

## **5. KEY ISSUES FOR FURTHER EXPANSION**

There is a danger that rapid expansion of health insurance coverage without appropriate safeguards could result in health systems moving away from the primary goals of efficiency, effectiveness and protection of the poor and the vulnerable. The success of health insurance in achieving health reform goals is closely related to its particular institutional characteristics and managerial capacity. Usually, middle- and high-income countries, whose economies can sustain a larger proportion of employed labour workforce, are capable to expand the coverage of social health insurance as quickly as possible. They initially start with multiple agencies handling social health insurance or social mutual funds through prepaid schemes and are later consolidated into small funding groups. They act as fund managers and purchase services from both public and private health care providers.

Several countries around the world which have relied heavily on tax-based health financing are moving towards expanding social health insurance. Many households are spending large proportion of their HH expenses (out-of-pocket expenditure) on public-funded health care facilities (which are supposed to provide health care literally free of cost). There are many reasons of inefficiency of public health care providers in the form of low quality, inadequate coverage, by-passing of care, under-the-table and over-counter (unofficial) payment, rising cost of travel expenses, overcharging by private providers, etc. Most countries have a mix of specific arrangements for insurance, such as social health insurance (independent or within social security), commercial health insurance, and community prepayment schemes which varies across countries. Ultimately, it is the government that must provide subsidies for the poor and disadvantaged groups, by ensuring the financial and health risk protection for those who cannot afford to fully finance their own health expenses. Some countries have made detailed studies on this aspect, in collaboration with external agencies including ILO, GTZ, UNDP, UNICEF, the World Bank and ADB, etc. More information is required to study these issues comprehensively in the Region.

### **5.1 Prerequisites for Introducing or Expanding the Coverage SHI**

Social health insurance is just a mechanism to ensure equity and efficiency by pooling the health and financial risks. Once the SHI scheme reaches a certain high level of population coverage, there is a strong potential to foster health

systems equity and efficiency through monopsonistic purchasing power of the Insurance Fund. While SHI is a promising alternative source of financing in order to promote equity and efficiency, it cannot be the only solution to bridge the financial gaps for resources required for additional health funding. The SHI scheme, alone, is not a panacea or remedy to replace other mechanisms or forms of health care financing, particularly financing based on general tax revenue. The government should not shirk its responsibility to ensure and regulate provision of health care, including essential public health functions, whether directly by public or private health care providers.

The main reasons for adopting the SHI scheme,<sup>49</sup> in general, are:

- It can provide a stable source of revenue for health care;
- It would ensure self-reliant financing of health care compared to loans, grants and other external sources;
- The flow of funds into the health sector is visible;
- It can assist to establish patients' rights as customers.
- It combines risk pooling with mutual support, by allocating services according to need, and distributing financial burden according to the ability to pay;
- It can operate within government health policy goals, yet maintain a degree of independence;
- It can be associated with efficient provision of health services, and
- It solves equity and affordability of health care financing contribution in which the private health insurance fails to facilitate.

Health systems and health care are necessarily shaped by the politics of their countries, with the emphasis given to different health system goals, the relative importance assigned to health, and the assignment of responsibilities for health care among individuals, families, and society. People who use health care services, medical professionals, insurance institutions, employers, and unions are among the prominent groups that take a particular interest in public policy towards health financing. In most countries, large sums of money are at stake and different groups will benefit depending upon how these funds are allocated and regulated.

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<sup>49</sup> Modified from Normand C. & Weber A, Social Health Insurance: A Guide for Planning, WHO/ILO 1994 (WHO/SHS/NHP/94.3) p15

All of this is a normal consequence of combining the political processes of governance and collective decision-making with the widespread recognition that public policy must play a significant role in guiding the health system. Therefore, the design of health financing in any particular context should not only recognize political influences, but explicitly address and take advantage of the opportunities presented by political debate and governance. What kind of alternative financing options should be considered depends upon the intensity and source of pressure. It is the alternatives but the balanced mixture of many alternative health financing options that the countries need to consider. The former central-market-economy-oriented countries like those of the Eastern European Region and similar Asian countries like Myanmar, India and Sri Lanka, with low levels of public health spending, low salaries for health care professionals, and inadequate quantity of health care interventions and facilities do require a higher level of health funding by governments. The main pressure usually comes from health professionals (both public and private) to improve their incomes.

Considering various options through intercountry comparison, policy makers/analysts usually concluded that the Asian developing countries tend to spend in health from public sources less than expected (given their income levels compared to Latin American countries or even among themselves). They advocated for an increase in the level of public health spending, exclusively focusing on the inputs to the health systems like expanding or upgrading hospitals, opening more and more medical universities, etc. It is worthwhile to look more carefully not on how much of this additional fund, but on how this additional spending could better benefit the poor and how it could assist in reducing inequity and improving health systems efficiency.

Expanding the social health insurance coverage is one possibility. This expansion is traditionally linked with national social security policy and programmes. Only four out of the 11 Member Countries of the Region introduced SHI schemes, without a wide coverage for some decades, except Thailand. Other countries have not yet implemented SHI schemes on national scale. Since the labour markets are growing rapidly in countries where governments provide free health care utilizing funds from general tax revenue, these countries may need to consider the SHI scheme as an alternative health financing. Health ministries usually have limited budgets and are competing with other sectors. In situations where basic services are already free, SHI could be an added advantage in ensuring access to health services, especially

from private providers. Before looking at the policy dimensions, it is important to look at the technical feasibility of SHI, since insurance arrangements are more complex than tax-based funding. The major issues that need to be examined carefully are:

- **The labour and financial market structure:** If the country has more formal labour establishments (usually a country with fair or good economic growth, liberal trade, education and employment opportunities), there is the possibility of expanding the coverage of SHI. The regular collection of contribution from salaried income of employees from formal sector would be easily managed, while contribution from informal sectors, usually of unstable labour market, would be difficult. There are some instances where group health insurance are organized for covering bus, truck or taxi drivers and conductors, fishermen, village agricultural cooperatives. Appropriate managerial set-up on how premium from informal sector employees can easily be collected without much burden, such as payment on kind or contribution on quarterly or yearly fees, has to be considered. In addition to the need for an understanding of the importance of mandatory contributions (national solidarity), there is a need for nation-wide financial institutions to manage the collection and disbursement of funds.
- **Existence of other forms of insurance schemes:** Some countries have introduced many forms of insurance part of financial market arrangement or under the social security framework. Almost all countries have private health insurance as “health riders’ to life insurance, mutual funds, and other insurance packages offered by financial institutions. “Third-party insurance” for accident and injuries is another area health ministries kept out-of-touch.
- **Regular contribution from the payroll:** The SHI contributions come from regular deductions from payroll and accumulated as a “Health Fund”. Although the total contribution is calculated as a percentage of the monthly income, the amount is normally split between the employee and employer, and sometimes even additional subsidy by the Central or State Governments, depending upon the national policy and social consensus. One actuarial issue is what proportion of salary should be compulsorily deducted (along with other deductions like pension and provident fund, income tax, etc.).

- **The health infrastructure:** The SHI schemes act as main purchasers and can help to ensure that those covered under them receive appropriate health care. The schemes have to work in an environment where the health care facilities are functioning in an adequate manner so that access to health care by the insured people is not denied for any reason. It does not mean that the schemes themselves should establish their own health care facilities. Traditionally, social security schemes in India and Myanmar established their own health care facilities in order to fill the gaps made by public health care providers. Similarly big state or private enterprises like mines, railways, electricity, petrol-chemical industries and other heavy industry complexes have established their own health care facilities. Some even have secondary and tertiary health care facilities that inadvertently led to inequity. Those population groups who are not insured (due to differences in their employment status, especially people from informal sectors and mainly from agricultural, fishery and animal husbandry sectors) are often not able to get appropriate health care due to their inability to pay contribution regularly or in most cases because of lack of social health insurance coverage. Thus the main aim of SHI scheme is to add on the health financing resources for universal coverage, and not to treat them as a mere alternative.
- **Management infrastructure:** The SHI schemes need a large **social capital** in all aspects: appropriate human resources with skill and knowledge in social science, commerce and economics, disease burden, clinical management, public health management, banking and financial management (i.e. health economists, insurance mathematicians, actuarial scientists, social economists, accountants, demographers, epidemiologists, medical record keepers and statisticians, information specialists, public health legislators). Many countries do not have much national capacity to fulfil the requirement of national social capital. Regional solidarity may be required to improve and strengthen the capacity of social capital. In addition to the need for setting up appropriate collection of funds, there must be a nationally approved mechanism for managing this fund. It is critical to ensure the independence of the "Health Fund" from the general management of public finance. There is also the need to ensure transparency in Fund management, particularly to

strengthen the people's trust in the public management of the Fund. Some countries are still keeping the social security agency or agency managing social health insurance, as an integral part of government public departments. They collect the contribution and put them into the general revenue. The Fund Agency has to compete with other public agencies for annual budget, thus limiting the scope and work of the agency. In many middle-income countries, the SHI fund is usually managed by an independent single agency or multiple agencies, as parastatal bodies or private enterprises (with their own budget, legal status and management). However, they all should be under the strict control of national legislation and its subsidiary body.

## **5.2 Issues in Expanding SHI Schemes**<sup>50,51</sup>

There are some limitations of SHI that make it inappropriate to fund certain health functions. For example, people are generally not happy sharing the cost of public goods such as public health programmes and infrastructure (e.g. immunization, water supply and sanitation, food safety, disease surveillance, etc.). People are also unwilling to share the costs of highly personalized treatment such as cosmetic surgery. However, there are more and more countries which are accepting the inclusion of alternative care, using traditional health care practices.

In those countries where public health facilities provide health care free of cost at the point of use of care (although the expenditure may be through general revenue or any other financing mechanisms), the expansion of SHI will need a lot of awareness-building among the general population to accept the idea of prepayment and cost-sharing. There is the possibility of resistance to change a system where payments are more visible. Usually, higher-middle and high-income countries whose economies can sustain a larger proportion of employed labour are able to achieve complete or near universal coverage through social health insurance. They initially started with multiple finance managing agencies handling various social health insurance schemes, some as part of the overall social security measures. They tended to contract out health care provision to both public and private care providers.

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<sup>50</sup> Detailed analysis can be reviewed in "Guy Carrin, Social health insurance in developing countries: a continuing challenge, *International Social Security Review*, p57-69, Vol.55, 2/2002".

<sup>51</sup> WHO-SEARO, Report of Regional Consultation on Social Health Insurance, 7-9 July 2003, Bangkok, Thailand

It is necessary to build a stronger evidence base for analysing and evaluating the health financing function. There are a lot of information gaps on evidence for policy in health care financing. Most countries have not yet established or updated their national health accounts. While many countries may have regular socioeconomic surveys, the results of these surveys are not properly analysed for policy trends. Countries need to initiate, in collaboration with WHO and other agencies, a variety of activities to address these needs. Such future studies should:

- Emphasise good primary data collection and secondary data analysis;
- Emphasise greater care to eliminate bias, misinterpretation and to do systematic literature reviews;
- Generate ways to measure the effectiveness of health insurance under different systems;
- Analyse different ways of expanding prepayment schemes: including top-down and bottom-up approaches;
- Learn more about how households view fees and prepayment schemes; and
- Understand better how providers respond to mixes of payment mechanisms.

The ultimate goal of health care financing is to achieve universal coverage. Health care financing based on general tax source is the fairest way. Some countries with a high proportion of salaried workers in formal and informal employment sectors might need to consider implementing or expanding the SHI schemes. Experience has shown that several SHI schemes are facing difficulties in controlling costs if fee-for-service billing is the major form of provider payments. There are different methods available for reimbursing service providers.<sup>52</sup> These include salaries, fee-for-service, capitation/block contract, fixed budget, daily allowance and case-based payment. The following table shows each of these methods associated with certain negative behaviours by service providers.

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<sup>52</sup> Detailed framework on providers' payment is in "J. Kutzin, A descriptive framework for country-level analysis of health financing arrangements, *Health Policy* 56 (2001) 171-204

**Table.** Payment method and provider behaviour

| Payment method   | Provider behaviour   | Remedy   |
|--|--|--|
| Salaries or contract                                       | Restrict number of patients, services  | Performance-rated payment and variety of incentives                |
| Fee-for-service, with or without fee schedule              | Overproduction: expand the number of cases, service intensity, expensive services, diagnostics and drugs     | Combined with budget and adjust fees when specified level exceeded |
| Capitation and block contract with or without fund holding | Underproduction: Attract more registered persons, minimize contacts per patient, service intensity           | Integrated referral system   |
| Fixed budget   | Reduce the number of patients, services  | Balanced budget on performance                                     |
| Daily allowance  | Expand the number of bed days, longer stay, more admissions  | Control daily payment by adjustment on long stay                   |
| Case-based payment, DRG                                    | Overproduction: expand the number of case, less serious, decrease service intensity, less expensive services | Need negotiation from the start                                    |

While a number of developing countries have started introducing SHI or to further extending the existing social security or social welfare schemes, a review of such schemes in many low-and middle-income developing countries has shown the following major difficulties.

- **Deficient in understanding the basic conceptual framework on social health insurance and lack of nation-wide consensus** between stakeholders is a major issue in the adoption of SHI for achieving universal coverage. Appropriate policy framework has to be adopted to ensure the basic concept and ground rule of SHI, i.e., to guarantee equitable health benefits to those with similar health needs, regardless of the level of contributions.

- **The need for trust building by the potential members on the fund (its creation and management)** is also another major hurdle. Consumers (beneficiaries) have to fully understand of the basic concept, the contributory obligation, agreement of benefit packages, and how it is easy for them to be in the system, etc.
- **Inadequate or ineffective health care** provided to the insured members may be another constraint impeding expansion. If the existing health care system is not able to provide an essential basic health care package, it makes little sense to start an SHI scheme.
- **Insufficient or lack of human capital or social capital** leading towards inefficient and ineffective managerial or administrative capability or capacity to organize nation-wide SHI schemes, could lead to inadequate collection, reimbursement, capitation payment, inefficient management of revenues and assets collected, or lack of monitoring the necessary health and financial information.
- **Political instability**, usually linked with national internal politics, and social and economic insecurity are the main hurdles. In some cases, there is also lack of policy debates between high-level policy-makers and beneficiaries.

While a few countries in the Region might face similar impediments for expansion of SHI schemes, there are many examples where opportunities could be exploited to facilitate the acceleration of SHI implementation, or the transition from other financing options to social health insurance.

### 5.3 Ingredients of Successful Expansion of SHI

The main ingredients of successful expansion of SHI schemes are:

- **Political stability:** Stability in governance, with a strong political and social commitment towards adopting SHI policies by the stakeholders as a solidarity measure, within the national framework of social security and welfare policy, will be the *raison-d'être* for the success of the SHI programme.
- **Economic growth:** There is no doubt that economic growth has an impact on the speed of expansion of insurance coverage. If the growth spreads more equitably within the country, the willingness and ability to pay SHI contributions could be enhanced.

- **Level of income:** Once the general population has access to better income, they tend to participate in health insurance schemes and to make higher contributions. If people are willing to pay and can afford to pay even a small amount, it would be a prime time to start with.
- **Expanding risk pools (Universal coverage):** The challenge for countries which do not have a higher coverage of risk-pooling is the enormous task of expansion that would require significant political will and an enhanced managerial and technical capacity. There is a need to increase the risk pool by expanding the beneficiaries or adding essential packages. Partnerships of employers, employees, families and enterprises will ensure that the direct burden of financing is spread more widely among them.
- **Solidarity:** There is no general rule about the proportion of the population to be covered with an SHI scheme. No single country starts with a clean slate. There are historical, political and technical reasons for not covering the whole population. It is a measure of social solidarity to protect every citizen against financial and health risks. If people accept this, it facilitates in arriving at a general consensus faster, on the type of SHI, premium and the benefit package to be made available.
- **Relative size of informal and formal sectors:** The larger the size of the informal employment sectors, the more difficult it is to determine and collect contributions and to provide appropriate benefit health care packages to reach them effectively and efficiently. For the SHI schemes covering only employees from the formal sectors, it could easily be expanded to dependents, pensioners and temporarily unemployed workers.
- **Managerial capacity:** Adequate capacity of financial sectors such as banking and financial transactions including actuarial and managerial arrangement is essential for the success of SHI schemes.
- **Transparent Policy Debates:** For the success of SHI, a thorough political process of debates is required before any policy is adopted, especially what type of social health insurance, the level of the premium, what proportion of contribution to be made by the government, employers and employees, what are the benefit packages, how to contain cost, who are the providers and how they are paid, and what are the total financial returns, etc.

- **Globalization and liberalization of multilateral trade and commerce:** There are increasing concerns that liberalization of multi-lateral trade and commerce in services, especially promoting foreign competition in the financial and health sectors through multilateral trade agreements like TRIPS agreement and the General Agreement on Trade in Services (GATS) could pose risks to equity, access to health services, and the quality of health care. However, countries could easily handle these concerns through appropriate rules and regulations. Governments can regulate the private insurance market including financial institutions handling private/commercial health insurance, by enforcing on them that they should offer to supplement the basic minimum health care packages, prohibiting dumping of high-cost patients on the public health care systems, and encouraging them to ease exclusion criteria.
- **Democratization and decentralization:** Even though SHI schemes do not have the widest coverage in least developed countries, experience shows that they could consolidate, expand, and catalyse various local-level community-based health insurance schemes and transform other community-based health financing schemes to expand risk-sharing. Within the context of democratization and decentralization, there could be fewer hurdles in administrative and managerial capacity and financial capability.
- **Institutional arrangements:** Establishment of appropriate institutions to be responsible for governance, technical skill development and administrative and management capacity-building, as well as the monitoring and evaluation of SHI schemes is vital.
- **Time implications:** Experience indicates that more than two to three decades are needed to reach the target of universal coverage. Appropriate strategic development plans are required, as most countries of the Region would take several decades to achieve universal coverage.

#### 5.4 Role of Community-based Health Insurance

Most countries have adopted different forms of community-based health insurance (CHI), through non-formal insurance initiatives, covering certain targeted groups such as poor women, low-wage labourers and the semi-employed both in rural and urban settings. A lot of these initiatives have

exclusion criteria and problems of economic sustainability. Some of these initiatives could be merged into the national health insurance policy framework like in Thailand and now in Indonesia. Many other countries have still not made any major policy efforts to expand these schemes or to integrate them into the national SHI stream.

There is no doubt that community-based health insurance is well established in some Asian countries as part of their social and cultural norms for community risk-sharing. Households in the community tend to assist each other with finance and voluntary labour at various social events like births, marriage, religious ceremonies, health crisis, and deaths. They always share equally for the expenditure and in some cases, even capital costs like building schools, health centres or hospitals. Some of the funds generated as trust funds are also managed by them. As most countries where the government-financed health care system is inadequate to provide financing for all health care activities, the community comes with resources to share the burden. Various cost-sharing schemes have mushroomed in these countries with the aim of increasing the access to essential drugs and diagnostics. Drug-revolving funds have been established to reduce the financial burden for drug costs. People have to pay a fixed amount for each consultation or user-charges are levied upon the type of illness and medicines prescribed. The funds accumulated are used locally to purchase supplies, to maintain the health facilities and to provide incentives to carers.

Evaluation studies are needed to review these funding arrangements to determine whether they are viable in the long run. Preliminary results have showed a mixed response, indicating that some are viable and good providing increased access to essential drugs. Some studies have also shown that people are willing to pay more for better health care services. A few other studies have revealed the non-viability of the system if it is not properly developed and managed. In some countries, prepaid voluntary health insurance schemes have been initiated at the community level, mainly provider-initiated, by wealthy or dedicated persons, or by piggy-backing on other micro-insurance schemes like *Gonosasthya Kendra* (GK) and *Grameen Bank* in Bangladesh, or *SEWA* in India and other community-based schemes as indicated earlier. Some schemes are implemented as part of the national or sub-national poverty reduction programme.

While CHI plays a significant role in institutionalizing the idea of pooling risks and strengthening the capacity to manage at the community level, its role

in expanding the coverage is still limited. It is no doubt that it would reduce the burden of the OOP expenditure (despite minimal amount).<sup>53</sup> It also ensures health care provision reaching to the poor and the underserved population, making them familiar with financial and health risk-pooling, customizing health benefit packages and promoting self-reliance and solidarity spirit. The CHI could be used as transitional mechanism before the full implementation of nation-wide SHI schemes or tax-based health care systems. The CHI could easily be integrated into other community-based financing schemes, mainly initiated through poverty reduction programmes. Even though CHI schemes play some role in health financing, they cannot be a replacement to government's health financing.

The major reasons for such CHI schemes not being able to expand coverage are:

- **Policy Commitment:** National poverty reduction strategies (PRSP) and related strategic programmes (like microcredit schemes) usually address the issue of financial risk protection for poor families. However, the so-called social subsidy for poor, food-for-work or other social safety net (SSN) programmes or similar national programmes for subsidizing the poor families, especially below the poverty level (BPL) households, are not addressing much to promote community-based health insurance schemes. There is strong evidence that governments should regulate, promote and assist in designing new CHI schemes, provide financial incentives and even subsidize funds earmarked for poor families, and monitor implementation of these schemes.
- **Technical issues:** The CHI schemes tend to use a lot of adverse selection or risk selection, if they enrol only specific population groups such as pregnant women, workers in stone quarries or other hazardous workplaces, and fishermen etc. As all of them are already in high-risk groups, this adverse selection could lead to higher health care costs and discontinuation of insurance, unless funds are pumped in from other sources, including government tax revenue and mostly from external donor funding. The contributions for each individual could become very high and the scheme may not be viable because it would lose potential members. The CHI should

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<sup>53</sup> Ranson MK, Reduction of catastrophic health care expenditures by a community-based health insurance scheme in Gujarat, India: current experiences and challenges. Bulletin of the World health organization 80 (8) 613-621, 2002

have a larger pool of low and high risks and also cater to both ambulatory and inpatient care.

- **Existence of socially cohesive groups:** Some countries are promoting development cooperatives, microcredit organizations or other social groups based on people's trust. It might be easier to initiate CHI in such communities. The health care system in China was successful in the 1970s with a wide coverage of the rural cooperative health care systems which were in place in almost 98% of villages. With the breakdown of collective economic units in the communes which resulted from market economy reforms, the collective health care financing schemes were reduced to less than 10% by 1993. After some years of gap, the Chinese Government re-introduced in 2002, the rural community-based health insurance schemes based on prepaid risk-sharing principles, in a phased manner. Similar approaches may need to be revived, introduced or expanded in some countries of the Region.

It is not a good strategy to promote sporadic CHI schemes but to integrate them as much and as fast as possible into the national health insurance framework. The government may provide support and augment the coverage with subsidy, as the CHI schemes usually operate in areas where government health care delivery system is not able to provide full coverage. The CHI schemes also flourish where institutional capacity is too weak to organize nation-wide SHI schemes.

## 6. CONCLUSIONS AND RECOMMENDATIONS

All countries in the Region are facing a formidable challenge in expanding social health insurance as an alternative mix, together with other mechanisms of health care financing. The situation is much more complex, especially in least-developed countries (LDC) of the Region, where most payments are made at the time when people seek allopathic or traditional health care, which is sometimes more than they can afford to pay. For the poor, who are unlikely to have any prepayment schemes and are frequently unable to benefit from tax-funded subsidized public health care, the out-of-pocket payment (OOP) is the only mechanism for them to ensure adequate health care. It is thus difficult to have a sustainable, effective and equitable health care system facing a heavy burden due to the heavy OOP expenditure in the long run.