Paper laid by Hon Kulundu (Dr)
[illegible]/8/2002

REPUBLIC OF KENYA

NATIONAL ASSEMBLY

REPORT

OF THE

DEPARTMENTAL COMMITTEE ON HEALTH, HOUSING, LABOUR & SOCIAL WELFARE ON STUDY TOURS OF HEALTH INSURANCE SCHEMES IN SOUTH AFRICA, CHILE, GERMANY, UNITED KINGDOM, MALAYSIA, PHILIPPINES AND THAILAND

APRIL-JUNE, 2002

Clerk's Chambers
Parliament Buildings
NAIROBI

August, 2002

PREFACE

Kenya has operated NHIF as a compulsory social health insurance for 36 years since 1966. In 1972, there was a policy review to accommodate self-employed persons who were not covered under the existing policy.

In 1990, there was a second amendment to allow for contributions based on level of income.

In 1998, the 1966 Act was repealed and replaced by the National Hospital Insurance Fund Act No. 9 which transformed the NHIF from a government department to a state corporation for greater efficiency in service delivery.

The main objectives of establishing NHIF are:

i) To make inpatient health care accessible to the majority of Kenyans.

ii) To make in-patient health care services subsidized by the high income for the benefit of the low-income group.

iii) To promote preventive and primary health activities as opposed to the existing curative measures through introduction of outpatient services. Achievements of NHIF in the context of the original objectives for its establishment include:

   a) It has provided affordable premiums as low as Kshs.30 per month and draw benefits as high as Kshs.360,000 in a year.

   b) It receives an average of Kshs.2.2 billion per year from over 1.5 million members. Out of this 22% is paid out as benefits to members and about 25% is used for administrative purposes, and the rest invested.

   c) It has provided cover, at least theoretically, to 1 out of every 3 Kenyans or about 10 million people.

   d) The middle and high income contributions account for about 70% of the total contributions received.

   e) All major stakeholders are represented at the NHIF Board of Management. All 13 members of the Board represent various interests e.g. civil service, insurance industry, employers, employees and health providers.

   Challenges facing NHIF include:

      a) The question of what to do with huge investments of Kshs.6 billion in the face of rampant illnesses. The investments made are not business driven but based on government policy.

b) NHIF provides little incentives for health providers to meet high standards of quality service delivery.

c) Membership registration is not demand driven but compulsory.

d) NHIF provides low benefits for inpatient care thus failing to match the health needs of beneficiaries.

e) NHIF benefits are considered low vis-à-vis the high transaction costs.

f) There is a significant increase in benefits claims due to terminal diseases like cancer, HIV/AIDS and re-emergence of old diseases like TB and Malaria. These patients occupy over 50% of medical beds in public hospitals.

g) Cost escalation. Mechanisms to control costs should be instituted.

Arising from the above challenges, the NHIF has instituted several policy measures based on new strategic objectives in order to be the best social health insurance for all Kenyans, to provide affordable, accessible and sustainable health insurance and to finance healthcare activities countrywide.

However, for these measures to bear any fruit, the country as a whole needs to implement appropriate structural, financial and organizational reforms to reduce the burden of disease, particularly malaria, HIV/AIDS and other preventable diseases. There is need to develop human and physical capacities besides putting in place cost-effective interventions to combat disease and ill health, expand the coverage and accessibility of health services to the vulnerable groups.

Parliament is an indispensable player in the envisaged drastic and fundamental reforms in the health sector.

To assist the relevant House Committee understand the requisite reforms that needs to be undertaken in the health sector generally and in health insurance in particular, the Committee undertook study visits to the following countries in two groups as below:

Group I (April-May, 2002)

Hon. Eng. Joshua Toro, MP - Vice-Chairman
Hon. Fredrick Kalulu, MP
Hon. George Nyanya, MP
Hon. J. J. Mugalla, MP
Hon. James Koske, MP

The Committee was accompanied by:

Mr. David K. Ziah	-	Clerk Assistant
Mr. John Gakuo	-	MOH
Mr. George Muchai	-	NHIF Board
Mr. Abdi K. Hussein	-	NHIF
Mr. S. Mutai	-	NHIF
Mrs. Grace Otieno	-	NHIF
Ms. Lucy Rono	-	NHIF

i) South Africa
ii) Chile
iii) Germany
iv) United Kingdom

Group II (May-June, 2002)

Hon. Dr. Newton W. Kulundu, MP - Chairman
Hon. Zebedeo J. Opore, MP
Hon. Njehu Gatabaki, MP
Hon. Norman M.G.K. Nyagah, MP
Hon. Kihara Mwangi, MP

They were accompanied by:

Mr. Stephen Njenga	-	Clerk Assistant
Mr. Silas K. Kobia	-	Vice-Chairman – NHIF Board
Mr. Barrack Amollo	-	Ministry of Finance/NHIF
Mr. Charles Makone	-	NHIF
Mr. Jason Namasake	-	Federation of Kenya Employers
Mr. Ismael Hassan	-	NHIF

i) Malaysia
ii) Philippines
iii) Thailand

The visits were kindly sponsored by the National Hospital Insurance Fund and the Committee takes this opportunity to thank the Board of Management for the gesture.

It is our hope that the experiences of the Committee will not come to naught but will be useful in the reform process. This is the basic reason why this report has been prepared. It is not, however, conclusive. It is aimed at being a catalyst in raising the profile of health insurance so that the health of the people can be taken much more seriously by all the parties concerned, starting with the Government. The issue of health should be firmly and permanently placed in the national priority list.

The Committee notes that the Government recently set-up a taskforce to review health insurance system in the country. This is a positive step but we should not

expect the task force to be the panacea to the delivery of healthcare in Kenya, which is bedeviled by numerous impediments. We must all participate in improving accessibility and affordability of health services to all our people as a deliberate effort to increase the longevity and quality of life.

Hon. (Dr) Newton W. Kulundu, MP
Chairman – Departmental Committee on
Health, Housing, Labour & Social Welfare

7/8/02.
....
Date

SOUTH AFRICA

The Vice Chairman and Leader of the Delegation introduced the subject that the NHIF has been in operation over many years in Kenya. It is an employee compulsory contributing scheme for both those employed as civil servants and those in the private sector. Interim reforms were effected through the NHIF Act of 1998. There is need to widen the scope of NHIF hence the reason why the study tour had to be undertaken to find out the experiences of other nations on the subject.

DELIBERATIONS WITH THE NATIONAL DEPARTMENT OF HEALTH

The Department informed the Delegation that the South African Government was not operating a social insurance scheme but there existed voluntary medical schemes which are funded through voluntary contributions. The employer also pays half of the contribution. People outside the scheme get government medical cover. Primary health care is free. Public collection is very weak because South Africans are not compelled to contribute towards the medical scheme.

Paper laid

A paper outlining the social health insurance system for South Africa was laid before the Committee. The Paper stated that the white Paper on the transformation of the Health Sector set out the broad mission whose objectives were:

(i) to reduce disparities and inequalities in the health service delivery and increase access to improved and integrated services based on primary health care principles.

(ii) to mobilize all partners, including the private sector, non-governmental organizations and communities in support of an integrated National Health System.

The document spells out the specific objectives which are:

- to support the pubic health system.
- to provide an effective mechanism for collecting hospital fees by ensuring that all formal sectors employees and their dependants are insured for public hospital treatment.
- to provide formal sector employees with state sponsored insurance cover for essential hospital cover at a low cost.

THE NEED FOR DEVELOPMENT OF SOCIAL HEALTH INSURANCE IN SOUTH AFRICA

(i) There are extreme inequalities in health provision between the public and private sector. In 2000/01 fiscal year, the public sector had a budget of R32

billion to provide for health care for 36 million people while the private sector spent an estimated R40 billion in providing health care for 7 million people.

(ii) The private health care sector experienced extreme cost escalation while the public sector experienced a decline in per capita public expenditure with providers opting out of the public sector.

Reforming the National Health System

Legislation of the medical schemes Act of 1998 was done and regulations were formulated. All this was intended to regulate the private sector and reverse the negative trend experienced by the public sector. The Act introduced community ratings, open enrolment and prescribed minimum benefits package (PMB).

The Medical Schemes Act compels all medical schemes to fully reimburse public hospitals in instances where their members use public hospitals. The problem is that public hospital facilities have declined to an extent that medical scheme patients prefer to use the private health facilities.

Requirements for reforms

(i) A mechanism has to be found so that the total national budget is protected. This is because the revenue by Social Health Insurance is intended to be an addition to the health budget. The mechanism must ensure that the revenue generated by SHI is retained and will not be substituted for tax revenue.

(ii) The benefit principle must be satisfactory. People will not insure themselves for a service that is not defined. The quality of services have to be improved to attract targeted social health insured person.

(iii) Majority of South Africans cannot afford current medical aid costs. A low cost environment must be created before the establishment of a mandatory contributory system. This could start with the civil servants as a project.

(iv) The tax subsidy on medical cover should address the inequalities. The current system favours high income earners. Currently deductions amounts to R1000 per medical aid beneficiary compared to R900 per person contribution for the public health system.

(v) There is need to create a risk equalization fund.

CHARACTERISTICS OF THE SCHEMES IN SOUTH AFRICA

Open enrolment

The schemes are compelled by law to enroll any member who wishes to be a contributor. The scheme has no option but to accept such a member.

Prescribed minimum benefits (PMB)

The amount to be charged for a kind of sickness is prescribed. Schemes pay the provider the PMB and the patient meet the difference if the cost is higher.

Medical subsidy

Employers who contribute to the health insurance of their employees get back upto 75% of their contributions as a tax subsidy.

Community rating

All members of the family of a contributor get medical cover and are entitled to the same benefits.

REGULATORY BODIES OF HEALTH INSURANCE IN SOUTH AFRICA

In 1994, the National Department of Health was established. This introduced a unitary health system where the minister was in charge of both the public and private health insurance schemes.

The 1998 Medical Scheme Act established the Council for Medical Schemes. The Council consists of 15 people who are required to regulate all the medical schemes and make sure that they abide by the rules and regulations as approved by the minister for health.

The office is responsible for the registration and making of regulations for the schemes. These regulations have to be approved by the Minister.

PRIVATE HEALTH INSURANCE IN SOUTH AFRICA

The committee was informed that there were about 200 private insurance schemes in South Africa.

The contributor is free to choose which scheme to join and he/she is free to chose the doctor to attend to when he/she falls sick. The medical schemes enter into a contract with the doctor and pay him a monthly fixed cost. This is called capitation.

The problem is that 60% of the claims made were fraudulent. There is need to change the policy from fixed fee per month to fee for services.

Benefits are based on the level of contribution which is determined by the contract between the contributor and the medical scheme and the risk involved. Those who become contributors after 30 years of age are penalised while those who are 30 years and below do not pay any fine. This principle is aimed at encouraging people to contribute to social health insurance at an early age and not at old age where the risk of sickness is high.

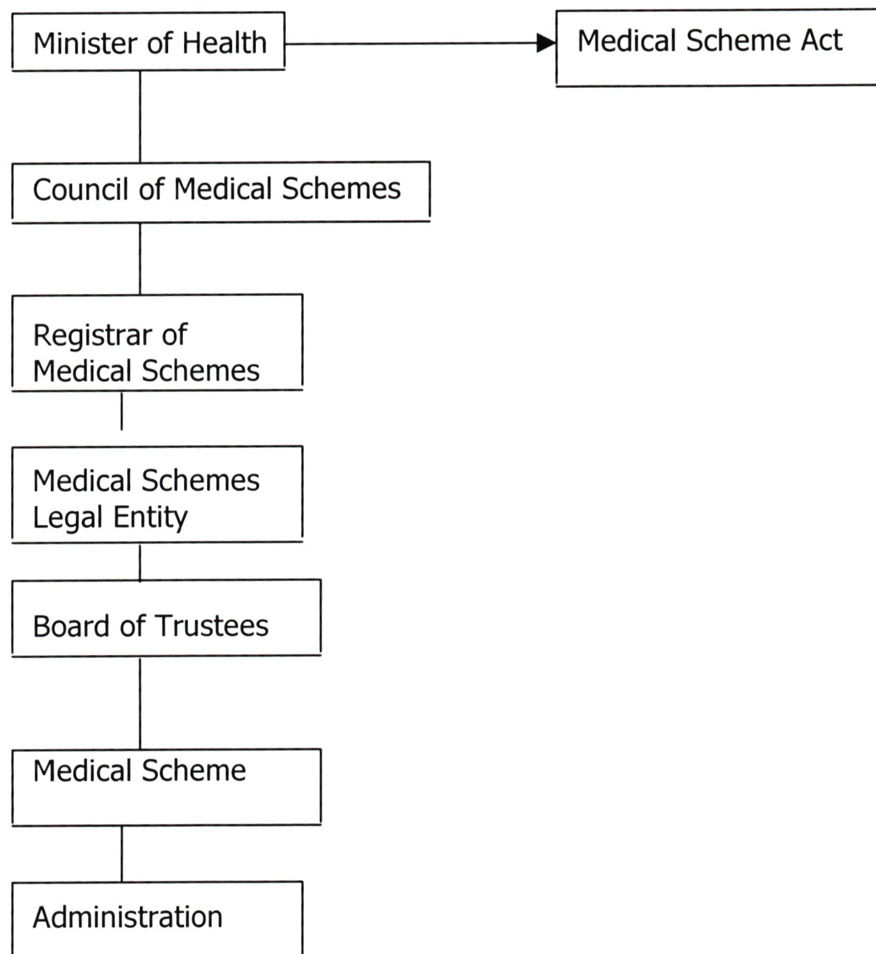
HEALTH CARE SYSTEM IN SOUTH AFRICA

The Committee was informed that the health care system in South Africa is a two-tier system, this is public health care and private health care.

Under public health care provider, it is the state hospitals and clinics that provide the services while in the private sector, medical schemes provide the services.

The public health care system is funded by taxes and it caters for both the unemployed and the employed, who are not enrolled as contributors. Membership is not compulsory. Private health care is funded from subscriptions collected from employers and workers together with a tax subsidy from the state.

Private health care is regulated by the Minister for health. The regulations are found in the medical schemes act of 1998. He is assisted by the council of Medical Schemes and the office of the registrar of medical schemes. The diagram below illustrate the organization:



Benefits covered

The benefits covered are hospitalization, dentistry, radiology, pathology, specialist services such as gynecologist, dermatologist, general practitioners, pharmacies, physiotherapist, psychologist and maternity.

One cannot belong to more than one scheme and the services and benefits are stipulated in the medical scheme Act of 1998.

CHILE

Socio-economic and demographic indicators

Total population:	15.4 million (2001)		
Poverty:	20.5% (1999)		
GDP:	$70.7 billion (2000)		
Adult literacy:	96%		
Life expectancy:	75 years (2001)		
Mortality rate:	-	infant:	10 per 1,000 births (1999)
	-	under 5:	12 per 1,000 births (1999)
Total fertility rate:	2.3 births (2001)		
Maternal mortality rate:	20 per 1,000 births (1999)		

Health system and finance indicators (1998)

Total expenditure on health as % of GDP: 7.5%
Public expenditure on health as % of total expenditure in health: 39.6%
Public expenditure on health as a % of total public expenditure:

- Social security expenditure as % of public expenditure on health: 75.7%
- Tax funded and other public expenditure as % of public expenditure on health: 23.9%

Private expenditure on health as % of total expenditure on health: 60.4%
Out-of-pocket expenditure as % of private expenditure on health: 66.2%
Per capita total health expenditure: $369

INTRODUCTION TO THE CHILEAN SYSTEM OF HEALTH INSURANCE

Private Health Insurance

Chile has a health insurance system with an active participation of both the public and private sector. The private component works as a health insurance system based on individual contracts between the insured and the health insurance institutions called Isapres. The benefits granted depend directly on the amount of premiums paid.

By law, workers must allocate 7% of their taxable income to the payment of mandatory health insurance. However, when the insured is contracted with an Isapres, the worker may pay additional voluntary premiums to achieve higher benefits. Those workers with relatively lower incomes have access to a state subsidy the maximum of which is 2% of taxable income.

PUBLIC HEALTH INSURANCE IN CHILE

This component is managed by the National Health Fund known as FONASA. It is financed by mandatory premium equal to 7% of the taxable income of its insured (policy holders) and by resources from the general taxes. Forty five per cent (45%) of the FONASA budget comes from general taxes. The benefits provided by this system are the same for all insured regardless of the amount of premium paid and the size of the family.

Organization of the Health system in Chile

The indigenous population receives free care with no payment of premiums or co-payments. They get the service free from primary care centres (clinics) managed by municipalities and in secondary and tertiary care centres (highly complex clinics and hospitals) managed by the National Health Service System (SNSS).

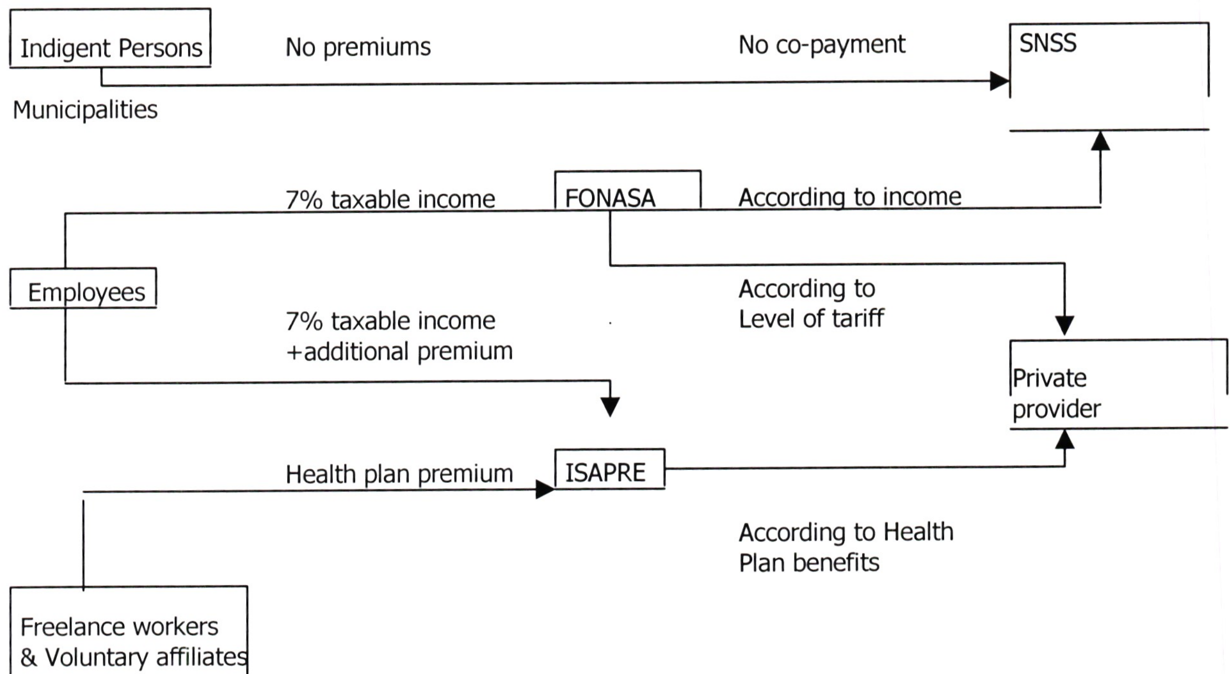
Employees are obligated to allocate 7% of their monthly taxable income to health insurance and are free to choose between the state insurer FONASA or any of the 28 private health insurance institutions (Isapres).

Employees may choose to use public or private providers under an agreement with FONASA. When a FONASA insured uses public providers co-payments will be determined by their income. The co-payments are denominated as percentages of cost of the health benefit and may total 20%, 10% or 0%. When a FONASA insured choose to use private providers under an agreement (free choice) he/she makes co-payments according to rates charged by the provider. The lowest co-payments would correspond to 50% of the cost of the health benefit provided by the provider.

CHILEAN HEALTH SYSTEM

Minister for Health

Beneficiaries Premiums Insurers Co-payment Providers



Before the privatization reforms, the Chilean health system was totally centralized in structure, run by state and had minimal private sector involvement. The system therefore suffered from many of the shortcomings inherent to the state run systems, such as major administrative deficiencies, limited coverage of the population, lack of resources, frequent evasion of social security payment, inequity and non-existent market involvement in the allocation of health care funds.

The political constitution of the state provides that all people residing in Chile have a right to health care and free and equal access to health promotion activities, health care, recovery and rehabilitation. This right is exercised through freedom of choice of insurance plans and the service providers and those who cannot make contributions receive free care in public health institutions.

Regulatory framework of the private health system in Chile

At the end of the 70s, Chile undertook reforms which were aimed at modernizing the state administration. The reform of the social security sector was one of the most important.

In February, 1980, through a decree law (DL) 3500 and 3501, the private individual capitalization method was introduced. According to the decree, the employee is the one responsible for deciding in which particular institution he will place his obligated amount to allocate to social security (health and retirement) and may choose between public and private sector organizations.

In 1981 another Decree Law 3626 and DFL No.32 which regulated the private health insurance institutions (Isapres) came to being. It also set the health premium initially at 4% of a worker's taxable income which was increased in 1986 to reach the current 7% of the taxable income.

In 1990, through the enacting of a Law 18933, DFL 32 was repealed and the Superintendent of Health Insurance Institution created. This is a technical entity in charge of controlling Isapres and ensuring compliance with regulations. This law also introduced modification of the contracts by establishing new rules for the granting of benefits.

In 1995, Law 18933 was amended to reduce the number of restrictions on the granting of benefits, giving policy holders greater flexibility to change Isapres and regulating the use of premiums.

The Chilean public health system

Public health insurance in Chile is managed by the National Health Fund or Fonasa. It obtains its finances from a mandatory single premium deducted from employees with equal to 7% of the taxable income of its insured and the employer also contributes the same. It is also financed by resources from public taxes.

Fonasa has three basic functions namely insurer, control and purchase functions.

The Insurer function

(i) implementation of health plans
(ii) identification of affiliates to private insurance.
(iii) collection of payroll tax and administration of the state budget
(iv) direct contribution of the beneficiary (co-payment).

Control function

a. Control of payroll tax

(i) agreements on the payroll tax
(ii) identification of employers and insured
(iii) control of late payment
(iv) control of evasion of payroll tax

b. Control of benefits

(i) Affiliation control. These are subsidies from the public health sector to the private health sector.
(ii) Control of the financing of health services
(iii) Provides control, conduct inspection programmes on health providers.
(iv) Control of administrative technical conditions of the health care services.
(v) Beneficiary control to minimize misuse of credentials.

(c) Purchase function

Development and establishment of payment mechanism to providers of health care services.

The private health insurance plans (Isapres)

These are private firms in charge of financing and delivering medical services to affiliates using compulsory health care contributions. Individuals may also make additional voluntary contributions to obtain enhanced benefits.

Isapres offer their affiliates medical services through a network of providers who have agreements with the Isapres. The affiliates or insured choose doctors and private clinics from a list of service providers. Currently all plans include the freedom to choose any service provider but for reasons to contain the escalation of costs there are trends to offer closed plans with specific doctors and clinics (closed group plan). Isapres also sell "preferred Provider Plans".

Achievement of Chile's Health Insurance System

The mortality rate has dropped from 80 in every 1,000 live births in 1970 to 10 in every live birth by the year 2000. Likewise, life expectancy in Chile has improved and now stands at 72.2 years.

The workers are assured that the payments they make each month to finance their private insurance entitle them to certain benefits which are strictly connected with the amount of their contributions.

The growth of private medical infrastructure and technological development is evident in that before 1980 there was almost no private medical and hospital attention. Today Chile has state of the art medical technology available to persons of different income levels.

A significant number of middle-income workers have left the state run system finding better quality health care in private sectors than in public system. With this decrease in public system usage, the state has been able to channel more resources to aid the poorer sections of society.

GERMANY

Socio-economic and demographic indicators

Total population:	82.2 million
Poverty:	NA – Unemployment: 18%
GDP:	$1.9 trillion
Adult literacy:	95%
Life expectancy:	78 years)
Mortality rate:	- infant: 5 per 1,000 births
	- under 5 per 1,000 births
Total fertility rate:	1.3 births
Maternal mortality rate:	8 per 100,000 births (1999)

Health system and finance indicators

Total expenditure on health as % of GDP: 10.5%
Public expenditure on health as % of total expenditure in health: 75.8%
Public expenditure on health as a % of total public expenditure:

- Social security expenditure as % of public expenditure on health: 91.6%
- Tax funded and other public expenditure as % of public expenditure on health: 8.3%

Private expenditure on health as % of total expenditure on health: 24.2%
Out-of-pocket expenditure as % of private expenditure on health: 52.8%
Per capita total health expenditure: $2,697.

HISTORICAL DEVELOPMENT OF HEALTH INSURANCE IN GERMANY

The German health care system traces its origins back to 1883 when Bismark established the rudiments of the system in an attempt to curb social unrest brought by rapid industrialization. The compulsory health insurance law of 1883 provided such payment and some medical services primarily to manual industrial workers who became ill.

This law was followed by other laws which provided for accident insurance and old age pensions. These formed the skeleton of the present social insurance system. Health insurance is either provided through statutory or compulsory contributions or private health insurance.

BASIC ELEMENTS AND CHARACTERISTICS OF THE STATUTORY HEALTH INSURANCE IN GERMANY

There are various characteristics and elements of the statutory health insurance in Germany. These are:

Solidarity

There is a shared view among the Germans that as a community, they have a responsibility to provide for one another through collective action to guarantee an adequate level of well being for everyone and to moderate the burdens of bearing adverse risk. Age, sex and health risks of the insured have no impact on the contribution. The right to benefits and health services is the same regardless of the size of contribution.

Save for the co-payments for drugs there is no cash payment for medical treatment. Co-payments are seized by the provides of services at 2% of the income for all people and 1 % for people who are chronically ill for more than a year.

Funds have to accept everyone except for special funds for farmers miners, seamen and those which are not open t o the public . there is freedom of choice between all physicians in providing health care.

Self Government

In the German health care system, decision making powers are shared between the Federal government and the 16 lander (regional) governments and the Germany system of self-management in the health sector. The Federal government, especially the ministry of Health, provides the legal framework for the health care system. It is responsible for the general laws providing and financing health care services. The lander (regional) governments are responsible for ensuring that there is an adequate number of hospitals for their populations and for maintaining hospital infrastructure.

Contributions financed

The statutory system is financed through mandatory payroll deductions, with employees and employer each paying an equal percentage of the taxable income. The percentage deducted is the same for all members of a particular fund and that the rate is not affected by the number of the employees' dependants, the age of family members or the family's expected need for services. The employer transmits the revenue generated from the contributions to the sick funds as per the employees choice of a fund. Statutory deductions are made in % of the covered earnings as follows:

Unemployment insurance	-	3.25%
Health Insurance	-	13.6%
Pension Insurance	-	9.75%
Long-term Insurance	-	1.7%

Comprehensive coverage

Statutory health insurance offers a comprehensive social security cover. 90% of the Germany population is covered. There are additional benefits for parents, children welfare and housing.

Branched social security system

The social security system falls into several branches namely pensions insurance, health insurance, unemployment insurance, accident insurance, and long-term benefits insurance. The role of pension insurance is to rehabilitate and secure working ability, pay pension benefits to elderly, disabled people, widowers and orphans.

Accident insurance aims to cover accidents and illness, rehabilitation for workers injured in accidents and paying pensions benefits to the retired workers.

Unemployment insurance aims to procure employment and guidance, creation of job measures, offer vocational training and pay unemployment benefits in case of loss of employment.

Long term care insurance pays benefits in cash and in kind to institutions which provide home care or nursing home care to contributors. The role of health insurance is to cover medical costs for the insured.

Self Management Principle

The Social Health Insurance funds have a central position within the system. Their responsibility include negotiating costs, quantity of services and quality assurance measures with the provider organizations.

The provider side falls under physician associations, organized as self governing bodies. They exist in every Lander (region). Every physician treating social Health Insurance Members on an ambulatory basis has to be a member of the regional physicians association. The main duties of these associations are to negotiate the financing mechanism and the details ambulatory benefits packages with the social Health Insurance funds and distribute the money from the funds among their members.

The hospitals are represented at lander level by lander hospital organizations and at the Federal level by the Federal Hospital Association.

SICKNESS FUNDS

The sickness funds are the key to understanding the nature of the Germany system. Membership in the sickness funds is compulsory. Only people whose income is above 3,357 Euros can opt to buy private insurance or remain with the statutory insurance. Once they opt to buy private insurance, the law forbid them to return to statutory insurance unless salary levels reduce below the 3,357 Euro requirement.

The sickness funds act as insurers, collect the premiums from employers negotiating payment rates with providers and transferring monies to the providers to pay for services provided to sickness fund members and their dependants. There are two

kinds of sickness funds. These are primary funds and substitute funds. The primary funds enroll most of their members from blue collar workers.

There are three types of primary sickness funds. These are local sickness funds AOK, Sickness funds for companies originally covering employees from the companies but now people who work for other companies can be insured. Third are the guild sickness funds which cover manual workers, craftsmen and farmers. Membership here is defined by the nature of the job.

Lastly, the substitute sickness funds whose membership is the white collar workers are nationwide. Each sickness fund sets its own contribution rate at the level necessary to cover the fund's projected expenditure on a current basis.

HEALTH INSURANCE BENEFITS

Germany enjoys generous health benefits under the statutory health insurance system. All workers' dependants are automatically covered. Members are covered for unlimited hospital and physician services, maternity care including household help. Prescription drugs, medical supplies and devices, preventive care, family planning , rehabilitation services, dental care, attendant care and recuperative stays at health span.

There are also a number of cash benefits paid to the covered by sickness funds. These include a sick pay, maternity pay and death benefit to defray funeral expenses.

Co-payments (cost sharing) apply only to a few cases such as purchase of glasses and prescription drugs. The patients who are hospitalized also pay a small fee for each of the first fourteen days of hospitalization during a year. For low income people, there are provision for waiver forgiveness to assure that co-payments do not create financial burdens.

Patients in the statutory system have freedom in choosing providers. The patient may select any local physician. The local physician may refer the patient to an appropriate specialist.

Sickness and maternity benefits are also paid. In case of sickness, the employer pays full wage or salary for the first 6 weeks . thereafter, the sickness funds payable 70% of the gross earning for upto 78 weeks in 3 years for the same illness.

PAYMENT FOR SERVICES

The sickness funds reimburse hospitals for operating costs by paying an all-inclusive per diem rate. This daily rate is derived from the hospital budget that is negotiated annually between sickness funds and individual hospitals.

Hospital capital costs are met directly by the state governments whose parliaments determine the amount to be spent within each state. Only hospitals whose capital

investments plans are approved by the state are eligible for reimbursement of capital costs.

ENROLMENT CHOICES

Blue collar workers must enroll in the primary sickness fund applicable to their place of employment. White collar workers enroll with the substitute funds. The self employed are not automatically enrolled in a sickness fund. Those who previously belonged to a sickness fund as a worker or dependants and have maintained the membership are permitted to continue with that fund if they wish.

Such people make payments according to a schedule of contributions. They contribute an amount equivalent to the sum of the employer and employee contribution.

Self employed people who have never been members of a sickness fund or who chose to terminate their membership may not join a sickness fund but may choose to buy private health insurance.

Civil servants are not permitted to join sickness funds. Instead their employer Federal state or local government directly reimburses them for between 50% and 95% of the cost of medical and hospital services. Most of these civil servants purchase private insurance cover.

Retirees who are not private insured remain in the sickness fund to which they belonged at the time of retirement. Insurance cover for retirees is deducted from his social insurance pension.

Unemployed workers receive unemployment compensation benefits which can last for upto one year after loss of employment. These remain in the same sickness fund in which they were enrolled as workers. Their contributions comes from the National Unemployment Insurance Fund.

THE LONG TERM CARE INSURANCE

The long-term care insurance has been existing since 1995. It comprises both a statutory long-term care insurance and a private compulsory care insurance. The principle which applies is that anyone insured in the statutory health insurance is automatically a Member of the statutory long-term care insurance. Persons who have private insurance coverage must take a private long term care. Benefits and services are provided either on an in-patient or an out-patient basis.

The person receiving long-term care has a choice between benefits in kind that is by the care funds contracting partners or get a nursing benefit in cash with which the patient can guarantee the necessary nursing care through relatives. It is also possible to get a combination of benefits in cash and in kind. Another benefit is the possibility of a holiday. Non-professional carers who have no gainful employment are

entitled to take four weeks holiday a year if he or she has been providing home care to the beneficiary for at least 12 months.

Persons who provide care for another person and do not work elsewhere are granted statutory pension cover. The pension contributions are paid by the statutory long term care insurance. Carers also have statutory accident insurance cover for the time during which they provide care.

FUNDING THE LONG-TERM CARE INSURANCE

The statutory long-term care insurance is financed by means of contributions paid equally by employers and the insured employees. The contribution depend on the income of the insured person.

FUTURE OF THE STATUTORY LONG-TERM CARE INSURANCE

It is the intention of the Federal Government to continue to develop the long-term care insurance and prepare it to meet new challenges. Two Bills are currently being prepared. One on quality assurance and the strengthening of the consumer rights in the long-term care insurance. Secondly, an Act on the promotion of day care as a first step in improving the care available to people suffering from diseases.

THE HEALTH CARE REFORMS ACT OF 2002 AND ITS IMPACT

The main aim of these reforms was to replace the existing system of hospital payment with a comprehensive payment system based on Diagnosis Related Groups (DRG) for all hospital services by 2003.

The responsibility for its implementation has been left to the National Association of Social Health Insurance Funds and the German Hospital Federation. These two parties were left to decide the basic principles of the system.

The two institutions decided to adopt Australia's refined diagnosis related group system of hospital reimbursement. Before the DRG system can be put into practice there is still a lot to be done.

(i) German translation of the basis of DRG system as well as a comprehensive coding system for diagnosis, procedures and other grouping criteria has to be complete.

(ii) Calculation principles and definitions have to be agreed upon.

(iii) The tasks of calculating the real costs of the DRG and evaluating the DRG systematically will be made by a DRG institute in which both the social health insurance funds as well as the German Hospital Federation will take an active part. This new body will also evaluate how new treatments should be included in the DRGs.

(iv) Social health insurance funds and the German Hospital Federation have to decide on a system of extra charge for several hospital services that cannot be reimbursed by DRG such as emergency cases. The cost weights and level of extra charges and deductions are to be agreed upon by the end of the year 2002.

(v) To make sure that there is adequate level of supply even in rural regions, hospitals with costs above the average can receive additional financial compensation. There is need to secure an adequate level of inpatient service all over the country.

LEGISLATION TO REGULATE THE DRG FRAMEWORK

The German parliament has passed a law to regulate the framework. The law has the following main aspects:-

(i) Introduction phase of 2 years by 2003/4 during which hospitals must introduce DRGs without direct financial budgetary implications. The budget being based on the current used system, per diems.

(ii) Hospitals can opt for DRG introduction either in 2003 or 2004. However, the earlier option requires approval by the social health insurance fund.

(iii) The regulation advises the calculation of relative weights using the Australian system for those services where in the year 2003/2004 will have been established.

(iv) During the 2005 and 2006 a step-by-step approach to go over to the new payment system will be applied. The former budget calculated as per the old system will be adjusted so that the new budget can be drawn up on the basis of the DRG system. From 2007, hospitals will only be compensated for their services through the DRG system.

(v) Those hospitals introducing the DRG system can negotiate an additional payment with the social health insurance funds.

The legislation also contains numerous regulations to tighten quality assurance as follows:

(i) a minimum number of agreed patients to be treated in any field is necessary for a hospital to continue to qualify for payments by the insurers or be disqualified from further treatment of such patients.

(ii) Hospitals are obliged to submit quality reports, which are to be published on the internet.

(iii) Health insurers and doctors are allowed to use these reports as a basis for giving information and treatment recommendations to patient.

The legislation proposes numerous mechanism for expenditure controls. For example, the average basic DRG rate should be reduced if expenditure in service grows faster than income received by health insurers.

PRIVATE HEALTH INSURANCE

Private health insurance in Germany originated out of the principle that statutory health insurance only covered the employed. The protection of the remainder of population was left to the initiative of private institutions, which operated parallel with the state institutions in offering insurance cover.

FINANCING OF PRIVATE INSURANCE IN GERMANY

Private health insurance premiums are fixed in accordance with the risk, age at entry and state of health of the individuals to be insured, together with the scope and level of insurance cover.

The employer and employee contribute half of the contribution each regardless whether the policy has been taken out with a private or a statutory health insurance fund.

RANGE OF BENEFITS IN PRIVATE INSURANCE

Private health insurance offers a wide range or types of cover. They include cost of out-patient treatments, hospital treatments, dental care, daily hospitalization, allowances, cover for loss of earnings resulting from sickness, long term care, supplementary cover for expenses not borne by the statutory insurance health insurance, for travel abroad and many more. The insurer is free to choose the policy that suits his needs.

UNITED KINGDOM

Socio-economic and demographic indicators

Total population:	59.7 million (2000)
Poverty:	17% (2000)
GDP:	$1.4 million (1999)
Adult literacy:	99% ()1997)
Life expectancy:	77.2 years (2000)
Mortality rate:	- infant: 5.7 per 1,000 births (2000)
	- under 5: 6.0 per 1,000 births (2000
Total fertility rate:	1.7 births (1999)
Maternal mortality rate:	7 per 100,000 births (1999)

Health system and finance indicators (1998)

Total expenditure on health as % of GDP: 6.8%
Public expenditure on health as % of total expenditure in health: 83.3%
Public expenditure on health as a % of total public expenditure:

- Social security expenditure as % of public expenditure on health: 11.8%
- Tax funded and other public expenditure as % of public expenditure on health: 88.2%

Private expenditure on health as % of total expenditure on health: 16.7%
Out-of-pocket expenditure as % of private expenditure on health: 66.8%
Per capita total health expenditure: $1,499.

OVERVIEW OF THE NATIONAL HEALTH SERVICES IN THE UNITED KINGDOM

What Does The NHS Do

The Committee was informed that the fundamental purpose of NHS is to secure through the resources available the greatest possible improvement in the physical and mental health population by promoting health, treating disease and caring for those with long term illness and disability

Organization, structure and Functions

The Committee was informed that the organization and structure of National Health services was highly centralized headed by the Department of Health, which has regional and District offices. The department of Health determines the allocations to regions and the regions determine the allocations for districts It is also charged with the formulation of a National Policy, strategies to implement the policy, carry out annual patient surveys and performance management. Expenditure is tightly controlled from the center.

Financing health care in the United Kingdom

The system of financing health care in the United Kingdom is less complex than in other countries visited by the Committee. The NHS is financed mainly through central government general taxation and through user charges.

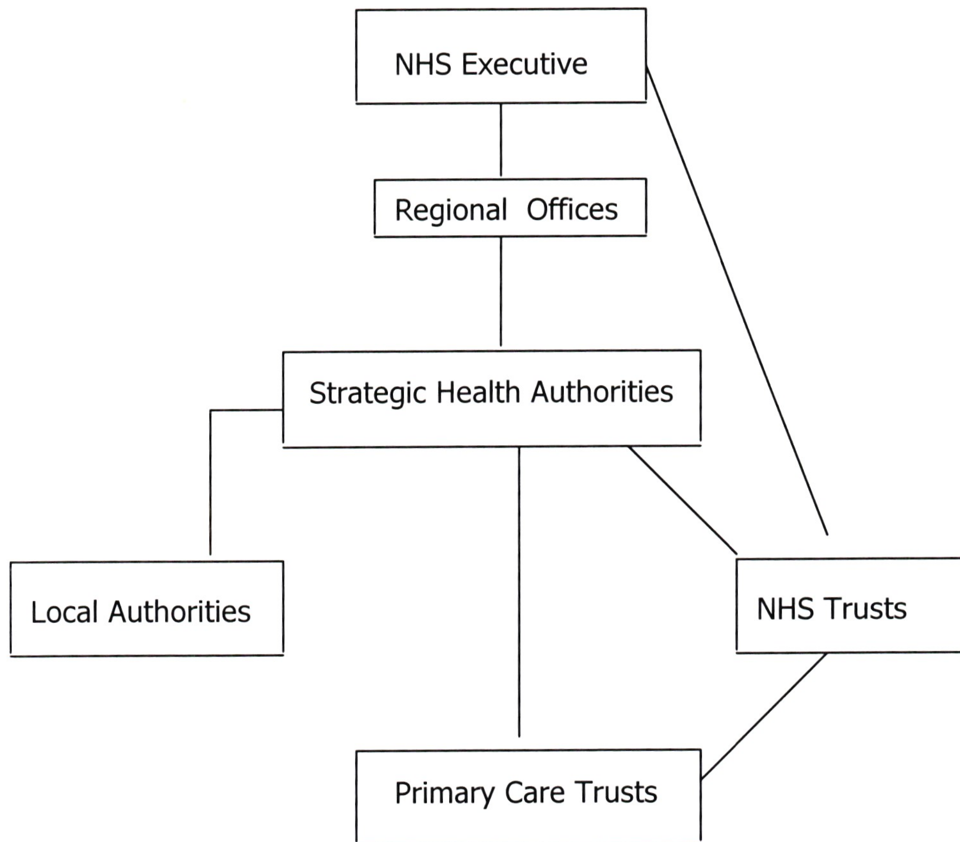
Private medical insurance takes two forms, employment company based insurance and individual insurance. There is also voluntary employee paid groups whereby employees meet all or part of the costs of premiums themselves.

Eligibility for NHS care in the UK

All persons normally residents in the United Kingdom are eligible for services through the NHS. The National Health Service Act 1977 provide that all hospital and specialised services are to be provided free of charge unless the law specify such charges.

The Reform Process

The Committee was informed that the performance of the health sector is a highly sensitive issue in the United Kingdom. The government was committed to significantly increase health spending to bring it in line with its European counter-parts. The measures will include exporting patients overseas to be treated at a lower cost and in countries with excess bed capacity or employ health professionals from other countries where they are in over supply. These efforts are expected to solve the problem of long waiting lists and lack of trained manpower in the health sector. The new reformed National Health Service will be organized as illustrated in the diagram below.



Models of Primary Health Care

The system had six models of primary care namely, primary care groups, personal medical services, walk-in centers (private clinics),primary care trusts, integrated care trusts and direct National Health Services

Functions of Primary Care Trust

The functions of the primary care trusts were given as:-

(i) Promoting the health of the local population;

(ii) Formulation of health improvement programs;

(iii) Commissioning of health services;

(iv) Monitoring performance;
(v) Development of primary care services; and

(vi) Integrated care.

Functions of the NHS Trusts

(i) Work out modalities where competition will be replaced with cooperation;

(ii) Responsible for operational management;

(iii) Promote the use of service agreements to replace contracts in the delivery of services;

(iv) Clinical governance; and

(v) User involvement where the patient is free to choose where to get the service.

Strategic Health Authorities

Their responsibility will be as follows:

(i) Formulation of the Annual Delivery Agreement;

(ii) Support primary care trust and NHS trust;

(iii) Set up local health targets and standards;

(iv) Allocate resources; and

(v) Manage performance in the delivery of health services.

Performance assessment frame work

The NHS uses the following parameters when assessing performance:-

(i) Improvements in Health provision;

(ii) Fair access;

(iii) Effective delivery of appropriate health care;

(iv) Patient care experience; and

(v) Health outcome .

MALAYSIA

The Committee held discussions with the following and also visited institutions listed below:-

i. Courtesy call on the Minister for Health
ii. ministry of health officials
iii. the Director, Institute of Medical Research
iv. the Chief Executive, MediExpress, which is a private health insurance company
v. management, Takaful National, which is an insurance company based on the Islamic system and entails a mutual fund to cover risks
vi. Selayang Referral Hospital, which is implementing total hospital system Malaysia's first paperless hospital
vii. President of the Association of private hospitals in Malaysia (covering about 500 hospitals) and tour of Pantai Medical Centre

The Committee was informed as follows:

Health facts

Land area (square Km) 330,113

Population (2002) 24 million who are relatively young. Only 7% of the population aged 65 years and over.
Population density (square Km) 69
Annual population growth rate – 2.3%
Still birth rate (per 1000 live births) (1998) – 3.9
Infant mortality rate (per 1000 live births) (1998) – 0.3
Life expectancy at birth – 73 years
Percentage distribution of live births by birth weight (peninsular Malaysia) 1998 – under 2.5 kgs –9.7, 2.5 kgs and over 90.3

Incidence rate and mortality rate of communicable diseases per 100,000 population, 1999.

	Incidence rate	mortality rate
AIDS	5.2	3.8
HIV	20.8	___
Cholera	4.7	0.03
Malaria	25.9	0.09
Measles	5.4	0.09
Syphilis (all forms)	11.7	0.01
Typhoid and paratyphoid	3.7	0.01
Viral hepatitis (all forms)	27.0	0.01

Principal causes of hospitalisation in Ministry of Health (MOH) hospitals in Malaysia (1999) include:

a) Delivery - 21.51%
b) Complications of pregnancy, childbirth and the puerpeirum – 10.98%
c) Accident - 9.37%
d) Diseases of the respiratory system - 6.76%
e) Diseases of the circulatory system - 6.71%
f) Certain conditions originating in prenatal period- 5.55%

Principal causes of deaths in MOH hospitals in Malaysia (1999) include:

a) Heart diseases and diseases of pulmonary circulation – 15.02%
b) Septicaemia – 12.74%
c) Cerebrovascular diseases – 9.59%
d) Malignant neoplasms – 9.08%
e) Accidents – 7.56%
f) Certain conditions originating in the prenatal period – 6.33%
g) Pneumonia – 4.83%

Total number of deaths – 29,672

Admissions and outpatient attendance in MOH facilities in 1999 were as follows:

MOH hospitals – 1,571,078
MOH special medical institutions - 16,694

Outpatients

Hospital/satellite clinics and special medical institutions – 12,832,405 (45.4%).

Public health facilities (including mobile health team and flying doctor services), 15,463,554 (54.6%).

Dental health attendance at dental clinics – 7,851,660

Maternal and child health

- Antenatal attendances - 3,737,392
- Postnatal attendances - 564,323
- Child attendances - 5,732,669

Environmental health (1999)

Percentage of population served with safe water supply – Rural 86%,
Urban – 97%.

Percentage of population with adequate sanitary latrines – Rural 99%, Urban – 100%.

Health facilities (1999)

Total number of MOH hospitals – 114
Total number of beds in MOH hospitals – 28,163
Total number of MOH special medical institutions – 7
Total number of beds in MOH special medical institutions – 6,293
Total number of private hospitals, maternity/nursing homes – 225
Total number of beds in private hospitals, Maternity/nursing homes– 9,498
Number of MOH Dental Clinics - 1,667
Number of MOH health Clinics – 773
Number of Rural Clinics – 1,990
Number of Mobile Clinics – 194

Health Human Resources (1999)

Total number of doctors – public 8,723
Total number of doctors – private 6,780
Doctor population ratio – public – 1:2,604
Doctor population ratio – private – 1:3,350
Total number of nurses – public – 20,914
Total number of nurses – private – 6,322
Nurse population ratio – public - 1:1,086
Doctor patient ratio (2002)- federal territory - 1:300
Rural areas – 1:2-4000

Financial Allocation (1999)

Total MOH budget	–	RM 4,237,960,000 (US$1,145,394,590)
Operating budget	-	RM 3,494,774,000 (US$944,533,510)
Development budget	-	RM 743,186,000 (US$200,861,081)
Per capita allocation	-	RM 191.00 (US$51.6)
Per capita gross national income (2002)	-	RM 13,411 (US$3,529)
Percentage of total MOH allocation to national budget	-	6.61%

Childhood immunisation

a)	BCG	-	100%
b)	Diphtheria, tetanus and whooping cough	-	93.2%
c)	Polio	-	93.20%
d)	Measles	-	86.6%
e)	Hepatitis B	-	90.7%

Other social economic indicators (2001)

Real GDP growth	-	8.3%
Unemployment rate	-	3.1%
Literacy rate	-	93.8%

Health care provision

i) **Public sector**

a) Ministry of Health (the major provider)
b) Ministry of Education
c) Ministry of Defence
d) Ministry of Housing and Local Government
e) Ministry of Home Affairs
f) Ministry of Human Resource

(In 1983, the public sector provided 70% of the services, 50% of which were by the MOH).

ii) **Private sector**

iii) **Alternative medicine**

iv) **Non-governmental organisations**

Malaysia Health Care System

The provision of health care is managed at various levels as follows:

i) **Rural Health Unit**

This consists of one health centre, four rural health clinics and mobile clinics.
Each rural unit serves a population of 15,000-20,000.
Each rural health clinic covers a population of 2,000-4,000.
Here, services are given free of charge.

ii) **MOH urban health services**

These provide one-stop health services similar to rural health centre.
The rural and urban health units provide primary health care.

iii) The MOH district, regional/state hospitals and eventually the national referral centre provide institutional care through a well-defined referral system from the lowest to the national level.

iv) **Traditional/complimentary medicine**

Traditional healers continue to play a significant role. This is practiced and accepted by both rural and urban population.

Traditional medicine is multi-billion dollar industry as the service is utilised by over 40% of the Malaysian population.

v) Non-governmental organizations also play a part in health care provision. These are usually associations and societies whose services are voluntary and non-profit in nature. In 1996, accessibility to static health care facilities was over 90%.

HEALTH CARE FINANCING

- Health services in Malaysia are basically public sector driven. Government hospitals are highly subsidized; for example, a liver transplant would be undertaken free of charge to poor patients. By law, a rich patient would be required to pay up to R 500 (US$135).

- Currently, the country is doing heart transplants and also bridge transplants (3 months, 1-year etc).

- However, due to the rising costs of health care, the policy of subsidy is not sustainable. Consultations are underway to set up a National Health Financing Authority (NHFA) to cater for medical costs i.e. health insurance in Malaysia still in the planning stage.

The government will eventually become the regulator while the Authority will finance health care services. Below is an exposition of health care financing strategies being explored.

There are three major health policy questions in health financing, namely:

1) How to mobilize funds?
2) How to allocate funds?
3) How to control cost?

MOH national health financing concerns:

1) Who pays?
2) How much?
3) For what?
4) Who benefits?
5) What mechanism?

Methodology of developing the National Health Fund (NHF) policy is based on the principle that financing health care is not only about:-

a) collection of funds from contributors; and
b) payment of money to health care providers.

To be effective, Health Care Fund must focus on the whole spectrum of service delivery ranging from the regulator, the financier, the health care provider, amount and quality of health care and the cost thereof.

The development of National Health Fund Scheme may have a profound impact on the planning, provision and future direction of Malaysian health care system.

The policy of setting up a NHFA is based on the following rationale:

1) Rising demand and expectations for high tech and high cost medical care due to:

   a) improved standards of living
   b) changing disease pattern
   c) demographic changes

2) Inequitable distribution of resources:

   a) movement of health personnel to private sector
   b) differing range, scope and quality of services delivered by public and private sectors.

   c) Increasing trend in private health expenditure. This trend has to be controlled to ensure health care is not left to market forces, resulting in greater inequity.

3) Over reliance on public sector services

   a) **Utilization of public facilities and services**

      Hospitalization, maternity care, long standing and complex illnesses in public facilities – utilized by 80% of the population.

      Mostly utilized by population from rural areas, less developed states, large families, Malay households, lower income, lower education and households headed by government employees.

   b) **MOH Revenue in 2001**

      Revenue collected by MOH from providing medical, health and dental services amounted to 2.2% of MOH operating budget.

4) Inadequate integration and co-ordination between public and private sectors.

(a) Private sector concentrates mainly in urban areas. Unable to address the inequitable distribution of health services and resources.

(b) Access to private hospitals restricted to rich.

(c) A study in 1996 reported that the hospitalization cost in the private sector is 30 times more expensive than in government hospitals.

Another parameter is the number of beds in public hospitals which account for 79.7% against private hospitals which total 20.3% yet the former is served by 53.8% doctors compared to 46.2% in the latter.

Utilization of management of complex cases by specialists stands at 70% in the public sector and 25% in the private sector while percentage of specialists is 41.2% and 58.8% in the public and private sectors respectively.

5) **Emergence of private health insurance**

(a) Which are risk-rated in nature.

(b) Which prefers to cover high-income, low risk consumers and cover limited range of medical treatment.

(c) Premium for high-risk consumers and to cover a full range of services is high. All these factors lead to greater inequity.

6) The World Health Report of 2000 ranked Malaysia 49th in terms of accessibility to and affordability of health services.

It noted, quite correctly, that high out-of-pocket expenditure on health services exposes families to unexpected expenses. WHO prefers some form of prepayment mechanism be introduced in Malaysia.

Expected benefits of national health financing to stakeholders.

To consumers:-

- accessibility and affordability
- integrated care
- minimizing out-of-pocket payment at point of service delivery
- comprehensive care and freedom of choice
- more responsive health care system

- encourage individual responsibility

To healthcare providers:-

- reliability and profitability
- pay commensurate with workload, skills and expertise
- integrated health care services
- incentives for health care providers to open at rural and less profitable areas

To Government/purchasers:-

- integrated health services
- optimal utilization of resources and services at both public and private sectors
- quality
- ability to manage the rate of healthcare spending
- efficiency
- greater equity
- cost sharing

Characteristics of the healthcare financing system

- **mandatory**
- able to manage the rate of growth of healthcare spending
- allows for flexibility and innovation in health care delivery
- ensures
    - Equitable access
    - Greater equity
    - Quality
    - Efficiency
    - Freedom of choice
- provides for greater integration of health services including between public and private sectors
- provides care nearest to home
- does not deny emergency
- maintain the strengths of present system
- keep government expenditure at a manageable level
- viable, acceptable and sustainable
- covers comprehensive range of services
- wellness paradigm
- community rated health financing system
- stress on individual and family responsibility

- establishment of NHFA and a statutory body, run as a not-for-profit entity (not to be privatised)
- encourage private sector involvement
- improve health status
- in line with vision for health, national vision policy and vision 2020

Main principles of equity in financing

National solidarity and community rated. The young subsidize the old, the rich subsidize the poor, the healthy subsidize the sick, and the small families to subsidize the large families.

Sources of financing – recommendations

Main sources

Taxation (except civil servants and disadvantaged groups) plus national health insurance complemented by medical savings account e.g. through Employee Provident Fund (EPF) plus others e.g. private insurance. Health insurance is one of the benefits for civil servants.

Taxation as a means of funding health care cannot be relied on in countries with high levels of unemployment.

Perhaps it should be legislated to indicate how much of direct taxation should go into health care financing.

National Health Financing Authority

The envisaged institution will be owned by the government, accountable to the MOH to implement health financing policies of the Ministry in line with vision 2020, vision for health and national vision policy.

NHFA should be a statutory body set up by an Act of Parliament. It should be a single collector, single payer, not for profit and not to be privatized.

Main functions of the NHFA

1. Health financing policy, research and corporate planning.
2. Health facilities and providers assessment.
3. National health care financing data bank and evaluation.
4. Strategic human resource planning and training.
5. Health services (scopes/packages/health education and promotion).
6. Health fund collection and distribution, health administration and accounts.

There is also merit in the set-up of the National Health Advisory Council (NHAC) consisting of stakeholders in health whose function will be to advise MOH and NHFA on aspects related to health. The government's role will be regulatory, policy

formulation and monitoring. The basic objective is to ensure quality, equity, accessibility, affordability and sustainability.

PHILIPPINES

The Committee met and held discussions with the following:

i. the Future's Group International – (Dr. Aurora Perez)
ii. Management Sciences for Health (Dr. Benito Revevente)
iii. Philippines National Aids Control Council
iv. Friendly Care Foundation Inc (Dr. Alberto Romualdez Jr)
v. Philippines Health Insurance Corporation (Dr. Ma Ofelia Alcantara)
vi. Health Policy Development and Planning Bureau (Dr. Mario Villaverde

The Committee was informed as follows:

- The Philippines is a tropical country of 7,100 islands lying in the Pacific Ocean with a total land area of 300,000 square kms.

- The country is prone to natural disasters brought about by volcanic eruptions, earthquakes, floods and typhoons.

- The tropical temperature favours the existence of disease vectors and parasites.

- Estimated population in 1999 was 74.7 million which is projected to increase to 82.6 million in 2004.

- Population density is 249 people per square km although this is unevenly distributed throughout the islands. The population density of metropolitan Manila is 16,051 people per square km.

- Annual population growth rate stands at 2.32% but is projected to decrease to 1.9% in 2004.
- About 38% of the population are under 15 years. Those aged 65 years and over comprise 3.5% of the population and are expected to increase to 4.2% in 2004.

- Literacy rate stands at 83.8%. Although this rate is high, folk beliefs, misconceptions and practices detrimental to health are still rampant. Socio-cultural barriers to health are prevalent and more apparent in indigeneous communities.

- The congestion and pollution in urban areas are harmful to health, including nuclear pollution from a former military base occupied by the US army. In frontier areas, the people's health is affected by difficult access to health services and the presence of locally endemic diseases like malaria, filariasis (elephantiasis) and schistosomiasis (bilhazia).

- The local government units comprise the political subdivisions of the Philippines. These are made up of 78 provinces headed by governors, 82 cities and 1,525 municipalities headed by mayors and 41,939 barangays or

villages headed by barangay chairmen. LGU's are guaranteed local autonomy under the Constitution.

- From 1988-1997, the country's GNP grew at an annual average of 4.1% while the GDP went up by an average of 3.4%. The GDP in 1997 was mainly from the service sector (43%), industry (36%), agriculture, fishery and forestry sectors (21%).

- The poor comprise 37.5% of the population which is 15.5% lower than in 1988.

General Health Status

- Life expectancy (1999) 71.28 years for females and 66.03 years for males.

- Crude birth rate for 1997 is 28.4 per 1,000 population while the crude death rate is 6.1 per 1,000 population.

- Total fertility rate in 1999 was 3.36 children per woman – estimates at 3.08 in 2004.

- Infant mortality rate (1995) – 49 per 1,000 live births.

- Maternal mortality rate (1995) – 179 per 100,000 live births.

- Most of the leading causes of mortality are communicable diseases. These include diarrhea, pneumonia, bronchitis, influenza, tuberculosis, malaria and varicella (viral infection).

- Leading non-communicable causes are diseases of the heart, hypertension, accidents and malignant neoplasm.

- Leading causes of mortality are diseases of the heart and the vascular system. These comprise 39.6% of the deaths attributed to the leading causes.

- WHO ranked the country at number 60 out of 191 states in health system performance.

Health Care Delivery System

The state recognizes health as a basic human right.

Section II, Article XIII of the 1987 Constitution provides as follows:

- The state shall adopt an integrated and comprehensive approach to health development, which shall endeavour to make essential goods, health and other social services available to all people at affordable cost.

Priority to the needs of the underprivileged, sick, elderly, disabled, women and children shall be recognized.

- Likewise, the Philippine Constitution mandates decentralization and devolution of health services to local government units (LGUs).

- The Department of Health is the lead agency in health. It maintains specialty hospitals, regional hospitals and medical centres.

- With the devolution of health services to the LGUs, the provincial and district hospitals are under the provincial government while the municipal government manages the rural health units (RHUs) and barangay health stations (BHSs).

- In every province, city or municipality, there is a local health board chaired by the local chief executive. It serves as an advisory body to the local executive and the Sanggunian or local legislative council on health-related matters.

- Although the health care system is extensive, its access, especially by the poor, is hampered mainly by high costs and physical and socio-cultural barriers.

- The human resources for health are enormous but unevenly distributed. Most health practitioners are in metro Manila and other urban centres.

- In 1995, there were 82,494 doctors, 259,629 nurses and 102,878 midwives.

- In 1997, there were 3,123 doctors, 1,782 dentists, 4,882 nurses and 15,647 midwives employed by LGUs while the Department of Health had 4,232 doctors, 179 dentists, 4,837 nurses and 241 midwives.

- The ratio of government health workers to the population was one doctor per 9,527 people, one dentist per 36,481, one nurse per 7,361 and one midwife per 4,503.

- In 1997, there were 1,812 hospitals with total bed capacity of 81,905 or one per 873 people. Although only 644 or 36% were public hospitals, these contribute 42,070 beds.

  There were 2,405 Rural Health Units (RHUs) and 13,556 Barangay Health Stations (BHSs). On average, each RHU serves 29,746 people while each BHS serves 5,277 people.

Health Care Expenditures

- In 1998, the government spent 2.83% of the budget on health.

- In 1997, only 3.5% of GNP or around P88.4 billion (1 US$ = P49) were spent on health by both the government and private sectors. This amount is below

the health spending prescribed by WHO for a developing country which is at least 5% of the GNP.

- 72% or around P63 billion went to personal health care services. Public health care services accounted for 13% or P12 billion. Overhead costs amounted to 15% or P15 billion.

- 46% of the total health spending was paid out-of-pocket of individual families. The financial burden on individual families is heavy. Government's share was 39% (21% national and 18% local).

- The National Health Insurance Programme financed only 7% of the total health spending while private health insurance and community based health financing schemes shared 8%.

- Although health spending has increased in real and per capita terms from 1991-97, the health sector is not spending enough or effectively. There was heavy spending on hospital or curative care and not enough for preventive and promotive health services. In addition, the subsidies for health services are poorly targeted.

In order to address these problems, the agenda for health sector reforms has been developed. The Health Sector Reform Agenda (HSRA) describes the major strategies, organizational and policy changes and public investments needed to improve the way health care is delivered, regulated and financed.

Health Sector Reform aims to undertake the following:

i) Provide fiscal autonomy to government hospitals. Government hospitals must be allowed to collect socialized user fees so they can reduce the dependence on direct subsidies from the government.

   Their critical capacities like diagnostic equipment, laboratory facilities and medical staff capability must be upgraded to effectively exercise fiscal autonomy.

   Appropriate institutional arrangement must be introduced e.g. allowing them autonomy towards converting them into government corporations without compromising their social responsibilities.

ii) Secure funding for priority public health programmes. Investments must be undertaken to effectively address emerging health concerns and to advance health promotion and prevention progammes.

iii) Promotion and development of local health systems and ensure its effective performance. Appropriate mechanisms for sustainability and continued delivery of quality care must be developed and institutionalized at the LGUs.

iv) Strengthen the capacities of health regulatory agencies to ensure safe, quality, accessible and affordable health services and products. Appropriate legislation must be enacted to fill regulatory gaps. Public investments must be made to upgrade facilities and manpower capability in standards development, technology assessment and enforcement.

v) Expand the coverage of the National Health Insurance Programme. Social health insurance must expand to extend protection to a wider population especially the poor.

Health insurance benefits must be improved to make the programme attractive. Adequate funding must be secured for premium subsidies needed to enroll indigents. Effective mechanisms must be developed to cover and service individually paying members.

As membership expands and benefit spending increases, appropriate mechanisms to ensure quality and cost effective services must be introduced and developed. Capacities and new administrative structures must be developed to allow the Philippine Health Insurance Corporation (PHIC) to effectively service more members and manage increased benefit spending.

The HSRA aims to improve the health status of the people through greater and more effective coverage of national and local public health programmes, increase access to health services especially by the poor, and reduce financial burden on individual families.

Health care financing framework

In 1995, the Congress of the Philippines enacted the National Health Insurance Act, which instituted a National Health Insurance Programme (NHIP) and also established the Philippine Health Insurance Corporation. Further, it instituted the indigent programme or *Medicare para sa masa* in partnership with LGUs.

This was a deliberate plan to make health insurance a social security scheme where risks are shared and benefits enjoyed by all.

The main objective of National Health Insurance programme is to provide all Filipinos with the mechanism to gain financial access to quality health care services within 15 years of its implementation.

The programme is mandatory for the employed in the public and private sectors. There is voluntary coverage for the self-employed or informal sector and free coverage for the poor in partnership with LGU's which provide counterpart financing.

Coverage also includes non-paying retirees of the government or private sector on reaching the age of 60 years (56 years for the Armed Forces) after making 120 monthly contributions.

There are several levels of healthcare funding.

i) The formal self employed who contribute a premium to PhilHealth. The premium of the formal sector is based on the salary bracket.

ii) The national government gives a share of its health budget to PhilHealth i.e. funds appropriated by the Congress. The national government also contributes premiums for its employees.

iii) The LGU provides budgetary support to hospitals and Health Centres within its area of jurisdiction. In addition, it pays premiums for its employees and the indigent population.

iv) PhilHealth dispenses funds to the Health Centres on a capitation basis.

v) The accredited hospitals claim reimbursement from PhilHealth on services delivered.

Benefits

i) In-patient hospital care which includes services of health professionals, diagnostic and laboratory exams, prescription drugs, use of surgical or medical equipment and facilities. The contributor benefits are utilized by the legal spouse, children (legitimate and illegitimate) and parents over 60 years.

ii) Out-patient care which includes services of health professionals, diagnostic and laboratory, prescription drugs, personal preventive services, emergency and transfer services. This is, however, only available to the indigent population who number about 3.5 million people.

Other health services

Such other health care services that the corporation shall determine to be appropriate and cost effective.

Exclusions

- Non prescription drugs and devices.
- Out-patient psychotherapy and counseling for mental disorders.
- Drug and alcohol abuse or dependency treatment.
- Cosmetic surgery, home and rehabilitation services, optometric services, normal obstetrical services and cost-ineffective procedures as defined.
- PHIC spends 12% of collections on administrative costs, 60-70% on benefit payments and 18% on short-term investments. Emphasis is laid on low yielding, low risk government bonds. Fund utilization stands at 70%.

Managed care and Health maintenance organizations in Philippines

- The Department of Health regulation of HMO's started in the 1990's. This resulted in rapid growth in enrolment and revenues.

- 2-3 HMOs collapsed in the latter 1990s leading to entry of multinationals.

- The driving force for managed care in the Philippines is financial access to quality service. The essence of managed health care is control over provider, utilization and quality culminating into efficiency.

- HMO's combines the delivery and financing of health care. Receives a fixed pre-paid fee to provide health care as agreed in a health plan.

HMO statistics 2000

Total revenue	-	P 4.5 B
Claims expenditure	-	P 3.6 B
Enrolment	-	3 million people
Average return of profitable HMOs	-	2%

Managed care market trends

- Industry growth of 57% per year between 1991 to1997.
- 25% of top 1,000 corporations covered by managed care plans.
- PhilHealth adopting managed care features to control costs, access and quality.

Health Care Financing Reforms

- With better benefits and more members, there will be more leverage for better programme performance where financing is adequate, better secured and abuses minimized.

- To deal with the projected increase in insurance workload, the PHIC administrative and management infrastructure needs to be improved. This includes establishment of local health insurance offices to decentralize activities and the computerization of systems and procedures to improve collection, reimbursement, data gathering and controls against abuses.

- Mechanisms for complementation and partnership with community health financing schemes will be created to increase the coverage of the health insurance system.

THAILAND

The Committee held discussions with the following and made visits as below:

a. The House Committee on Public Health
b. Bamrungraj Hospital
c. Ministry of Health officials

The Committee was informed as follows:

Health and Geographical Facts

Population 62.3 million (2000), 31% of who live in urban areas.

Divided into 4 geographical regions, 76 provinces, 876 districts, 7,255 sub-districts and 70,886 villages.

- Elderly population aged 60 years and above – 5.5 million in 1990. Estimated to reach 15.25 million in 2020.

- Children aged between 0-14 years accounted for 25.05% in 2000.

- Average annual GNP growth rate between 1991-96, 8.3%. After the economic crisis of mid 1997, the growth rate stood at – 3.5% in 1999.

- The provision of health services is undertaken by both the public and private sectors.

- There has been rapid expansion of both public and private health facilities. The private sector mostly located in Bangkok and big cities.

- The Ministry of Public Health has expanded community hospital and health centres to cover all districts and sub-district areas.

- In the past decade, national health spending in Thailand has risen significantly from 25,315 million Baht in 1980 to 283,570 million Baht in 1998. The per capita health spending had risen from 454 Baht (Ksh863) in 1980 to 4,663 Baht (Ksh8871) in 1998. (1 US$ = 41 Baht).

- Private sources of health care financing (mainly out-of-pocket) have been on a downward trend. 55% in 1994, 44% in 1996 and 39% in 1998.

Overview of health insurance in Thailand

The Thai Constitution clearly stipulates that it is the entitlement for Thai people to receive health care services according to their health needs and preferences, regardless of income level, social status or residency.

To streamline the operations in the health insurance industry, a draft of the National Health Insurance Bill is being considered by Parliament.

Health insurance provides two basic functions, namely:

- Access to effective health care services when needed, and
- Effective protection of family income and assets from the financial costs of expensive medical care.

Thus, not only contributory schemes but also tax based welfare schemes are considered as health insurance.

Health insurance in Thailand can be classified into four main categories according to the nature and objectives, namely:

1. **Medical Welfare Scheme**

   This Scheme provide free medical care for the indigent and other people who make various forms of contribution to the society e.g. the elderly, children up to secondary school level, the disabled, monks, community leaders plus family and volunteer health workers and their families. The aim of the Scheme is to ensure accessibility to care for the indigent and also provide a fringe benefit to useful members of the society.

2. **Civil Servant Medical Benefit Scheme**

   This is provided as a fringe benefit to government employees and dependants to complement their low salaries.

3. **Compulsory Social Insurance**

This is at three levels:-

a) Social Security Scheme – provided as a health security for workers in formal sector. This depends on tripartite contributions from the employer, employee and the government. All enterprises with one or more workers are included.

b) Workmen compensation Scheme – This aims to protect workers from work-related injuries or illnesses and contributions are solely from the employer.

c) Traffic accident insurance – aims to ensure accessibility to care of all traffic accident victims and hence contributions are from all car owners.

4. **Voluntary Schemes** which can be divided into two:

a) Government Health Card Scheme – provided as an alternative health security for those who are not covered by any other health scheme yet may get into debt due to expensive medical care. Target population includes those in informal sector e.g. farmers, fishermen, self-employed and workers in small enterprises.

b) Private health insurance – alternatives for the rich who would like to get health security or supplement to uncovered benefit from public insurance.

Distinct from the above major health insurance categories, some community financing schemes through a community saving fund also existed. These are usually small and cover limited to only a member of a saving fund in a particular village.

Benefits provided in the schemes are limited and not comprehensive besides the fact that payments are made retrospectively to members at the end of the year according to money available.

Trend and coverage

Insurance coverage for the Thai population has been increasing from 33.5% in 1991 to 46% and 60% in 1996 and 1999 respectively in the various schemes. However, there are huge differences in terms of contribution, public subsidy, benefits and quality of services. The population coverage is 80%. There are weaknesses also in terms of efficiency, quality and equity.

The health insurance system is in the process of being overhauled to achieve universal coverage as stated in the national strategic policy.

In addition to undertaking reforms in the current health insurance schemes, the government has begun implementing a compulsory scheme, "the 30 Baht Policy".

This programme covers personal prevention and promotion services. It also includes vaccination, family planning, ANC, anti-retrovirals for prevention of mother to child transmission and dental prevention care in children without any co-payment.
In addition, outpatient and inpatient services with fixed amount of co-payment, 30 Baht per visit. It excludes cosmetic treatment and procedures, eye glasses, organ transplants, experimental treatment, dialysis and ARVS.

The office of Health Insurance in the Ministry of Public Health is the "fund holder" responsible for oversight of the programme and allocation of the

budget to every province using the formula which reflect the need of each province.

Sources of funding for this scheme are general tax and out-of-pocket co-payment fee and extra services with the exception of indigents who get the services free of charge pursuant to the Constitution.

All the schemes will be managed under the same organization after the national health insurance Act is enacted contrary to the present practice.

The theme of the universal coverage of health care project is about the levels and the management of financial resources which need to be well designed to ensure sustainability. The ultimate goal of the project consists of:

1. Equity in distribution of health expenditure due to the economic status and affordability including equality in accessing needed health services.

2. Efficiency of budget allocation and management in the best way and well governed to induce cost effectiveness. Most services will be delivered through primary care networks, which will produce low cost health outcome.

3. Choices of standard and qualified health services for people in both public and private sectors in order to enhance competition in improving quality of health services.

4. Emphasizing on health promotion and preventive cares.

Future reform

Two important policy contexts influencing the observed policy direction are worth mentioning.

i) General reform of the public sector towards good governance, decentralization, lean government and privatization has increased the role of the private sector and the community in a variety of social issues.

ii) Health reformists have advocated universal coverage through legislation for the uninsured population.

There is, however, some consensus that Thailand will in future have two main schemes:

a) The first would be the Social Insurance Scheme covering both public and private formal employees.

b) The rest of the population will be covered by National Health Insurance Scheme. This will be financed through compulsory contribution and general subsidy to the poor.

Private insurance should not be allowed to provide basic package but could play a role in providing additional benefit. Co-payment could play a significant role of combating moral hazards by putting a signal to the insured for efficient consumption in all schemes.

Capacity for premium collection, beneficiary database and organization management capacity has to be developed simultaneously.

Fee-for-service reimbursement model must be avoided. A contract model and closed end payment such as risk or age adjusted capitation and global budget are advocated for both schemes.

In the meantime, efficiency improvement, coverage extension by social security scheme, proper targeting the poor, cost recovery in health care scheme are immediate reform agenda.

NOTES AND OBSERVATIONS

The population of Kenya is currently estimated at 30 million, of which 5% are under 1 year; 20% under 5 years; and 50% under 15 years.

Women of reproductive age i.e. 15-49 years constitute 20% of the population.
The population growth rate that stood at 3% at independence rose to a record 4% in 1979 before declining to 2.9% in mid-1990's.

Life expectancy is currently estimated at 54 years with AIDS. Without the pandemic, however, it would have been 60 years. Crude birth rate is estimated at 38 per 1,000 while crude death rate is estimated at 12 per 1,000 (1997).

Doctor population ratio (1996)	-	14.1:100,000 people
Dentists	-	2.4:100,000 people
Pharmacists	-	25: 100,000 people
Registered Nurses	-	25.2: 100,000 people
Clinical Officers	-	10.9: 100,000 people

Out of about 6,000 doctors in Kenya, only 600 are in public service.

Fertility declined from 8.1 in 1977/78 to 5.4 in 1990/92. It is estimated to fall to 3.25 by 2010.

In 1993, under 5 mortality rate was estimated at 97.1 for males and 98.3 for females per 1,000. The 1998 Kenya Demographic and Health Survey shows that the figure has risen to 112 deaths per 1,000 live births.

Infant mortality rate was estimated at 62 and 74 per 1,000 live births for the periods 1988-1993 and 1993-1998 respectively. The AIDS pandemic is likely to increase mortality rate reducing life expectancy by about 12 years for males and over 15 years for females by 2015.

Other Socio-economic and health indicators (1998)

GDP per capita – about US$230.

Recurrent health budget (as % of total government expenditure – 3.8%).

MOH per capita recurrent health expenditure – US$3.4 (Ksh272).

Public health expenditure (as % of GDP) – 2.3%.

Epidemiological trends

The morbidity pattern over the last 10 years features malaria as a priority disease followed by acute respiratory infections, skin conditions, diarrhea and intestinal worms infestation. Peri-natal and maternal health complication account for 27% of the total burden of disease in Kenya as measured in terms of life years lost. The HIV/AIDS pandemic now poses a greater challenge by taking a disproportionate share of resources meant for development of health services.

The first report on poverty in Kenya indicates that close to 30% of the absolute poor live in rural areas and 10% in the urban areas and cannot meet their food requirements even if they did not spend on other requirements.

The implication is that this category cannot afford to pay for health services at all.

A study on the implications of the introduction of user fees for health services carried out in 1989 indicated that there was a drop in the number of people seeking health care as a result. Poverty and low incomes resulting from the depressed performance of the economy have, therefore, negatively impacted on the health seeking behaviour of individuals, especially the poor.

Organisation of the health sector

- This sector comprises the public heath system with major players being the MOH and the Ministry of Local Authorities. Other players are NGO's, mission hospitals and the private sector.

- Health services are delivered through a network of about 4,200 health facilities with the public health system accounting for 51% of the total.

- The overall mandate for health services promotion is vested with the MOH under the Public Health Act, Cap. 242 and under various subsidiary legislation. The Ministry is assisted to administer health services by various Boards and Councils.

- The Ministry has the responsibility to formulate policies, establish and enforce standards and mobilize resources for health services development while the provincial and district levels have the important role to implement health programmes and deliver health services.

- The GOK has remained the major source of funding to the health sector accounting for 47% of the total. Private individuals account for 41% while the NHIF and donor agencies account for 4% and 3% respectively.

- The recurrent budgetary allocation to the MOH rose from Ksh2.56 billion in 1990/91 to Ksh9.1 billion in 1998/99 a rise of 255% in nominal terms. In real terms, however, the growth has been marginal at 6%. The per capita expenditures have declined over time from US$9.5 (Ksh760) (1980/81) to US$3.4 (Ksh272) (1997). This indicator is expected to decline.

- This is the reality that Kenyans cannot run away from and for which they must seek ways and means of remedy collectively. The focus will undoubtedly be on health care financing but as alluded to earlier, it will involve a total overhaul and reinvigoration of the entire health delivery systems.

RECOMMENDATIONS

i) The first available step is to raise the level of resource budget allocations to the Ministry of Health from the current level of about 3.8% to 15%. This will not only reduce the Ministry's dependence on donors who account for over 90% of the development, budget but more significantly, it will improve per capita expenditure on health which translates into a higher allocation to purchase drugs, equipment etc.

ii) There is more than a desire to decentralize health care delivery system in Kenya. This is an unavoidable measure if the health care services are to be improved. This can be done at several levels.

    a) One, the hospitals need to be given some degree of autonomy to operate as business entities without losing sight of their societal responsibilities. Centralization of health care service delivery establishment at the MOH has choked the whole system compromising accessibility and affordability of health services. The few hospitals, which have been granted state corporation status show, though not without hiccups, what can be achieved in that regard. An improvement in the quality of care in public hospitals will see a corresponding increase of revenue from health insurance, which currently stands at 20%.

    b) The local authorities have completely abrogated their responsibilities in health care services to their residents. This must be reversed if we are to achieve universal coverage in health. The failure by the Nairobi City

council, for example, to provide reliable health facilities, has been cited as one of the causes of overcrowding at the Kenyatta National Hospital (KNH).

This situation leads to other problems, for example, KNH is supposed to be a referral and teaching centre and hence amounts to misuse when utilized for primary care services. In the same breath, the MOH should establish an elaborate referral system from the health clinic through the dispensary, sub-district hospital all the way to the referral centre.

The Local Government Act should be amended to require local authorities to allocate a fixed amount of their revenue on provision of health services.

c) Health insurance is crucial in shifting part of the curative burden to private health care providers. The insurance market is, however, currently dominated by the relatively centralized National Hospital Insurance Fund. To create additional resources and enhance efficiency, there is a need to remove this monopoly by opening up the health insurance market to multiple firms and agencies for healthy competition.

The NHIF should also be decentralized and reformed to remove the cumbersome claim procedure associated with reimbursements. We must enact, the National Health Insurance Act, which will regulate players in the health insurance sector contrary to the current practice where Health Management Organizations operate under the Ministry of Finance like other companies providing general insurance.

The NHIF should be restructured to improve efficiency in resource mobilization. Utilization ratio of 22% is grossly inadequate and the 25% expenditure on administrative costs unacceptable and so is the high annual investment portfolio, which places funds in projects which have nothing to do with health. Section 34 of the NHIF Act should be repealed. Any surplus funds should be utilized in enhancing health benefits and/or increasing the scope of coverage. Health insurance organizations in some of the Asian countries visited attained a utilization ratio of 70%. The Fund, in collaboration with the MOH and the local authorities must have a clear policy of providing subsidy to the poor.

The NHIF must also develop and market different health insurance packages to attract more members and enhance its benefits.

d) The government must encourage employer/employee schemes in the private health insurance sector.