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).

to co-finance services. It is a method that is able to achieve stable financing for a package of health services (health insurance benefits), while at the same time achieving greater access to health care among the population.

To be characterized as "social" and "insurance", the SHI must have certain characteristics. Countries that implement SHI schemes on a national scale usually adopt broad social security policies and legislation within the social policy stipulated under the National Constitution. In some cases, it is determined by the society's consensus. Major characteristics are:

(1) Compulsory or mandatory membership of individual or groups of individuals, and/or their immediate households and other dependents, initially targeted to cover civil servants and other formally employed people, from the public and private, commercial, semi-commercial, industrial and agricultural establishments and, usually expanding coverage to informally employed people, non-working people, retirees and even schoolchildren (*inclusion of target population does not necessarily depend on the structure of the economy*);

(2) Responsibility at the members for payment of the regular income-related contributions or flat-rate contributions, with added contribution from employers and the Government (*deduction as insurance contribution or as a pre-payment* [22] *from regular payroll or pre-set amount collected from individual or groups*);

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

(4) Establishment of appropriate collection mechanisms for collecting regular contributions;

(5) Choice of health care according to the health needs (basic benefit packages are usually pre-set and the schemes allow the members to make co-payment and also to purchase supplementary health care services);

[22] There is some fundamental difference of "prepaid" or "prepayment" for insurance with other "prepaid" services like "prepaid telephone card" or "prepaid goods'. The money spent for the goods or services by the consumers in such cases is limited to the amount prepaid. Whereas, in health insurance, the goods/services received by the consumer might get will be costing many times of the actual value prepaid. The term "insurance contribution" may be better used than "prepaid". (Personal communication with Professor T. Hasbullah)

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

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

(8) Covering a significantly large proportion of population, and

(9) Funds collected from contributions to be pooled as a single or multiple fund arrangement, administered by a quasi-independent public body.

According to the International Labour Organization (ILO) Convention No.130, its Member Countries are free to choose different "Social Security Schemes" (SSS), inclusive or with a separate SHI scheme. A country will fall into the category of "those with SHI" only if the major proportion of the population of that particular country is legally covered under an SHI scheme with a designated (statutory) purchaser through non-risk-related insurance contributions separated from general taxes or other legally mandated payments.

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

SHI and the general revenue-based health care financing system share similar characteristics of pooling risks and contributions. In SHI, people as members of insurance schemes are directly aware of their insurance contributions (*explicit*).[23] Usually people contribute from their daily, weekly, or monthly payroll. These contributions are the pre-set, proportionate and prepaid collections from members (employees), employers, and governments.

In the ***general revenue-based or tax-funded systems***[24], the resources for health care come directly from general revenue and, in some cases, from special or earmarked taxes or revenue. In this method of financing, people or

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

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

enterprises contribute for health care in an *indirect* way via general taxation. Thus, people are not aware of the amount they contribute solely for health care (*implicit*).

SHI is generally associated with compulsory or mandatory membership involving all people. This would ensure compulsory inclusion of certain underserved groups such as the poorest and the vulnerable people who are usually left out from the voluntary private health insurance schemes. The compulsory scheme would guarantee an appropriate mix of good and bad health risks.

SHI schemes aim at reaching ***universal coverage.*** Once the target is achieved or is near achievement, there is a strong potential to foster efficiency and effectiveness of health systems performance, by pushing forward the ***monopsony***[25] of purchasing power, in ensuring the quality of care and efficient resource consumption. Many countries with SHI schemes that either relied on fee-for-services payment mechanisms are now modifying them into more closely regulated payment mechanisms, such as capitation, global budget and DRG. It is more of a self-sustaining health care financing mechanism, provided it is properly managed.

3.2 Regional Experiences

The introduction of SHI schemes as a method of financing health care in the Region dates back to more than fifty years. Since the socioeconomic and political development of the countries varied widely, it actually affected the development of SHI schemes. *Carrin et al* [26] analysed that by 2000, about 80 countries around the world have advanced risk-sharing health systems. A majority have either general tax-based health care financing system (50 countries) or a social health insurance scheme (30 countries). A total of 61 countries are in the medium risk-sharing category with three variants. In the first group of nine countries, all employees including the self-employed are covered under health insurance. In the second group of 20 countries, the SHI schemes cover only employees, while in the third group of 32 countries, the SHI schemes cover specific population groups. Besides, a total of 50 countries are in the low risk-sharing group and are generally under-financed.

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

[26] Carrin G. et al, The Impact of the Degree of Risk-sharing in Health Financing on Health System Attainment, HNP Discussion Paper, The World Bank, 2001

According to the WHR 2000, more than 50% of industrialized countries selected SHI as their health financing mechanism. Not a single developing country with a GNP per capita US$ 760 or below had a full-fledged SHI scheme. Among the lower middle-income countries (with a GNP per capita between US$ 761 and US$ 3 030), the only country with a fully-fledged SHI was Costa Rica.[27] India, Indonesia, Myanmar and Thailand have mixed health care financing systems with certain percentages of coverage under the SHI schemes.

The historical development of SHI schemes over the decades, from a single to a multiple-fund arrangement, is worth noting. Even in some East Asian countries with substantial and sustained economic growth, the expansion of SHI to achieve universal coverage was slow and steady for over 30-50 years. Each country has therefore to consider introducing and expanding the SHI slowly and steadily over several decades to achieve universal coverage, or to make a ***big-bang*** transformation by jumping certain steps.

India[28]

India, with a GDP of around US$ 1 800 per capita, spends about 5% of its GDP on health, of which less than 17% accounts for public sector health facilities and human resources (hospitals, clinics and preventive establishments). SHI mainly covers civil servants and a certain proportion of employees in the formal sector. Private health insurance is still negligible, but growing rapidly. Out-of-pocket payments to the private clinics, hospitals and pharmacists including traditional medicine practitioners account for 83% of health expenditure.

The financial burden on the national health system has increased in recent decades with spiralling health costs aggravated by an increasing burden of new and emerging diseases and also by the increasing demand for health care. Hospitalization for major illnesses like cardiovascular diseases, diabetes and renal diseases is a cause of indebtedness for low- and middle-income groups. A large section of the population, especially from the low-income

[27] See WHR 2000, op cit

[28] India Country Paper on SHI, presented at the Technical Discussions session of 40th CCPDM, 5 September 2003; Sujatha Rao. Social Health Insurance in India, Presentation made at the regional meeting on SHI, 13-15 March 2003; and Indrani Gupta, et al, Health Insurance in India: Prognosis and Prospectus, Economic and Political Weekly, January 2000 207-217

groups does not have easy access to good quality health care. Because of the resources crunch faced in recent years, the federal government is not in a position to increase health budgets. State governments too are facing a fiscal crisis and are unable to meet the recurring health expenditure. In this scenario, health insurance is seen as an alternative mechanism for financing health care.

The Government established a health insurance scheme called the "Employees State Insurance Scheme (ESIS)" under a health insurance act in 1948 to provide cash and medical benefits as part of a compulsory social security benefit scheme for formally employed workers from industrial sectors. The ESIS provides financial and other social protection measures to employees with regard to sickness, maternity, disability and death caused by employment injuries. The ESIS scheme has its own health care facilities providing care to employees and their family members free for cost. Originally, ESIS scheme covered all power-using non-seasonal factories/industries employing 10 or more people. Later, it was extended to cover employees in all non-power using factories with 20 or more persons. While persons working in mines and plantations or an organization offering health benefits as good or better than ESIS, are specifically excluded, some service establishments like shops, hotels, restaurants, cinema houses, road transport and newspapers printing are covered. The monthly wage limit for enrolment in ESIS is Rs 6 500, with a prepayment contribution in the form of a payroll tax of 1.75% by employees, 4.75% of employees' wages to be paid by the employers, and 12.5% of the total expenses borne by the state governments. The number of beneficiaries covered are more than 33 million, spread over 620 ESI centres across the states. Under the ESIS, there are 125 hospitals, 42 annexes and 1 450 dispensaries with over 23 000 beds. The scheme is financed by the Employees State Insurance Corporation (a public undertaking) through state governments, with a total expenditure of Rs 3 300 million or Rs 400 per capita insured person.

India is implementing the Central Government Health Scheme (CGHS) since 1954. The scheme is aimed at providing comprehensive medical care to employees (present and retired) of the Central Government; staff of autonomous and semi-government institutions; Member of Parliaments; judges; freedom fighters and journalists. The benefits include all OP facilities, preventive and promotive care at public dispensaries, inpatient care at both public and approved private hospitals. The premium is progressive with salary

scales (ranging from Rs 15 to Rs 150 per month). Beneficiaries under the CGHS are about 4.5 million. The CGHS scheme has been criticized for quality of care and accessibility. Beneficiaries also complain about the delays in reimbursement and about the high proportion of out-of-pocket payment (co-payment).

The General Insurance Corporation (GIC) and its four subsidiary companies, public-sector undertakings, have been offering voluntary health insurance (*Mediclaim Plan*) since 1986. These schemes mainly cover hospital care and domiciliary hospitalization benefits (specified outpatient care provided in lieu of inpatient treatment). In addition, certain private insurance companies also offer health insurance. The GIC recently introduced a new health insurance to extend the coverage of health care needs to middle-and low-income groups. It has also introduced the *Jan Arogya Bima*, an insurance policy specifically targeting poor population groups. It covers the reimbursement of hospitalization costs up to Rs 5 000/- annually for an individual premium of Rs 100 per year. In 2002, the schemes of GIC covered around 7.2 million people.

Both public and private sector companies offer some forms of risk-sharing by providing free health care at employer-owned facilities (Tata and Reliance), or by way of lumpsum monthly or annual payments and bonuses, partial or full reimbursement of health expenditure incurred by employees, and arrangement of health care coverage under group health insurance policies (such as Bajaj Allianz, ICICI Lombard, Royal Sundaram, or Cholamandalam group insurance policies). The population coverage under these schemes is low and is estimated to cover around 30-40 million people.

The National Health Policy (NHP) 2002 of India acknowledged that access to the public health care systems was inequitable between those better endowed, and the more vulnerable sections of society. The new policy thus aims to evolve a system which would reduce inequities and enable the disadvantaged sections of the population to have a fairer access to essential health care. The NHP aims to increase the aggregate health investment from public sources through increased contribution from the Central (Federal) and state governments. It encourages the setting up of private insurance for increasing the scope of coverage of the secondary and tertiary sectors.

The national federal budget of India for 2002-03 introduced an insurance scheme called "***Janraksha***", designed to provide financial protection to the needy population. With a premium of just Re 1 per day, it

promises a benefit package that would include: (a) inpatient treatment up to Rs 30 000.- per year at selected and designated hospitals, and (b) outpatient treatment up to Rs 2 000 per year at designated clinics and hospitals, including civil facilities, medical colleges, private trust hospitals and other NGO-run institutions.

During the budget year 2003-04, another initiative called "***Community based universal health insurance scheme***" is to be introduced. This scheme aims to provide easy access to quality health care for underprivileged citizens. With a premium equivalent to Re 1 per day for an individual, Rs 1.50 per day for a family of five, and Rs 2 per day for a family of seven, the insured persons would benefit from (a) reimbursement of medical expenses up to Rs 30 000 towards hospitalization, (b) a cover for death due to accident for Rs 25 000 and (c) compensation due to loss of earning at the rate of Rs 50 per day up to a maximum of 15 days. To ensure the affordability of the scheme to below-poverty-line (BPL) families, the Government would contribute Rs 100.- per year towards their annual premium costs.

The following are a few issues involved in implementing or expanding the SHI scheme.

- India is a lower middle-income country, with 26% of the population living below the poverty line and 35% of the population being illiterates with skewed health risks.
- Social health insurance coverage is inadequate, limited to only a small proportion of people working in the organized formal sector, covering less than 10% of the total population.
- Even though there is a rapid improvement in banking and other financial infrastructure, the introduction and expansion of social health insurance is slow and weak. While some voluntary nongovernmental organizations have introduced various collection mechanisms for financial contribution, these are not yet applied widely on the national scale.
- Most of the SHI schemes adopt exclusion and adverse selection, having moral hazards and cream skimming. Much of the focus of the existing schemes is on expenses for hospital care.
- The schemes have not been addressed the quality of care effectively.

There is inadequate information about various social health insurance schemes. Different financing options would need to be developed for different target groups. India as a heterogeneous country needs to undertake several pilot projects to provide a wide range of evidence-based experience on various health insurance schemes including other alternative risk-sharing mechanisms, and to develop options for different population groups. Health policy and health systems research institutions, in collaboration with economics policy study institutes, need to gather information about the prevailing disease burden at various geographical areas; develop standard treatment guidelines; undertake costing of health services to enable one to develop benefit packages to determine the premiums to be levied and subsidies to be given and map health care facilities available and the institutional mechanisms which need to be in place, for implementing health insurance schemes.

Indonesia[29]

The health status of people in Indonesia has improved over the last few decades, with some slow progress in recent years. The Asian economic crisis of the late 1990s has had the additional impact on the health status, making people less accessible to health care. Data from national surveys for the last decade showed that the access to hospital care has been very poor for the bottom 60% of the population. In most cases, each household has to spend more than its income whether public or private. One of the principle reasons for the slow improvement in the health status is the presence of some deficiencies in managing health care financing reforms. While some form of social health insurance had been implemented even before independence, as lots of work needs to be done in order to reach universal coverage.

The Dutch colonial government implemented a reimbursement scheme for civil servants, originally including only European employees, and later national civil servants. After independence in 1948, the government continued this scheme with reimbursement for health care. It had several drawbacks such as high moral hazards and discrimination between high- and low-ranked civil servants. In 1960, the Government initiated a pilot social health insurance project to cover the cost of inpatient care but not medical

[29] Hasbullah Thabrany & Ascobat Gani, et al. Social Health Insurance in Indonesia: Current Status and the Proposed National Health Insurance, Updated working paper submitted originally at the regional meeting on SHI, 13-15 March 2003 and later presented as country paper at the technical discussions on SHI at 40th CCPDM meeting, September 2003

fees. The scheme suffered a huge budget deficit and was later abandoned. Since then, several landmark initiatives have been undertaken. In 1965, the Honourable Minister of Health initiated an extensive expansion of basic health care facilities under a "New Order" of the Government. The Ministry of Health, after a year, established a contributory sickness fund for civil servants, which failed after a few years. In 1968, the Ministry of Labour established a civil servant welfare team, a forerunner management team for the present-day civil servant health insurance scheme. Reimbursement was based on fee-for-service (FFS) system and the premium was 5% of salary. In 1984, the *Perum Husada Bhakti* (PHB), a public corporation, was formed to be responsible for the insurance of state employees with 2% of basic salary as contributions. After four years, a pilot project was implemented for private employee's health insurance. By 1992, the national PHB was transformed into a for-profit state-owned company - ***PT Askes*** (*Asuransi Kesehatan Indonesia*) (a Civil Servant Social Health Insurance Company), within the legislative framework of the national regulation on insurance.[30]

The ***PT Askes*** scheme provides mandatory health insurance coverage to all civil servants, pensioners and military personnel of all public and semi-public establishments. All have to contribute 2% of the basic monthly salary as prepayment premium, regardless of their marital or family status. There is no ceiling. Since early 2003, the Central Government started contributing 0.5% of the basic monthly salary. The scheme is supposed to provide a comprehensive health benefit package with no specific exclusion. The coverage of beneficiaries includes the spouse and two children less than 21 years old, who are not working and are not married. The health care packages are provided through provider networks, consisting of over 7 000 government health centres, nearly 400 public hospitals and 150 private hospitals. Special fee schedules have been established by the Government, which are 40-70% of the public fee schedules. The ***PT Askes*** pays the providers using prospective payments mostly on a "per case" and per diem basis. Drugs are covered if prescribed on the national formulary. The ***PT Askes*** covers nearly 15 million civil servants. The contribution is about 4 000 Rupia (Rp) per capita. This figure has not been revised since 1993 and has depreciated due to inflation. Currently, it is equivalent to just about Rp 1 000.- as compared to the 1993 value. The scheme has expanded its products in the form of Health Management Organization (HMO) products on commercial basis to more

[30] MGS Aritonang, Social health insurance in Indonesia, presentation at Bangkok SHI meeting

than 2 500 companies covering about 1.5 million members. While the ***PT Askes*** have been awarded and rated the best agency for its efficient outputs amongst the government agencies, it still has the following problems and constraints:

- Delay in collection of premium, despite the fact that the major contributors are all civil servants;
- Too ambitious benefits compared to small contributions;
- Historically high-cost sharing due to the low price tag set by the Ministry of Health;
- Relatively low reimbursement level to providers (transforming public hospitals into corporate management led to increases user-charges, and made people to pay more from out of pocket);
- Relatively richer individuals (high-salaried people) covered by very low premiums, creating gaps in expectation and satisfaction;
- Adverse selection from retired military personnel;
- Request for decentralization of management of *PT Askes* funds by local authorities; and
- For-profit operation creates jealousy among providers.

Another social health insurance scheme introduced in Indonesia in 1993 was the SHI scheme for employees of formal private sectors- the ***PT Jamsostek*** scheme that was established under the Social Security Law of 1992. This scheme is also managed by a for-profit government company. From the start, the scheme provides exemption to cover those employed people who could access health benefits by any means including self-insured, or who could purchase more generous health insurance packages. Due to this, a majority of employers opted out in *PT Jamsostek* in other make arrangements for own insurance coverage either from other public or private insurance companies. The *PT Jamsostek* scheme is a mandatory insurance scheme for all private employers with 10 or more employees or with monthly payrolls exceeding Rp 1 million. The scheme is non-contributory as employees do not have to contribute anything. It is the employers who have to contribute 100% of the premium, 3% (single) and 6% (married) of employee's salary. There is a contribution ceiling of Rp 1 million per month. The benefit package is comprehensive, with excludes cancer treatment, cardiac surgery, haemodialysis, and congenital diseases. Drugs are covered if prescribed on the national formulary. The beneficiaries also include the

spouse and children under 21 years, up to the third child, who are not working and are not married. Health care services are provided through various health care providers either contracted directly or indirectly by *PT Jamsostek*. The scheme also use the main providers as the management contractor who could manage capitation and FFS for service providers. Except for a limited out-of-network emergency care which is reimbursable, health care in general is provided "in kind" by the registered network of providers. The *PT Jamsostek* scheme now covers nearly three million formal employees, with an average contribution of Rp 5 000 per capita. This scheme also has some setbacks:

- Adverse selection due to the provision to opt out (if the scheme's policy is strictly followed and no opt-out option is allowed, it would be possible to cover around 100 million employed people, which is nearly 50% of the country population);
- Low income employees enrolled, while the higher-income employees opted out;
- Big employers are less likely to enrol and retired employees are not covered;
- Expensive procedures are not covered;
- High administrative costs lead to less incentive to providers, and
- For profit operation creates a perception of mismanagement.

The Ministry of Health through the Health Act of 1992, introduced another scheme called the nationally managed health care scheme - ***Jaminan Pemeliharaan Kesehatan Masyuarakat (JPKM)***, similar to the US Health Maintenance Organization (HMO). The scheme was originally meant for protecting financial risk for the poor. The scheme was promoted widely through local governments, private businesses, private insurance companies and communities at large. It became effective as a national programme in 1995. The promotion of *JPKM* led to the development of *bapels* (Indonesian version of HMO). By the end of 2002, there were 24 licensed *JPKM bapels*, which are basically non-insurance companies selling health insurance products as carriers. These *bapels* are mandated to provide comprehensive health benefits through a network of health care providers and to make payment to providers on capitation. The *bapels* are also supposed to conduct quality assurance, utilization review, grievance procedures and other cost and quality control measures. Most *bapels* are actually selling a combination of

managed care and traditional insurance products. The scheme covers less than half-a-million people. The conflicting interest of business and social causes, and the deficient managerial capacity of the Ministry of Health to regulate and supervise has led to slow progress in coverage by this scheme.

The ***Dana Sehat*** (Community Health Fund or micro-health financing scheme) was introduced in the mid-70s starting from a small scale in various parts of the country. The scheme was further expanded on a national scale by introducing local schemes mainly in areas where poor people constituted large proportions of the population. The scheme was based on contributions of the people by consensus among beneficiary households. Recent studies have indicated that the smaller proportion of the population, less than 2%, are either holding health cards or are members of a community health fund. The majority of these local schemes could not expand the geographical or population coverage for various reasons. Many local community-based schemes have stopped functioning after the wide introduction of the ***social safety net (SSN)*** programme in the health sector in the late 1990s.

The ***social safety net*** programme was introduced as part of national efforts to mitigate the economic crisis in the late 1990s and later as social packages for the poor in 2000s. The programme was implemented through different financial assistance mechanisms to ensure that the poor were able to get access to essential health care. The first scheme targeted high risk pregnant women by providing a block grant of Rp 10 000 per household, and the fund was directly given to a village midwife. The midwife, in turn, could use the fund, for referral of high-risk pregnant mothers (beneficiaries) to the nearest health centres or hospitals for further treatment, including payment for drugs, health care or transportation costs. This programme actually benefited pregnant mothers by facilitating their access to hospital care, especially for complicated obstetric cases. The second SSN scheme promoted the JPKM scheme of the Ministry of Health. Under this scheme, the funds were provided to pre-*bapels* such as private businesses, cooperatives and/or foundations seeking to be established as JPKM *bapels* (HMO), with Rp. 10 000 per poor family in each district. These pre-*bapels* retained 8% of the funds received for administrative costs. The remaining funds were marketed for HMO products to non-poor families. After a year, however, the programme was terminated due to non-viability. The third SSN scheme aimed at public health facilities. These health care facilities (health centres) were provided with a block grant of Rp 10 000 per poor family which could use the funds to buy essential drugs and other essential medical supplies, in order to

supplement the supplies already provided by the Ministry of Health. Under the fourth scheme, the public hospitals received some block grants for meeting operational costs to take care of the poor. Some reports indicate that people in the category of the marginally poor (not qualified for SSN assistance such as self-employed, part-time workers, seasonal workers and, landless farmers) and also those who were unable to pay for expensive medical care, face financial problems in meeting their medical needs.

A few policy and managerial actions are required to improve the current SHI schemes in Indonesia. These include:

- Increase the premium rate – for both employers and employees, supplemented by the government for those people who may not be able to afford;
- Improve the health care benefit packages, to make them more reasonable and acceptable;
- Increase the payment levels set by the government at public health establishments, in order to improve the quality and access of health services;
- Remove the "opt out" or exemption option by *PT Jamsostek*;
- Change the "carrier" status of *PT Jamsostek* and *PT Askes* from "for-profit" companies to "not-for-profit" establishments so as to be consistent with the national social policy;
- Improve transparency in management in all institutions;
- Expand the coverage to retired private employees, small employers, the poor, and self-employed, and
- Benefits must be the same for everybody regardless of contribution.

In 2002, the President of the Republic of Indonesia established a "Presidential Taskforce on Social Security" to look into the restructuring of the existing SHI schemes. Similarly the Ministry of Health has also reviewed its policy on health care financing and has proposed to reform it. The National Parliament is also making a review of social health insurance as part of national social security and drafting a bill. The aim of these initiatives is (a) to integrate public and private employee schemes into one scheme, creating a specialized SHI management under a National Social Security System, with uniform benefits for all; (b) to look into the possible merger of the *PT Askes* and *PT Jamsostek* into a single "Independent SHI Agency" at the national

level, like "National Health Insurance"; and (c) to make the "New Carrier" to be independent, not-for-profit, controlled by a tripartite body (representation from employees, employers and the government). Currently, there are three almost similar alternatives to be considered, with each of them having its own strengths and weaknesses. National debates and consensus-building are required and more evidence-based information is needed to evaluate each of the proposed models. The first is a ***model of National Health Insurance*** proposed by the Presidential Taskforce. Indonesia having high proportion of nonformal workforce, low family income and low government budget needs to adopt a comprehensive social health insurance that has the following characteristics: (i) works on contribution and the general revenue model; (ii) simplicity, uniformity, portability, efficiency; (iii) intersectoral commitment and supported by many parties; (iv) very ambitious and large programme, but develop in stages; (v) address unequal distribution and quality of providers, and (vi) possible opposition from the existing insurance companies, JPKM *bapels* and also from local governments. The second proposal which originated from the Ministry of Health, was the ***model of Oligo Insurers,*** a national mandatory health insurance with multiple HMO that***:*** (i) accommodates interests of insurers, regions, and sectors; (ii) makes unequal distribution and quality of providers, and (iii) is less efficient and portabe. The third proposal is the draft bill prepared by parliamentarians, the contents of which are similar to the proposal of the Presidential Taskforce, except that it proposes to have a single agency to manage the total health insurance fund.

Though Indonesia has considerable experience in implementing SHI on a national scale, the growth has been very slow due to inconsistent implementation of the principles and policies. The current implementation needs improvement in expansion strategies as well as other areas, such as benefit packages, premiums, management, and payment to providers.

Thailand [31]

Thailand introduced the national social welfare scheme for the poor low-income households in 1975. The low-income medical welfare scheme (MWS) was originally introduced for providing free medical care for poor workers but was later extended to cover people over 60 years, children under 12 years,

[31] Viroj Tangcharoensathien, Overview of Health Insurance Systems, Chapter 2, Health Insurance System in Thailand, HSRI, Thailand, 2002; and presentations made the regional meetings on SHI in WHO-SEARO and Bangkok and Ponpisut Jongudomsuk, Achieving universal coverage of health care in Thailand through 30 Bhat scheme, paper presented at SEAMIC conference in January 2002.

secondary school students, the disabled, veterans and monks. The service package included free medical care at public facilities for ambulatory and inpatient care. By 2000, around 20 million people were covered under this scheme. The budget was allocated from general revenue on capitation basis but was inadequate. The scheme was poorly designed with no provision to ensure accountability or quality of care. It often excluded poor families as there were no effective mechanisms for means-testing.

In 1980, under a Royal Decree, Thailand introduced the Civil Servants Medical Benefit Scheme (CSMBS), in order to extend the SHI coverage to all government employees (including staff of state enterprises), pensioners and their dependents (parents, spouses and children). Currently, the scheme covers around seven million civil servants and their dependents. It is a fee-for-service reimbursement model and the source of funds is from the general revenue as a non-contributory fringe benefit scheme. The FFS model has resulted in a longer hospital stay and frivolous use of drugs and clinical investigations. The capacity of the scheme to monitor fraud and overcharging is poor. Following various studies and as an after-effect of the economic crisis of the late 1990s, the government reformed the CSMBS to include capitation for ambulatory care, global budget and diagnosis related groups (DRG) for inpatient care. An electronic disbursement system was introduced for inpatients using DRG.

Following the enactment of the Social Security Act 1990, the government introduced another national health insurance for mandatory coverage of employees for all private companies with more than 20 employees using a capitation, low-cost contract model. In 1994, the coverage extended to companies or commercial establishments with more than 10 employees, and by 2002, it included small enterprises with more than one employee. Compulsory health insurance for formal employees had certain strengths, as it was based on the contract models. Employees had the choice of any registered public and private contractors (outpatient and inpatient health facilities). The scheme covered, by now, around six million employees. The administrative costs were low, while maintaining decent quality of care. The financial contribution was progressive with a five-fold gap between the contribution of the highest and lowest wage earners. Still, there were some drawbacks since the scheme covered only employees as beneficiaries, and not family members. There was also some reluctance to expand the facility to the self-employed sector. Preventive and promotive health needs were not adequately addressed.

The Voluntary Health Card (VHC) project was started with the possibility of expansion of health insurance coverage in 1983, initially covering MCH care. It was expanded in 1994 to cover the village health volunteers and local leaders with 100% government subsidy. The VHC covered around 11 million people. It was a voluntary health insurance programme with an affordable premium for rural households not covered by the national social welfare scheme. Different health cards were introduced, based on the type of health care benefits, maternal care and immunization, curative medical care, or the totally free health care. Unused health cards were no longer renewable. By the mid-1990s, the VHC scheme was revised with a single card for an individual or an individual family, and it started offering a comprehensive health benefit package. Since 1994, the government is subsidizing in the ratio of B 500/- for every B 500/- paid by each family for a family card. This has had several important implications, as it creates adverse selection and limited risk-sharing. The sick usually joined while the healthy opted out. The financial viability was a major issue and there also was inequitable access between the urban and rural members. The referral system was inefficient, with frequent bypassing of primary care. A smaller number of people who could afford the contributions were covered under private voluntary health insurance schemes.

The timeline for expansion of SHI schemes in Thailand is:

1975: Free Medical Care for the poor (Medical Welfare Scheme), drawing lessons, gradual expansion and amendments in the health systems;

1980: Royal Decree for CSMBS;

1983: Voluntary health insurance (Voluntary Health Card) scheme: transitional measures, building up the social capital and institutional capacity to manage insurance fund;

1990: Social Security Act: Introduction of SHI for employed sector, capitation, and predecessor of the current universal coverage (UC) design;

1992: Reform of CSMBS - not very successful;

1996: Reform of health systems including financing (drafting national health insurance act), and

2001: Political will to adopt universal coverage of health care – financed from general revenue.

The Universal Coverage (UC) Scheme, notably the "30 Bahts-Scheme", was introduced in October 2001 on a national scale covering all provinces, with the idea of replacing the existing "Social Welfare Scheme" and the "Voluntary Health Card Scheme". It aimed at incorporating the 30% uninsured population into a "Single SHI Scheme". The UC plans to provide comprehensive health care coverage with virtually no co-payment by users, apart from a nominal fee of just "30 Bahts" per each health visit or hospital admission. The scheme is subsidized by general revenue. The coverage of "30 Bahts Scheme," by the end of 2002, was around 76% of the total country population. The remaining population is still covered by the CSMBS (11%) and social health insurance under social security for employees (13%). Some people are still not accepting the "30 Bahts Scheme" as strictly being social health insurance, as the payment is not on prepaid contribution, but is based on payment at time of illness.

Reforms related to the "UC scheme" are expected to provide several benefits, such as favourable cost-containment (around B1 400 per capita); use of close-end provider payment method; ensuring an overall systems efficiency by introducing quality assurance measures and merging the existing health insurance funds; decentralizing the management of funds, and having almost no financial impact on families due to catastrophic illnesses. The prepayment component of the total health expenditure would probably increase to 90%, leaving less than 10% for out-of-pocket. There would be a convergence of the benefit packages and expenditure across the three public schemes. The Royal Government has laid down the legal framework for universal coverage by promulgating the National Health Insurance Act in November 2002. The National Health Security Organization (NHSO) is now fully operational to undertake full universal coverage in the near future. The NHSO has many important tasks ahead such as the need for standardizing the benefit package(s), the payment methods, and the level of budget subsidy across the three public schemes, amending the benefit package and seeking sources other than general revenue, and finally how best to work with two other continuing SHI schemes (CSMBS and Social Security), and other private health insurance establishments, as well as the Ministry of Public Health which has the major control over public health care providers and facilities.

Myanmar[32]

Myanmar introduced a nationwide SHI scheme in 1956, within the stipulation of the National Social Security Act of 1954. The social security scheme is managed by the Social Security Board (SSB) under the Ministry of Labour. The scheme provides mandatory insurance of all formal employees from both public and private sector enterprises, which employ more than five people. Dependants are not yet included under the scheme. Exemptions are also provided for for some state enterprises that are already covered by some legal and administrative arrangements for health care and social security, such as the railways, mining and petroleum industries, and ports and dockyards. The benefits of SHI scheme under Social Security include free medical care and cash benefits for general insurance for sickness, maternity and deaths, and partial or full salary for some period based on employment-related illness and injuries. The scheme covers around 765 000 workers from around 25 000 establishments. The SSB has also established its own health care facilities (three hospitals and 89 dispensaries) in addition to utilizing all available public facilities. The premium contribution is derived from proportionate deduction of monthly payrolls, from employees (2.5%) and employers (1.5%). The government provides additional budget for current and capital items depending upon the annual expenditure of the SSB. A revised policy framework for expansion of SHI in Myanmar is under consideration. The Myanmar Insurance Enterprise, another public agency, also provided special health benefit packages as 'health riders'[33] for their life insurance policy holders. The benefits include lumpsum reimbursement for hospitalization, major surgery, disability, delivery and death. Since the early 1990s, Myanmar has introduced various community-based health finance options in order to reduce the financial burden on the poor.

Experiences from other countries within the Region

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

[32] Aung Kyaing and Aung Lin, presentation on SHI and SSS in Myanmar at Bangkok meeting on SHI, June 2003

[33] Health riders: explanation

civil servants, does not have any social welfare packages. National social welfare policy and schemes are under consideration. As part of tourism, some private insurance companies operating in Maldives are covering a few people as health riders on life insurance.

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

Nepal[34] has implemented various alternative health financing approaches, such as user-charges at public health care facilities, drug revolving funds and other community-based drug financing mechanisms, and community-based health insurance schemes. Most of these rely heavily on the out-of-pocket payment by users at the time of illness. The government recently promoted social health insurance by implementing a few pilot schemes. Only a small number of private agencies provide medical benefit packages, including membership of private insurance schemes to their employees. The following models on health insurance of limited coverage are under operation:

(1) **The Hospital-based micro-social health insurance scheme** was initiated in 2000 at the BPK Institute of Health Sciences which offers health care services to rural and urban household members through linkage with Village Development Committees (VDC), local cooperatives, business associations, and educational institutions etc. The premium for urban areas is four times higher than for rural areas and the scheme covers 2 400 members from 565 households. The service package includes free consultations and investigations, hospital beds, medicines and operation charges beyond a certain limit. The entire premium, and contributions from VDC etc. go to hospitals. The income shows surplus, but does not include expenditure, borne for manpower, and equipment cost etc.

(2) **The Community Health Post-based Insurance** was initiated in 1976, as Lalitpur Medical Insurance Scheme, with a coverage of 19 to 52% of the rural population in six health posts, near Kathmandu. The premium varied and the scheme was managed by the local committee. The government also

[34] Pande, Maskey & Chataut, presentation on SHI and SSS in Myanmar at Bangkok meeting on SHI, June 2003

subsidized the drugs. Registration-fee based free clinical service was provided at the clinics and the user-changes for cases referred to Patan Hospital. There was no surplus revenue over the expenditure. Sustainability may be a problem with the existing premium.

(3) **The Health Cooperative Model** was initiated by an NGO, PHECT (Public Health Concern Trust) of Nepal, which offered health service through a Cooperative Society with the members maintaining a daily saving of a nominal amount to contribute for health, both in rural and urban areas in and around the Kathmandu City. The community clinics provided primary care services as also the referrals to Kathmandu Model Hospital (KMH). A half of the total collections went to the funding of KMH. Subsidies or exemptions were provided to the poor on referral cases. The scheme covered 2 038 persons from 438 households.

(4) **The General Federation of Nepal Trade Unions (GEFONT)** supported another cooperative health scheme for transport and industrial workers. A monthly premium was collected from workers to establish a "Health Cooperative Fund" which ran a clinic for primary service and supported the referred cases to go to KMH. For the poor, PHECT Nepal provided financial support as part of solidarity. The fund covered around 500 families (two members from each family) out of 300 000 GEFONT members.

The National programme in Nepal, under the ILO's Strategies and Tools against Social Exclusion and Poverty (STEP) Global Programme, provided technical assistance to civil society groups to carry out feasibility studies to set up and manage the micro-insurance systems based on solidarity at the grass-root-level. The aim is to extend social protection measures through health micro-insurance schemes, which are gender-sensitive, accessible and affordable for the poor, vulnerable and excluded workers in the informal economy of Nepal. Support through this initiative was provided to the Credit and Savings Cooperatives, (GEFONT) and Social protection provided for porters and their families in Solokhumbu district, etc. Nepal has an opportunity of expanding and integrating the existing community-based health financing schemes into the community-based health insurance schemes so as to have a higher proportion of coverage, provided there is a strong political will and strategic actions are developed through political and technical consensus.

3.3 Experiences from Selected Asian Countries outside the Region

China

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

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

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

Vietnam

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

Philippines

The total health spending of the Philippines is around US$ 2.2 billion (about 3% of GDP) with per capita health expenditure of approximately US$30, and has remained unchanged for the last few decades. Around half of this is out-of-pocket private expenditure. Under the Medicare Act of 1969, the Philippine Medical Care Commission was established and the social security systems (SSS) for private sector employees and the Government Social Insurance System (GSIS) for government (public) employees were set up. The medical benefits under the national SSS included reimbursement of inpatient and outpatient care provided by both public and private health facilities. The premium was a mandatory payroll deduction of 2.5% of monthly wages up to a ceiling of Peso 3 000/- with employers and employees contributing equally. The GSIS provided medical benefits for civil servants. Both schemes are operated by the Philippines Medicare Commission (PMC). It is almost self-financed with limited public subsidies. By early 1990s, the PMC covered around 40% of the population.

With the enactment of the National Health Insurance Act in 1995, the Philippines Health Insurance Corporation (***PhilHealth***) was established as a para-statal corporation attached to the Department of Health with quasi-judicial functions, and administered the national SHI scheme. It has expanded the coverage to around 75% of the total population, consisting of employees from formal and informal sectors, and has sponsored indigent members and non-paying members (retirees and pensioners who enjoyed life-time

coverage, after paying at least 120 monthly contributions). The voluntary individual membership to ***PhilHealth*** has grown from around 165 000 in 1999 to seven million in 2002. Efforts are being made to reach universal coverage as soon as possible. The benefit packages include: subsidy for room and board, drugs, diagnostic examinations (X-ray and laboratories), professional fees, operation room charges and consultation costs for inpatient care and reimbursement for outpatient care charges, including chemotherapy and radiotherapy and minor operations. The government provides finance for SHI through regular payroll deduction (1.25% of the salary by employers and employees, with a salary cap of US$ 189 per month), and general tax revenue. Another feature is the strong involvement of local governments and their commitment to the subsidized indigent programme. The number of indigent members has increased from about 15 000 in 1997 to seven million in 2003 due to increasing sponsorship by local government units, legislators, private wealthy citizens, NGOs and other government agencies.[35]

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

Republic of Korea

The Republic of Korea started the SHI scheme with the enactment of health insurance legislation in 1963. The national mandatory health insurance initially covered employees of formal sector establishments (with more than 500 workers). In the 1980s, the programme expanded to cover government employees and teachers and firms with less than 300 employees. This was further extended to small firms of less than 16 employees and then to the self-employed in all urban and rural areas. Since 1989, almost 96% of the 47 million population of South Korea are covered under the mandatory social

[35] Fransco T Duque III & Ruben John Basa, PhilHealth, Moving towards universal SHI coverage in the Philippines, a presentation at Bangkok meeting on SHI, June 2003 (unpublished) and School of Economics, University of Philippines, Proceedings of a Regional Conference on Health Sector Reform in Asia, 22-25 May 1995

health insurance scheme. The remaining 4% of the population are covered by a medical aid programme for the poor, fully subsidized from the general revenue of the government. The proportion of public to private health facilities decreased from 40% in the 1970s to less than 10% by the 1990s.

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

4. OTHER FORMS OF HEALTH INSURANCE AND PREPAYMENT

4.1 Role of Savings in Covering Medical Expenses

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

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