

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

total cost per person of only US\$ 12." In addition, countries spending below US\$ 10 per person per year seldom appear to achieve more than 75% of the life expectancy that should be possible. The Report of the WHO Commission on Macroeconomics and Health (WHO-CMH) recommended that countries should adopt an essential set of interventions with an average cost of US\$ 30-40 per person.⁹ There is evidence to show that health systems which spend less than approximately US\$ 60 per capita find it difficult to deliver a reasonable, minimum range of services.

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

In 1981, an indicator, "the number of countries with at least 5% of GNP spent on health", was proposed for the purpose of monitoring and evaluation of the global strategy for health for all by the year 2000 (HFA2000).¹⁰ While WHO and its Member Countries have not been able to formally adopt this indicator, the numerical level, i.e. "5% of GNP spent on health", has been used frequently in many policy debates, and even been mentioned in some cases as the "WHO- recommended target".

According to the World Health Report 2001 (WHR2001), the countries of the Region on an average had a total health expenditure (THE) of around 2-8% of GDP. In reality, except four countries, Bhutan, India, Maldives and Thailand, others could not spend more than 5% of their GDP on health. Similarly, many countries around the world never achieved this "fictitious target". A recent International Monetary Fund study suggested that effective

⁹ WHO, Report of Commission on Macroeconomics and Health on investing in health for economic development, 2001

¹⁰ WHO, Health for all 2000 (HFA2000) Series No. 4, Development of indicators for monitoring and evaluation of HFA2000, and Health for all 2000 Series No.3, Global strategy for Health for All by the Year 2000

health coverage would require around 12% of GNP in low-income countries in order to meet the international development goals.¹¹

An appropriate percentage benchmark or target for health spending, like the fictitious target above, is extremely difficult to set. Research is under way to better define the **minimum amounts** of finance that countries should invest in order to optimally develop their health systems. In its 2001 Report, the WHO-CMH recommended that the low-income countries should increase their domestic spending on health by an additional 1% of GNP by 2007, and by an additional 2% by 2015, keeping in view the existing and future trends of economic growth.¹² Good governance, strong political leadership and political will of all stakeholders are required for increasing the investment in health.

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

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

The World Bank in 1997 estimated that when a country's taxation is low (10% of GDP or lower), it would take 30% of government revenues to meet 3% of the GDP health expenditure target, through formal collective health financing channels.¹³ Usually, poorer countries have widespread tax evasion among the rich and the middle class in informal sectors, thereby leading to low tax collections. They also rely heavily on taxation on international trade

¹¹ IMF study “Public spending on health care and the Poor”, 2001

¹² WHO, Report of the Commission on Macroeconomics and Health, Macroeconomics and Health: Investing in Health for Economic Development (WHO-CMH), 2001, p18-19 and p108-111

¹³ World Bank, Sector Strategy Health, Nutrition & Population, 1997

(exports and imports) and have the added limitation of broad-based taxes such as income tax or value-added tax.

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

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

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

A worldwide study in the early 1990s on external assistance to the health sector between 1972 to 1990 revealed that the least developed countries received more funds from external assistance, either in loans and grants, and the total funds accounted for around 20-30% of the total health

expenditure.¹⁴ The WHO-CMH Report indicated that least-developed countries received an annual average of US\$ 2.30 per person, from 1997-1999, as donor assistance for health, while the total outlay of donor assistance for health for these countries was around US\$1.4 billion.¹⁵

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

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

The recent entry of Rotary Club members and other national and international entrepreneurs as private philanthropists, in health and other social sectors such as the Sasakawa Health Trust, the HP Foundation, the Ted Turner UN Foundation, the Bill and Melinda Gates Foundation, Rotary Club, with multi-billion dollar contributions to specified funds and programmes for global health development, are making health an important investment for

¹⁴ C. Michaud & C.J.L. Murray, Bulletin of World Health Organization, 1994

¹⁵ WHO-CMH Report op cit

development. Presently, their inputs are usually aimed at special health development *funds or programmes* and/or assigned for certain *geographical areas*.

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

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

The Royal Government of Bhutan established the *Bhutan Health Trust Fund* in 1998 with the aim of safeguarding its primary health care services through a continuous supply of essential drugs and vaccines for its population. By June 2003, the Trust Fund received donations, sponsorships and partnership totalling nearly US\$ 18 million. The famous "Health Walk" by the Minister of Health and Education and his team, done as part of the World Health Day 2002 "Move for Health" campaign in late September 2002, resulted in an additional fund of around US\$ 1.7 million. A total of Bhutanese Ngultrum 1.4 million (US\$ 30 000.-) was used in mid-2003 for purchase of Hepatitis B vaccines. It is understood that once the level of the Fund reaches US\$ 24 million, the interest earned would cover a major portion of the annual health expenditure for essential drugs and vaccines.¹⁶

¹⁶ Web access: Bhutan Health Trust Fund: <http://www.bhtf.gov.bt>

In many countries, the *out-of-pocket payments* (OOP) form a major part of the total health expenditure (THE). The analysis of NHA tables in WHR2002¹⁷ indicated that in 60% of countries with incomes below US\$ 1 000 per capita, OOP constituted 40% or more of THE, whereas only 30% of middle-and high-income countries depended as heavily on this kind of financing. Most countries in the Region have more than 50% of THE coming from OOP.

While people have the freedom of choice for paying out of pocket for health expenditure, and it might provide especially the rich, high satisfaction, there is no guarantee that the majority of the population would be able to afford health care costs through OOP. The real issue in many developing and even in developed countries is that of the high proportion of catastrophic expenses of households in all income deciles, especially among lowest and highest deciles.

People become impoverished due to the higher and/or rising costs of medical bills, because of the uncertainty of the amount of expenditure needed to meet the health care needs on an individual basis. In some cases, people have to incur 'under-the-table' expenditure for getting access to public health facilities. And, in other cases, the unskilled and unqualified private providers might charge higher rates for their service in exploitation of quick and easy access and convenient service hours. Strong stewardship of the government is required to rationalize the provider-consumer relationship. In fact, a strong purchasing power could play a better role in controlling health care costs, to a certain extent.

2.2 Resources Pooling

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

The essence of "health insurance" is the pooling of funds and spreading the risk for illness and financing. Health insurance may be classified into "Social" and "commercial" health insurance. The social health insurance has

¹⁷ WHO, The World Health Report 2002, Reducing Risks, Promoting Healthy Life, Annex Table 5, 2002

in general three main characteristics: mandatory membership, contribution based on community-risk rating, and the objective is to meet the health needs rather than meeting the individual demand for health care. Commercial health insurance on the other hand is private, voluntary, involves individual risk-rating in most cases, and the objective is to meet the individual's need. A few countries have tried to expand different types of social health insurance (SHI) schemes to achieve ***universal coverage***¹⁸ or near-universal coverage. Evidence shows that people with health insurance coverage, both social and commercial, tend to utilize more health care services than those with less or no insurance at all.

Recently, various mechanisms and schemes for voluntary, private, and multiple risk-pooling have emerged in many developing countries. These *risk-sharing schemes* were started covering informal sectors especially in rural areas, and their existence highlights the importance being given by national or sub-national governments in ensuring the financial risk-sharing is extended to the vast rural population. Section 3 provides an overview of the regional experience on resources especially with regard to social health insurance.

2.3 Purchasing

In order to have an effective and efficient health insurance, the essential health care packages should be available to the consumers literally free-of-cost, rather than under a fee-for-services arrangement for reimbursement. In addition, there should be a orivusuib if large amount of co-payment. The insurance agency or agency managing insurance fund must make various arrangements for purchasing services from health care providers, on behalf of consumers (insured). Health care providers from national public or private health care systems should ensure that the health care packages which they provide have to be responsive and financial fair. This can be achieved through strategic *purchasing*.¹⁹

¹⁸ The term "Universal Coverage" means "effective protection of health and financial risk for all citizens". It is the provision of essential and affordable health care packages to everybody according to the needs and preferences, regardless of income, social status or residency (coverage by essential health care for all and not all possible care for whole population). (See WHR 2000, op cit p15) Joe Kutzin further defined it as "effective health risk protection at the least cost possible and the coverage may be in depth – the range of affordable health care packages, and in breadth – the proportion of people that would effectively protect from health risks. (Sanguan N. and A. Mills Achieving Universal Coverage of Health Care, 1998)

¹⁹ "Purchasing" refers to the transfer of pooled resources to service providers on behalf of the population for which the funds are pooled. It means not only to include explicit purchases from public and private entities, but also to include management processes that allocate funds to providers within public agencies.

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

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

The strategy to use public funds to buy clinical and non-clinical services as well as preventive and promotive health care from private providers is intended to improve the productivity of public resources by purchasing the gains in efficiency perceived to exist in the private sector. Service contracting (capitation, global budget, diagnostic related group, etc.) is primarily to improve the efficiency and/or increase the quantity of services that can be made available for a given amount of expenditure. An appropriate payment system also stimulates a better quality of health care. This kind of a competitive approach has also been introduced in a few countries of the Region.

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

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

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

Many countries *have promoted* or are in the process of *promoting privatization efforts* in the health sector, with or without the active participation of health ministries. Some countries have attempted to reduce public involvement in the management and delivery of health services like hospital or health centre autonomy as part of their privatization efforts. The rapid privatization without effective legislative action leads to higher and higher user-charges and increasing burden to the consumers spending more from out-of-pocket to meet their health needs. Without a balancing privatization effort with expansion of social health insurance coverage, privatization would increase inequity in health status, and result in unfair financing; and in the long run, it might lead to lowering the health status significantly.

3. CURRENT STATUS OF SHI SCHEMES

3.1 Basic Concept

Social health insurance (SHI) is a mechanism for financing and managing health care through pooling of health risks of its members on the one hand, and the financial contributions of enterprises, households, and the government, on the other.²⁰ It is generally perceived as a financial protection mechanism for health care, through *health risk-sharing* and *fund pooling* for a larger section of the population.²¹ It usually forms part of a broader national **social security** framework, covering all contingencies which need financial protection and risk-sharing. It is not merely a new method to collect money

²⁰ Carrin G. et al, Social Health Insurance Development in low-income developing countries Building Social Security: the challenge of privatisation, X. Scheil-Adlung (ed.). Transactions Publication, London 2001

²¹ This model of health care financing is popularly known as "**Bismarck Model**" that is applied in most EU countries like Germany, Belgium, Austria and Netherlands (based on a system of entitlement to health insurance on employment status and payment of contributions).