Annex 1

REPORT OF THE TECHNICAL DISCUSSION ON SOCIAL HEALTH INSURANCE HELD DURING THE 40TH CCPDM

Introduction

Technical Discussions on Social Health Insurance agenda item 7 of the 40th session of the Consultative Committee for Programme Development and Management (CCPDM) were held on 5 September 2003 at WHO-SEARO, New Delhi. Dr Gado Tshering, Director of Health Services, Ministry of Health, Bhutan, and Mr Anil Jha, Director, International Health, Department of Health, Ministry of Health and Family Welfare, India, were elected as Chairman and Rapporteur respectively. All the CCPDM participants, special invitees and concerned WHO staff, participated in the discussions.

Opening Remarks by the Chairman

The Chairman in his opening remarks highlighted the importance of selecting the subject and said that the crux of the discussions should be based on policy perspectives rather than the detailed technical aspects of social health insurance (SHI). He also briefly provided the history of the collaborative work done by WHO with Member Countries in health care financing[*], including social health insurance. Noting that SHI is an important alternative mechanism for financing and health care management, many low income countries had succeeded in providing adequate coverage with SHI. Unable to cope with increasing health expenditure, many countries in the Region still relied primarily on tax funded finance. Indonesia and India with middle income levels, had much lower coverage, compared to the stage of their socioeconomic development. WHO had organized a meeting of an expert group in March 2003, and a regional consultative meeting on SHI in July 2003, in order to review the regional experience and major issues. The outcome of this consultative meeting had been incorporated in the background paper prepared for the technical discussions. The discussions could concentrate on a review of SHI schemes within the broad framework of

[*] Throughout this document, "health care financing" and "health financing" have been interchangeably used.

health care financing, and identification of major issues and policy options in implementing various SHI schemes. He urged the delegates to formulate implementable recommendations to be considered by the 56th session of the Regional Committee.

Introductory Remarks

In his presentation, Dr U Than Sein, Director, (Evidence and information for Policy), WHO-SEARO, provided a brief overview of health financing functions within the framework of health systems development. Every health system aims at attaining the highest level of health for all (HFA), through universal coverage, i.e. effective protection of health and financial risk for all citizens. Health financing is one of the major functions of the health systems and has three main components: a) Collection of financial resources; b) Pooling of resources and health risks; and c) Strategic purchasing.

He further elaborated on "Risk pooling", which is sharing of the financial and health risks across individuals and households, who are willing to pool their income to deal with the financial burden of health care in times of need. There are several methods of pooling health and financial risks: (a) public financing through general tax revenue; (b) social health insurance, (c) private (voluntary) health insurance, (d) community health financing, and (e) other private and public funds including earmarked tax, foundations, trust funds, and saving accounts.

Social health insurance (SHI) is generally perceived as "a financial protection mechanism for health care, through health risk sharing and fund pooling for a larger group of population". It is popularly known as the "Bismarck Model". There were certain characteristics and pre-requisites for introduction of SHI, such as solidarity, compulsory membership and ensuring equitable and sustainable social financing, and fostering health systems efficiency and effectiveness.

Most countries also adopted different forms of community health financing (CHF) schemes, through non-formal insurance initiatives to cover certain targeted groups such as poor women, low-wage labourers and the semi-employed both in rural and urban settings. Some of these initiatives had been merged into the national health insurance policy framework, as in Thailand and now in Indonesia. Many others had not made any major policy efforts to expand these schemes or to integrate them within the national SHI stream.

A few policy directions could be developed based on the following options.

- ***Increase Public Revenue for Health***: Almost all countries of the Region have a low investment in health from public resources. There is a possibility to increase the public investment in health sector, by allocating more from general tax revenue in each budget year, by promoting earmarked indirect tax (sin-tax), and by mobilizing external resources both in grants and loans and also internal resources from foundations, trust funds, and saving accounts.
- ***Promote pooling of financial risks***: Almost all countries have a low or medium coverage of risk pooling. Various mechanisms for financial risk-pooling could be introduced or expanded by the increasing coverage of various health insurance schemes (mandatory and voluntary and public or private). Establishing or promoting other risk and resource pooling schemes including community-based risk-pooling schemes and public trust funds can be considered.
- ***Strategic Purchasing***: Countries should also adopt various financial and managerial incentives and instruments in order to implement strategic budgeting such as service-based purchasing; use of appropriate technology and cost-effective interventions; promoting essential public health functions; and establishing various competitive and contracting mechanisms. Countries should establish a national quality assurance and accreditation policy and procedure, in order to provide incentives for public and private health care providers.

Discussions

The following sections provide the highlights and conclusions of the discussions on various issues relevant to health care financing and social health insurance.

Definition and Scope of SHI

Countries were in different stages of health care reforms, and some laid more emphasis on development of social health insurance with the aim of achieving universal coverage. Four countries (Thailand, Indonesia, India and Myanmar) were implementing social health insurance on a national scale with varying degrees of coverage. Most of the other countries had some experience of

health insurance programmes either through private sector or community-based financing schemes. It was agreed that national SHI schemes should include the following characteristics:

- Compulsory or mandatory membership;
- Earmarked deduction as prepayment contribution from regular payroll, based on income and not risk related;
- Cross subsidization and coverage of a large proportion of the population;
- Benefit based on need; and,
- Collected fund administered by some type of quasi-independent public body.

If the above principles and scope of SHI are applied, the scheme would exclude a large proportion of people working in the informal sector in many countries of the Region, particularly those who cannot afford to make regular pre-payment contributions. Thus, expansion of SHI schemes based on traditional principles might not by itself be able to achieve the goal of universal coverage. One option that could be considered is the possibility of governments subsidizing the premiums for those unable to pay. National programmes on 'subsidizing the health care costs of the poor', implemented in India and some other countries need to be studied further.

Most SHI schemes in the countries of the Region cover mainly the protection of financial risk for hospital care and usually inpatients' care only. According to empirical evidence, the cost of health care for hospitalization is only a proportion of other costs (such as transportation, cost of medicines and consultation, under-the-table payments, etc.). There is a need to consider covering such risks as well. Experiences from countries with high coverage of SHI schemes showed that there were gradual developments over decades from single-funded SHI to multiple-funded SHI, and national health insurance. Countries considering expansion of SHI schemes need to study how they would embark from the SHI stage to NHI within a specified, though a long time frame.

Role of SHI as an Alternative for Health Financing

The ultimate goal of health care financing is to achieve universal coverage. Health care financing based on general tax source is still falling in the biggest proportion for health financing and also it is the fairest way.

Some countries with a high proportion of salaried workers in the formal and informal employment sectors may consider implementing or expanding SHI schemes. Even in countries where governments are providing free health care utilizing general tax revenue, they may consider SHI as an alternative means for health financing because health ministries have limited budgets, competing as they are with other sectors. In situations where basic services are already free, SHI has an added advantage to ensure access to health services, especially from private providers.

Social health insurance is not a panacea or remedy that can replace other mechanisms of health care financing, particularly finances based on general tax revenue. Governments should not shirk responsibility to provide essential health care and public health functions.

There are several limitations of SHI making 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. People are also unwilling to share costs of highly personalized treatment such as cosmetic surgery. There are a lot of information gaps on evidence for policy. Most countries have not yet established or updated their national health accounts. While many countries may have regular socio-economic surveys, the results are not properly analyzed for policy trends. SHI schemes should also cover the preventive and promotive aspects of health care.

The Governments have to ensure health care for the poor by protecting their health and financial risks through various means of financing. WHO should provide appropriate policy guidance and advocacy materials to Member Countries. National consensus and political commitment are considered necessary for initiating and sustaining the social health insurance programme. Poor understanding of the basic conceptual framework and lack of nationwide consensus between stakeholders are the major issues in adoption of SHI as a means for achieving universal coverage. An appropriate policy framework leading towards the enactment of social health insurance is essential to ensure the wide acceptance of 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 (income).

While the expansion and improvement of public health care facilities still need to be undertaken, governments have to ensure proper control of private health care providers. If the existing health care system is not able to provide full access to essential health care, it makes little sense to start a SHI scheme. However, experience indicates that SHI provides a good financial opportunity to control the service providers.

Role of the Private Sector in Development of SHI

Development and expansion of SHI should be seen in the context of globalization and rapid liberalization of international trade including opening markets for the private sector. Private health insurance schemes need to be regulated to ensure the basic principles of solidarity, cross-subsidization and control of exclusion. In some cases, there is a mismatch between funds and services. It is the role of health ministries to monitor the impact of the rapid growth of private health care providers and, at the same time, the growing number of private health insurance schemes in a liberalized environment.

Community-based Health Insurance (CHI)

Social capital, which is a pre-requisite to implement CHI, varies among states and even among localities, and thus, the design and action programmes are very local and specific. This makes it difficult to replicate the schemes in other areas. There should be a strong stewardship from the government in enhancing CHI and, if possible, its funding. Many CHI schemes have limited scope as they are often expensive, considering the high hidden costs, which are usually subsidized by donors and governments. Once donor funding dwindles, only 10% of such schemes survive.

Existing CHI schemes in most countries cover limited packages of benefit that generally include preventive health care including very basic medical and diagnostic services. When a comprehensive package is introduced these schemes usually collapse. The CHI schemes with a small pool of participants are not viable financially in most cases. Experience abroad has shown that HMOs (health management organizations) with less than 100,000 participants are not viable.

Many CHI schemes are related to, or a part and parcel of, national or sub-national poverty reduction programmes including those related to micro-financing or social subsidy or social safety net. As CHI schemes are carried out as sideline benefit packages, it has hampered the sustainability. The experience gained in implementing various models of CHI schemes, especially in ensuring consensus on solidarity and contribution, community management of collecting and allocating funds, could play a useful role in expanding the national SHI schemes.

Conclusions and Recommendations

After reviewing the SEAR country experiences where some form (with varying degrees of coverage) of social health insurance was already in place, it was unanimously felt that all countries needed technical support of WHO in reviewing the country situations, providing evidence-based research findings, developing policy options, providing models for consideration, and facilitating policy debates among the stakeholders including donor coordination.

The group made the following recommendations:

Member Countries

- An in-depth study on the possible options for alternative health care financing, within the context of national socioeconomic and development policies, should be undertaken.
- Countries that already have a wider coverage of social health insurance should document their experience on various social health insurance schemes by comparing the target population and coverage, contribution mechanism, management of funds, packages of services and their accessibility and quality.
- Countries considering adopting social health insurance need to review the basic pre-requisites for introducing SHI, such as the labour and financial market structure, existence of other forms of insurance schemes, the possibility of collecting contributions and the capability of managing funds, the existing of health infrastructure (both public and private), including their accessibility and quality.
- Based on the evidence collected from the indepth studies, a policy framework has to be developed for introducing or expanding social health insurance, by reaching consensus through different policy development mechanisms. In this regard, parliamentarians could play a crucial role in soliciting national consensus.
- Steps should be explored to increase the public health expenditure by increasing the allocation of national budget or through earmarked taxation.

WHO

- Technical support should be provided in reviewing the country situations and in providing evidence-based research findings for implementing SHI on a countrywide basis.

- The work on development of an Organization-wide policy on health care financing should be expedited.
- Member Countries should be supported in developing a national framework for expanding social health insurance or in adopting national legislation for introduction of SHI as an alternative to health care financing.
- With the involvement of WHO collaborating centres and national centres of excellence, and the national and regional expertise on health economics and health policy analysis, policy options and models should be developed for consideration by countries, and for facilitating policy debates among stakeholders including donor coordination.

Considering the background situation of social health insurance in the South-East Asia Region and having arrived at the above conclusions and recommendations, the CCPDM recommended to the 56th session of the Regional Committee to adopt a resolution on SHI.

RESOLUTION*

SEA/RC56/R5

The Regional Committee,

Recalling its own resolutions SEA/RC48/R6, SEA/RC50/R3 and SEA/RC53/R3 on alternative health care financing, health sector reform and equity in health and access to health care,

Acknowledging the need for increasing investments in health with a balanced mix of alternative health care financing options, and expressing its concerns on the high level of out-of-pocket expenditures, which would lead to impoverishment of a majority of families,

Being aware of the need to review and adopt appropriate strategies for expanding the various risk-pooling mechanisms, including social health insurance, and

Having considered the report and recommendations of the Technical Discussions on "Social Health Insurance" (SEA/RC56/17),

1. ENDORSES the recommendations contained in the report;

2. URGES Member States:

   (a) to facilitate the optimal use of available financial resources for health care by suitable financing mechanisms;

   (b) to strive for equity in access and efficiency of comprehensive health care while implementing national policies, strategies and plans for various health care financing options, and

   (c) to study and explore social health insurance as one of the alternatives for health care financing for countries which have not yet adopted it on a national scale, and

3. REQUESTS the Regional Director:

   (a) to share evidence-based information and country experiences on social health insurance and other risk-pooling mechanisms;

* SEA/RC55/R4

(b) to provide appropriate support to Member States in their efforts to introduce or expand alternative health care financing, including social health insurance schemes, in partnership with WHO collaborating centres, national centres of excellence and national expertise, and

(c) to assist Member States in capacity building in managing health care financing and policy analysis.

Sixth Meeting
12 September 2003