

1. INTRODUCTION

Currently, the world is witnessing higher achievements in health outcomes than at any other time in history. Improvements in socioeconomic, technology and health interventions with accompanying social policies, especially in health and education, have resulted in significant gains in human development. Enhancements in health systems performance have made a tremendous impact on the overall development.

One of the major functions of the health systems, i.e. financing health care, has three interrelated areas: (a) **collection** of revenue, (b) **pooling** of financial resources, and (c) **use of** financial resources either by **allocating** them or **purchasing** interventions. The challenge of reforming the three sub-functions of health care financing is to harmonize them, in such a way that, *health systems protect* people *financially* in the *fairest* way possible and that *appropriate incentives* are given to *health care providers* to motivate them to improve the health of the people by improving the responsiveness of the system.¹

Harmonization depends on the technical, organizational and institutional arrangements of health systems. Health care financing denotes not only the use of disposable income of each household on health, but also the methods of financing, such as general taxation, insurance, or out-of-pocket payments as well as how they are used.

A **health system** is considered to be *fairly financed* if the ratio of contribution of each household to its ability to pay is identical for all households, independent of the household's state of health or use of health systems. *Fair financing* deals with whether funds are raised through progressive collection mechanisms and protection of catastrophic health expenditure directly linked to the household's capacity to pay. WHO defines health expenditure as "catastrophic" whenever it is greater than or equal to 40% of the capacity to pay (total household non-subsistence effective income).²

¹ Health care financing, financing health or financing health systems are used interchangeably throughout this document.

² Kawabata K. et al. Preventing impoverishment through protection against catastrophic health expenditure, WHO Bulletin, (80) 8 p612

The Forty-eighth session of WHO's Regional Committee for South-East Asia, held at Colombo, Sri Lanka in September 1995, debated the topic of "alternative financing of health care" as a subject of technical discussions. The Committee urged Member States to undertake various alternative financing reforms, within the framework of solidarity, equity and expanding essential coverage.³ A follow-on regional consultative meeting held at Bangkok in October 1995 reviewed the regional experience of health care financing reforms, including development of social health insurance, and noted the importance of careful studies on various policy options and adoption of appropriate policy decisions.⁴

In May 1999, the Health Ministers of Member Countries of the Region participated in the "Ministerial Round Tables: Lessons learnt on world health" held during the 52nd World Health Assembly in Geneva. The Health Ministers agreed on the need to assess the consequences of health care financing reforms through an update of national health accounts and related studies.⁵ At their 6th meeting held at Yangon, Myanmar, in February 2001, the Health Secretaries of Member Countries of the Region debated the experiences on health care financing reforms. They noted that while each country of the Region may have adopted different health care financing reforms based on its specific socioeconomic, political and health systems, there were a lot of lessons that could be learnt from each other. They requested WHO to share such evidence-based policy options.⁶

Several countries of the Region initiated reforms of health systems including those for health care financing, especially in attempting to expand the coverage of social health insurance or similar social protection for the poor. Subsequently, the 55th session of the WHO Regional Committee for South-East Asia held at Jakarta, Indonesia, in September 2002, having expressed its concern on the high level of out-of-pocket health expenditure and the low level of public spending on health in almost all countries, decided to hold technical discussions on social health insurance (SHI) at the fortieth meeting of the Consultative Committee on Programme Development and

³ WHO, Report of the Technical Discussions on "Alternative financing of health care", 48th session of WHO Regional Committee for South-East Asia, September 1995 (SEA/HSD/195)

⁴ WHO, Health care financing reforms: Report of Intercountry Consultation, 2-6 October 1995, Bangkok, Thailand (SEA/Econ./13)

⁵ WHO, Ministerial Round tables: Lessons learnt on world health (WHA52/1999/REC/2 {p217-271}& WHA52/1999/REC/3 {p128-133})

⁶ WHO, Report of Sixth meeting of Health Secretaries, February 2001, Yangon, Myanmar

Management (CCPDM), to be held prior to the 56th session of the Regional Committee in September 2003.⁷

Subsequently, the technical discussions on SHI were held at the 40th meeting of the CCPDM and the discussions and recommendations arising out of the technical discussions were submitted to the 56th session of the Regional Committee for its consideration. The Regional Committee, after thorough review and debate, passed the resolution SEA/RC56/R5. The background paper to this resolution highlights the regional overview of social health insurance in the Region within the broad framework of health care financing, explains the major issues in implementing various SHI schemes, and examines similar experiences elsewhere, with possible policy options for promoting and expanding SHI within the Region.

2. OVERVIEW OF HEALTH CARE FINANCING

2.1 Revenue Collection

There are five broad ways of revenue collection for health care financing, namely, general revenue (taxation); social health insurance, voluntary or private health insurance; out-of-pocket payments, and internal donations. Each country in the Region was adopted different ways of *collecting revenue*. Globally, in 1998, the estimated health expenditure (after adjusting purchasing power) was around US\$ 3.1 trillion or 7.9% of the global income, with an average expenditure of US\$ 503 per capita. The per capita health expenditure ranged from US\$ 82 in Africa to over US\$ 2 000 in OECD countries. While nearly 30% of this global expenditure came from taxation, around 20-25% was from out-of-pocket payments (OOP) and the same from social health insurance (SHI) contributions, with another 15% by private insurance. There is a wide variation in the distribution between different sources of financing. The Asian and African countries have spent more from out-of-pocket than from government general revenue or social health insurance.

According to the World Health Report 2000⁸, "... in poor countries, roughly one-third of the disease burden in 1990 might have been averted at a

⁷ WHO, Decisions and List of resolutions, 55th session of the Regional Committee, Document SEA/RC55/19, [Decision SEA/RC55/(1)]

⁸ WHO, The World Health Report 2000, Health Systems: Improving Performance, 2000