

## 20 Health insurance schemes in Asia<sup>3</sup>

Korea, Thailand, and the Philippines offer a host of experiences that Yemen could benefit from. In the following we will try to learn some lessons from countries that introduced or expanded social health insurance, recently. Only such countries will be dealt with that the author of this report had a chance to study details of the social health insurance there. More details can be found in the literature or through the authors of this report.

### 20.1 South Korea

In South Korea universal social health insurance coverage was achieved during a bit more than a decade.

Table 1: The development of health insurance in South Korea

1976	–	Health Insurance Law as social part of fourth 5-year plan
	–	Mandatory insurance in corporations > 500 employees
	–	Medical programme for the poor
1979	–	Extension to government employees and teachers
	–	Mandatory insurance in corporations > 300 employees
1981	–	Mandatory insurance for industrial workers in firms > 100 employees
	–	Pilot program for self-employed in 3 rural areas
1982	–	Pilot program for self-employed in 1 urban and 2 rural areas
1983	–	Mandatory insurance for industrial workers in firms > 16 employees
1988	–	Mandatory insurance for industrial workers in firms > 5 employees
	–	Inclusion of all rural self-employed
1989	–	Inclusion of all urban self-employed
Source: Soonman Kwon (2002): Achieving health insurance for all: Lessons from the Republic of Korea. Geneva (ILO)		

Main aspects and problems of this expansion strategy included:

- Evaluation in the 70s showed that North Korea had a better health system, presumably
- Former militaries as presidential candidates tried to get support from voters
- Economic progress in the 70s and booming economy in the 80s
- Contribution based system shifted the burden away from government
- Very low contributions and benefits
- Self-employed could pay and government could subsidize but physicians charged self-employed higher than insured; therefore there was an opposition from self-employed regarding contribution assessment, low availability of providers, etc.
- Government raised consequently the subsidy from 33% to 50% for self-employed
- Government decreased, later on, considerably the subsidies to regional societies for self-employed in spite of the fact that the self-employed had higher contributions than others until 1999
- Corporations wanted to keep influence in their insurances; they opted for the pluralistic approach
- Self-governance and self-financing shifted burden away from government
- There was never a competition between insurance societies and small insurances had no bargaining power
- Health insurances were mere financial intermediaries

<sup>3</sup> Written by Detlef Schwefel

- Very low contributions (e.g. 1993 / 1999)
  - Government employees & teachers 3.8% / 5.6%
  - Industrial employees 3.1% / 3.8%
- Heavy co-payments: 20% in case of inpatient care, 55% for outpatient care in general hospitals, 100% for the many not insured (modern) services
- Benefits did not differ, since 2000 no ceilings but small benefits
- Health care financing in 1997
  - 42% by health insurance
  - 48% out of pocket payments
  - 10% other sources
- Questionable „social“ health insurance: higher contributions needed and higher benefits needed
- Theoretical options
  - Catastrophic illnesses covered
  - High cost-sharing for minor diseases
  - Only cost-effective interventions
- All three types of health insurances experienced deficits since 1997 because of
  - Ageing population
  - Sophisticated hospital care
  - High cost increases for drugs and medical supplies
  - Perverse financial incentives for providers, e.g. physicians prescribed AND dispensed
  - Small regional insurances with old and decreasing population
  - Self-governance did not work since CEOs were appointed politically and heavy central regulations were prevailing
  - High administrative costs in self-employed insurances
- Health care cost inflation and fiscal insolvency
  - Consequences of the bankruptcy
    - 1998: merger of government & teachers insurance with self-employed insurances
    - 2000: merger with industrial workers insurances
  - Single insurance society
    - 2003: all funds will merge
  - Just one health insurance payer will be the result.

## 20.2 Philippines

In the Philippines 1995 a National Health Insurance bill was introduced. It foresaw mainly the following components:

- Merger of existing formal insurances for private employees and government employees
- Indigency programme for up to 25%
- Insurance for the self-employed as national priority
- Accreditation of provincial and community-based micro-insurances (planned)

It achieved the following:

Table 2: Social health insurance coverage, Philippines, 2003

	Beneficiaries	Percentage
Private employees	20.767.114	55,4
Government employees	8.948.003	23,9
Indigents	2.847.464	7,6
Self-employed	4.181.648	11,2
Non paying	716.172	1,9
Total beneficiaries	37.460.401	100
Total population	77.925.894	
Beneficiaries as % of total population		48,07

The Philippines Health Insurance Corporation (PHIC) provides social health insurance under three main programmes: the Employed Program (EP), the Individually Paying Program (IPP) and the Indigent Program (IP). The EP is mandatory for all private and public employees, premia being 2.5% of income with a calculation salary ceiling of PhP120,000. While the PHIC Board has recently approved an increase in the income ceiling for premium calculations to PhP180,000, the level of contributions remains low by international standards and the low salary ceiling renders the schemes regressive and limits the potential for cross subsidisation within the scheme. PHIC operating expenses are limited to 12% of the premia collected, but are a higher percentage of the benefits due to the limited benefits payments made under the programmes. Figures for 2001 and 2002 indicate benefits payments of 74% and 70% of the premia collected respectively, and with PHIC operating expenses included total costs were 84% and 80%. Thus, the funds under PHIC control continue to accumulate.

### 20.3 Thailand

Thailand was a typical example of health insurances of a developing country, in 1987, when I first came into contact with social health insurance, there:

- a. health insurance for government officials and employees of state enterprises
- b. workmen's compensation scheme
- c. fringe benefit schemes of private companies
- d. other schemes of privileges, e.g. for monks
- e. free medical care programme for the poor.

The following tables present health insurance development and coverage in Thailand until the turn for the century.

Table 3 Health Insurance Development in Thailand

Health insurance scheme	Coverage, percent						
	1991	1992	1995	1997	1998	1999	2000
1. Medical care for the poor and the socially supported (underprivileged) groups	16.6	35.9	43.9	44.7	45.1	42.1	40.8
- The poor	16.3	20.7	15.5	13.4	13.5	10.5	10.6
- The elderly	-	6.2	4.6	4.9	5.5	6.4	6.4
- Children aged 0-5	-	-	7.1	7.3	7.3	-	-
- Primary and secondary schoolchildren	-	9.0	8.9	11.1	11.1	20.1	17.2
- War veterans	0.3	-	0.4	0.3	0.3	0.2	0.3
- Community leaders and schoolchildren	-	-	5.0	5.4	5.4	4.4	5.8
- The disabled	-	-	1.8	1.8	1.5	0.3	0.3
- Buddhist monks and novices	-	-	0.6	0.5	0.5	0.2	0.2
2. Medical services for civil servants and state enterprise employees	10.2	11.3	11.0	10.8	10.8	10.8	12.0
- Civil servants and family members	8.7	9.9	9.6	9.4	9.4	9.4	-
- State enterprise employees and family members	1.5	1.4	1.4	1.4	1.4	1.4	-
3. Compulsory health insurance	3.2	4.4	7.3	7.6	8.5	9.2	9.4
- Social security fund	-	4.4	7.3	7.6	8.5	9.2	9.4
- Workmen's compensation fund	3.2	-	-	-	-	-	-
4. Voluntary health insurance	2.9	3.9	9.8	15.3	15.9	15.8	17.5
- MoPH health insurance	1.7	2.3	7.8	13.3	13.9	13.8	14.2
- Private health insurance	1.2	1.6	2.0	2.0	2.0	2.0	3.3
Total : people with health insurance	32.9	55.5	72.0	78.4	80.3	77.9	79.7
Total : people without health insurance	67.1	45.5	28.0	21.6	19.7	22.1	20.3

- Source:**
1. For 1991, a survey conducted by the National Statistical Office, 1991.
  2. For 1992, Viroj Tangcharoensathien and Anuwat Supachutikul, 1993.
  3. For 1995, 1997 and 1998, Health Insurance Office, MoPH.
  4. For 2000, data for September 2000, coverage 81.58%.

Source: *Wibulpolprasert, Suwit Mobilization of Domestic Resources for Essential Drugs in Developing Countries: Case Study from Thailand*. Internet paper discovered 20.10.02

Table 4: Health insurance coverage in Thailand

Scheme	Coverage		Expenditure (Baht)			Premium	Payment	Health service	Drug
	Pop. (million)	Percent	Billion	% NHE	Per cap. (\$US)	(source of funds)	Mechanism	utilization	user
Social welfare	27.5	45.1	18.3	6.5	667 <sup>(2)</sup> (17)	Tax	Global budget	Assigned public+referral	ED <sup>(3)</sup>
CSMBS (civil servants)	6.6	10.8	16.4	5.8	2,491 (62)	Tax	Fee-for-service	Public	ED
Social security	5.2	8.5	7.6	2.7	1,468 (37)	4.5% payroll <sup>(3)</sup>	Prepaid capitation	Public & private	ED
Voluntary public health insurance (Health card)	8.5	13.9	6.4	2.3	750 <sup>(2)</sup> (19)	500\$/family +Tax (1,000)	Global budget based on OP&IP	Assigned public+referral	ED
Voluntary private health insurance	1.2	2.0	3.6	1.3	3,000 (75)	Varied	Fee-for-service	Public & private	No limit
Workmen's Comp. fund	5.2	8.5	1.6	0.6	308 (7.7)	0.2-3.0% payroll <sup>(4)</sup>	Fee-for-service	Public & private	
Car Accident	61.0	100.0	1.5	0.5	-	Private	Fee-for-service	Public & private	
<b>Total</b>	<b>49.0<sup>(1)</sup></b>	<b>80.3<sup>(1)</sup></b>	<b>55.4</b>	<b>19.7</b>	<b>1,067<sup>(1)</sup></b>	-	-	-	-

NB. (1) Excluding Workmen's Compensation Fund and motor vehicle accident insurance.

(2) Cross-subsidization added.

(3) 1.5% of payroll each from employers, employees, and government.

(4) Rate according to past history of claims.

ED = Essential Drugs

1 US\$ = 40 Baht

Source: Modified from Wibulpolprasert S, et al., 1998 <sup>(4)</sup>.

Details can be found in the literature or with the author of this report. A very intriguing component of the health insurance schemes in Thailand is the so called Health Card Programme. It started as a voluntary scheme of promoting maternal and primary health care for self-employed farmers. Now it is one of the internationally most interesting programmes for poor self-employed and is getting subsidies from the government so that no more ceilings are being used for the provision of health care. Some aspects on the situation in 1987 for the health card programme:

- Pre-payment scheme for public health facilities with faster services, better services, good referrals instead of uncertain user fees for rural communities
- (Pre)Payment for one year service
- Individual and family memberships in case that certain percentage of villagers join
- Up to six illness episodes per family covered
- Chronic disease conditions excluded
- Strict referral requirements
- Service privileges in a 'green channel'
- Cost ceilings for illness episodes (about 6x premium)
- Drug discounts of 10% beyond the ceilings
- Subsidized by the public sector
- Part of the income can be spend for village issues

This scheme is now integrated into the national health insurance. Still, it is a voluntary health insurance for self-employed, mainly, to provide security to the people and to cover all services of the public sector. It is now working in 68 provinces and covers 20% of the population or 21% of the households. Families with 5 and less members pay 20\$ per year. Government subsidy amounts to 20\$ per year, too. There e is not any more a limit for using the card. Health service units receive 80% of the funds. 20% is for incentives and administration.

In 2001 this programme was overruled by the so-called 30 Baht "universal access" policy which gives everybody who is not insured all needed health care if a small flat rate of about 0.75 US\$ is paid per illness episode. Government subsidises this programme heavily by different capitation rates for outpatient care, inpatient care, catastrophic care, etc. Eligibles must get an identification card to access the benefits of this scheme.

## 20.4 Pro-poor programmes

All countries in South-East Asia do have indigency programmes or specific programmes for enrolling the poor into health insurances:

- Thailand – more than 40%
- Philippines – up to 25%, according to the law
- India – it is a special sector of health care
- Nepal – more than 80% of the population; for them a drug programme is being developed
- Korea – included since the beginning.

Means testing is being done differently

- the poor mans programme in Thailand uses a rather arbitrary wealth ranking
- the indigency programme in the Philippines uses a certification by communities
- the beneficiaries programme in Colombia is based on a sophisticated questionnaire approach

## 21. Health insurance schemes in Latin America<sup>4</sup>

Chile, Paraguay, and El Salvador offer a host of experiences that Yemen could benefit from. In the following we will try to learn some lessons from countries that have partly introduced and expanded social health insurance, recently. Only such countries will be dealt with that the author of this report had a chance to study details of the social health insurance there. More details can be found in the literature or through the authors of this report.

### 21.1 Chile

Chile is generally known as a typical example of market-driven health sector reforms, and not as a representative of recent social health insurance implementation or reform. However, the South American country has a long and relatively successful history of social health insurance that is worth to take in account. Concerning more recent experiences, Chile can offer a series of interesting conclusions with regard to privatisation of health care and the implementation of universal coverage based on mixed financing, targeting and exemptions.

Since its market-oriented social sector reform in 1981, Chile is generally considered the prototype of privatisation of health care. In fact, the intention was to re-organise the widely state-run system in a way that allowed for an increasing relevance of private insurers and providers. The reform was realised under the conditions of a military dictatorship where political opposition against the radical re-structuring of the whole social sector was inexistent. However, reality defeated the ideology-driven attempt to shift health care from public to private responsibility. Even in times of robust economic growth and relative welfare in the late nineties, affiliation to private health insurance companies (ISAPREs) never exceeded one third of the population. Due to economic recession, the proportion of privately insured Chileans is currently below 20 %.

#### **Privatisation of Social Protection– a pathway to extending coverage?**

In theory, all citizens have the freedom of choice between FONASA and an ISAPRE. The latter, however, can select their enrollees according to economic capacity because affiliation to an ISAPRE is not comprehensive while FONASA has to enrol any person who requires it. The entrepreneurial logic forces for-profit insurance companies to make sure that the expected expenditure for services do not exceed the income from premiums (van de Ven 2001). In a social security system with externally fixed premium rates (7 % of the taxable salary) the need to generate profits limits *a priori* the target segment of private enterprises to the population with higher relative income (Valenzuela 1998). This makes the public health insurance act as the last resort for the citizens.

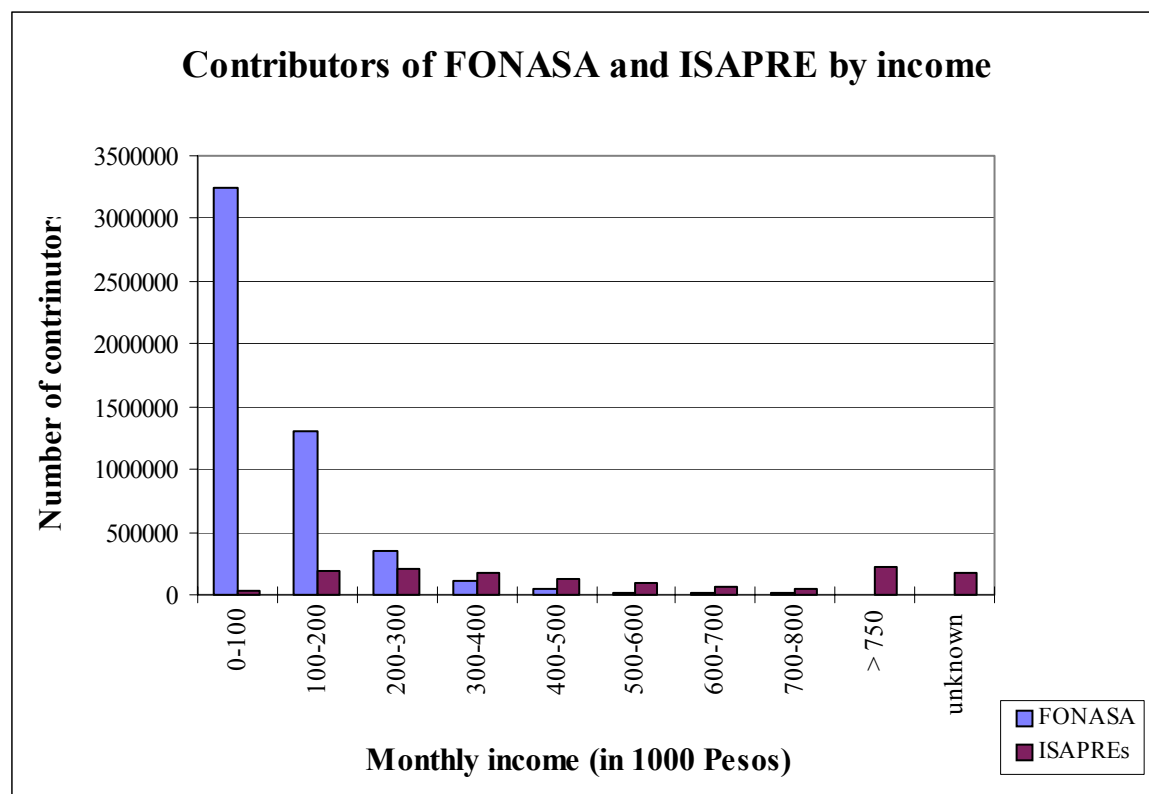
#### **Market-oriented health care reform - shift towards risk and income selection**

In Chile, customers are allowed to change the insurance company after a minimum period of 12 or 24 months. On the other hand, ISAPREs have the right to "adjust" their health plans to the general economic condition and to the current individual situation of the contributor and his dependants. By this, the reformers wanted to give the customers the possibility to induce an effective competition on the health insurance market by opting out in case of being unsatisfied. Due to the horizontal permeability of the dual system, however, the short-term conditions of private health plans question seriously the sustainability of social protection in Chile. As private health insurance companies in Chile concentrate on the healthier and the better-off, they induce a strong risk and income selection what has relevant effects on the efficiency of the overall system. In fact, in 2000 nine out of ten -contributing FONASA-enrolees earned less than 400 US-\$ per month, and the income of two out of three members was even below 200 US-\$ (Holst 2004c, p. 272).

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<sup>4</sup> Written by Jens Holst

The serious equity and fairness problems the Chilean health care system depicts are mainly attributable to risk selection applied by the private insurance companies. Chilean legislation and regulation give them broad options to avoid the affiliation of poorer and even to get rid of older enrollees before they start presenting higher risks. The co-existence of a solidarity-driven public sector and a for-profit private sector operating with risk-adjusted premiums has led to a two-tier health insurance system (Holst 2004c, p. 271). Additionally, the exogenous, wage-related fixation of contributions forces private insurers who work according to the equivalence principle to apply hyper-regressive user fees on the expenditure side: The lower the incomes, the higher the average burden of cost sharing, while the better off are free from relevant co-payments (Holst 2004c, p. 278f). The following Figure illustrates the degree of *cream skimming*:



Source: Data of the Study Department of FONASA from January 25 of 2000; Superintendencia de Instituciones de Salud Previsional. Statistical Bulletin January-December 1999 and January-December 2000. Santiago 2000/2001.

More than 20 years after the wide reaching sector reform, the results are relatively far away from the initial intentions. The pretended extension of private health care and financing has not been achieved, and more than two thirds of the citizens of the South American country still depend on the public services.<sup>5</sup> Evidence shows that efficiency gains are to be located rather in the National Health Fund (FONASA) than in the private health care sector (Liebig 2000, p. 120f). During the last fifteen years since the end of the military regime, the democratic governments have invested heavily in public service. At the same time, FONASA underwent a series of internal reforms and a re-structuring of its functions.

A major problem affecting overall efficiency as well as cost containment of health care in Chile is the far going segmentation of the system. Organisational and financial relationships between public and private sector are incipient and weak. In case ISAPRE beneficiaries receive treatment in public hospitals, the latter have little chance to charge the insurance company for the benefits granted. On the other hand, contributing FONASA beneficiaries have the chance to use some private providers only in

<sup>5</sup> About 10 % of the population rely on the autonomous insurance schemes run by the armed forces including the police, the large universities and some public enterprises as the national copper industry CODELCO, and others (Holst 2001, p. 19, 79).

case they are willing and able to shoulder relevant co-payments. The most dramatic consequences of the separation between both sectors have been overcome due to the legal obligation for all providers to give emergency care to every patient, whatever his insurance situation is. The interaction between FONASA and ISAPREs, however, is still limited and more or less casual, except the recently implemented catastrophic insurance for ISAPRE beneficiaries. Facing the real costs of complex and cost-intensive care, the private insurance companies decided to sacrifice one of their crucial reasons of being. The freedom of choice has always been a key argument for the private health care sector. But for receiving medical care according to the catastrophic insurance implemented in both sub-sectors, in most cases ISAPRE beneficiaries are entitled in public hospitals only.

### **Linking up taxes and contributions**

Achieving universal coverage is one of the major challenges in most developing countries. Whilst most analysts are focussing upon the effects of privatisation and competition in health financing, another fundamental lesson learned from Chile is generally under-represented in the current debate. Today, however, it is also one of the very few countries in Latin America that provide practically universal coverage in health. This has become possible due to the combination of the Bismarck- and the Beveridge-system. The formal economy and parts of the informal sector are counting for a contribution-based insurance system. The poor are protected by a tax-financed welfare system administered by the same public social health insurance FONASA. Both public sub-systems are solidarity-driven and their combination guarantees for progressive financing and effective redistribution in the public health care sector (Bitrán 2003, p. 62). A set of waivers and exemptions within the public system is diminishing the negative social effects and the discrimination produced by out-of-pocket payments. Altogether, under the roof of FONASA an effective linkage of contributing and non-contributing members has been implemented and continuously managed.

### **Conclusions for Yemen**

1. Universal coverage is possible.
2. Segmented health systems – state-run, social health insurance and private – are inefficient.
3. Private insurance and insurance markets need strong and effective regulation.
4. The poor have to be covered without discrimination.
5. Linking tax-financing for the poor with national health insurance is possible.
6. Good exemption mechanisms are necessary to protect people from impoverishment.

## **21.2 Paraguay**

Being the poorest country in the South American economic block Mercosur, Paraguay's health care system is in a deploring state and presents a series of typical patterns of a developing country. At the same time, it is facing the challenges of good governance, economic growth and poverty reduction that include better access to quality health care for the population.

### **Country context and background information**

Paraguay is one of the least developed countries in Latin America. Almost 50 % of the population is still living in rural areas, and generally it stands out as a country with little economic growth and high poverty. Its epidemiological profile shows the typical transition of developing countries that combine elevated rates of infectious and parasite diseases with an increasing prevalence of chronic-degenerative diseases, cancer and accidents. One and a half decades after the end of the Strössner dictatorship, political institutions are still weak, and the implementation of democratic and participative social structures is advancing slowly. The access to social protection is limited to a minority of the better off and mostly concentrated in urban areas.

Recent research has revealed that only one out of eight Paraguayans is contributing to some kind of pension fund, and just about 20 % of the population is counting with some kind of health insurance.

Thus, social exclusion in a generally poor, and the recessive socio-economic surrounding is a major problem in a country with a high prevalence of corruption and a practically inexistent experience of good governance. On the other hand, the current Paraguayan situation offers special conditions to prove that the difficult task to consolidate the economic development by a progressive extension of social protection is not only possible. It is even more because extending coverage appears to be a promising approach towards economic growth and poverty reduction (World Bank 2002b, p. 8).

### **Potential for extension of social protection coverage**

The Paraguayan health care system is a mosaic of public entities and private for-profit and not for-profit organisations.<sup>6</sup> The diversity of actors is accompanied by a lack of institutional coordination between the different sectors. In some communities, health care services are completely missing while in other geographic areas the duplication of responsibilities is inducing an unnecessary competition between medical providers. The segregation of both the health insurance and the health care provision sector reduces the effectiveness of the overall system performance.

Private out-of-pocket-expenditure is high and affects severely household income of the poor, one typical indicator for a lack of fairness and effectiveness. Though public spending in health is very low, even compared to other countries in the region, the public health care system shoulders the health care provision of the majority. The Ministry of Health and Social Welfare provides and finances a network of public facilities for the poor population, and the National University offers low-cost treatment for the worse-off. The Social Security Institute (Instituto de Previsión Social—IPS), that combines health and pension insurance, is limited to the formal sector except civil servants who are obliged to contract a private insurance policy. Up to now, the medical service of the army and the police is exclusively restricted to the members of the armed forces and their families, as it is the insurance schemes of the bi-national power-plant enterprise of Itaipú.

### **Roads taken towards extension of social protection**

Since 2001, the Paraguayan health ministry is organising a regional health insurance scheme in the rural department of Caazapá (Seguro Integral de Salud Caazapá - SI). Focussing firstly on young mothers and children up to five years, the SI represents an important effort to introduce public insurance in the Caazapá hospital as well as in the citizen's mentality. First steps towards the inclusion of first level providers in the department have been undertaken recently. If extension of the coverage by the scheme is wished, contracting of additional public and also private facilities will be unavoidable for guaranteeing overall access and adequate services to the beneficiaries.

In the East-Paraguayan department of Itapúa, the relatively affluent community of Fram built a communitarian insurance scheme (Seguro Comunitario de Salud de Fram) in order to make the services granted in the local health post available and affordable for the poorer citizens. Different from the Caazapá experience where the solidarity principle is implemented in a rudimentary way, the Fram scheme applies the equivalence principle offering different packages according to the contribution. The communitarian insurance has implemented an interesting system to measure income and contracts with several providers in and outside the village.

A series of urban and rural communities, mainly in the above mentioned department of Itapúa, have organised Social Pharmacies (Farmacias Sociales) in order to provide less expensive drugs to the poor. In spite of some problems and a large variability of experiences, in today's Paraguay these drug programs represent an important low-level approach to improve access to affordable health care. And they can transform into a starting point for the implementation of more sophisticated pre-payment schemes.

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<sup>6</sup> The Ministry of Public Health and Social Welfare, the Social Providence Institute (IPS), the National University and the Military and Police Health System coexist with a series of private for-profit insurance companies, physician practices and clinics, with private or cooperative non for-profit providers like charitable hospitals and others.

A number of private insurance companies and other health financing organisations complete the fragmented scenario of the Paraguayan health care system. Most of the private insurers called Prepaid Medicine (*Medicina Prepaga*) and covering one third of the insured Paraguayans - namely 7 % of the whole population - offer a reduced benefit package with many exclusions and limitations. With the exception of very few cases, private insurance companies are not pretending to link up with other health care and even less with other health financing institutions. Many of the Prepaid Medicine enterprises are facing serious economic problems, and their potential to contribute to universal coverage is low.

### **Reaching out to the informal sector: concrete examples**

Other schemes were implemented by health care providers with charitable goals in order to assure affordability for their clients and their own financial sustainability.<sup>7</sup> In this respect the project of the Paraguayan Trade Union Confederation to offer health care for their members is worth noticing because their project tries to make use of underemployed infrastructure by overcoming traditional social separation. The Health Service of the Trade Union Confederation (*Servicio de salud de la Confederación Paraguaya de Trabajadores*) to be implemented will establish a co-operation with the military health sector. As the armed forces still run an over-dimensioned network of health care services, some trade-unionists established negotiations with several facilities, mainly in the capital of Asunción, to find a way to assure adequate treatment of the workers and their families.

The wide reaching lack of quality health care is leading to an outbreak of alternative health care financing mechanisms on a regional, local, cooperative or enterprise level. Especially the growing cooperative movement in Paraguay offers a wide range of health care financing approaches based on risk sharing, mutual aid and solidarity mechanisms. A recent field research carried out by the GTZ-project PLANDES in Paraguay with technical support by the Sector Project „Social Health Insurance“ revealed an impressive variety of small-scale social security schemes in different parts of the country. Obviously, the lack of coverage has driven an increasing number of Paraguayan citizens to look for alternative social protection mechanisms in order to face typical life and especially health risks. The schemes show a huge variety concerning lifetime, experience, coverage, benefits and other essential aspects of health insurance, but all of them are worth to be taken into account if universal coverage is defined as a goal of social policy (Holst 2004a, p. 34, 39).

### **Co-operative movement**

Recent developments of the Paraguayan co-operative movement were widely unknown until the aforementioned GTZ-study showed a surprisingly high number and a large variety of health care financing mechanisms organised and partly implemented by various co-operatives all over the country. This group of health insurance schemes is playing an increasingly important role in economic and social life. As governance, stewardship and political reliance are weak and corruption is omnipresent in the South American country, about 650.000 persons are linked directly and about one out of three Paraguayans indirectly to one of more than 700 cooperative organisations.<sup>8</sup> The economic and financial relevance and the high organisation level make the co-operative movement a promising counterpart for the extension of social protection in health.

According to the obvious differences of size, activity and performance of co-operative organisations, their health insurance schemes show a broad variability. Depending on the economic activity and financial situation, some of them are implementing modest packages of health care services while others offer a plan that covers a wide range of benefits, in some cases including complex or intensive care unit treatment. Undoubtedly, the increasing coverage of co-operative members and their families will induce a growing demand of health care services. That raises the necessity to establish links and to regulate the relationship between different actors within and, in the medium term, also outside the

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<sup>7</sup> Namely the *Servicio de salud integral El Buen Samaritano S.A.* and the *Servicio médico San Cristóbal* are philanthropic health care financing and providing organisations, though the latter is limited to co-operative members.

<sup>8</sup> At the same time, co-operatives assets were estimated around 1 billion Euro ( $\approx$  1.500 € pro member), and their savings depot of 180 million Euro represents 11 % of national savings.

single organisations. Thus, the co-operative confederations face the challenge to create a support unit for consultancy, technical advice, management of knowledge and interchange of experience, and they could even organise a reinsurance structure in order to achieve better financial stability and sustainability of the schemes in a generally regressive macro-economic situation (Holst 2004a, p. 30f).

The need for implementing health insurance derives either from the wish to achieve access to affordable and quality health care for associated members or from the interest to guarantee financial viability of existing health care providers run by a co-operative. The dual motivation is reflected in two different types of insurance schemes within the emerging or existing funds: Some of them are acting as mutual health organisations or as “classical” insurance organisations contracting independent providers and focussing on the affordability of health care, while others are implemented by providers and characterised by vertical integration. In some cases, affiliation is mandatory, in other voluntary within the target group. The schemes also show different approaches concerning financing, solidarity mechanisms and redistribution of income. Most of the co-operatives feel hindered by the legal obligation to contribute to the public social security fund IPS in spite of being eligible for alternative social protection schemes.

### **Exceptional schemes**

Until now, only the best-developed social protection scheme implemented by the Mennonite colonies in the Western Chaco region has achieved full independence from the IPS monopoly. Due to the practical inexistence of Paraguayan health care facilities in the area, the 45.000 colonists of German origin started to organise their own network of health care facilities and to implement a sustainable financing system for health and other branches of social insurance. Though the Social Insurance Chaco (SVCh) has a lot of elements that are pretty far away from the Paraguayan value system and reality, the simple fact that it could be established in the South American country shows the wide range of options. The main success of the SVCh on the national level is the acceptance as a fully-fledged social security institution where the members are eligible to opt out of the mandatory affiliation to the IPS. SVCh is a living example of what alternative social protection schemes can achieve if they fulfil a series of conditions and criteria.

Even more relevant for networking and linking-up seems to be the social security scheme created by the Mennonites in Chaco for the original Paraguayan population. In 1987, they started to implement the Mutual Hospital Aid (Ayuda Mutual Hospitalaria, AMH) in order to offer social protection to the indigenous workers and day labourers contracted by the colonists. In case of the formally employed workers in the Mennonite colonies, both the employer and the employed transfer 5 % of the salary to the account of a local health fund. Especially interesting is the approach to extend affiliation to the informal sector. Non-regular workers who subsist as independent farmers are covered by their local AMH health fund contributing 5 % of their irregular income, and the employer transfers another 10 % from his bank account. As long as an independent farmer makes contributions at least once a month, he is entitled to a relatively broad range of primary and hospital health services. The AMH, however, is currently not accredited as a full-cover social insurance institution that allows its members to opt out of the IPS (Holst 2004b, p. 3, 33).

### **Conclusions for Yemen**

1. It is a long way towards universal coverage.
2. Closer collaboration of public and non-public institutions needed.
3. Improvement in public health care provision is of utmost importance.
4. Detection and assessment of all existing health financing schemes is a crucial starting point.
5. Co-ordination of various funds will promote solidarity and equity.
6. Linking up might improve health outcomes.

### 21.3 El Salvador

The smallest Central American country offers an interesting example for a nationwide insurance plan for a specific professional group. Teachers' unconformity with the scope and quality of the social security plan and trade unions' demand for better access to appropriate medical care. In order to calm political protests, the Government initiated the BM in order to improve the accessibility to adequate medical and hospital care for the teachers and their families.

#### **Teachers health insurance Bienestar Magisterial (BM)**

The Salvadorian Ministry of Education started the BM in the late 60ies in order to improve the quality of health care for teachers in public schools. As public sector employees did not have a health insurance, they depended on the health ministry's facilities of generally bad quality. The target group of the BM are exclusively teachers of the public sector and their families. The BM offers a broad, practically integral benefit package for its beneficiaries. Primary health care is offered by hired medical staff only, while for second and third level treatment the enrolees are attended in private and public facilities contracted by the BM. Several cost containment mechanisms are in place, the scheme shows a high flexibility improving performance and efficiency.

Administrative and management tasks and organisation of claim processing and provider payment could be improved, in some aspects the dependence from the education ministry does not facilitate activities, and low prices as well as delay in provider payment has brought up some conflicts in the past. In spite of having in place some very effective mechanisms to control costs and overuse, other areas of health care financing are under a high risk of moral hazard by users and providers. Client information and transparency seems also to be a problem though the general perception of the BM by its beneficiaries is positive.

#### **Special social health insurance scheme**

The Teacher Welfare Insurance in the smallest Central American has had a long development and performance. The insurance plan is directly linked to formal employment, mandatory for a specific professional group and close to integral with regard to the covered health care package. Parity and wage-related contribution (7,5% employer, 3 % employee) as in other social health insurance schemes characterise financing of the BM whose monthly income is of 22 million US-\$, 3 per cent of which is spent for administrative tasks. Undoubtedly, the Bienestar Magisterial (BM) fulfils the relevant criteria of a "traditional" social health insurance like obligatory contracts, mandatory enrolment, wage-related and bipartite contributions, linkage to pension insurance. Thus, it might be considered a formal sector health insurance as such. However, some specific characteristics can justify an analysis of this scheme within a micro-insurance perspective. One important reason is the fact that the BM co-exists with a comprehensive and countrywide social health insurance for formal sector employees (Instituto Salvadoreño de Seguridad Social – ISSS). The relatively small target group of the BM, in connection with the scope of coverage and a series of recent changes in order to compare, allows for a series of conclusions for other health insurance plans covering a specific and limited population share.

Primary health care is offered by contracted medical staff, second and third level treatment is accessible in various private and public facilities contracted by the BM. Several cost containment mechanisms are in place, the scheme shows a high flexibility improving performance and efficiency. However, administrative and management tasks, claim processing and provider payment might be improved. The dependence from the ministry of education affects internal affairs, and low prices as well as delay in provider payment has caused conflicts in the past. In certain areas of health care, moral hazard by users and providers is difficult to control. Client information and transparency is insufficient, but the beneficiaries' general perception is positive.

**Conclusions for Yemen**

1. Government initiatives towards social health insurance can work out.
2. Special professional groups can take leadership in social security.
3. Teachers belong to the most active groups with regard to health insurance.
4. Administration and adequate management are crucial for health insurance.
5. Claim processing and provider payment are relevant for cost-containment.

## 22 Health insurance schemes in MENA region

The experiences with social health insurance of two other countries in the MENA region provide interesting examples for existing schemes on a national level in countries, which have many similarities with the Republic in Yemen – notably concerning culture, religion, language, a colonial past, and armed conflict in recent decades: Egypt and Algeria.

### 22.1. Egypt<sup>9</sup>

Egypt has a complex health system, with many different public and private providers and financing agents (Gericke 2004). There are four main financing agents: i) the government sector which is understood in Egypt to refer to the various ministries and departments of the government (Rannan-Eliya et al 1998); ii) the public sector, consisting of financially autonomous organisations owned by the government, the largest being the Health Insurance Organisation (HIO) and Curative Care Organisations (CCO); iii) private organisations, like private insurance companies, unions, professional organisations, and nonprofit NGOs; and iv) households (Rannan-Eliya et al 1998). Health care providers in the government sector are the Ministry of Health (MOPH&P), teaching and university hospitals, HIO, and the Ministries of Interior and Defence. Public providers are HIO, CCO, and other public firms. The private sector consists of both nonprofit and profit providers, such as private clinics, hospitals and pharmacies (Rannan-Eliya et al 1998). NGOs are currently one of the fastest growing sectors (Rafeh 1997).

In the Egyptian financial year 1995, health spending totalled E£7.5 billion or 3.7% of GDP, equivalent to E£127 (US\$38) per capita (Rannan-Eliya et al 1998). Public financing, mainly from general taxation, contributed 1.6%, private financing 2.1% of GDP (Rannan-Eliya et al 1998). In 1999 government revenues totalled 23.6% of GDP. Central tax revenues accounted for 15.6%, transferred profits for 3.2% and other, not-tax revenues for 1.8%. Local revenues accounted for 2.9%. Since 1994 total revenues have decreased steadily from 30% of GDP, and tax revenues from 17.9%, respectively (Ministry of Economy 2000).

Social insurance, which accounted for 18% of public funding (Rannan-Eliya et al 1998), is mandatory for formal government and company employees, who contribute 0.5 and 1% of their base salary, and their employers 1.5 and 3%, respectively (Rafeh 1997). 5% of funding was raised by firms, private insurance and syndicates, and 51% were spent by households (Rannan-Eliya et al 1998). Sources of finance are summarised in Table 1.

Source of Finance	Percent of Total Health Revenues
Households	51
Ministry of Finance	35
Social insurance contributions	6
Firms	5
Foreign donors	3

Source: (Rannan-Eliya et al 1998)

Despite the radical economic policy shift that has occurred during the 1990s, there has been little change in the overall financing and structure of the health system since 1991. The only notable

<sup>9</sup> Written by Christian Gericke

changes were the expansion of social insurance coverage to 10 million schoolchildren in 1993 (Rafeh 1997), and an increase in total health spending from 3.4 to 3.7 of GDP (Rannan-Eliya et al 1998).

Some issues were apparent regarding the social health insurance schemes in Egypt (Gericke 2004):

- The separate provision of services for SHI insured and associated privileges should be discontinued since they decrease the solidarity of the overall scheme.
- The current policy to allow companies to opt out of the social insurance scheme should be discontinued.
- In order to maintain the better-off contributors in the public financing scheme, only a complementary voluntary insurance should be permitted and substitutive voluntary health insurance schemes should be discouraged.

## 22.2. Algeria<sup>10</sup>

Algeria's health services are partially financed from the state budget, from a social health insurance scheme (Caisse Nationale des Assurances Sociales) and from out-of-pocket payments. In 1998, Algeria spent 3.6% of its GDP on health, down from 6% in the 1980s and 4.6% in 1993 (Ministère de la Santé, de la Population et de la Réforme Hospitalière 2004). The funding for health from the general government budget has decreased dramatically from 3.6% of GDP in 1987 to 1.6% in 2002. This decrease together with a strong population growth has resulted in a decrease of the expenditure on health from US\$ 165 per capita and year in 1990 to US\$ 58 in 2002. About 1% of GDP comes from the social health insurance scheme, another 1% from out-of-pocket expenditures by households. Public expenditure defined as a percentage of total expenditures on health totalled 72% - combining funding from the general budget and social health contributions by employers and employees. The ministry has only little information about expenditures in the private sector. A major problem now is that because of the decrease in funding from the general budget, social health insurance funds are increasingly used to cross-subsidise health care for non-insured populations, which in turn leads to decreased access and quality for the SHI insured. This is clearly not sustainable and points to one of the problems of having parallel SHI and general tax funded sub-systems.

## 22.3 Syria<sup>11</sup>

On November 12, 2003, a new health insurance law was proposed by the Minister of Health. This law proposes to establish a National Health Insurance Organization and its regional offices in the governorates. The National Health Insurance Organization will buy or provide diagnostic, curative, rehabilitative and preventive services. Beneficiaries include all subscribers from the private and public sectors. The contribution rate of the employees or workers should not exceed 3% of the salaries; the employer will have to share 6%. This framework law supersedes the health insurance law of 1979, which was never implemented.

This law has to be seen in the context of an already existing social security related law on old age, disability, death, labour injuries and accidents. The work accidents scheme asks for a contribution rate of 3%. The contribution rates for the old age, disability and death insurance are 7% for the workers or employees and 14% for the employers. This scheme covers private and public employers with 5 or more employees. Below this ceiling there is a 2% salary deduction just for disability and death but not for retirement. The aforementioned schemes plus the new health insurance will absorb 33% of the salaries or wages.

Currently there are only three types of health benefit of health insurance schemes existing in Syria.

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<sup>10</sup> Written by Christian Gericke

<sup>11</sup> Written by Detlef Schwefel

- Many government administrations give health benefits to their employees. In 2000, 50% of the employees enjoyed these schemes that are very different from ministry to ministry. The cost is 82 € per employee and year and it covers mostly family members, too.
- Some public companies, like Damascus Electricity Company, provide good benefit packages to their employees sometimes even without asking them for nominal contributions.
- Some professional group formed health insurances, especially teachers, workers unions, dentists.

The following table gives detailed information on five schemes that were described with InfoSure methodology, supported by the Health Sector Modernisation Programme of the European Union.

### Characteristics of five health benefit and health insurance schemes in Syria

Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health
<b>1</b>	<b>Setting up the scheme</b>						
1.1	Set-up period	Year of decision	1970	1965	1975	1975	2000
		Year of first contributions	1970	1965	1980	1975	2000
		Year of first benefits	1970	1965	1980	1975	2000
1.2	What kind of need/ problem led to the creation of the scheme?	Ability to pay					
		Dissatisfaction with existing scheme					
		Poor quality of care					
		Unstable/low salaries of health workers					
		Political motivation					
		Commercial interests					
		Problems of providers with payments					
		Consumer empowerment					
		Other: Doctors not only working in hospitals					
1.3	Role of external stakeholders	Initiative or Support	I S	I S	I S	I S	I S
		Leader, pioneer					
		Healthcare provider					
		Community, association, ..					
		Government					
		Private insurance company					
		Religious communities					
		Trade union					
		Dev. agency					
		Researcher					
		Employer					
		Donors, sponsors					
		NGO					
		Private enterprise					
		No support					
		other					
1.4	What kind of support was given?	Financial support / Technical assistance and Training / Administrative Logistics Support	F T A	F T A	F T A	F T A	F T A
		Donors, sponsors					
		Government					
		Health insurance					
		NGOs					
		Health research inst.					
		Private enterprise					
		Other: own support					

Questions		Multiple-choice answers	Ministry Trans- port	Teachers Associ- ation	Workers Union	Dental Associ- ation	Ministry of Health
1.5	Who participated in the decision-making process?	Providers					
		Community, association, cooperative, village					
		Churches and religious communities					
		Trade unions					
		Government					
		Private insurance company					
		Development agency					
		Research institution					
		Employer					
		Other					
1.6	What preparation / investigation was carried out (feasibility studies)?	Economic situation of target group					
		Willingness to pay					
		Understanding of insurance					
		Existing solidarity mechanisms					
		Social environment					
		Health situation					
		Perception of health problems					
		Healthcare provider network					
		Utilization of healthcare services					
		Available healthcare services					
		Costs of healthcare services					
		Provider payment					
		Expected costs					
		Expected revenues					
		Infrastructure					
		Legal requirements					
		Available financial services					
Actual							
Other							
No: no study was done							
1.7	Which data was available	Population data of target group					
		Health data of target group					
		Data on cost of services					
		Income data on households/individuals					
		Studies documents on local environment					
		Manuals on insurance in local language					
		Other					
<b>2</b>	<b>Membership</b>						
2.1	What are the target groups?	Entire population of the country					
		Total population of defined region					
		Professional groups					
		Social groups					
		Communities					
		Formally employed					
		Informal workers					
		Employees of enterprises					
		Pensioners					
		Unemployed					
		Poor					
		Dependants					
		Other					
2.2	Were there any groups that were unwanted?	Yes					
		No					

Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health	
2.3	Was there a difference between the initial target group and the members who joined in reality?	No, the expected target group was achieved						
		Yes, expected groups did not join the insurance schemes						
		Yes, unexpected groups joined the insurance scheme						
			Seasonal, engineers		New associations	Retired dentists		
2.4	Exclusivity of membership	No other members than target group						
		Other members are admitted						
		No clear regulation						
2.5	Economic activity of the target groups	Employed with contract						
		Informal (day to day) employment						
		Self-employed, small business, farmers						
		Subsistence farmer						
		Other: all dentists						
2.6	Social and economic characteristics of the target group	Employed in public sectors, mainly. Professional organizations						
2.7	How is membership constituted	Voluntarily						
		Compulsory by law						
		Compulsory by group membership						
		Opting out of social insurance scheme						
		Varies according to the group of members						
		Other: decision of ministry						
2.8	How are members recruited?	No acquisition (compulsory for all members)						
		Through marketing measures						
		Through communities						
		Through enterprises						
		Through providers						
		Through stakeholders						
		Other						
2.9	Contract between member and insurance scheme	There is a written contract						
		There is an informal contract (handshake ...)						
		Other: identification card						
2.10	Unit of subscription	Individual						
		Household, family						
		Enterprises						
		Communities (associations, cooperatives, ...)						
		Other						
2.11	Definition of family members	Max. number of household members covered	all	all	all	0	all	
		Maximal number of spouses covered	1	1	1	0	all	
		Maximal number of children covered	all	all	all	0	6	
		Male spouses covered	0	0	0	0	0	
		Parents covered dependant parents	Dep.	0	Dep.	0	Dep.	
		No clear definition						
		Other						
2.12	Status of family members	No special status of family members						
		Family members pay lower contributions						
		Family members are covered free of charge						
		Family members are not covered at all						
		Other: not covered						



Questions		Multiple-choice answers			Ministry Trans- port	Teachers Associ- ation	Workers Union	Dental Associ- ation	Ministry of Health			
3.2.6	Agency collecting the contributions	Insurance office										
		Other insurance scheme or agency										
		Tax authorities										
		Contracted agencies										
		Banks										
		Post office										
		Health providers										
		Community, cooperative										
		Employer										
		Other: no contributions by members										
Other: association												
3.2.7	Control of contribution payment	Check of receipt upon claim for benefit										
		Check of contribution record										
		Insured person must ask for voucher										
		No control										
		Other: according to branch office										
		Other: no contributions by members										
3.2.8	Measures to enforce contribution payment	Not paying members are excluded										
		If employer do not pay, members are excl.										
		Non-payers or late payers are sued										
		Employers who do not pay are sued										
		Declarations by employers are checked										
		No enforcement										
		Other: can not open dental clinic										
		Other: no benefits after one year										
3.2.9	Period and periodicity of payment	Weekly										
		Monthly										
		Quarterly										
		Seasonal										
		Yearly (TA: for retired)										
		Irregularly										
		Different according to group of members										
		Other										
3.2.10	Exemptions from contributions		exempt	reduced	E	R	E	R	E	R	E	R
		Poor										
		Dependants										
		Children										
		Surviving dependents										
		Senior members										
		Unemployed										
		Chronically ill										
		Handicapped										
		No exemptions										
Other: for retired												
3.3	Co-payments											
3.3.1	Are there any co-payments											



Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health
3.5.3	Source of loan	Ordinary bank					
		Development bank					
		NGO					
		Development agency					
		State					
		Members					
		Employer					
		Other: workers union					
3.5.4	Conditions	To prove solvency					
		To deposit property as security					
		To provide a warrantor					
		Other					
<b>4</b>	<b>Benefits provided by the insurance scheme</b>						
4.1	Definition of benefits	Written standard provisions for benefits					
		If yes: Insured are informed about these					
		If yes: Providers are informed about these					
		There is a margin for case-related decision					
		B are defined by providers case by case					
		Most benefits granted on arbitrary basis					
		B are depending on financial situation					
		Other: according to law					
Other: mutual understanding							
4.2	Access to benefits	Access to defined benefits any time					
		Waiting lists for certain benefits					
		Proof of contributions paid is needed					
		Members have to register with providers					
		Certain b upon referral/approval only					
		In practice some benefits are often denied					
		No equal access for all groups of members					
		Regional disparities in access to benefits					
Other							
4.3	Classification of benefits	Classical insurance (risk sharing)					
		Pre-payment (earmarked saving accounts)					
		Crediting					
		Discount on prices					
		Other					
4.4	Benefit package						
4.4.1	Primary care	Yes					
		No					
		Optional					
4.4.2	Preventive services	Yes					
		No					
		Optional					
4.4.3	Specialist outpatient care	Yes					
		No					
		Optional					
4.4.4	Laboratory services	Yes					
		No					
		Optional					
4.4.5	Diagnostic services	Yes					
		No					
		Optional					

Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health
4.4.6	Hospital care (boarding and lodging)	Yes					
		No					
		Optional					
4.4.7	Hospital care (medical treatment)	Yes					
		No					
		Optional					
4.4.8	Maternity	Yes					
		No: no normal deliveries					
		Optional: complications					
4.4.9	Drugs	Yes					
		No					
		Optional					
4.4.10	Transport	Yes					
		No					
		Optional					
4.4.11	Other benefits	Yes: chronic diseases long term					
		Yes: dental care					
		Optional					
4.5	Excluded benefits	All those not mentioned in the standards					
		Treatment and diagnosis over cost limit					
		Defined treatments and products					
		Treatment of certain diagnoses					
		Pre-existing diseases					
		Other: dental care					
4.6	Relation of benefits provided by other schemes	Better than other schemes					
		Other schemes supplement benefits					
		Competing insurances for same group					
		Not known					
4.7	Financial arrangements						
4.7.1	How are the benefits paid?	In kind					
		Reimbursement of bills					
		Other					
4.7.2	Reimbursement rules	Reimbursement of total cost of bills					
		Reimbursement up to a ceiling					
		If yes: Is fee limited by a fee schedule?					
		Reimbursement above a certain threshold					
		Reimbursement of % of total costs					
4.7.3	Practical problems	No problems with guaranteed benefits					
		Providers complain about payment					
		Members complain about payment					
		Transparency lack of benefit regulations					
		Too generous benefits					
		Unnecessary benefits					
		Lack of provider network					
		Fraud					
		Moral hazard					
Other							
4.7.4	Reasons for the benefit package	Medical and health policy arguments					
		Affordability					
		Availability of services					
		Preferences of the target group					
		Experiences from other schemes					
		Profitability					
		Arbitrary					
		Other					

Questions		Multiple-choice answers	Ministry Trans- port	Teachers Associ- ation	Workers Union	Dental Associ- ation	Ministry of Health
<b>5</b>	<b>Risk management</b>						
5.1	Rules of adhesion	Insurance is compulsory for members					
		Group membership					
		Other					
		Individual voluntary membership					
		If yes: can insurance reject applications? yes					
		no					
		Household membership					
		Different according to group of members					
		Other					
5.2	Administrative risk management	Concentration on low risk groups					
		Exclusion of certain groups of individuals					
		Health questions					
		Exclusion of pre-existing diagnoses					
		No coverage of specific diagnoses (AIDS)					
		Qualifying periods					
		Possibilities to cancel membership					
		Possibility to time-limit membership					
		Other: long lasting utilization/diseases					
		Other: none of those					
5.3	Financial risk management	Reinsurance (e.g. excess loss)					
		External guarantee for some risks (epidemics)					
		If yes: by which organization					
		State					
		NGO					
		Other: own organization					
<b>6</b>	<b>Services</b>						
6.1	Other products offered by the insurance scheme	No other products					
		Sick pay					
		Prevention					
		Pension					
		Funeral benefits					
		Savings					
		Transport of the sick					
		Other: soft loans					
		Other: grants in special cases					
6.2	Information for members	Visits of insurance staff to communities					
		Meetings and public events					
		Leaflets, brochures					
		In the offices of the insurance scheme					
		By providers					
		Other: boards, advertising					
6.3	Decentralised presence	No decentralized presence of scheme					
		Regional (district, village) insur. offices					
		Involvement of insured in administration					
		Agreement with other organization					
		Telephone advise					
		Other					
<b>7</b>	<b>Legal issues, constitution</b>						



Questions		Multiple-choice answers	Ministry Trans- port	Teachers Associ- ation	Workers Union	Dental Associ- ation	Ministry of Health											
7.9	Administrative and organizational structure																	
7.9.1	Internal organization	Nomination of management elections																
		By appointment																
		Any formal requirements for managers: yes																
		No																
		General assembly																
		Council of administration																
		Supervisory board																
		Management board																
		General director																
		No formal regulation																
		Other: integrated in Ministry																
		Other: special commission																
		Other: Office of solidarity fund																
Other: no specific office																		
7.9.2	External organization	Scheme is member of association																
		Is part of a network of insurers																
		Part of an umbrella organization																
		Part of other healthcare organization																
		No external integration																
		Other																
<b>8</b>	<b>Administra- tion</b>																	
8.1	Administrative tasks		Ins.	3P	N/A													
		Registration																
		Contribution collect																
		Claim processing																
		Healthcare provision																
		Contacts with providers																
		Financial management																
		Statistics																
		Controlling																
		Bookkeeping																
		Marketing/recruitment																
Health info & promotion																		
8.2	Administrative methods																	
8.2.1	Registration of members and employers	Computer and software																
		Standard forms																
		Administrative guidelines																
		Other: no regulated methods																
8.2.2	Contribution collection	Computer and software																
		Standard forms																
		Administrative guidelines																
		Other: no regulated methods																
8.2.3	Claim processing	Computer and software																
		Standard forms																
		Administrative guidelines																
		Other: no regulated methods																

Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health		
8.2.4	Healthcare provision, contracts with providers, quality assurance	Computer and software							
		Standard forms							
		Administrative guidelines							
		Other: no regulated methods							
8.2.5	Financial management, financial planning	Computer and software							
		Standard forms							
		Administrative guidelines							
		Other: no regulated methods							
8.2.6	Statistics	Computer and software							
		Standard forms							
		Administrative guidelines							
		Other: no regulated methods							
8.2.7	Controlling	Computer and software							
		Standard forms							
		Administrative guidelines							
		Other: no regulated methods							
8.2.8	Bookkeeping	Computer and software							
		Standard forms							
		Administrative guidelines							
		Other: no regulated methods							
8.3	Administrative infrastructure	<b>data will be provided later</b>							
8.3.1	Human resources	Number of own salaried staff	10	18	?	17	0		
		Number of voluntary workers							
		Staff employed by third party							
		Other							
8.3.2	Offices (including branches)	Property, number of rooms							
		Number of rented rooms							
		Rooms made available by 3 <sup>rd</sup> party							
		Other							
8.3.3	Transport for administrative purposes	Number of cars							
		Number of motorcycle							
		Number of bicycles							
		Public transport							
		Other							
8.3.4	Equipment (functional)	Computers							
		Printers							
		Computer network (LAN)							
		Number of telephone lines							
		In-house telephone network							
		Radio transmitter							
		Number of mobile phones							
		Number of fax machines							
		Copying machines							
		Commercial printing services available							
		E-mail available							
		Internet available							
Other									
8.4	Autonomy of the insurance scheme		Yes	~	No	+ ~ -	+ ~ -	+ ~ -	+ ~ -
		Financial							
		Administrative							
		Benefits							
		Political							

Questions		Multiple-choice answers	Ministry Trans- port	Teachers Associ- ation	Workers Union	Dental Associ- ation	Ministry of Health																																																																																																																																																																
8.5	Environmental infrastructure	No differences between the schemes																																																																																																																																																																					
<b>9</b>	<b>Healthcare provision</b>																																																																																																																																																																						
9.1	General situation	No differences between the schemes																																																																																																																																																																					
9.1.1	Availability of healthcare provision	No differences between the schemes																																																																																																																																																																					
9.1.2	Regional distribution of providers	<table border="1"> <thead> <tr> <th><u>urban</u> <u>both</u> <u>rural</u></th> <th>Urban</th> <th>both</th> <th>Rural</th> <th>None</th> <th>U</th> <th>B</th> <th>R</th> <th>U</th> <th>B</th> <th>R</th> <th>U</th> <th>B</th> <th>R</th> <th>U</th> <th>B</th> <th>R</th> <th>U</th> <th>B</th> <th>R</th> </tr> </thead> <tbody> <tr> <td>Primary care</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Specialist outpat.</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>In-patient care</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Others</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	<u>urban</u> <u>both</u> <u>rural</u>	Urban	both	Rural	None	U	B	R	U	B	R	U	B	R	U	B	R	U	B	R	Primary care																				Specialist outpat.																				In-patient care																				Others																																																																																				
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9.2	Relationship with providers																																																																																																																																																																						
9.2.1	Does the insurance scheme operate its own healthcare services (or vice versa)?	<table border="1"> <tbody> <tr> <td>If yes: are insured obliged to use them</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Are they offered better conditions than non-members</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	If yes: are insured obliged to use them																				Are they offered better conditions than non-members																																																																																																																																																
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9.2.2	Does the insurance scheme contract with external providers?	<table border="1"> <tbody> <tr> <td>Yes</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>No</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Yes																				No																																																																																																																																																
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9.2.3	Does the insurance scheme reimburse external bills?	<table border="1"> <tbody> <tr> <td>Yes</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>No</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Yes																				No																																																																																																																																																
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9.3	Choice of insured parties	<table border="1"> <tbody> <tr> <td>Limited choice of providers</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Free choice of providers</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Depends on tariffs or group of insured</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Depends on the case</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Limited choice of providers																				Free choice of providers																				Depends on tariffs or group of insured																				Depends on the case																																																																																																								
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9.4	Provider profiles	See part 4																																																																																																																																																																					
<b>10</b>	<b>Provider payment</b>																																																																																																																																																																						
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10.1.1	Hospitals																																																																																																																																																																						
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Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health
	Regulation	Law					
		Public fee schedule					
		Contract					
		Other					
10.1.2	Specialized out-patient care						
	Kind of payment	Per capita					
		Per case					
		Fee for service					
		Other: own facilities					
	Basis of payment	Number of patients					
		Number of cases					
		Number of cases acc. to list of diagnoses					
		Per period					
		Fee schedule					
		Other					
	Regulation	Law					
		Public fee schedule					
		Contract					
		Other					
10.1.3	Primary care						
	Kind of payment	Per capita					
		Per case					
		Fee for service					
		Other: no PHC benefits					
		Other: own facilities					
	Basis of payment	Number of patients					
		Number of cases					
		Numb. of cases according to list of diagnoses					
		Per period					
		Fee schedule					
		Other: no PHC benefits					
		Other: own facilities					
	Regulation	Law					
		Public fee schedule					
		Contract					
		Other: no PHC benefits					
10.1.4	Pharmacy						
	Kind of payment	Per individual item					
		Per substance (only generics)					
		Per product according to list					
		Other: given in kind					
	Basis of payment	Wholesale price with fixed margin					
		Wholesale price without fixed margin					
		Own pack dispensing					
		Other: retail prices					
	Regulation	Law					
		Public fee schedule					
		Contract					
		Other: own regulation					
10.2	Administrative issues						
10.2.1	Hospitals						

Questions		Multiple-choice answers	Ministry Trans- port	Teachers Associ- ation	Workers Union	Dental Associ- ation	Ministry of Health
	Transfer for invoices	By mail					
		By fax					
		By messenger					
		Electronically					
		Daily					
		Weekly					
		Monthly					
		Quarterly					
		Other: by member					
	Method of payment	Bank transfer					
		Cash / cheque					
		Other: budget of ministry					
	Collective documents	List of patients and bed days					
		List of cases with diagnosis					
		Other: no collective document					
	Individual data provided	Diagnosis					
		Diagnosis according to ICD					
		Treatment					
		Treatment according to code					
		Name of patient					
		Name of treating health worker					
		Date of treatment					
		Other					
10.2.2	Specialized out-patient care						
	Transfer for invoices	By mail					
		By fax					
		By messenger					
		Electronically					
		Daily					
		Weekly					
		Monthly					
		Quarterly					
		Other: by member					
	Method of payment	Bank transfer					
		Cash / cheque					
		Other					
	Collective documents	List of cases					
		List of cases with diagnosis					
		Other					
	Individual data provided	Diagnosis					
		Diagnosis according to ICD					
		Treatment					
		Treatment according to code					
		Name of patient					
		Name of treating health worker					
		Date of treatment					
		Other					
10.2.3	Primary care						

Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health
	Transfer for invoices	By mail					
		By fax					
		By messenger					
		Electronically					
		Daily					
		Weekly					
		Monthly					
		Quarterly					
		Other: by member					
		Other: no PHC benefits					
	Method of payment	Bank transfer					
		Cash / cheque					
		Other					
	Collective documents	Invoice with list of services provided					
		List of insured					
		Other					
	Individual data provided	Diagnosis					
		Diagnosis according to ICD					
		Treatment					
		Treatment according to code					
		Name of patient					
		Name of treating health worker					
		Date of treatment					
		Other					
10.2.4	Pharmacy						
	Transfer for invoices	By mail					
		By fax					
		By messenger					
		Electronically					
		Daily					
		Weekly					
		Monthly					
		Quarterly					
		Other: by member					
			Method of payment	Bank transfer			
Cash / cheque							
Other							
	Documents	Prescription					
		Other					
	Data provided	Diagnosis					
		Name of patient					
		Product					
		Price					
		Other					
10.3	Attitude of providers	Providers stick to contracts	yes				
			no				
		Any problems with fraud	yes				
			no				
11	<b>Financial profile</b>	Expenditure during last year	14 Mio SP	316.292.655 SP	200 ass. à 5 Mio SP	2 Mio SP	N/A
12	<b>Statistical profile</b>	Number of target population	1.100	290.240	1 Mio	11.164	60.000
		Number of members	1.100	288.204	1000 pas	11.268	60.000
		Number of beneficiaries	6.000	1.15 Mio	4000 pas per assoc	11.268	258.000
13	<b>Implications</b>						

Questions		Multiple-choice answers	Ministry Trans- port	Teachers Associ- ation	Workers Union	Dental Associ- ation	Ministry of Health				
13.1	Access to healthcare services for non-members	Considerable impact									
		No impact									
13.2	Quality of care	Considerable impact									
		No impact									
13.3	Quantitative aspects	Considerable impact									
		No impact									
13.4	Prices	Considerable impact									
		No impact									
<b>14</b>	<b>Health authorities – role of the state</b>										
14.1	Which authority is responsible for supervision the insurance scheme	Local authority									
		Regional authority									
		National authority									
		International authority									
		Ministry									
		Special agency									
		Branch association									
		Other									
		No supervising agency									
14.2	Regulation of the activity of the health insurance scheme		Yes	No	Y	N	Y	N	Y	N	
		Tariffs									
		Solvency requirements									
		Accreditation									
		Registration									
		Other									
14.3	What is the position of the ministry of Health and other mini- stries on the insurance scheme?	Support the insurance scheme									
		Are against the insurance scheme									
		Indifferent									
		Depends on the ministry									
		Not clear or not known									
		Other: information and approval									
		Other: no relationship									
14.4	Regulation of healthcare sector	<u>Ministry Health / other / no</u>	M	O	N	M	O	N	M	O	N
		Quality standards									
		Quality control									
		Provider licensing									
		Provider accreditation									
		Price regulation									
		Worker qualification requirement									
		Different acc. providers									
		Other									
14.5	Market access for providers	Service accreditation for insurance									
		License to practice in healthcare sector									
		Supervision									
		Contracting (services, prices, etc.)									
		Other									

Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health
15	Plans for the coming years	Growth of membership					
		Growth of turnover					
		Growth of equity					
		Growth of profit					
		Improvement of services offered					
		Improvement of provider network					
		Improvement of administr. efficiency					
		Not clear or not known					
		Other: Increase of benefit ceiling					
		Other: inclusion of family members					
		Other: fund for old workers					
		Other: waiting for national health insurance					
Other: absent, has to be asked later							
16	Summary						
16.1	Main problems (ranking)	Recruitment of members					
		Contribution or premium collection		1		2	
		Compliance of providers					
		Administration	2				
		Legal obstacles no law		2			1
		Resistance by public authorities					
		Qualified staff					
		Fraud incorrect diagnoses	3	3		1	
		Ethnic, religious or other differences					
		Other: low funds	1				
Other: absent, has to be asked later							
16.2	Main achievements (ranking)	Better ability to pay		1		1	
		Better quality of care	1	2			1
		Better payment of healthcare workers					
		Fewer problems of providers with bill payment	2				2
		Better position of members				2	
		Other: absent, has to be asked later					
16.3	Negative impacts	Exclusion of certain groups					
		Changing behaviour of providers					
		Changing behaviour of the insured					
		Other: small benefit package					
		Other: absent, has to be asked later					
16.4	Monitoring	Monitoring system NOT in place					
		Monitoring financial monitoring system					
		utilisation of services					
		in place utilisation of drugs					
		health data					
		membership data					
		administrative efficiency					
		What is data financial management used for?					
		negotiations with providers					
		acquisition of members					
		administration					
Other: absent, has to be asked later							
17	Questions to the evaluator						

Questions		Multiple-choice answers	Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health
17.1	Quality of the questionnaire	Questions are <u>not</u> clear and to the point					
		Questions are clear and to the point					
		Concept of questionnaire understandable					
		Concept of question. <u>not</u> understandable					
		Applicable to type of scheme evaluated					
		<u>Not</u> applicable to type of scheme evaluated					
		Questionnaire is too detailed					
		Questionnaire is too short					
		Questionnaire is OK					
		Other: absent, has to be asked later					
17.2	Open questions						
17.3	Additional remarks						

The answers were given during a six days training and assessment seminar conducted by the Health Sector Modernisation Programme of the Ministry of Health, between 21<sup>st</sup> of November and 2<sup>nd</sup> December 2004. All questions were given in a questionnaire in Arabic language, in company with two other questionnaires – one with the same questions asking for open answers and another one on financial and statistical issues of the participating schemes.

### Health Benefit Schemes of Ministries in Syria, 31.12.2000

Compiled by Dr. Tarek Al-Sheik

Ministry name	Total staff	Health scheme beneficiaries	Annual cost in S.P.
Agriculture	40.774	10.104	20.037.965
Building and construction	46.819	46.278	145.686.647
Cabinet	462	0	0
Communications	24.896	21.761	80.394.706
Culture	3.163	509	606.967
Defence	65.07	63.579	74.232.620
Economy and external commerce	29.024	27.894	252.965.516
Education	270.09	0	0
Electricity	24.944	24,582	223.370.677
Environment	333	0	0
Finance	22.279	3.99	52.157.132
Foreign affairs	669	0	0
Health	59.528	0	0
Higher education	21,374	8.462	14.212.834
Housing and public utilities	19.414	17.45	68.978.930
Industry	65.639	64.183	421.790.580
Information	389	0	0
Interior	63.365	63.365	75.000.000
Irrigation	17.93	17.893	117.330.648
Justice	11.393	0	0
Labour & social affairs	4.58	1.833	21.053.170
Local administration	55.27	28.822	124.898.283
Petroleum and mineral resources	37.519	37.258	346.553.629
Planning	586	0	0
Presidency affairs	754	384	0
Religious affairs	5.438	0	0
Supply and internal commerce	35,280	25.326	242.053.370
Tourism	2,266	0	0
Transportation	2.775	2.775	12.100.000
<b>Total</b>	<b>932.023</b>	<b>466.448</b>	<b>2.293.423.674</b>

## 23 Health insurance in Kenya<sup>12</sup>

Historically, Kenya's health system has been financed from government revenue. In trying to find a balance between social justice and scarce finances, user charges were at times introduced, scrapped, and later reintroduced. In 2004, the ministry of health stipulated that care at dispensary and health centre (lowest) level should be free for all. In the same year, a health financing reform was submitted to parliament that included the establishment of a national social health insurance to cover the entire population. Getting to this point has been a long process. Already the previous government stated its intent to develop such a scheme. In 2002, a new government established a task force to prepare legislation and an overall implementation strategy. Although Parliament approved the health insurance bill in late 2004, the president has since postponed its ratification and further amendments are being deliberated.

Kenya has had a health insurance covering the formal sector and government employees for almost 40 years. Contributions to this "hospital insurance fund" are deducted from salaries and membership is compulsory, although not all companies comply, especially those outside the capital. The hospital fund pays for inpatient services only, to which members still have to contribute out of pocket. It has been plagued by inefficiency and a lack of transparency, which has done little to create trust in the eyes of the general population. The new social health insurance is to take over the infrastructure of the existing insurance. For this, a major overhaul of the institution is necessary, including capacity building, better management practices and auditing. This naturally takes time, and so the process has already started, even though the new social health insurance has legally not yet been created.

The underlying aim of the proposed reform is to achieve universal coverage and thus appropriate health care at an affordable cost for all. By accrediting and remunerating private service providers, it will also bring the public and private sectors under one financing umbrella and allow people to access both. It is the political will of the government to bring these benefits especially to the poor, and as rapidly as possible. There is some debate, however, about how to finance this. Employers and employees of the formal and government sectors are expected to contribute a percentage of their salary. People in the informal sector are to pay a flat fee per person. A significant proportion of membership cards are to be given to the poor for free (30% has been suggested). To afford this free coverage, funds from other sources than contributions are necessary. The initial strategy explicitly called for subsidies directly from government revenue. However, within the government this led to considerable debate.

The financial planning for the health insurance at first included amounts that some employees currently receive as medical cash allowances, i.e. these allowances would go towards the health insurance contribution in return for membership. However, the concerned groups quickly turned against any such proposals and compromises had to be sought. Also, private insurance providers and health maintenance organisations feared some loss of business to the social health insurance and provided vocal opposition in the public sphere. In the current plans they can offer top-up packages to anyone.

To keep administrative processes simple and efficient, a provider payment concept of flat fees has been proposed. A flat fee per inpatient day (reduced after some days to discourage excessive stays) and a flat fee per outpatient visit is paid to the provider. Further fine tuning, such as differentiating according to diagnosis, is foreseen for the future. Extra funds for service development and an extra allowance for higher quality are under consideration. Accreditation of providers is to be only upon adherence to health standards and quality criteria specifically set out in a new Kenya Quality Model.

The plan is to eventually enrol every man, woman and child in the country in a national social health insurance. It is still an open question how fast this can or should be achieved. There are some concerns about what will be done about the plight of the poor in the years until they are covered. Partly in

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<sup>12</sup> Written by Ole Doetinchem

response, primary level care was declared free of charge. Other temporary programmes to improve the health of the poor are being discussed with donors.

Some of the lessons that may be relevant for Yemen:

- Allow for time to develop a strategy, an implementation plan and legislation - start early.
- Include all stakeholders in the planning process. Address all concerns before presenting the final package for approval, especially those from the Ministry of Finance.
- Start working on capacity building, efficiency gains and better management now – you do not need to pass a law first.
- Do not assume that anyone will freely and readily give up any benefits that they currently enjoy.