

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

of financial and administrative management. This makes the pure savings approach less attractive to policy-makers as a choice of health care financing in most cases.

One possible approach of using savings to cover medical expenses is to develop an additional component of the national SHI schemes, as pioneered by the famous "3M" health financing schemes, i.e. *Medisave*, *Medishield* and *Medifund* of *Singapore*.<sup>36</sup> The *Medisave* scheme is an individual saving scheme for which the accumulated savings could be used for medical care expenses. It generally excludes the expenses for outpatient services, in order to take care of paying for infrequent but highly costly inpatient care. As the scheme depends on inter-temporal pooling over the individual's lifecycle, it is not actuarially feasible for *Medisave* balances to insure against truly catastrophic contingencies. To solve this problem, Singapore introduced *Medishield*, a back-up health insurance programme based on cross-sectional risk-pooling, designed to finance the extreme catastrophic tail of risk distribution. In addition, the Government of Singapore also introduced *Medifund*, which is an endowment fund for those whose health care costs are beyond their means, even with *Medisave* and *Medishield*.

The "3M" health financing schemes rely heavily on individual responsibility for health care costs. The system combines the non trivial co-insurance rates with explicit targeting of costly risks. Even though on average, about 60% of hospitalization costs in public hospitals are subsidized by the government, the residual 40% are charged to patients through their *Medisave* and the OOP payments. Thus, consumers (patients) have a double burden of individual responsibility, not only in the form of 20% co-insurance paid out of their *Medisave* account, but also another 20% paid directly as OOP payment. Claims for back-up *Medishield* coverage of catastrophic expenses are also subject to 20% co-insurance on top of high annual payment.

Countries with higher level of life expectancies for both sexes usually recognize the need for social security measures for the elderly. Rapid urbanization and the increased mobility of young working people are also eroding extended family networks and traditional means of support for older people. Newly industrialized countries that are developing "old-age social security systems" could fall into the trap of repeating the costly mistakes of the earlier groups of industrialized economies. Social security schemes for the

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<sup>36</sup> Phua Kai Hong, Social Health Insurance and Medical Savings, Presentation at 3<sup>rd</sup> Forum of Asia Pacific Health Economic Network, Manila, February 2003

elderly should have basic functions of social security systems: redistribution, savings and insurance. The first is a mandatory publicly-managed and general revenue-based health care financing system, in which the financial burden is redistributed. The second is a mandatory privately-managed personal savings system, where each individual has the obligation to set aside a portion of his/her income as savings for future use in covering medical expenses in part or whole. These two could be supplemented by a third, which is a voluntary system of occupational or personal saving plans. These three pillars together would co-insure against risks of old age while, at the same time, not impeding growth in ageing societies. Countries like Sri Lanka, Indonesia and Thailand, which now have increasing proportions of elderly people could consider this alternative financing mechanism as options.

The health care financing systems of Singapore have shifted from a tax-based "national health service" model to a "mixed system" where public financing plays a dominant role in providing universal coverage through a combination of taxation and savings, with social health insurance only for catastrophic illness and long-term care. It is purposely designed to move away from the comprehensive and overly generous insurance models that may be unsustainable. The role of the state is as a large resort to support the truly needy, while average individuals and families are expected to contribute towards greater cost-sharing of increasingly expensive health care, to achieve greater sustainability. These considerations have formed the basis for the existing integrated systems of old-age social security and social health insurance in countries such as Singapore, which are fully-funded saving schemes that would avoid the inter-generational transfer problems of pay-as-you-go systems financed from taxation.

The attractiveness of the "mixed financing" system with **medical savings** comes with several issues in its implementation.<sup>37</sup> Firstly, the management of medical savings requires strong political will and onerous administration and management capability and competency at various levels to regularly collect money, process claims, manage accounts, and invest the fund. This would be a difficult position for countries with predominantly rural population or countries with large proportion of informally employed sectors. Secondly, population in poverty or population with chronic diseases or disability would not have adequate savings from the beginning. Introducing medical savings

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<sup>37</sup> Piya Hanvoravongchai, Medical Savings Accounts: Lessons Learned from International Experience, EIP Discussion Paper No. 52, WHO, Geneva ([http://www.who.int/whosis/discussion\\_papers/](http://www.who.int/whosis/discussion_papers/))

and high cost-sharing without adequate social safety nets would result in financial inaccessibility, or could also lead to increasing number of households with catastrophic spending and increasing income inequality. Lastly, stewardship role of the government is crucial in the "mixed system" despite the concept of increasing individual responsibility. Singapore itself demonstrates many of its stewardship roles such as control on the provider, wide and extensive public education, and the provision of social safety net.

## **4.2 Role of Private Health Insurance**

The role of the private sector in providing health care is expanding rapidly in the Region as a result of many national health systems not being able to cope with rising costs, especially for co-payment, and increasing demand for services. The WHR 2 000 has indicated that "low-income countries could encourage different forms of prepayment-job-based, community-based and provider based- as part of a preparatory process of consolidating small pools into larger ones." Development and expansion of national SHI and private health insurance schemes should be seen in the context of globalization and rapid liberalization of international trade, including opening of markets for the private sector.

Private health insurance could also be classified into three main categories: (1) private for-profit or commercial health insurance; (2) private not-for-profit health insurance (voluntary health insurance), and (3) community health insurance. Experience shows that there is a continuum of arrangements between private insurance and social health insurance. Private health insurance can serve as one of the sources of coverage or act as augmentation for co-payment to public/social health insurance.

Private health insurance in one way might reduce the OOP expenditure and evolve in the long run towards a broader social health insurance system. Unless majority of population is covered by the social health insurance or tax-based financed health systems, there is a need to have appropriate regulation of private health insurance schemes to ensure the basic principles of solidarity, solvency requirements, cross-subsidization and control of exclusion.<sup>38</sup>

Private health insurance can serve as an alternative source of health financing, if the principal coverage is aimed at the larger segment of

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<sup>38</sup> Neelam Sekri, Using private health insurance to serve the public interest, presentation at Bangkok SHI meeting, June 2003

population with comprehensive health packages. Countries that have instituted or are soon going to introduce private or commercial health insurance markets should be aware of their side-effects and should ensure a proper regulatory framework. Many private financial and insurance companies have introduced health insurance schemes for the young, productive and high-income groups setting high premiums, with lucrative and limited benefit packages (one or two major health crises). In addition to adverse selection and risk selection (cream skimming), there are issues such as risk-related premium, different benefit packages designed by insurers, moral hazard, opt-out option, cost escalation and high administrative cost. The scheme is usually of limited population coverage, but the demand for its expansion is growing due to increasing advertisement and advocacy by financial and insurance enterprises, as well as due to pressure from the growing number of high-income groups.

While the total market outlay of private health insurance in **India** is unknown, it is expected to be less than 1% of the total health expenditure (THE). Since 1999, after India adopted the Insurance Regulatory and Development Authority (IRDA) Bill, which seeks opening up the insurance sector to foreign and private insurance investors, a series of policy debates and feasibility studies have been conducted to review various possibilities. The IRDA Bill aims to facilitate the establishment of the Authority to protect the interests of insurance policy holders by regulating, promoting, and ensuring orderly growth of the insurance industry. International investors can hold up to 26% equity.<sup>39</sup> The IDRA Bill will also apply to health insurance market. Many NGOs which have established various community-based health insurance schemes have expressed concerns on the IRDA Bill, mainly on its regulation of capital outlay requirement. A few life insurance and non-life insurance companies have started promoting different schemes of individual and group health insurance as “health riders”.

**Thailand's** private health insurance covered less than 2% of THE in 1999. Most of the health insurance policy holders are “health riders”, extending their existing individual or group life insurance package by covering hospitalization and major surgery or part of the group life insurance combined with accident and health insurance as a comprehensive package, usually offered by a life insurance company.

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<sup>39</sup> Gupta I., Private health insurance and health costs, Economic and Political Weekly, Vol.37, No. 27 July 2002

In other countries, there may be a non-life insurance company (usually mutual funds or medical-aid or health insurance) which provide individual or group life insurance policies. The premium is linked to the benefits offered. The insurance business is usually tightly regulated by the government because of the public financial liability and national security. Thailand adopted a series of legislative frameworks for private insurance including health insurance, with the most recent amendment in 2000 for allowing foreign investment (up to 25% equity). Even though the number of insurers in foreign insurance companies is around 6% of the total insured in private insurance, the premium volume is one-third of the total estimated funds of 115 million bahts.<sup>40</sup>

Health ministries have to monitor the impact of rapid growth of private health care providers and, at the same time, the growing number of private health insurance schemes in a liberalized environment. Is the country ready for the introduction or expansion of private (commercial) health insurance? What is the consumers' reaction? Are they willing to pay and participate in private health insurance schemes? What impact will these schemes have on the existing SHI schemes as well as on health care delivery systems in ensuring equity and efficiency? These are a few policy questions that need to be addressed with solid evidence in the context of each country.

According to a recent trend analysis, accidents and injuries would become an increasing cause of global and regional burden and may emerge as one of the five major killers and crippers in the next few decades. While efforts have to be made in road construction and traffic control, there is need to restructure the traffic accident insurance. While all countries have traffic insurance as part of a Third Party Insurance to reduce the financial and health risks from the individual to a pooled one, there is a mismatch between funds and services.

For example, in Thailand, a majority of accidents and injury cases are taken care of by public sector facilities (with the excuse of being police cases), thereby placing a burden on public funds. As the "Third-Party Health Insurance" funds, handled by private insurance companies do not go to public sector facilities, the private companies make huge profits with fewer claims.

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<sup>40</sup> Tangcharoensathien. V. & Pitayarangsarit S., Private Health Insurance, Chapter 7, Health Insurance System in Thailand, HSRI, Thailand , 2002

### 4.3 Community-based Health Insurance

During the last few decades, voluntary pooling of resources for health at the community level emerged as another health financing mechanism in low-income and lower-middle income countries. These community-based health insurance (CHI) schemes, based on voluntary risk-sharing (both in the formal and informal sectors) highlight the importance of national or sub-national governments ensuring that financial risk sharing covers vast populations. Presently these risk-sharing schemes have limited coverage, both in terms of population and health care provision range.

For example, in India, various states had established a multitude of community-based health insurance schemes including variations of community-based health financing with some form of risk-pooling. These schemes mainly serve the people living in same localities or communities, with an estimated coverage of 30-50 million, and the main benefits are in preventive care. In some cases, ambulatory and inpatient care are also covered. The premiums are financed through fee-for-service arrangement at time of providing care, and through government subsidies and community donations. Some schemes have introduced premiums based on the regular income level, while others charge a flat rate. Provider payments are mainly fee-for-service.<sup>41</sup> Some examples of community-based health insurance or risk-sharing schemes include:

- (1) Gujarat: *Self-Employed Women's Association (SEWA)*: provides health, life and assets insurance to women working in the informal sector and their families; enrolment in 2002 was around 93 000. This scheme was established in 1992, and operates in collaboration with the National Insurance Company (NIC). A premium of Rs 85 per woman is paid for life, health and assets insurance. At an additional payment of Rs 55, her spouse too can be covered. Rupees Twenty per member is then paid to the NIC who provides coverage, upto a maximum of Rs 2 000 per person per year for hospitalization. After being hospitalized at a hospital of one's choice (public or private), the insurance claim is submitted to

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<sup>41</sup> See details in (a) Ranson Kent & Acharya Akash, Community based health insurance: the Answer to India's risk sharing, Health Action, March 2003; and Ranson Kent & Jowett Matthew, Developing health insurance in India: Background paper presented at National Health Insurance Workshop, 3-4 January 2003, New Delhi, India and presentations made at Bangkok meeting on SHI, June 2003

SEWA. The responsibility for enrolment of members, and for processing and approving of claims rests with SEWA. NIC in turn receives premiums from SEWA annually and pays them a lump sum on a monthly basis for all claims reimbursed.

- (2) Gujarat: *Tribhuvandas Foundation (TF)*, Anand: It was established in 2001, with an enrolment of over 100 000 households, and the membership is restricted to members of the Amul Dairy Cooperatives. It is acting as a third party insurer.
- (3) Karnataka: *Mallur Milk Cooperative*: It was established in 1973, covering 7 000 people in three villages. The outpatient and inpatient health care are directly provided by the cooperative health facilities.
- (4) Maharashtra: *Sewagram, Wardha*: An NGO, established in 1972, it started the scheme covering about 14 390 people in 12 villages; and provides outpatient and inpatient care to members directly through its own facilities.
- (5) Tamil Nadu: *Action for Community Organization, Rehabilitation and Development (ACCORD)*, Nilgiris; established in 1991, covering around 13 000 under a group policy purchased from New India Assurance;
- (6) Tamil Nadu: *Kadamalai Kalanjia Vattara Sangam (KKVS)*, Madurai: A voluntary health insurance scheme was established in 2000 with enrolment in 2002 of around 5,710 families, covering members of women's self help groups and their families, and acting as third party insurer;
- (7) Tamil Nadu: *Voluntary Health Services (VHS)*, Chennai: the scheme was established in 1963, and by 1995, its membership was 124 715. The scheme offers sliding premium with free care to the poorest; the benefits include discounted rates for both outpatient and inpatient care. The VHS is both an insurer and health care provider, and suffers from low levels of cost recovery due to problems of adverse selection.
- (8) Chhatisgarh: Raigarh *Ambikapur Health Association (RAHA)*: was established in 1972 with an enrolment of around 100 000 and is acting as a third party administrator.

Bangladesh also has a few community-based health financing schemes, a few of which are based on social health insurance principles. A few selected community-based health insurance or risk-sharing schemes<sup>42</sup> include:

- (1) **BRAC: BRAC health programme:** covered around 12,000 families with a prepaid contribution ranging from Tk 100-350 according to economic means, with the benefit packages of free consultation, limited curative care, delivery, co-payment for referral, medicine and diagnostics. BRAC's networks of health care facilities provide free health care.
- (2) **Gonosasthya Kendra (GSK), Savar:** The GSK health care system covers over 10 000 households (30% of families living in GK area, with sliding scale of premium. The benefit package includes free preventive and curative care with a fixed-term for co-payment.
- (3) **Integrated Development Foundation:** covers around 30 000 members with TK 150 per month as premium and provides care through its own health care facilities. Co-payment is also fixed for medicine, specialist consultations and diagnostics.
- (4) **Society for social services:** covers around 54 000 members registered through the health card system and free health care is provided through SSS hospitals with a provision for co-payment.
- (5) **Dhaka Community Hospital:** also established a hospital-based health insurance, covering around 200 000 people, as registered on health card with some payments. The benefits range from free medical care to co-payment.
- (6) **Grameen Bank Health Programme:** covers around 143 000 members. The premium ranges from Tk 120 for Grameen Bank members, Tk 150 for non-Bank members and Tk 10 for schoolchildren. The Grameen Bank health care facilities provided free health care for outpatients and re-imburement of around 10% of inpatient care.

Similarly, a few other countries have developed various forms of *CHI schemes* to cover certain targeted groups such as poor women, low-wage workers and the semi-employed both in rural and urban settings. The major

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<sup>42</sup>Ministry of health and Family Welfare, Bangladesh, Social health insurance in Bangladesh, paper and presentation made at Bangkok SHI meeting, June 2003

*policy challenge* is how to accelerate the development of community health-risk-sharing initiatives and facilitating a broader coverage of people. Continuous and sustained support and incentives from national and local governments are required to improve the managerial skills and to provide opportunities for pooling of funds to generate greater financial viability and sustainability.

Large financial pools are better than small ones as they can provide for a better sharing of health risks, and, at the same time, raise more revenue. A larger pool can also take advantage of economies of scale in administration and reduce the level of contributions required to protect uncertain needs, while ensuring that sufficient funds are available to pay for services. Experience has shown that pooling risks to cover both health problems and financial burden have increased the efficiency of health systems, creating better health outcomes. WHO-CMH recommended that out-of-pocket expenditures in poor communities should increasingly be channelled into 'community financing' schemes.... [through] an incentive scheme, in which each \$1 that the community raises for pre-paid health coverage would be augmented, at some rate of co-financing, by the national government (backed by donor assistance). This method would offer a degree of risk-spreading, so that households would not face financial catastrophe in the event of an adverse health shock to household income"<sup>43</sup>. The World Bank in its World Development Report 2002 has emphasized the relevance of community-based health financing schemes.<sup>44</sup>

Community-based health insurance (CHI) schemes are voluntary private membership using the principle of pooling health risks and resources, usually known as rural health insurance, mutual health organizations or associations, medical aid societies, medical aid schemes. There are different from other forms of community-based health financing, like community cost-sharing, drug-funds, in which risk-sharing can even be absent. These non-formal, community-based health insurance initiatives are usually launched on non-profit basis, to cover certain targeted groups. A few studies have shown that smaller number of such schemes cover large proportion of groups, while larger number have lower coverage of the eligible population. Most people join these schemes only at the time of illness. The WHO and ILO studies

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<sup>43</sup> WHO-CMH Report *op cit* p60-61

<sup>44</sup> World Bank, World Development Report 2002, p179

indicated that enrolment was very low, and more than 90% of the schemes did not bear the bulk of the financial risk.<sup>45,46,47,48</sup>

Existing CHI schemes in most countries cover limited medical care benefit packages and sometimes include preventive health care with minimum medical and diagnostic services. There is a possibility that if a comprehensive package is introduced, these schemes would collapse.

The CHI schemes with a small pool of participants are not viable financially in the long run. Experience shows that CHI schemes with less than 100 000 participants are not viable. Many schemes are usually provider-driven, initiated by wealthy people as a trust, linked with or are part and parcel of national or sub-national poverty-reduction programmes, including micro-financing schemes. The CHI schemes are often carried out as sideline benefit packages. This hampers sustainability. Many community-based schemes have limited scope, as they are often expensive, considering the high hidden costs which are covered by donors and governments. Once donor funding ceases, only 10% of such schemes survive. In order to overcome this, CHI should be implemented as a 'core business' addressing the poor, as shown historically in Germany and the Netherlands, where such schemes were initially established as sickness funds.

Social capital is a prerequisite to implement CHI schemes. Since social capital varies among states and even among localities, the design of the scheme including management of programmes should be local-specific. This has led to difficulties in replicating the schemes in other areas. There should be a strong stewardship from the government in enhancing CHI and, if possible, providing additional funding. For various reasons, the NGOs' involvement in community-based social health insurance development on a wider scale is relatively marginal compared to other development areas. This issue needs to be addressed. The experience already gained by implementing various models of CHI schemes, especially in ensuring consensus on solidarity and contribution, and on community management of collecting and allocating funds, could play a useful role in expanding the national SHI schemes.

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<sup>45</sup> Bennett S, Creese A, and Monasch R (1998). Health Insurance Schemes for People Outside Formal Sector Employment, WHO Geneva (Document WHO/ARA/CC/98.1)

<sup>46</sup> Carrin G, et al (Ed.) The Economics of Health Insurance in Low and Middle-income countries, Social Science and Medicine (Special Issue), vol.48, 1999

<sup>47</sup> ILO and PAHO, Synthesis of case studies of micro-insurance and other forms of extending social protection in health in Latin America and the Caribbean (<http://oitopsmexico99.org.pe>)

<sup>48</sup> Baeza C. et al, Extending Social Protection in Health through Community based Health organizations: Evidence and Challenges, ILO, Geneva 2002