (may be useful for hospital pharmaceutical services)	
Ancillary services	Not applicable	

14.8.2. Establishment and calculation

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

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

The calculation of more complex capitation fees as shown above is more demanding.

14.8.3. Impact on cost containment, quality, efficiency and administration

Capitation systems are good for containing costs. There is no parameter the provider can influence that can lead to waste or unnecessary costs.

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

There is also a possibility, however, that a capitation system can reduce incentives to provide good quality service. If a provider is guaranteed a payment for each person on his or her register, there may be no motivation to provide high quality care and/or to ensure a surplus by reducing costs beyond that which is desirable. This problem may be solved by giving the patients the right to change physicians (providers). A physician who provides services of inferior quality will find it difficult to get enough patients. However, this works only if there are enough physicians to give the patient a real chance of finding a good physician whose list has not yet been closed and if the patient is able to judge the quality of care given. Another way of solving the problem is to establish and apply clear standards for the providers. If providers do not

meet these standards, the health fund can withdraw them from the list of providers. However, this requires mechanisms to monitor providers.

The administration costs of the capitation fee system are low, particularly when compared with fee-for-service systems. The only real administrative complication arises when patients change providers or when the SHI is performing sophisticated monitoring activities.

14.9. Performance-related payment / Bonus payment

14.9.1. Description

In recent years, a broad discussion of performance-related payment systems has been taking place. Additional complementary methods to those already mentioned are being evaluated and experience exchanged. These systems are based on measurement of outputs or outcomes (changes in agreed indicators). Performance-related payment systems depend on the definition, measurement and effective influencing of performance of providers and can be combined with other payment methods.

A performance-related payment or a bonus can be paid to providers in addition to their core remuneration mechanism as an incentive to achieve certain objectives. These objectives may be economic in nature or may be related to the country's health-policy objectives.

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

A health-policy objective may be to achieve a certain percentage of immunizations among the population. Family physicians are usually responsible for immunization, so one way to achieve a higher immunization rate is to pay a bonus to every physician who succeeds in achieving a certain rate of immunization among his/her relevant patients. Bonuses may also be paid to promote other objectives of preventive medicine and public health.

14.9.2. Establishment and calculation

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

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

14.9.3. Impact on cost containment, quality, efficiency and administration

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

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

Monetary performance incentives are part of a set of incentives and circumstances that influence people's behaviour and performance. Other factors influencing performance include intrinsic motivation to do good and to do a good job, especially in a field which involves direct and potentially important effects on survival and the quality of life. Health workers are also motivated by in-kind benefits for staff who move to remote areas, promotion rules, social protection benefits, a good working environment, appropriate and up-to-date equipment, a reasonable workload, social recognition and status of work, and income security. Job security and limited competition may also be important to people.

These factors were not taken into account in the above description of provider payment mechanisms and it is not easy to include them in a standardized format. They should be considered when payment systems and other factors are negotiated between SHI and providers. Limiting discussion to payment systems can jeopardize the objective of the best possible health care for the available funds.

14.10. Comparison of different payment systems

Tables 20 and 21 summarize the different payment systems and their effects on cost containment, quality and administration. Some systems have clear advantages over others with respect to one or more performance characteristics. Capitation systems, for example, score high on both cost containment and administration. It is not easy to choose between the systems, and the most efficient system for a given country will depend on the local situation.

These systems may be combined, which greatly increases the number of options. Combinations can also produce a unique set of incentives, encourage certain behaviour, or penalize inappropriate patterns of health-service provision. As an example, it is possible to combine a capitation fee as the basic payment, fees for service for certain acts (e.g. immunization, preventive medicine, a flat rate for approved investments, a budget for drugs and ancillary services, and performance-related incentives.

Table 20: **Comparison of performance of different payment systems**

Payment system	Cost containment	Quality	Administration
Salary	Fair	Fair	Easy
Budget	Good	Fair	Easy
Fee-for-service	Poor	Good	Difficult
Case payment	Good	Fair	Difficult
Daily charge	Fair	Poor	Easy
Bonus payment	Good	Good	Easy
Flat rate	Good	Good	Easy
Capitation	Good	Fair	Easy

Table 21: **Principle characteristics of provider payment systems**

	Definition of basis for payment (unit)	Technical requirements
Salary	Period of work (usually one month)	Negotiation, tariff
Budget	All services for SHI members in a certain period	Calculation, negotiation
Fee-for-service/ price-per-item	Single act or product	Calculation of fee or price schedule
Case payment	Single case diagnosis	Fee schedule
Daily charge	Patient day	Calculation of charge, negotiation
Bonus payment	For specific acts (e.g. immunization) or behaviour (e.g. low prescription rate)	List, calculation
Flat rate	For approved investments	List of approved items, calculation, negotiation
Capitation	All services for one person during a fixed period	Calculation, negotiation

A combined payment system similar to the one described above is used in Germany, Philippines and the United Kingdom. Under the United Kingdom's system, general practitioners are paid capitation fees for every individual registered with the provider, up to a maximum number of patients. Capitation fees may vary depending on where the practice is located (urban or rural). Fees for specific services, including night calls, maternity services and adult vaccinations are also paid. There are bonus payments for reaching certain performance targets (e.g. immunization of children). In addition, general practitioners are reimbursed for overhead costs and are provided allowances for other expenses, such as equipment.

In negotiating a system of payment mechanisms it is important to remember that, at least to some extent, the interests of the SHI funds and the providers conflict. Providers do not want good cost control and in many cases will argue against capitation, salaries and budgets, and in favour of fee-for-service. Providers are normally opposed to points systems for paying doctors since they control total payments to doctors. This is of course quite natural, but the debates and negotiations on payment systems will feature many arguments from interested parties.

14.11. Questions raised

- Should providers be employees or contractors?
- What income and what form of remuneration are providers accustomed to at present?
- What kind of infrastructure exists in the country?
- What kind of incentives will be useful?
- How strong is the political influence of provider groups?
- Will it be possible for providers to operate under a number of different remuneration systems?

Chapter 15.
Operational and administrative efficiency

15.1. The internal organization of health funds

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

- registering members and dependants;
- collecting contributions(though in some countries one central agency collects contributions for all kinds of social security institutions;
- monitoring employers (ensuring that they register their employees and deduct contributions correctly);
- assessing the income of self-employed members, advising members about entitlement to benefits, processing and checking claims, planning and organizing health services, selecting and negotiating with providers;
- checking invoices and vouchers for conformity with fee schedules and benefit regulations, ensuring that patients are entitled to the benefits claimed and that there is a contract with the provider (this depends to a large extent on the provider payment system and the method of registering with providers);
- developing a clinical records system to record the diagnosis and treatment given and for use in claim payments;
- paying invoices and vouchers;
- monitoring health providers (e.g. prescription behaviour, quality control, accreditation) personnel administration, training, staff development and organization;
- acquisition, administration and maintenance of buildings and equipment (e.g. information technology, furniture, materials);
- financial management and planning;
- accounting;
- statistics.

The development of an internal structure and the assignment of administrative tasks must take into account:

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

The overall objective in designing an internal organizational structure is that all SHI fund services that require direct contact between members and staff should be as decentralized as possible. This means that the tasks listed above should be distributed to different levels of the health fund.
A health fund should have *local offices* to carry out tasks such as:

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

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

- contracting with providers;
- processing claims;
- paying providers;
- assessing and accrediting of providers;
- collecting contributions, and other contacts with employers;
- monitoring employers, providers and local offices' decisions about medium-cost infrastructure, and recruiting staff for smaller local offices.

The *central level* should carry out the following tasks:

- planning and decision-making about high-cost infrastructure (e.g. buildings), contracts with providers that are organized at central level, finance, accounting;
- compiling and analysing statistics;
- informatics;
- staff management (personnel department) staff training and qualifications (training centre) internal monitoring.

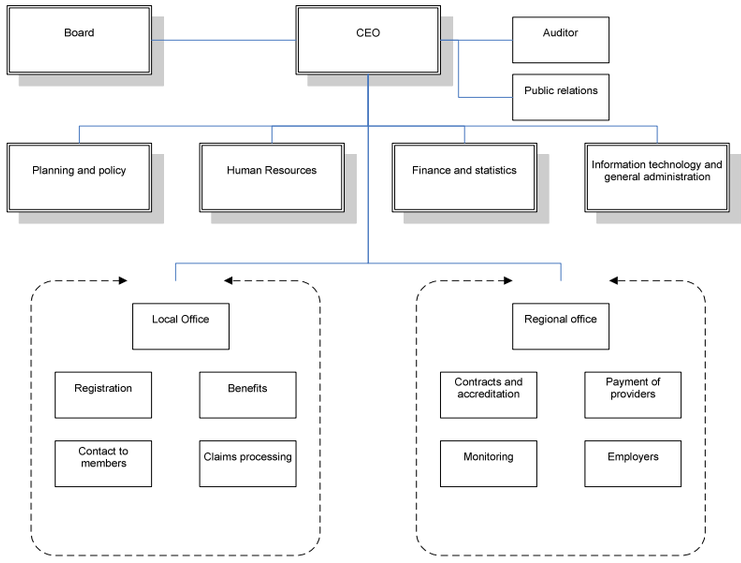
Figure 9 shows an example of the organizational structure of an SHI.

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

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

In order to save costs, synergy effects can be created with other private and public institutions, especially in remote and less-populated areas. Agreements can be reached between the SHI and these organizations to outsource certain tasks such as registration of members and collection of contribution. Similar synergy effects can be obtained if the SHI maintains an office in such areas and improves its cost-recovery by helping other organizations to outsource their tasks to SHI.

Figure 9: **Organizational chart of an SHI fund**



15.2. Staff management

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

- recruiting and selecting staff;
- drawing up employment contracts;
- designing an appropriate staff payment system;
- organizing payment of salaries and deduction of social security contributions and taxes, supervision of staff in respect of holidays, sick leave, etc.;
- ensuring that staff qualifications and capabilities are used for the benefit of the organization;
- establishing principles and criteria for staff promotion, training and development.

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

15.3. Computerized information systems

The overall efficiency of a health fund's operations can be enhanced through the use of computerized information systems. The use of computers can help to provide up-to-date countrywide information, prevent fraud, standardize administrative procedures, compile and compare statistics, and facilitate centralized and decentralized information on entitlements, benefits received, claim histories and contributions paid.

Some of these objectives may, of course, be achieved using paper-based membership records (systems in which "member history" cards are kept for each member). The use of paper-based records can also be cheaper than computerization, depending on the level of staff costs in a country. Without computerized systems, however, any summary or comparison of data is difficult. For example, with a paper-based system it is more difficult to compile statistics, produce accounts, check whether a member has paid a contribution in a particular month, or check on the appropriateness of provider behaviour (e.g. prescription practices).

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

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

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

Computerization is expensive. The construction of a computerized information system includes not only the costs of hardware and software, but also associated costs such as staff (for operations management, hardware and software management, user support etc.), regular updating of software, maintenance of hardware (including repair and replacement), staff training, and requirements for buildings and air conditioning.

It is important to ensure that the health fund's computer information system is as productive as possible, given the substantial resources that will be required to develop and maintain it. In addition to the general objectives described above, a well-designed computer information system should be able to handle a variety of specific applications, including:

- employer registration;
- employee, self-employed and dependant registration;
- recording of monthly employer and member contributions;
- identification of late payers and non-payers;
- registration of providers, status of accreditation, and applications pending from providers recording the registration of insured persons with providers (physicians, hospitals), allocation of social security identity (ID) numbers and production of social security ID cards, annual accounting and quarterly reports statistics.

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

- a guarantee that the data are not used for objectives other than those defined by law;
- data access that is selective and restricted to the field of work of the staff member concerned (i.e. no general access);
- no access whatsoever by employers to members' data;
- internet access and utilization that is protected.

Developments in hardware and software happen rapidly. Since the publication of the first edition of this book the world has changed very much. New technologies like biometric identification, high-speed data transfer, intelligent software, multimedia and the Internet provide new possibilities for cost-saving and better SHI services.

The enormous progress made in the field of information technology in the last 10 years has made many things possible. For instance:

- Running the entire information system of a health insurance fund on one modern personal computer means that the costs of information technology have fallen.
- New technologies for controlling access and payment of contributions have emerged such as the smart card or biometric scanners;
- Data storage and retrieval has made enormous progress, which makes managed care more feasible but also has dangers in terms of data abuse.
- Computer technology has improved medical equipment and has made some treatments cheaper and more effective.
- The Internet gives access to all kinds of information for patients and providers, and allows out-sourcing and new types of collaboration and decentralization of SHI services.

15.4. Financial management

The task of financial management is to keep the health fund in financial equilibrium, which includes maintaining an adequate operating reserve (to cover unforeseeable short-term risks). SHI is normally managed on a pay-as-you-go basis. This means that it covers costs out of the current income from contributions. Health funds must maintain an operating reserve in case of unforeseen changes in morbidity (e.g. epidemics, accidents), unforeseen changes in costs (e.g. staff, equipment), and unforeseen changes in income (e.g. higher levels of unemployment which may reduce the level of contributions).

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

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

Another task of financial management is to invest the money properly. Part of the fund should be invested in medium-term securities and a smaller amount should be available on demand. It should be clearly defined by law what types of financial transaction are allowed using the reserve resources. It is not advisable to invest reserve resources in stocks or high-risk bonds.

It is also a role of financial management to forecast income and costs (see section 15.8 on Planning). Health fund planners must observe developments in the economy and the labour market (collective bargaining for wages, unemployment and inflation) as well as in health costs (for each benefit sector) in order to prepare adjustments to contributions. These tasks will be easier with an efficient and up-to-date computer-based control system, as described in the previous section.

15.5. Accounting

Accounting and frequent reporting form the basis for planning, efficient administration and cost containment. The accounting system must outline a clear picture of all the financial flows in the health fund. Moreover,

it should be accompanied by an efficient statistical information system. These two systems go hand-in-hand, although they are discussed separately here.

The basis of an efficient accounting system is proper recording of data (see section 15.3 on Computerized information systems). The accounting system should contain detailed data on the areas shown in Table 22.

Table 22: **Routine financial reports**

Statement of income and expenditure		**Balance sheet**	
Income	**Expenditure**	**Assets**	**Liabilities**
Contributions Interest from investments Other income: Rent Sales Reimbursements Refunds etc	Health care services Hospitals Ambulatory care Dental Drugs Administration Staff costs Capital costs Rents Material Equipment Other	Real estate Security holdings, bank accounts Other assets Equipment Vehicles Materials Accounts receivable and outstanding debts	Capital Reserves Bank loans Unpaid vouchers and bills
Deficit	***Surplus***	***Net liabilities***	***Net assets***

An authentic statement of income and expenditure would require more detail than is shown in Table 23. For example, the category “Staff costs” should have separate lines for each type of staff, for basic salary and bonuses, and for social security contributions, taxes and so on.

Routine financial reports should include a balance sheet in addition to a statement of income and expenditure. A balance sheet depicts the financial status of the health fund at a particular point in time, whereas the statement of income and expenditure shows financial flows during a particular period of time. These are the basic statements required. Other useful instruments include an inventory of assets. Since many organizations get into trouble due to cash flow problems it is also wise to have routine reporting of cash flow forecasts.

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

15.6. Statistics

Good statistical information provides the basis for planning and control. Statistics should be gathered routinely in order to:

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

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

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

Health sector costs
- costs per kind of service (e.g. hospital treatment, drugs)
- costs of health care for specific member groups (e.g. according to age, sex, status) or specific regions;
- costs per provider.

Administration costs by
- category of cost;
- costs per administrative unit.

Revenue by
- region;
- status of members.

Utilization rates by
- consultations, inpatient-days, prescribed items;
- provider;
- patient category by region.

Diagnoses by
- age and sex;
- profession and region.

Members and dependants by
- age and sex, profession and region;
- status (e.g. active, retired, unemployed, dependant, disabled).

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

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

15.7. Other applications of information

The data compiled in the health fund's information systems are not only useful for administrative and managerial purposes but can also serve as input into the development of more effective preventive health care strategies and as evidence for decision-making. The health fund's ability to gather and use information on health status and health developments will depend on the means available, the social characteristics of the population concerned and, above all, on the health problems involved. Nevertheless, it should be possible for the health fund to gather demographic and epidemiological data that will be useful for developing

strategies to deal with AIDS prevention, family planning, immunization, maternity care, and health screening for children.

Information collection activities and the development of preventive health strategies require close cooperation between health funds and other authorities such as the Ministry of Health. However, it is important for health funds to take a leading role in the process of strategy development since the funds will bear the costs of poorly designed or inadequate programmes for disease prevention and health promotion.

The health funds can participate in this process through broadcast and print media, courses, meetings, personal visits by qualified health insurance personnel (especially to remote areas), and information desks in local offices that offer information and advice.

15.8. Planning

Planning is an integral part of managing an SHI scheme. Some specific planning activities include annual budget planning (forecasting costs and revenue in order to adjust contributions over time), planning of infrastructure (in order to provide appropriate services for members), and planning of health activities and programmes (to meet objectives such as combating particular diseases).

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

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

15.9. Internal and external monitoring

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

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

There should be detailed internal monitoring of entitlement to benefits, invoices and vouchers, demand for services from providers, and the quality of service provision.

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

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

15.10. Cost control

15.10.1. The CHALLENGE of cost control

Controlling costs is one of the major challenge in SHI. It is the experience in nearly all countries with health insurance schemes that per capita health-care expenditures tend to rise faster than per capita gross domestic product (GDP) and faster than salaries. This leads to higher contribution rates (in salary-based systems) or to contributions rising faster than GDP (in other systems).

The reasons for this include:

- a tacit alliance between providers and patients to prescribe, deliver and consume more and better products and services;
- services and products that to a large extent are not paid for at the point of service delivery but before and after by means of contributions, making users less sensitive to price changes;
- ageing in many societies which increases demand for health services; improvements in medical technology that are both more rapid and more expensive (which to some extent is related to the improvement in services described above);[7]
- a relatively stable demand for health services even if the price rises (low price elasticity);
- labour-intensive health care with limited possibilities to increase productivity;
- to some extent, providers can define the demand for their services (and thus their incomes);
- a rising demand for services created simply by the existence of health insurance;
- taken together, these factors may mean that inflation in the health sector is above the general inflation rate.

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

There are many possible strategies for containing costs, and a long history of attempts to do so. Nevertheless, it is possible to identify approaches that could be adapted for use in a particular country.

15.10.2. Strategies for cost containment

Cost-containment strategies are closely related to the design of SHI. This is why it is important to be aware of the dangers and the possible ways of preventing cost increases when designing and establishing SHI. An analysis of rising costs can concentrate on two sides of the problem, and therefore two sets of options for cost containment – the supply side and the demand side.

On the supply side, costs and their growth depend mainly on the way providers are paid and the incentives that are set (see chapter 14 for details of provider payment systems). The provider's qualification, experience, motivation and performance incentives are the driving forces behind quality and the quantity of health services. It is important to make the best use of the skills of providers, using both financial incentives and other motivational factors such as the desire to provide an excellent service and generate good outcomes for patients. The best approach must take many factors into account, but must focus strongly on the provider payment system and its effects.

Traditionally, in most SHI schemes, economics and medicine were completely separate. It can be useful to make medical staff aware of the financial consequences of their decisions. There are various ways of

[7] New products also benefit from protection through patents so that competition does not reduce prices. In times when innovation is rapid, this can lead to cost increases. New products and services also often create additional demand.

doing this (e.g. making monthly reports to physicians about the costs for which they are responsible, teaching economics to medical students). But practice has shown that other factors may also affect the decisions of medical professionals, even if they know about the financial consequences. For instance, in the USA the legal situation has encouraged doctors to use all available techniques in order to prevent threats of litigation. The training of medical professionals may guide them to use more expensive alternatives. Professionals may feel under pressure to provide patients with the best available care regardless of cost, and this can be reinforced by media reporting of any restrictions on what is provided. Poor information flow between providers can lead to duplication of services. This is not to take responsibility off medical professionals for the financial consequences of their services and from the need sometimes to refuse requests. However, it should play a role in discussions between SHI and health care providers just as health care providers should understand the need for SHI to be affordable and to obtain a maximum of service for the available budget.

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

- careful design of the benefit package (i.e. deciding what should be included and specifying it clearly; the package must be revised from time to time and can also contain some flexibility);
- co-payments and user charges;
- incentives to prevent the use of health care services (e.g. through bonus schemes);
- incentives to use cheaper products and services (e.g. by reducing co-payments for cheaper solutions);
- restricted access to providers, sometimes known as gate keeping (e.g. not allowing direct access to hospitals, specialists or drugs, or restricting the frequency with which patients can change their physician), which can be combined with co-payments if patients bypass the gatekeeper;
- refund of part of the contribution at the end of a year if the patient has claimed no benefits;
- restricted choice of providers or products (e.g. a limited list of drugs which the health fund will pay for, or reduced co-payments for more cost-effective and less expensive services and drugs);
- provision of information and education for users of health services.

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

15.11. Questions raised

- How will the health fund be managed?
- Who decides what?
- How will SHI be brought as close as possible to the members?
- How will staff be selected?
- What kind of information will be needed and where?
- How can SHI make use of computerized information systems?
- How will fraud and waste be avoided?
- What are possible methods of cost containment?

Chapter16.
Organizational embedding of social health insurance

16.1. Political independence of social health insurance

The political independence of the health fund is a critical issue. Although SHI schemes may be organized in many ways, traditionally there are two main possibilities:

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

The health fund may be an independent body. In this case, the health fund has its own budget, its own legal status and its own management. Under this arrangement, it must be decided how and by whom the management of the health fund should be selected, appointed and controlled. The minister may, for example, nominate managers, or they may be elected by those who pay the contributions (insured employees and employers). Thus, in the first case professional managers run the health fund, and in the second case elected representatives run it. Even if the managers of the health fund are nominated by the minister, the fund may have greater independence than in the first model.

It is generally advisable for the health fund to have a certain degree of independence from the government. There are several important advantages to this, including:

- strict separation of budgets (contributions are not made for political objectives but solely for health insurance – a point that is very important since it may be crucial for increasing people's willingness to pay contributions;
- decision-making that is (to some extent) independent of changing government policies and is oriented to long-term objectives;
- management practices and an organizational structure that are more like those of private enterprise than public administration.

On the other hand, a strong government is needed, especially in the phase of building up SHI (maybe against the resistance of interest groups) and later in relation to ensuring compliance with legislation and monitoring and setting the framework for SHI operations.

16.2. Rules, regulations and legislation in policy development

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

- the general design of the health system;
- the benefit scheme;
- the adjustment of contributions;
- investment decisions (which can involve very high levels of spending);
- employment of staff;
- contracts with providers (which to a large extent determine the subsequent costs of the system).

The general design of health insurance and the benefit scheme should be defined by law. Appropriate legislation should specify:

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

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

16.3. Roles of the ministry of health

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

- to set overall health policy goals;
- to create the policy framework for the operations and activities of the health funds and providers;
- to monitor the performance of health funds and service providers;
- to monitor the quality of care;
- to ensure that mechanisms are in place to fund and provide staff training and development;
- to ensure that the overall costs of health services are kept under control.

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

16.4. The role of social partners

Social partners (e.g. employers, trade unions, government) play a crucial role in social protection. In many countries they administer social protection schemes, especially SHI. Their responsibility for negotiating wages and working conditions makes them first choice for the task of overseeing and guiding SHI. Social partners can thus fulfil their task of balancing labour costs and contributions for the financial risk protection of workers.

However, most workers in developing countries do not have representation by trade unions and collective bargaining. Some are organized in communities, cooperatives or other types of NGOs. This is why a social protection policy focusing on social partners may have to take into account these organizations and work with them to develop SHI for the informal sector.

16.5. Legal considerations

If SHI is to work effectively, it is necessary to equip it with certain legal instruments, or to link it to institutions that provide these. Some examples are as follows:

- If SHI is expected to implement compulsory membership, it needs legal instruments and powers to do so. It must be able to perform checks in enterprises and in case there is fraud it must have effective instruments to enforce the law.
- SHI must be able to enforce the collection of contributions. This means that there may be an exchange of sensitive data – for instance, with employers, tax offices and other social insurance institutions. SHI must have the power to audit enterprise accounting and registration systems, it must have access to facilities, and it needs power to prevent fraud, enforce payments and impose fines. If SHI does not have these powers it must at least be able to rely on other institutions that do have them.
- SHI may need special legal instruments to negotiate and enforce provider payments and to accredit providers.
- SHI may need to have a not-for-profit statute.
- SHI should be exempt from value-added tax, corporate tax and insurance taxes because these will unnecessarily increase contributions and generate resistance. Keeping contributions as low as possible is important.

Another question is whether the SHI should be administered by civil servants, since the SHI fulfils public tasks.

Part of these legal requirements, especially the enforcement, could be handled by courts. However, experience with both SHI and tax collection shows that if SHI has to go to court for every fraud detected, this may hamper effective enforcement, increase costs and cause delays.

This is why in many countries SHI is a public or semi-public institution equipped with special laws and privileges. Alternatives to this setting are discussed later in this chapter.

16.6. Practical experience

Practical experience in many countries, especially developing countries, shows that the organizational setup of SHI is crucial. Legal, political, institutional and financial considerations are often a bigger obstacle to functioning health insurance than getting the agreement of employers, workers or the self-employed. Many countries struggle with enforcement, where in practice there is a trade-off between success of enforcement and containment of administration costs. Often SHI has no instruments to monitor providers or to negotiate with them on an equal footing. Monitoring, prevention and prosecution of fraud is another issue, which is often unsolved.

Beyond these issues, the organizational setting also raises questions such as whether it is necessary to create new institutions or whether to use existing ones to perform tasks. Can the tax office collect SHI contributions? Can the pension scheme be used to administer SHI? Should ineffective existing structures be reformed or should new ones be created? Should SHI work with the private sector to create synergy effects? How far should SHI be brought to the client, even in remote areas? Who should govern SHI?

In many countries the creation of new institutions is more important in terms of creating job opportunities, and interesting and well-paid management posts, rather than seeing it as a chance to improve governance. SHI raises important governance issues, and questions of how and by whom it is governed are crucial. There are many examples of institutions around the globe which have been run down or have never been developed to their potential because of fraud, corruption and political interference.

16.7. Who should run social health insurance?

There are many options for how to organize SHI, including its management and decision-making structures. These include the following:

- SHI can be an independent institution under public law, governed by professional (non-public servant) managers and with a board of key stakeholders such as employers, insured persons, and possibly the government.
- SHI can be a semi-state body governed by civil servants and reporting to the responsible ministry.
- SHI can be a mix of these alternatives.
- SHI can have all the tasks such as registration, contribution collection, claims handling, enforcement, prosecution, information systems and so on, or it can outsource some of these. In theory it would be possible for other institutions to collect the contributions.
- SHI can be completely outsourced to private companies or to NGOs, leaving enforcement, setting of framework standards, monitoring and prosecution tasks to the state.

Regardless of the organizational setting that is chosen, there remain some basic questions, such as:

- Who approves the budget and up to which level of detail?
- Who appoints the management and the board? What is their term of office?
- Which decisions does the management take, and which are taken by the board or by the government?

16.8. Links to other organizations and institutions

Normally there are various organizations in a country with links to SHI. These include public health authorities, other health insurances, pension funds, accident insurance, tax offices, registration offices, employer organizations, trade unions, provider organizations, price control agencies, anti-trust organizations, and the police. The development of the organizational setting of SHI has to map these bodies in order to see how synergy effects can be created and how SHI can get support (without violating interest in data protection and fraud prevention) and also how SHI can support other institutions and systems to achieve their goals. The links can be many, especially:

- financial (there can be transfers between the schemes);
- administrative (in terms of information, synergy effects, outsourcing);
- policy and governance (SHI can support health objectives in other systems through its benefit package or through exchange of data).

16.9. Competition and market forces

As mentioned at the beginning of this book, there is a special relationship between health care and market forces. Health care and health insurance require more extensive regulation and frameworks in which SHI can operate than a private company or even a private insurance company.

Nevertheless, experience in various countries has shown that SHI and competitive market forces are not mutually exclusive. If the right framework is set and the rules are clear, competitive health insurance funds can be an option for SHI.

16.10. Public-private partnership

Traditionally, SHI schemes are run by or attached to governments. Few countries, like Colombia, allow private companies or NGOs to participate in the provision of SHI. The reason for this has been mentioned above under 16.5. Nevertheless, there is no reason why SHI should not be run by private insurance companies if they are regulated and adhere to a common framework such as working on a non-profit basis, providing insurance packages that conform to SHI principles like non-rejection of high risk, contributions according to affordability, coverage of benefits and population groups, accessibility and absence of cream-skimming.

Apart from private companies, another option is for NGOs to run SHI. Brac and Grameen in Bangladesh have shown how an NGO can organize health insurance around its classic products (Ahmed et al., 2005). Many NGOs have a large network and large numbers of members. Starting with their own members they can organize SHI in a comprehensive manner. Like private insurance companies, however, they would have to stick to a specific framework and set of rules.

Beyond the question of who runs SHI, there are many options for public-private partnerships. The philosophy behind this approach is that there is no need for SHI to organize services and structures if it can rely on others. There can be agreements with private banks and insurance companies, NGOs, and even with private stores or malls in the field of contribution collection, provider payment, communication with clients, and awareness-building.

16.11. International and cross-border issues and regional integration

Health care provision does not stop at the border. There are many cases in which the question arises as to how SHI benefits can benefit from or contribute to foreign partner institutions. In a globalizing world, cross-border perspectives grow more and more important. Questions that arise include:

- Should people be allowed to use only the providers in the country of the SHI?
- What happens to migrants and travellers in emergency cases?
- What if it is cheaper to use a nearby facility in a neighbouring country instead of a distant facility in the home country?
- What if services are not provided in the home country? Can insured persons seek help in other countries?
- Can foreign health products and health workers be recognized by SHI?
- What about people who return home from a foreign country? Do they have access to SHI? What if they are old and sick?

16.12. Future perspectives

From the issues mentioned above, there is clearly a broad range of institutional and organizational options. Those mentioned are not exhaustive. The future will show how countries will find new innovative solutions. There are many reasons to believe that flexibility will increase and prejudices and reservations towards novelties will decrease: Globalization and the internet will improve information about what others do. The need for international exchange and cooperation will increase and will have an impact on the discussions. New technologies will allow for new and effective methods of administration of SHI.

16.13. Question raised

- What is the political and institutional environment of SHI?
- Who should run SHI?
- With which powers and legal instruments should SHI be equipped?
- What is the role of market forces?
- What are the perspectives of public-private partnership?

SECTION IV.

Implementing social health insurance

CHAPTER 17.
Steps towards social health insurance

17.1. Planning the transition

As we have seen in detail, the establishment of SHI is a complex task which takes time. Many steps are necessary to establish SHI and many choices have to be made, such as which population group and benefit package to start with, and whether to start with a pilot project or with limited schemes such as micro-insurance.

If there is insufficient health infrastructure – such as hospitals, clinics, pharmacies and doctors – there is nothing SHI can cover. A key step in the transition to SHI may be to improve the availability and distribution of health care providers.

SHI is often introduced to supplement other systems of health-service financing. As coverage expands, it may become the largest, or even the sole, method of funding health care. If the scheme is the first stage of longer-term policy development, there may be a period during which equity objectives are not met. However, if the health insurance will never cover more than only part of the population, this may cause resentment among those who are refused membership. A temporary period of increased inequity can be a major drawback in the development of SHI. In many cases this particularly hits the poor in the informal sector, because the formal sector (usually the better off part of the population) is the first to benefit from SHI. As the introductory period quite often amounts to several years, if the situation remains unchanged this can do considerable damage. Steps should be taken to ensure that there is no worsening of the situation of the uninsured, that there are stop-gap measures in place to help them, and that there is a clear and agreed timetable to include the poorest or otherwise cater for their needs. It should be remembered that special and separate arrangements for poor people tend to become poor services (Titmuss, 1968)

It is worth considering the option of introducing SHI to cover the whole population from the beginning, but with „deemed“ (credited) contributions for those who cannot or do not pay for themselves. Once the necessary structures and procedures are in place, real contributions can replace deemed ones. A universal system of SHI will normally retain deemed contributions for specific groups, such as the unemployed, or retired or poor people.

Equity considerations have influenced thinking about access to health care for many years. If health insurance releases government resources to develop services for people not covered by the scheme, and thus raises standards for the people who are worst-off, health insurance may have positive effects on equity.

This chapter aims to show SHI as a dynamic process. The design features discussed in the previous section can be seen in a dynamic way. The next chapter identifies three possible components of a dynamic approach – an explicit development strategy, pilot projects and micro-insurance.

17.2. Development strategy

The development strategy should be based on a clear understanding of the planned features of the SHI scheme and an identification of the steps necessary to develop the new system. This strategy should comprise several elements already discussed above such as:

- an inventory of existing infrastructure and services;
- an assessment of financing capacity;
- a target which is where the country would like to go in terms of SHI design and coverage;
- a time-bound plan of steps towards this target.

This time-bound plan should show the way to the objective, identify the steps in development and specify who is responsible for each. Steps that have to be taken include:

- holding a public debate about design and targets (see chapters 6 and 19);
- running a pilot project;
- planning for the development of health services, establishing the administration of SHI, developing a financial and cash-flow plan, and planning the start-up;
- planning for scale-up and extension.

Table 23 shows a rudimentary example of an implementation plan in the form of a log-frame. In practice, this must be much more detailed.

17.3. Pilot project

Before implementing SHI countrywide it is general practice to run a pilot project. The reasons for this are:

- In a pilot project, additional information can be gathered within the local context about individual behaviours and the reactions of people involved.
- Certain alternative features can be tested and the implementation plan can be amended accordingly.
- A pilot project is important for building consensus. Stakeholders see how SHI works in the country context and are more willing to support SHI if the pilot is successful.
- A pilot project helps to reduce costs as it avoids making mistakes on a large scale. If there are failures, these are limited to the pilot area and thus limited in their impact on costs.

Several decisions have to be made when a pilot project is being considered, namely:

- The pilot area must be identified. This area should be large enough to allow insights into the possible effects of the countrywide implementation.
- The target groups must be identified. These may be all people in the target area. The group should be large enough to allow effective risk pooling.
- The period should be defined. The project should run long enough to allow insights into the functioning of SHI in the country and to draw conclusions for the final design. It should, however, not be so long that it loses momentum or creates pockets in the country where there is good health care financing while the rest of the country still lacks it. An appropriate duration of a pilot project is 3–5 years, taking into account that setting up the pilot takes a year.
- It should be decided whether the pilot project will comprise subgroups with different design features. If not, there should be a clear understanding of possible design so that the pilot can be homogeneous without subgroups.

Table 23: **Design and monitoring framework**

Design summary	Performance indicators/targets	Data sources/monitoring mechanisms	Assumptions and risks
Impact Reduce poverty caused by health care costs	The number of cases of families falling below the poverty line caused by health care costs is reduced by 80%	Household surveys	**Risk** There may not be enough funds to provide sufficient support value
Outcome A social health insurance scheme	A scheme has been set up and is functional.	Reports	**Assumption** There is political support **Risk** Resistance by certain stakeholders. Technical problems
Outputs			
Component 1: Implementation plan	A plan comprising - assessment of existing infrastructure, financing, target population and environment, - key design features, - target area and features of a pilot project, has been developed and discussed.	Implementation plan	**Assumption** Availability of data
Component 2: Pilot project	A pilot project has been conducted in region… The results have been evaluated and recommendations have been formulated. The implementation plan has been amended in line with view the results of the pilot project.	Progress reports, final report, recommendations, final implementation plan	**Risk** The pilot project shows that there are major obstacles to the development of SHI
Component 3: Draft law	A health insurance law has been drafted.	Draft law	**Assumption** There is enough information
Component 3: Consensus-building	The draft law and the implementation plan are agreed by the majority of stakeholders. (As applicable) the law has been passed.	Minutes of workshops, hearings and sessions. Parliamentary publications	**Risk** Major stakeholders are opposing the plan. There is no majority for SHI.
Component 4: Operationalizing SHI countrywide	SHI administration has been set up and is operational country wide	Reports, members' registration, monitoring	**Risk** Technical problems delay implementation and thus lead to criticism.
Component 5: Development	A monitoring, evaluation, and development process has been set up and is working	Monitoring reports. Reports about improvements and changes to the initial implementation plan	**Risk** Monitoring is not taken seriously enough after initial success
Activities with milestones Develop the implementation plan by … Start the pilot project by… Evaluate the pilot results by… Draft law developed by.. Hearings, workshops and parliament session by… Administration set up by… First members registered by… First monitoring report by…			**Inputs** • Consultants and government staff • Training, workshops • Buildings, equipment • Start-up funds • **Funding** • Government funding • Technical Assistance grants

It is very important to install constant monitoring mechanisms to gather as much useful information as possible. A final evaluation should be done at the end and recommendations should be drafted for the scale-up. The results of the pilot project should be publicly available.

The pilot will lead to a discussion and a decision process about the scale-up. If it is certain that SHI will be scaled up, then the pilot should be continued until SHI is implemented countrywide. Otherwise the people in the pilot areas will be confronted with the problem that SHI in the pilot area is stopped until the final implementation. This will damage the image of SHI in the country.

CHAPTER 18.
The role of micro-insurance

18.1. The potential of micro-insurance

Micro-insurance schemes have attracted increasing attention worldwide. This way of protecting people through community-driven initiatives has been shown to be a transitional mechanism on the way to SHI and universal coverage.

Given the political desire to improve access to health care for informal-sector workers and their families, there are two basic options:

- to provide them with free health care (this is quite expensive for the state budget and, unless the whole population has free access, informal-sector workers with high but unrecorded incomes may benefit from free care while poorer employed people have to contribute to the cost);
- to find ways to identify them and include them administratively within a comprehensive SHI system (this could be either a voluntary basis – which creates the problem of lack of awareness, negative risk selection and underestimation of the risk – or on a compulsory basis – which creates a problem with control of compliance).

Instead of comprehensive SHI schemes for the informal sector there is a history of attempts to begin with micro-schemes based on communities, small groups and other financial service providers such as micro-credit. This approach has proved to be feasible, though some problems have been identified such as difficulties in identifying people in the informal economy, relatively high administration costs, fragility, limited benefits, lack of risk-sharing, and high fluctuations in membership. As one solution, umbrella organizations and redistribution mechanisms have been discussed and partly implemented. is not a large body of experience with this approach yet. However, Ghana has implemented a national health insurance system that combines a social insurance approach with district-based mutual health insurance schemes that aim at universal population coverage. The approach is described in chapter 20.

In summary, micro-insurance and community-based organizations are seen as useful and valid instruments, particularly in the transition to universal coverage and comprehensive SHI. The main challenge is to manage the process of transition without discouraging and punishing those who have shown initiative and commitment to developing these schemes and being members of them. There are cases where a step-by-step approach has been effective in maintaining community structures and tasks while at the same time benefiting from larger risk-sharing communities and from administrative economies of scale.

There is a large literature and a number of handbooks on micro-schemes available, for example from the ILO programme “Strategies and Tools against social Exclusion and Poverty” (ILO-STEP).

Micro-insurance schemes are similar to conventional insurance in that they provide mainly risk-sharing services to their clients. The difference lies in the types of clients (mostly poor people), the kind of risks

(mostly small), the number of members (often small groups or communities) and the kind of organization (often community-based, less formalized, less elaborate administrative arrangements and cheaper infrastructure). Nevertheless, micro-insurance requires special skills and environments in order to function. Micro-insurance schemes have mushroomed around the world during the past decade and many are regarded as a useful complement to SHI, or at least as a step towards universal SHI.

18.2. Challenges of micro-insurance

This chapter summarizes some experiences with micro-insurance schemes and presents some conclusions (Weber, 2002). Although some problems and solutions mentioned in this chapter also apply to large SHI schemes, they are particularly common in micro-insurance schemes where they are more difficult to handle due to very limited resources, regional limitations, and limitations in risk mix. Micro-insurance schemes focus on the informal sector without having the possibility to rely on the formal sector for redistribution and administration.

Micro-insurers – like other private and public insurers – must be aware of multiple possible failures at every point in the health care system, whether in the market itself, the insurance and reinsurance systems, or systemic corruption and fraud.

The critical challenges facing micro-insurance schemes include the following:

- The environment in which micro-insurers operate is hampered by inadequate or poor providers so there is little a scheme can cover, clients have low incomes, and there is a lack of information about options for, and prices of, care. In addition, there is a deteriorating public health system and an expensive private system (this is not specific to micro-insurers).
- The development of insurance in many developing countries is inhibited by distrust and scanty knowledge of insurance practices, as well as by a lack of know-how, high transaction costs, lack of cash and financial intermediaries, high drop-out rates, lack of competition, and lack of sustainability (this is not specific to micro-insurers).
- Many schemes have to deal with the problem of adverse risk selection. Members try to join the scheme when they see an advantage in it (e.g. when they are sick or pregnant). They often drop out when they recover or if they see that they have paid contributions without obtaining any benefit from the scheme. Adverse selection can put a scheme out of business if it does not take protective measures (this applies to most voluntary health insurance schemes).
- Moral hazard is a challenge that can come from the insured as well as from providers. *From insured:* Early in their membership, many members try out benefits to see if the insurance scheme works. For this reason, a cost bulge typically occurs with new members. Apart from this, the amount of moral hazard from members depends on the benefit package. The risk of moral hazard is high if low-cost benefits such as consultations and drugs are paid and no co-payment is required. On the other hand, if more expensive benefits such as surgery and hospital treatment are covered, the exposure to moral hazard is lower. No one wants to undergo abdominal surgery, for instance, just to collect insurance benefits. *From providers:* Some providers deliver unnecessary services. The risk largely depends on the type of payment they receive. Fee-for-service payments invite moral hazard problems, whereas capitation payments give no incentive to overtreat patients (this problem is faced by all health insurance schemes).
- The impossibility of introducing reinsurance, and reinsurance failure, hit micro-insurance schemes hard. Reinsurance makes sense only if the basic insurance premium is calculated to cover average costs. Reinsurance can deal with risks but it cannot solve a chronic deficit on client insurance. To reinsure micro-insurance schemes, a group of micro-insurers must group together to enable risk-sharing. Reinsurance needs a sound basis for calculating risk. Many micro-insurers have anecdotal evidence about most of the data needed but no reliable statistics or accounting (this problem is faced by all health insurance schemes).

- Corruption is common in many countries and may seriously hamper an insurance scheme's chances of success. Fraud may originate with the insured who claim fictitious health care costs, or with administrators who divert monies collected by the insurer (this problem is not specific to micro-insurers).
- Risk coverage may fail. Sound risk analysis is the basis for ensuring that the scheme provides only the services that clients need. The main benefit of health insurance, especially for the poor, is coverage of catastrophic risk (illnesses or accidents requiring extremely expensive treatment in terms of the average household budget). However, experience shows that people who agree to pay contributions expect to obtain more than coverage for rare catastrophic events. Insurance against catastrophes alone is harder to sell than comprehensive coverage. Objective and subjective needs have to be separated. Objective needs may be medical (prevention, diagnostics, injuries, and available treatments) and they can be financial (coverage against the risk of treatment costs that are too high for an individual). Subjective needs are based on individual preferences, not objective criteria. Theoretically, any medical condition requiring diagnosis and treatment can be covered by health insurance. However, because of financial and other restrictions, micro-insurer benefit packages are very limited. Many micro-insurance schemes pay for health care services (even if they are cheap) until they run out of money. If the budget is exhausted or very small, expensive treatments, not the cheap ones, are cut first.

Setting up micro-insurance takes time and requires special skills and strategies that are different from those of traditional insurance schemes. The difficulty of setting up the scheme depends on the risks covered, the model chosen and other factors such as the experience of the implementing organization, familiarity with insurance in the country, and financial and technical resources, both internal and external). It may take a long time for the full benefits of insurance to be felt. This is less true in micro-insurance, but even here long-term client relationships can play an important role. This is even more relevant for certain life micro-insurance products (long-term life, endowments, annuities) that can mature after 15 years or even longer. This assumes a stable professional structure in the implementing organization, with a long-term vision and the ability to survive internal and external challenges in order to fulfil its commitments to its insured members (and the insurance provider in case of a partner-agent model). Table 24 gives an overview over the different types of micro-insurance and their complexity.

Table 24: **Relative complexity of the different fields of micro-insurance**

Field/product	Protection provided	Complexity
Crop	Financial compensation in case of crop failure caused by uncontrollable adverse events	HIGHLY COMPLEX
Health care	Compensation of health-care expenses in case of illness, childbirth and/or physical injury	
Life/old age (annuities, endowment)	Financial compensation in case of the death of the breadwinner and/or survival (old age)	COMPLEX
Property and asset	Financial compensation of damage or loss (destruction, theft) of assets, work premises and tools	MODERATE
Disability	Financial compensation in case of disability of the breadwinner	
Term Life	Financial compensation in case of the death of the breadwinner, plus compensation of burial costs	SIMPLE
Credit Disability	Ongoing loan payments if borrower becomes disabled	
Credit Life	Loan principal and interest paid on death of borrower	

Amended from: *Preliminary donor guidelines for supporting micro-insurance*. CGAP Working Group on Micro-insurance, October 2003.

18.3. Solutions

The following sections provide some common solutions to the most typical forms of problems related to insurance and micro-insurance.

18.3.1. Environmental solutions

Insurmountable though these problems may seem, some micro-insurers are solving them. In doing so, they have learned lessons that may help others who are new to the community health insurance business.

Lack of supply and lack of purchasing power: Insurers should start in areas that have a supply of health care. Insurance cannot be created without a health-care market, but insurance can help to build that market. Insurance both concentrates and increases purchasing power. Thus, with the establishment of health insurance, the market may develop, expanding both the supply of care and equality of access. An efficient insurance mechanism has an impact not only on the number of providers but also on the price, quality, and availability of care. The effect of insurance thus extends beyond risk-sharing. These side-effects help even the uninsured population. Moreover, coverage of transport costs may help to overcome gaps in infrastructure.

Lack of information about care possibilities: Some schemes cooperate with community health workers or village chiefs, who receive training concerning health care possibilities. Other schemes, which do not rely on "multipliers", run information campaigns. However, insurers may have an interest in not initiating too large a demand as it could overwhelm the system. *Lack of information about prices*. Some schemes try to allay patients' fear of being surprised by high prices by emphasizing negotiated fixed prices and posting them at the entrance to the facility. This practice has diverted demand from providers with opaque prices to providers with transparent prices, even if insurance does not cover the full cost. Consumer protection of this kind costs insurers nothing but it helps patients financially.

Split-care markets: One way to deal with the split-care market is to sign contracts with providers that exclude this option. Doctors receive contracts that allow them to earn their living at the hospital, but in exchange they must commit themselves to working exclusively in the hospital that employs them. A codex is agreed between health insurer and hospital, ensuring this exclusivity and stipulating sanctions for fraudulent behaviour. This arrangement could help many public hospitals to improve their services by attracting and keeping qualified staff if they also pay them competitive salaries. This will be possible only through (official) user charges and co-payments.

18.3.2. Insurance market failure

One of the main reasons micro insurers collapse is the lack of sufficient clients. Some micro-insurers have had good experiences using a variety of techniques. For instance, some have received support from donors and have used the donor's name as a selling point. Others have cooperated with local stakeholders such as village chiefs, public administrations, hospitals and other local providers, or have teamed up with well-known health care providers or organizations such as cooperatives or micro-credit institutions. Micro-insurers have also invested in social marketing, solicited technical support from international organizations and donors, both on start-up and later, or have accepted contributions in kind instead of cash payments. Some micro-insurers have worked closely with banks when setting up the schemes, enabling them to negotiate good service conditions and invest in information. It is important to involve members in designing benefit packages and contributions and to involve stakeholders in scheme administration. Another option is to make the insurance and benefit package as simple as possible, working with volunteers instead of professional staff, and tapping all available community support.

18.3.3. Reducing adverse selection

To reduce adverse selection, many micro-insurers have found practical solutions such as waiting periods, compulsory membership (e.g. in the case of marriage or affiliation with a cooperative), and group coverage (e.g. whole families or a minimum percentage of a community or a cooperative).

18.3.4. Moral hazard

To reduce moral hazard from members, many schemes set limits on claims. Such limits have proved especially useful in situations where members can easily influence demand (e.g. primary consultations). Moral hazard from the insured is less problematic if the insurance covers mainly catastrophic risks (nobody elects surgery just to collect benefits, but many people consult a doctor if it is free). Micro-insurers can also influence moral hazard from the insured by introducing co-payments.

The main tool for reducing moral hazard from providers is the choice of an appropriate provider payment mechanism (e.g. capitation instead of fee-for-service) and the use of effective quality control and patient referral systems. Implementing these measures, however, requires know-how and compliance on the part of the providers.

18.3.5. Reducing corruption

One proven method for reducing the risk of corruption and fraud is community involvement and social control. In communities where people know each other, the risk of corruption is lower than in large anonymous communities. The design of the benefit package and the administrative procedures can also help overcome this risk. To head off the risk of cheating on benefits, many community-based schemes have introduced membership cards with photos of the family covered.

18.3.6. Reducing failure of risk coverage

Sound risk analysis is a cornerstone of insurance. This means providing only those services that clients really need. To find out what those services are requires sound research into the risks involved in illness and accidents. Those are often not the risks covered by existing schemes. For instance, catastrophic risks are frequently not covered but they are one of the main causes of poverty. Faced with a catastrophic health event, families borrow money or sell land and cattle to pay for treatment, yet these goods are the basis of their subsistence. Insurance of catastrophe risk is the only way to help the target groups out of this dilemma.

Catastrophic diseases might be defined by cost, diagnosis or definition of a threshold. A cost definition might state, for instance, that costs exceeding two months' income of the target group will be covered up to a maximum amount. A diagnosis definition might name the most frequent causes of surgery and treatments that would be covered by fixed-case payments. A threshold definition might state that members pay treatment costs up to a set ceiling, beyond which insurance picks up the bill. In this case, "catastrophe" means accumulated costs of treatment, not the cost of only one intervention.

The coverage of catastrophic risks is also a challenge for reinsurance, but it can have an impact on coverage and administration of these cases. Catastrophic risks are easier to administer than many small risks because they occur less frequently.

18.4. Conclusions

This overview of micro-insurers' challenges and solutions shows that existing schemes have evolved in a difficult environment. Table 25 provides a summary of advantages and disadvantages of micro-insurance and community-based schemes.

Table 25: **Advantages and disadvantages of micro-insurance and community-based schemes**

Advantages	Disadvantages
Can reach the informal sector	Poor may be excluded unless subsidized
Can reach the close-to-poor segments of the population	May be financially vulnerable if not supported by subsidies
Strong social control limits abuse and fraud and contributes to confidence in the scheme	Coverage remains a small percentage of the population
Is a possible transition to SHI and a "learning experience"	Risk of adverse selection
Low-risk and low-cost alternative	Often is associated with lack of professionalism in governance and administration
Involves individuals and communities in financing	Relatively high administration cost as share of contributions
Is not dependent on state interventions but mostly depends on private and NGO initiative	Often concentrates on low-risk benefits and not catastrophic risks
Low political risk	May be threatened by high-cost events like epidemics due to small risk community
High potential for extension	Often confronted with high drop-out rates and fluctuation
Synergy possible with other micro-finance	

Micro-insurance schemes have arisen for three main reasons, namely:

- withdrawal of public funds from health care financing in many developing countries;
- providers' difficulties in collecting their fees from patients;
- external initiatives, mainly from NGOs and other stakeholders.

The involvement of local stakeholders, the adaptation to local customs, and the development of special techniques to overcome micro-insurers' typical problems have led to a series of schemes that are operating today in many developing countries. Many of these schemes are still struggling with problems, including high drop-out rates, large deficits (often covered by donors or by local government units), and fraud. The use of pluralistic health financing mechanisms and related linkages can improve the success of micro-insurance schemes (e.g. by improving supervision, technical assistance and financial sustainability). Cooperation between micro-insurance schemes and an emerging or extending SHI scheme can significantly increase coverage, acceptance and administration of SHI and at the same time support the sustainability of community-driven approaches like micro-insurance without discouraging their efforts.

18.5. Questions raised

- In what ways can the development of SHI be seen as process?
- What are possible steps towards the establishment of SHI?
- What are the features of pilot projects?
- What are the main challenges and problems of micro-insurance schemes?
- Which solutions to these problems have been tried and what are the experiences?
- What can micro-insurance schemes contribute to the development and creation of SHI?

CHAPTER 19.
Social dialogue

19.1. The need for social dialogue

Making decisions about the design and implementation of SHI is just one aspect of introducing SHI. The other aspect is consensus-building through social dialogue. In free and participative societies there is no alternative to this. This process has to happen partly during the planning and design process (see chapter 6) and partly once a proposal has been made.

Concern about public health and the increasing cost of health care have made health one of the most debated political issues in many countries. There is wide recognition of the role of social dialogue in advancing and sustaining reform processes in many areas of the health sector in order to improve health care and mitigate negative impacts on public health. In order to ensure better delivery of health services, the institutions and capacity for social dialogue need to be strengthened.

Social dialogue and consensus-building are needed because:

- social partners and stakeholders will eventually have to work with the new scheme and thus should accept it and support it;
- governments and planners cannot know all the concerns and problems of stakeholders without consulting them;
- the constitution of many countries foresees a social dialogue before decisions are taken, and decision-makers depend on voters and interest groups acceptance of decisions;
- social dialogue facilitates smooth implementation.

With the help of this guidebook, planners may be able to develop ideas about possible systems decisions. However, they will need not only expert advice but also the views of the people involved. Combining expert know-how with the voices of people makes for valid decisions.

19.2. Tools of social and national dialogue

There are formal tools of social dialogue such as official parliamentary or government hearings and non-formal types of dialogue such as exchange of information, conferences, and working groups.

Social dialogue can rely on direct dialogue or on indirect tools and methods. Direct dialogue includes all types of negotiation and consultation, starting with the exchange of information (between representatives of governments, employers, employees and other stakeholders) on issues of common interest relating to economic and social policy. These elements of social dialogue are crucial to the outcome sought by the social partners and their choice depends on the outcome desired. A common understanding has to be reached on the purpose of social dialogue. Therefore, at the start of a process of social dialogue, the social partners should have a clear idea of the elements of social dialogue to be included and who will decide on their inclusion.

Indirect tools are technical tools such as surveys, discussion groups, workshops, focus groups, and interviews with selected representatives of social groups. The purpose of all these instruments is to obtain information and quantitative and qualitative data about the problems, concerns and desires of the people involved. In the end it will be the people who will make the system succeed. Without knowing their will and ideas it is not possible to come to a valid decision.

19.3. Partners of social and national dialogue

The partners in social and national dialogue in health services are in principle all people concerned. People are usually represented through authorities and interest groups such as public authorities as regulators or as employers, private employers' and workers' organizations, and various stakeholders in the health sector. In view of the financial implications of the health sector for other government structures and for employers and workers, other stakeholders beyond the health sector may also be involved in policy development (except on matters that are properly the concern of parties that conduct negotiations and collective bargaining). The organizations or institutions that represent the groups in the health sector have changed over the past two decades. A greater variety of government levels are also involved. New private employers have entered the health sector and related services. Key partners and stakeholders are:

- central government (e.g. ministries and agencies such as the Ministries of Health, Finance, Labour, Social Welfare, Commerce, Agriculture, Economic Affairs, and the Planning Commission;
- local government (provincial and district governments, communities, selected villages, and mayors;
- employers' organizations and individual large, medium and small employers (through interviews, workshops and site visits);
- employees (either through trade unions or through focus group discussions, surveys and individual interviews);
- health care providers (through their respective organizations and or through site visits, surveys and individual meetings);
- existing health insurance schemes for certain population groups, or private health insurance schemes;
- civil society organizations and NGOs;
- community-based health insurance schemes;
- patients (through surveys and focus group discussions).

Many of these groups of partners have their own organizations or representatives which are the counterparts in the dialogue. However, in many countries, patients, community-based health insurance schemes and some types of providers do not have representatives. In order to get their opinions and ideas, specific methods of dialogue must be used, as discussed above.

The consent of some partners is sought because they will have an important formal or informal power when decisions are made. Consensus with them must be sought. Other groups do not have formal representatives or lobbies but their influence may nevertheless be important (e.g. in democratic systems where failures in decision-making may lead to loss of power through elections). Thus, decision-makers must seek the opinions of those people who have no representatives.

SECTION V.

Drawing on experience

CHAPTER 20.
Country examples

20.1. Choosing systems of finance and provision

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

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

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

20.2. Countries with mainly tax-financed systems

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

20.2.1. The health care system in England*

Health services in England are mainly financed by government through general taxation and national insurance contributions and are largely free at the point of use. They are mainly provided by salaried doctors and nurses in government-owned hospitals and by self-employed general practitioners (GPs). The National Health Service (NHS) provides preventive and primary care and hospital services to all persons "ordinarily resident" in England. About 11% of the population is covered by supplementary private medical insurance (PMI), which mainly provides access to acute care in the private sector.

The Department of Health allocates 80% of the NHS budget to 152 Primary Care Trusts (PCTs) using a weighted capitation formula that accounts for population size and various indicators of health-care need. PCTs are responsible for commissioning health services to meet the health-care needs of a given population, and also provide some primary care services. PCTs are monitored by 10 Strategic Health Authorities (SHAs) and are ultimately accountable to the Secretary of State for Health.

* This summary focuses on the health system in England. Prior to 2000 we could speak about the National Health Service in the United Kingdom. However, political devolution to the constituent countries of the United Kingdom (England, Northern Ireland, Scotland and Wales) in 1999 has resulted in a diversity of approaches. The way in which health systems in Northern Ireland, Scotland and Wales differ from the health system in England has become more marked over time.

Primary care is provided through GP practices, NHS Direct (a telephone and Internet service), NHS Walk-in Centres, dentists, opticians and pharmacists. Specialist care in the NHS is provided by specialists working in hospitals (known as "consultants") and different types of publicly-owned hospitals (known as "trusts"), as well as some private hospitals. In 2003 foundation trusts were established as publicly-owned hospitals with greater autonomy and independence from central government. In the same year, the government commissioned several independent (private) sector treatment centres to provide NHS patients with relatively straightforward elective or diagnostic procedures.

Patients can register with a local GP practice of their choice, and they require a GP's referral in order to access specialist services. Expanding patient's choice of hospital has been a key government policy in recent years. Since 2006 all patients needing to see a specialist have been able to choose from at least four hospitals or clinics. From April 2008 all patients needing planned elective care should be able to choose to be treated by any provider that meets eligibility criteria and NHS clinical and financial standards. Patients can also exert some control over the date and time of their specialist appointment using an electronic booking system.

Most health services in the NHS are purchased by PCTs. In 2005 the government introduced a system of practice-based commissioning (PBC). Under this system, GP practices commission (purchase) care for their registered patients using an "indicative budget". This means that commissioning resources remains formally under the control of the PCT, but power to allocate these resources is passed to practices. PBC aims to give practices greater involvement in purchasing decisions and may encourage them to provide services in-house or contract with new providers rather than continuing to refer to established hospitals.

In 2003 the government introduced an activity-based payment system for hospital services. The new system, known as "Payment by Results" (PbR), replaces a system of global budgets based on annually-negotiated block contracts. Under the old system there was generally no direct relation between activity, case-mix and payment; some PCTs negotiated cost and volume contracts with hospitals, but these were the exception rather than the rule. Under the new system, PCTs commission the volume of activity required to deliver service priorities, adjusted for case-mix, from a number of hospital providers. Hospitals are paid for any services they provide according to a national tariff per "health resource group" or HRG (similar to diagnosis-related groups). The national tariff is calculated by the Department of Health on the basis of the weighted average cost of NHS inpatient episodes and day cases, including all clinical and nonclinical costs. In 2005 the national tariff covered all patients admitted for elective care. In 2006 it was extended to cover outpatient, accident and emergency services and now accounts for about 30% of a PCT's budget. Health professionals working in hospitals are mainly paid by salary.

Most GPs are self-employed professionals who own or rent their own premises, hire their own staff and supply general medical services. In 2004 the government negotiated a new contract with GPs. Under the new system, a global sum is paid to each GP practice (rather than to individual GPs) to cover staff costs and to reflect patient numbers and characteristics. This change was intended to give practices flexibility in deciding on the skill mix necessary to provide patients with primary care services. The new system also represents a major focus on quality and outcomes. Fee-for-service payments are now designed to reward the achievement of targets in clinical standards, organizational standards and the patient experience. They also reimburse GP practices for providing specific "additional" services such as cervical screening, contraception and out-of-hours care. Around a third of GPs choose to work as salaried employees of PCTs under personal medical services contracts designed to meet the needs of a particular area.

Patients pay a fixed co-payment per prescription for drugs prescribed outside hospital, although many categories of patient are exempt (e.g. children, people on low incomes, pregnant women, people aged 60 and over, and people with specific chronic conditions) so that the majority of prescriptions are exempt. Patients also contribute to the cost of dental care and optometry services. Over time, NHS coverage of dental care has gradually declined. There are no patient charges for GP consultations or normal hospital services.
Public sources of health-care finance include general taxation and national insurance contributions paid by employers and employees. The size of the Department of Health's budget is agreed annually. Between

1980 and 2000 there was a steady decline in public expenditure as a proportion of total health-care expenditure (from 89% to 81%). Since 2000 the government has increased spending in the health system, bringing the proportion of public expenditure back up to 87%. Total expenditure on health has risen in recent years from 7.3% of GDP in 2000 to 8.4% in 2005. The proportion of the population covered by PMI has remained relatively stable over time. In 2000, out-of-pocket payments were spent on over-the-counter drugs (41%), PMI (17%), NHS charges (13%), hospital care (8%), ophthalmic services (8%), complementary or alternative medicine (7%), dental care (5%) and audiology (1%).

NHS reforms have been dominated by organizational restructuring and, more recently, changes to the way in which providers are paid. In 1990 the Conservative government introduced a purchaser-provider split and GP fund-holding and gave NHS hospitals greater autonomy. Subsequent reforms carried out since 1997 have consolidated rather than reversed these changes. In 1999, the creation of PCTs institutionalized the role of primary-care purchasing that was first attempted under GP fund-holding. In 2003, legislation creating foundation trusts outside the direct control of the Secretary of State extended hospital autonomy. Between 1997 and 2003, reforms intended to increase local autonomy were accompanied by the introduction of central targets to improve performance. Many of these targets were effective in reducing waiting times.

More recently, the focus on targets has been replaced by a new emphasis on making health services more responsive and accountable to the population in general and patients in particular, notably through expanded patient choice of hospital, greater competition between public and private hospitals, the new system of activity-based payment for hospitals, the introduction of practice-based commissioning and the establishment of independent regulatory bodies. There have also been attempts to expand NHS capacity through increased use of the private sector and the establishment of independent-sector treatment centres.

In the coming years, the government may encounter tension arising from, on the one hand, its desire to encourage responsiveness through local autonomy, competition and patient choice of provider, and on the other hand a need to control health-care expenditure in the face of growing demand and limited resources. In some cases, implementation of reforms has been slow and controversial. For example, active commissioning by GP practices is still not widespread, while payment-by-results applies only to a limited number of activities. Recent reports have found little evidence of the new hospital payment system leading to efficiency improvements or of independent-sector treatment centres increasing capacity. Concern about the impact of an expanded role for the private sector in providing health services seem likely to continue, particularly since the government has not yet issued detailed policies about how payment-by-results will apply to these providers.

20.2.2. The health care system in Canada

The Canadian health care system is characterized by public financing and private provision. The provinces are responsible for the organization and delivery of health care services. However, in practice each province operates a single-payer universal system of physician and hospital care covering Canadian citizens and permanent residents. The federal government contributes to the funding of the provincial systems, conditional upon their adherence to the five principles outlined in the 1984 Canada Health Act, namely.

1. Public administration: each provincial insurance fund must be administered on a non-profit basis by a public authority.
2. Comprehensiveness: each provincial insurance fund must cover all insured health services provided by hospitals, physicians or dentists (surgical-dental services in hospital) and, where the law of a province permits, similar or additional services rendered by other health-care practitioners.
3. Universality: each provincial insurance fund must cover all insured health services on uniform terms and conditions.
4. Portability: each provincial insurance fund must cover all insured individuals who leave the province

during the waiting period (not exceeding three months) after which the new province of residence assumes coverage.

5. Accessibility: each provincial insurance fund must not impede or preclude, either directly or indirectly, whether by charges made to insured persons or other means, reasonable access to insured health services.

General practitioners (GPs) are most often the first point of contact in the health system and they, along with specialist physicians, are private self-regulating professionals. Patients have free choice of GP and need a referral in order to access specialist care. Specialist care is almost wholly provided within hospitals. However, recent years have seen a focus on reforming and strengthening primary care, and an increase in specialist day-surgery clinics. Hospitals are mostly not-for-profit organizations run by regional health administration (RHA) boards (or hospital boards of trustees in the case of Ontario and some hospitals in Quebec and Manitoba). Hospitals are accredited on a voluntary, nongovernmental nature. While individual health facilities and providers are responsible for purchasing medical equipment, provincial health ministries play a direct role in planning and procurement of expensive advanced medical technology such as MRIs and CTs.

Provincial ministries of health allocate a budget to RHAs (or local health integration networks – LHINs – in the case of Ontario) for hospital and community (e.g. long-term) care either by a historical or population-based method. The devolution of funding from the provincial to regional level that took place mostly throughout the 1990s, termed "regionalization", aims broadly to improve coordination of hospital and community care and to increase responsiveness to local needs. Hospitals receive global operating budgets from the RHA/LHIN. These budgets do not include the cost of physician services that are mostly paid directly on a fee-for-service basis by the provincial ministry of health.

Physicians (via provincial medical associations) and provincial governments negotiate fee schedules. Alternative remuneration methods have slowly been introduced with some provinces contracting GPs on a blended system of salary, capitation and fee-for-service. Specialists working in hospitals are paid mostly by fee-for-service, although some alternative payment arrangements are in place in some provinces (e.g. for cancer and psychiatry specialties in British Columbia). In 2004 fee-for-service payments constituted about 83% of total physician remuneration.

Patients pay for services not covered by the provincial insurance plan, such as dental care, vision care, long-term care, allied medical professional services, and prescription drugs outside of hospital. However, the costs of these services (not including dental care) are subsidized for certain groups in the population to varying degrees across the provinces. For example, the costs of outpatient prescription drugs are largely covered for low-income individuals receiving social assistance in all provinces, and for individuals over age 65 by most provincial plans. Private insurance schemes, mostly employment-based, can be taken out to cover the cost of services not covered by the public scheme. Private insurance companies are prohibited or discouraged from offering insurance for services available under the public scheme (hospital and physician care).

The federal government directly funds national public health programmes, organizations responsible for pharmaceutical regulation and drug product safety, in addition to health care services for the aboriginal population living on reserves.

The majority of health care costs (about 70%) are financed from taxation by the provincial and federal governments. About one third of provincial health expenditure is from federal transfers of federal tax revenue (termed the Canada Health Transfer), the remainder from provincial taxes – in some provinces "health premiums" (either a flat tax, as in Alberta and British Columbia, or additional income tax, as in Ontario) – and to a limited extent municipal taxes.
Out-of-pocket payments constitute 15% of total health expenditure, funding most vision care and over-

the-counter medications. Private health insurance makes up 12% of total health spending, covering about half of dental care costs, about one third of prescription drug costs and one-fifth of vision care costs. Hospital and physician services are free at the point of use.

Total expenditure on health as a percentage of GDP is approximately 10.4% – similar to many other OECD countries but much lower than the USA. Over 40% of health expenditures were directed to hospital and physician services (insured services under the terms of the Canada Health Act). A further 22% was spent on provincial programmes and subsidies for long-term care, home care, community care, public health and prescription drugs, while an estimated 30% went to private health services (mainly dental and vision care) and over-the-counter and prescription drugs.

Recent reform initiatives have included introducing regional purchasers, improving primary care, and developing information systems. The most substantial cross-provincial reform was "regionalization". In the 1990s (earlier in Quebec and later in Ontario) all provinces established geographically-based regional health authorities to purchase and manage hospital and community services for their local population in order to improve coordination and continuity of care. Since, as yet, no province has devolved funding for physician remuneration or prescription drugs to the regional authority, this limits the potential integration of services at local level. With regard to primary care, although there have been different speeds and objectives of reforms across provinces, some initiatives included extending the role of nurse practitioners, introducing alternative GP payment methods to the prevalent fee-for-service model, improving out-of-hours care, and establishing community clinics/health centres. Improved health information collection and research has received increased investment on both provincial and federal levels, aiding the development of performance measurement and quality as well as waiting list management, the latter being the source of much public dissatisfaction.

20.3. Countries with some social health insurance financing

The four countries described here are taking very different approaches to SHI.

20.3.1. First steps to social health insurance in Ghana

Ghana's health insurance system has a unique mix of social insurance and mutual health organization principles that is driven by strong political commitment, a pro-poor focus and support from some development partners.

At the end of the last millennium all political parties in Ghana showed dissatisfaction with access problems associated with the out-of-pocket health financing system ("cash and carry"). Consequently, the government decided to abolish this financing mechanism and replace it with health insurance to reduce the burden on individuals and achieve better utilization rates. With the technical and financial assistance of DANIDA, USAID, GTZ, ILO and the World Bank, the government aimed to integrate 50–60% of the residents in Ghana into the national health insurance scheme within the next 5–10 years.

The new National Health Insurance System (NHIS) was approved by the Ghanaian Parliament in August 2003 and became legally effective with the accompanying Legislative Instrument (L.I. 1809) in November 2004. The NHIS as the regulatory body provides affordable access to health services through the District Wide Mutual Health Insurance Schemes (DWMHIS), voluntary not-for-profit mutual health organizations (MHOs) and private for-profit health insurance companies. Since the implementation of the NHIS, the rate of utilization of health care services has considerably risen among insured persons as well as among the non-insured. By December 2006, 29.4% of the population were enrolled in one of the district-wide health insurance schemes.

It is compulsory for every resident in Ghana to become a member of one of the three health insurance schemes. As part of the new NHIS, the government has made a commitment to "devise a mechanism for ensuring that the basic health care needs of indigents are adequately provided for". In the meantime, a

mechanism has been put in place that fully subsidizes the insurance premiums for the very poor through the National Health Insurance Fund. Additionally, insurance members' children under 18 years, formally employed persons (who are contributing to the social pension fund), pensioners and persons aged over 70 years are exempted from paying premiums but not from registration fees.

The minimum health care benefits are prescribed by the L.I. 1809 and cover most diseases in Ghana (about 95% of the disease burden). Additional benefits may vary from scheme to scheme, but in most cases they depend on the premiums paid and can be defined by members on an individual basis.

Health care providers have to meet accreditation criteria before being allowed to offer services. As of May 2007, the payment is usually fee-for-service following a tariff structure that was agreed between health service providers and the NHIS. However, the laws provide for other payment systems like capitation or DRG that may be used in the future.

The NHIS is financed by a combination of personal contributions from persons in the informal economy, a social insurance contribution of 2.5% for all members of the Social Security National Trust (SSNIT), and a 2.5% health levy (i.e. an indirect tax similar to value-added tax).

The system is also supported by the Global Social Trust, launched in February 2007 by ILO's Social Security Department. The privately collected funds will subsidize health insurance premiums of (selected) extremely poor persons and people who cannot afford the full amount (mostly pregnant women and mothers with young children). Further support is provided by DANIDA, the Netherlands, the World Bank and other partners.

With the majority of the registered persons (76.6%) belonging to the exempted category, and with a still fairly low coverage and a broad benefit package, the NHIS faces serious challenges in financial sustainability.

The NHIS has also struggled so far to fully integrate the poor and vulnerable. Most poor people do not qualify as being extremely poor, but they nevertheless cannot afford to pay the registration fees and premiums.

20.3.2. The health care system in Egypt

Health services are provided in Egypt by five completely distinct health care systems. First, everyone has (at least theoretically) free access to the tax-financed public health care system. Second, the Health Insurance Organization (HIO) runs its own health system, which is open to only about 50 % of the population – HIO members (not their dependants), retirees, children and students. Third, the two Curative Care Organizations (CCO) of Cairo and Alexandria also have clinics and hospitals exclusively for their members. Fourth, some ministries (social affairs, education, interior, transport and defence) run their own hospitals, which provide first-class medical care to their ministry staff. Finally, commercial companies and NGOs offer health service to everyone who is able to pay for it.

The benefits package covers primary care, outpatient hospital services, dental care, pharmaceuticals, medical appliances, hospital care and even evacuation for specialized surgery. It does not generally cover dependants.

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

Some 50 % of all hospital beds are in public hospitals which are administered by the Ministry of Health, but their quality is mediocre. In general, 30 % of the beds belong to the HIO, the CCO and the ministries, and their quality is much better. Only 20 % of the beds are in private or NGO hospitals, which reach the highest level of quality.
Contracts for the health care provided to HIO members by private providers (independent physicians,

nurses, health clinics, specialized hospitals) are mainly on a fee-for-service basis (i.e. patients have to advance the fee and are recompensed by the HIO later).

The HIO is funded by contributions of 4% of earnings, of which 75% is paid by employers and 25% by employees. Pensioners pay 1% and widows 2% of their income. For government employees, the contribution rates are 1.5% for the government and 0.5% for the employee. There is a ceiling on the level of income used to calculate contributions and there are small co-payments for the use of services. The HIO is subsidized by the Employment Injury Scheme. In addition, it receives subsidies from the government budget, thereby competing with the public health system for public funds.

Benefits under social insurance are 6–7 times greater than those offered by the state health services. Half of HIO spending is on drugs, and around a third is on its own facilities.

20.3.3. The health care system in Thailand

In October 2001, Thailand took a historic step towards achieving full population coverage in health care by introducing the Universal Health Care Scheme (called the UC scheme, and commonly known as the "30 baht" scheme). This scheme offers any Thai citizen who does not belong to the Social Security Health insurance scheme (SSO scheme) or the Civil Servants' Medical Benefit Scheme (CSMBS) full access to health services provided by designated district-based networks of providers (consisting of health centres, district hospitals and cooperating provincial hospitals). Eligible persons have to register with the networks, obtain a free insurance card and pay a nominal co-payment of 30 Baht (approximately US$ 0.75) for each outpatient visit or hospital admission. Drugs on prescription are free of charge. The scheme uses mainly public providers, funded by a combination of taxation and user fees. A number of medical benefit and health insurance schemes have existed in Thailand for a long time, including the CSMBS and the voluntary health card scheme, which covers the cost of care in government facilities.

The 1990 Social Security Act (SSA) aimed at extending considerably the use of social insurance funding for health services. The SSA originally applied to workers in companies of 20 or more employees (approximately three million people in total). In 1993, its coverage extended to employees in establishments with 10 or more employees, and in 2002 to enterprises with only one or more workers.

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

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

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

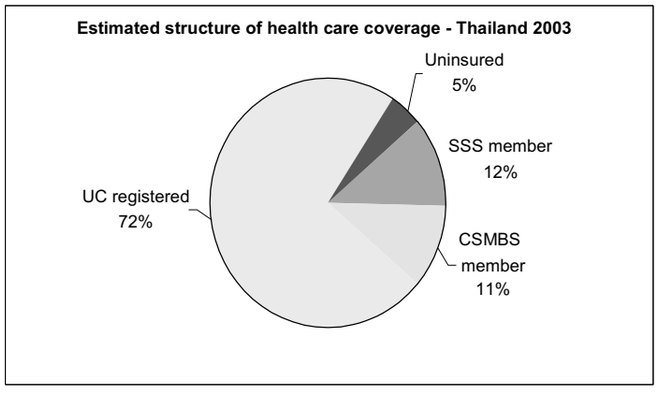
The scheme is financed by equally shared contributions from the insured person (1.5% of salary), the employer and the government. It is compulsory for all companies unless they can show that they provide a higher level of medical benefits through another scheme.

The scheme has been remarkably successful with respect to population coverage in its first two years. However, its long-term fiscal sustainability is as yet unclear. The national health care financing system of Thailand now consists of five major components:

- the SSO scheme covering currently about 7.4 million card-holders who are eligible for health care benefits;
- the non-contributory CSMBS covering some 7 million eligible people (including about 3 million civil servants and about 4 million eligible dependents, i.e. children, spouses and parents);
- the UC scheme with a registered total membership of 46.5 million people (UC beneficiaries can be classified in two groups: 24.3 million beneficiaries who are exempted from a co-payment of 30 baht per episode, and 22.2 million beneficiaries who must contribute a co-payment of 30 baht at point-of-service;
- a self- payer/non-covered group (i.e. people in remote area) of about 3 million people;
- voluntary private insurance which covers about 5 million people.

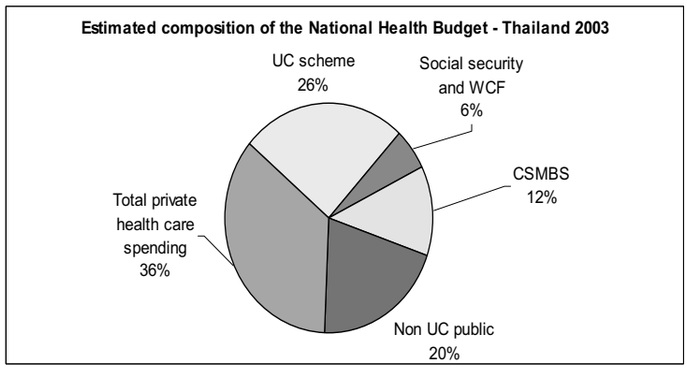
Figures 10 and 11 show, respectively, the estimated composition of the population coverage and the composition of the national health care budget in 2003. Population coverage with respect to access to health care in Thailand can be considered as virtually complete.

Figure 10: **Estimated population coverage by type of health insurance in Thailand**



Source: ILO and International Health Policy Programme mission estimates 15-20 May 2004.

Figure 11: **Estimated composition of health care budget in Thailand**



Source: ILO and International Health Policy Programme mission estimates 15-20 May 2004.

Currently the UC scheme – in theory – permits access to health care for about 70% of the population. The proportion of the population it actually caters for is likely to be smaller as not all people eligible and/or holding a UC card may actually take up the service. In fact, the Health and Welfare Survey 2003 conducted by the Thai National Statistics Office (NSO) showed that only about 57% of registered members used the outpatient services in public health centres and hospitals financed by the scheme, whereas 81% of the registered members used the UC inpatient service. The take-up rate varies greatly according to socioeconomic status and is significantly higher in the lower income groups. It appears that about a third of the better-off population tends to use the UC scheme as a fall-back scheme.

It is obvious that the change to the UC system in 2001 has increased government spending on health care. The actual amount is difficult to determine as the counterfactual (i.e. government spending on health in the absence of the new UC scheme) is not known. Nevertheless, from the increase in the spending level between 2000 and 2003 the additional cost of the scheme is probably in the order of 25 billion baht per year. That order of magnitude is confirmed by IHPP estimates of the dimension of household savings of out-of-pocket health expenditure. The amount was estimated as around 10–13 billion baht for all households that were newly covered by the UC third-party arrangement. Due to the differential take-up rates by income strata this is a substantial income transfer to the lower income households and confirms the Ministry of Health assessment that the reform has had substantial pro-poor effects.

The UC scheme is new insofar as it establishes a firm legal entitlement for all people to access health services. It abolishes significant financial barriers to access since co-payments are small and the needy are even exempted from this payment. However, in line with international experience from many other countries, recent research revealed that even low out-of-pocket payments prevent some people from using needed health care, and exemptions may favour the less poor rather than the very poor.

Entitlement to UC benefits is backed up by a new allocation mechanism for health care resources in the public sector (i.e. the capitation payment) which should ensure that all provider networks receive a fixed budget for each person to whom they provide care. In its present state the UC scheme is clearly not a fully-fledged health insurance scheme as it is not financed by income from contributions. It is rather a health financing variant of a system of National Health Service, in that it combines insurance elements (through legal benefit entitlements) and public service elements (through general revenue financing). The scheme has not had earmarked resources that it could rely on during the first years of its existence. Its resource base had to be renegotiated in an annual government budgeting process. From the point of view of long-term sustainability it is in the interest of the UC scheme to shrink as much as possible by conceding “market share” to the other schemes. It appeared logical to try to establish earmarked income sources that are isolated against annual budgetary competition, and this was done in 2005 when a certain proportion of the taxes on tobacco and alcohol were earmarked for the financing of the UC scheme. This arrangement helps to protect the resources for health care of the economically weakest sections of the population in times of fiscal difficulties.

The financial situation of the UC scheme can be stabilized in the long run only if the scheme constantly shrinks at the expense of other players. The most effective way to reduce government expenditure is through the extension of SSO coverage. Every SSO member is currently supported by a government subsidy of approximately 600 baht per year. That per capita amount leverages an amount of about 1200 baht per year of employer and worker contributions. A UC member costs the government about 1360 baht per year. The greater the number of people that can be covered by the SSO, the better it is for the government.

20.3.4. The health care system in Uganda

This chapter gives an example of a country that is currently discussing SHI at cabinet level. It illustrates the challenges of introducing SHI.

In Uganda, health services are provided by both the government and the private sector. The private sector comprises the private not-for-profit (PNFP), private for-profit, and complementary (traditional healers, traditional birth attendants, etc) health providers. The largest provider in terms of number, size and network of facilities and number of staff employed is the public health service. More than 60% of the facilities and nearly 60% of the beds belong to central or local government. The second largest health care providers are faith-based NGOs.

Government health facilities provide health services free of charge, except in their private wings. Generally, the private sector provides health services on the basis of full payment or part payment by consumers. User fees are charged to cover the cost of services plus a profit that is ploughed back to improve the quality and quantity of health services in the case of PNFP NGO health facilities. Cost-recovery lies between 20% and 80% according to the region or geographical location of the health facility. In some poorer regions patients are not able to pay fees that recover costs and the government and donors therefore cover the cost of health care services consumed.
Health services in Uganda have traditionally been financed from a range of sources – government, health development partners (donors), and private out-of-pocket payments. Government funds are come from taxation, loans and grants. There are multiple health development partners (donors) financing the health sector. Donors currently pay about 40% of the total health expenditure in budget and programme support.

The largest part of health care spending in Uganda is out-of-pocket. According to data from the household survey, the private expenditures of households vary significantly with income and with the rural and urban environment. According to these data, households in the highest income group spend over US$ 40 per household member per year for health while the lowest income groups spend slightly under US$ 6. The average of the country lies around US$ 8 per capita per year, or 3.3% of the total average household consumption (for the lowest income group, however, it is over 20% of household consumption).

Due to the increase in costs of health services, health facilities could no longer sustain themselves and had to increase the price of health services. The new prices were unaffordable by patients, and therefore financing schemes were started to generate additional income to health facilities. These schemes included user fees, drug revolving funds, and health insurance schemes. It was anticipated that these financing schemes would enhance equity, efficiency and sustainability of the health system. The user fees and drug revolving fund approaches were banned at government health facilities except private wings in 2001 because they had not performed to expectation. Nevertheless, user fees represent the main source of cost-recovery at NGO health facilities.

Community-based health insurance schemes are currently not performing well financially and are not yet self-sustaining, but they have enabled clients to seek quality health care services in time and reduced the burden of unpaid debts to the health facilities. In summary, the objectives of SHI (to improve access to health services by the local community, to provide a stable source of funding for the hospital, and to reduce the problem of bad debts) are being achieved in the Ugandan context. Community-based insurance schemes are based on the premise that in communities in Uganda, especially in rural areas, there is a strong collective spirit.

Arrangements vary from area to area. For example, in western Uganda there are Engozi societies. An *engozi* is a locally made stretcher which is communally used to transport patients who are unable to walk to health providers' premises, and to transport those who die at the health facilities back to their homes for burial. It is estimated that 96% of the residents of the district belong to Engozi societies. All members

of the Engozi society make regular financial and/or other forms of contributions to the community-based solidarity fund. There are conditions for cultural organizations to be eligible to subscribe to an insurance scheme. For example, for an Engozi society to be eligible to register in the insurance scheme, at least 60% of member families, or 20 families in the case of small societies, must be able and willing to pay the premiums and co-payments required.

Another method of financing health care services in Uganda is through employers. Some formal sector enterprises with permanent employees pay so-called "health care allowances" to their staff. These are paid together with the salary and in practice are regarded by staff members as part of the salary and not as a reserve. This is why some enterprises choose to hand these funds to a broker who pays the bills of a defined health programme and reimburse the broker for the expenses. Other employers (e.g. Bank of Uganda, Makerere University) have set up health facilities and hired their own health personnel to provide health services to their employees. Complicated cases are referred to designated specialized health facilities. There are other employers, especially those which are wealthy and have few employees, that pay into a health insurance for their staff. These enterprises and their employees, however, represent a very small part of the total Ugandan economy and are exclusively concentrated in Kampala.

Health insurance is being advocated and the Ministry of Health is in the process of introducing SHI. The SHI bill is being discussed at cabinet level. Nonetheless, there is private health insurance (basically for the well-to-do) and multiple community-based insurance schemes currently in operation. They all operate on risk-sharing by pooling. There is a broad initiative aiming at extending the coverage of hospital and community-based health insurance models across the country.

In the past, many private insurance companies did not fulfil their obligations in terms of paying bills. This led to the development of a negative attitude towards anything to deal with insurance. Therefore, existing community-based or hospital-based insurance models avoid the term "insurance" and are called health societies or health plans or health funds to ensure acceptability and support.

According to the results of a study by CIDR/EZE (CIDR/EZE, 1999), people's reluctance to trust insurance (apart from bad experiences) is often due to:

- not understanding the concept of insurance;
- reluctance "to pay for others";
- the risk of not falling ill and thus paying in vain;
- fear that people with chronic illnesses might empty the fund so that there is nothing left for the others;
- rejection of the idea of co-payment;
- fear that the premiums will be too high;
- difficulty in avoiding paying for health services once the precedent is set.

Nevertheless, there has been a change in perception, mainly due to:

- the influence of local opinion leaders (teachers, members of local councils), and discussions which highlighted the need for security;
- the fact that people considered new ideas after they were explained to them;
- an inability to consume health services elsewhere when services are not available at the health facilities where subscribers are insured.

Advantages of insurance were then perceived as:

- promotion of mutual help and solidarity;
- no need for ready cash at the time of illness (therefore creating a feeling of security), and increased ability to pay in case of serious illness;

- since not everyone falls ill at the same time, the healthy can help the sick;
- access to health services when the need arises, even with lack of disposable income to spend on purchasing health services;
- insured persons can seek health care in time before their health deteriorates;
- reduced sale of household assets to raise funds to pay for health services.

It can be seen from this case study that on the one hand there are factors which encourage the creation of SHI (such as the large need for risk-sharing due to increasing user charges), and on the other hand the general environment can make it a challenge to create SHI. The newly emerging community-based schemes, however, make people more accustomed to the idea of insurance.

20.4. Countries with mainly social health insurance funding

20.4.1. The health care system in Costa Rica

The health sector in Costa Rica is mainly funded by social insurance, with preventive services provided by the Ministry of Health. The Costa Rican Social Security Fund (CCSS) was created in the early 1940s to administer the social security insurance system.

The system has successfully contributed to improving the health status of the population. Costa Rica's health indicators resemble those of Canada, Europe and the USA, rather than those generally exhibited by countries with similar GDP per capita (PPP US$ 9481).

Population coverage has been expanded stepwise and, since the effective inclusion of independent and informal sector workers by 2005, access to CCSS health services is now almost universal.

The Ministry of Health oversees health promotion, disease prevention and environmental health. The CCSS (70% of total expenditure in 2004) provides curative and rehabilitative care, individual preventive services (e.g. immunization) and some educational services. The National Insurance Institute (INS) covers the treatment, rehabilitation and compensation of policy-holders for occupational illnesses and injuries and automobile-related injuries.

The CCSS owns and operates all the country's 29 hospitals, 893 primary-care centres and about 1800 temporary health care delivery facilities, providing 95% of hospital services and around 70% of all consultations. Except for three private clinics, virtually all health facilities are operated by the CCSS, the Ministry of Health or the INS, and form part of the national health system.

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

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

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

The main sources of financing are:

- compulsory tripartite contributions to the CCSS by employers, employees and the state;
- the hospital lottery;
- income from rents and interest.

Only about 1% of income comes from fees. Self-employed workers can elect not to contribute to the CCSS but must then pay a fee for using CCSS services, and services for the very poor are paid for by the state. The contribution rates paid by employers, employees and the self-employed that elect to contribute are among the highest in the world. While salaried persons contribute 15% of their salaries (employer 9.25%, employee 5.5% and state 0.25 %), self-employed voluntarily insured workers pay 10.5% and 10.35% respectively (with the government paying about half of the contribution rates). Retired persons contribute 14% (pension fund 8.25%, pensioners 5.5% and state 0.25%).

Financing and the quality of health services are likely to remain important issues. The high contribution rate for employers and employees has significantly raised the cost of labour in Costa Rica. Further increases could affect the competitiveness of Costa Rican products although the real impact of social insurance contributions on effective production prices are largely unknown and tend to be overestimated.

20.4.2. The health care system in the Philippines

While out-of-pocket expenditures in 2005 still financed 47.7% of the health sector in the Philippines, 9.2% was funded by social insurance – the Philippine Health Insurance Corporation (PHIC) – with basic curative services for those enrolled under the special programme for the very poor provided by the Ministry of Health and PHIC. Philippines initiated SHI for the employed sector 35 years ago and has many lessons for developing and middle income countries. PhilHealth was created in 1995 as a successor to the previous Medicare programme (Obermann et al., 2006).

The system has been very successful in improving access to health care, especially as it includes free-of-charge coverage of the poor (through a special programme funded and local Government). Nevertheless it still has a major problem with financial protection and there is concern about support value, especially in metropolitan areas. includes four categories of member: the employed in the formal sector, the poor, retired persons, and individually paying members (IPP).

Population coverage has expanded, and access to PHIC is now around 70%.

The Ministry of Health oversees health promotion, disease prevention and environ-mental health as well as running health care facilities. PHIC covers the treatment of its members and differentiates between three levels of care (ordinary, intensive and catastrophic) with different reimbursement schedules.

Health care facilities are either owned by the government or contracted to a large variety of private facilities.

Non-emergency patients enter the system through their local clinic or district hospital. Patients often have to wait a long time to be seen and are occasionally turned away. Patients often complain that they are reimbursed only a part of their costs. The general support value lies at around 60% and varies a lot according to which quality and level of facility a patient visits. The benefits are generally lump sums and capped.

The quality of care for inpatient services is considered to be quite high but dissatisfaction with the quality of care provided in ambulatory settings remains. PHIC has made considerable efforts to improve the quality, especially of rural health units, through incentive payments.

Health care providers in the public and private sectors are mainly paid fees, although PHIC has been experimenting with other options, including capitation payments.

The main sources of financing are:

- compulsory contributions to PHIC by employers and employees;
- contributions by individually paying members;
- co-payments;
- state subsidies, especially to cover the health care costs of the poor.

The support value and the population coverage are likely to remain issues of discussion. There have been proposals to pilot zero co-payment solutions for the poor but these have not turned out to be feasible. Previously the problem was that many poor did not register for free SHI because they could not afford the payments beyond the support value.

The Philippines has a large variety of community-based schemes which complement or substitute PHIC. In the past it was government policy to include the people covered by these schemes into PHIC. Nowadays the policy is rather to encourage these community schemes to administer SHI jointly and thus get closer to the people and not discourage community initiative. There are about 60 community-based schemes in the Philippines.

20.4.3. The health care system in Germany

Health services in Germany are mainly funded through compulsory contributions to statutory health insurance funds (normally referred to as “sickness funds”). These are self-administered corporatist institutions under public law. The system is regulated at the federal level in order to guarantee equity in insurance protection and in scope of benefits.

The contributions to statutory health insurance funds are income-related. The total sum of the contributions is reallocated between all funds taking into account the differences in incomes and risk profiles among their members (referred to as “risk compensation scheme”).

It is mandatory to be insured in Germany, either in statutory or private health insurance funds. Coverage in statutory health funds extend to about 89% of the population. Persons whose income is above a certain yearly adjusted assessment threshold have the option to be insured by private health insurance funds. Currently 9% of the population is insured in private health insurance funds which are organized under private law. Unlike statutory health funds they collect risk-based premiums on the basis of the age, sex and state of health of the person to be insured.

Insured persons can freely choose services from any appropriate provider – according to their preferences. Care is provided by self-employed physicians and by public, non-profit and private hospitals. For outpatient care, almost all physicians have their own surgeries and are self-employed.

Around one third of hospitals (but nearly half the beds) are publicly owned, 39% of the beds are provided by non-profit and voluntary organizations and 26% by private for-profit hospitals.

The statutory health insurance fund pays the costs of necessary medical treatments except for accidents or sickness that are work-related, which are taken care of by the accident insurance schemes. It also pays sickness benefits once the employer stops paying the salary after six weeks of an employee’s being unable to work.

Physicians working for patients insured in statutory health insurance funds are mainly paid fees for service, based on a points system for units of work. A few physicians work only for patients insured in private health insurances. Their payment is based on a different system of tariffs.

The total budget for physician services is agreed and then divided on the basis of the number of treatments given by each physician. If the total of treatments rises, the effect is that the amount paid for each treatment decreases. This effect could also be due to a limited number of doctors who increase the volume of treatments they provide, and thus these have a higher income at the expense of their colleagues who have a lower income with the same workload as before. This system has been applied for controlling the cost of physician services.

From 2009 physicians will be paid according to a new payment system. In contrast to the former system, the payment for physician services will be related to the morbidity of the insured person. Rates rise with increasing morbidity.

Only physicians who are affiliated to their respective association are party to the contracts and are therefore reimbursed by health funds for services provided. The sickness funds also form one association for the purposes of negotiation with providers. The most important body for the joint negotiations between sickness funds and physicians concerning the scope of benefits is the Federal Committee of Physicians and Sickness Funds. From 2008 a central umbrella organization represents all federal associations of sickness funds.

Hospitals are paid on the basis of daily charges covering reasonable costs according to the DRG (diagnosis-related groups). They must provide information to prove that the costs are reasonable (e.g. details of the methods of treatment). Cost containment of hospital services and drug costs, however, has not been very successful.

Employers and employees, who are both represented on the boards of the sickness funds, pay contributions to the health insurance funds. The average contribution rate is around 15% of salaries. While employers pay around 7%, employees have to pay around 8% due to the introduction of a special contribution of 0.9% for them in 2005.

Members receive a comprehensive package of health services, although there is some (very limited) variation in the benefit packages across sickness funds. Co-payments – e.g. for dentures, for a first visit to a physician per term, or for pharmaceuticals – are generally low (10.4% of health spending in 2004) but have been steadily rising in recent years.

From 2009 one single "Health Fund" will collect income-based contributions from all persons insured in statutory health insurance funds, and from their employers. The employees' additional payment of 0.9% of their contributory income introduced in 2005 will be maintained. The accumulated contributions will be redistributed to the different health insurance funds according to the morbidity of each fund's members. In 2007/2008 the German government paid an additional amount of •2.5 billion per year from its tax income to the statutory health insurance funds. From 2009 this sum will rise by •1.5 billion per year up to a ceiling of •14 billion in total and will be transferred directly to the new Health Fund.

The German health insurance system depends on a complex system of statutory regulation and tradition. It has evolved a long way from the original system set up 100 years ago. The German system has been successful in giving choice, ensuring high-quality care and containing the rise in physician fees, but has been less successful in controlling overall costs.

CHAPTER 21.
Some lessons learned

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

There is no right or wrong way to combine systems of health financing and health care provision. Social health insurance can be combined with health care provision from private providers, social health insurance providers or government providers. can also be combined with public funding. The choices made depend on the political and historical context in countries. Equally important is the need to follow certain rules and experiences in design – such as entitlement to benefits, method of provider payment, and cost control . This general rule applies to all systems, whatever their features may be.

Services cannot meet all the needs of all the population. In Costa Rica and the United Kingdom, this means long waiting lists. In Thailand, physicians are attempting to shift costs into the area of occupational health. In Germany, the problem is one of controlling costs, especially by controlling providers, excluding services and increasing co-payments. All countries struggle with the issue of cost control though their measures and experiences are different. Global budgets (Canada, Costa Rica, United Kingdom), capitation (Thailand, United Kingdom) and insurance-owned facilities (Costa Rica, Egypt) can be effective mechanisms for cost containment. Fees for service are a poor mechanism for cost control.

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

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

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

The examples of the Philippines and Uganda show how community-based schemes can play an important role on the way towards universal SHI.

SECTION VI.

Checklist

Analysing the economic and policy environment

Health policy

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

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

Yes/No

(3) Has that priority order been publicly accepted?

Yes/No

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

Yes/No. If yes, in the long term or in the short term?

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

Yes/No

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

Yes/No

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

Yes/No

(8) Who favours the SHI plan and who opposes it?

(9) What are the opportunity costs of increased health spending in the present economic circumstances of the country?

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

Yes/No

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

Yes/No

Desirability

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

Yes/No

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

Yes/No

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

Yes/No

Feasibility

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

Yes/No

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

Yes/No

(3) Is there a core of well-educated administrators who could be trained to operate an SHI?

Yes/No

(4) Is there a framework of law and enforcement procedures to support an SHI law?

Yes/No

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

Yes/No

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

Yes/No

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

Yes/No

Designing Social Health Insurance

Preliminary issues

(1) Are the health policy objectives of the country clearly stated?

Yes/No

(2) Have the new benefit entitlements been publicly accepted/demanded?

Yes/No

(3) Have measures been taken to develop health services to meet the new entitlements?

Yes/No

(4) Has planning begun for liaison between government departments and agencies?

Yes/No

(5) Has the organization and financing of staff training been considered?

Yes/No

(6) Are mechanisms in place to ensure an appropriate balance between primary, secondary and tertiary care?

Yes/No

(7) Who should be covered by health insurance, and have equity considerations been taken into account?

Yes/No

(8) Have the number and ownership of health funds been decided?

Yes/No

System components

(1) Has a table been drawn up showing the target population groups and numbers in each group?

Yes/No

(2) Is it feasible to register and collect contributions from the target groups?

Yes/No

(3) Have the patterns of risk and disease of the target groups been analysed?

Yes/No

(4) Has an assessment been made of the target groups' ability to pay contributions?

Yes/No

(5) Has it been decided which groups in the population will be offered cover first?

Yes/No

(6) Has a mechanism been agreed for deciding on entitlements?

Yes/No

(7) Have checks been made for a possible overlap with the services available from other funders or providers?

Yes/No

(8) Do providers of services have an appropriate legal status to allow them to enter into contracts with health funds?

Yes/No

(9) Are structures in place to monitor and regulate health care providers?

Yes/No

(10) Is there a strategy for health care information and financial information?

Yes/No

(11) Will health funds be allowed to provide services as well as funding them?

Yes/No

(12) Will the chosen provider payment systems reduce cost escalation and provider-induced demand?

Yes/No

(13) How will the health funds be governed, and will they have sufficient independence from government?

Yes/No

(14) Has a strategy on computerization been agreed?

Yes/No

Drawing on experience and building consensus

Drawing on experience

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

Yes/No

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

Yes/No

(3) Are there in-country experiences to draw on? (Existing schemes, micro-insurance)

Yes/No

Building consensus

(1) Have those who favour and those who oppose the SHI plan been identified?

Yes/No

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

Yes/No

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

Yes/No

(4) Is everyone aware of the personal advantages they can gain from SHI?

Yes/No

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

(6) Does the plan include existing schemes and experiences?

Yes/No

SECTION VII.

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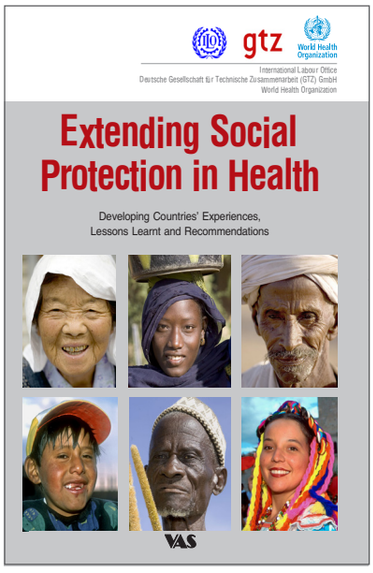

Extending Social Protection in Health

Developing Countries' Experiences, Lessons Learnt and Recommendations

People all over the world depend on having access to health services for maintaining their health or for their survival. It is crucial therefore that they are able to afford the treatment they need. Payments for health care push an estimated 100 million people into poverty every year. Functioning social health protection systems could prevent this. They entitle people to access the health services needed, they ensure that no one is impoverished by health bills, and they set prices and contributions according to what people are able to pay. This book represents the combined insight into social health protection from over 200 academics, policy makers and politicians, who gathered at the *International Conference on Social Health Insurance in Developing Countries* in Berlin in December 2005. The book tackles issues as diverse as universal coverage, social dialogue, poverty reduction or mixed financing systems and draws on experiences spanning four continents.

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