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Financing health in middle-income countries

While low-income countries are still struggling to raise sufficient resources to fund essential health care, countries in the middle-income group are focusing on a somewhat different set of priorities. With the ability to deliver basic health services, most middle-income countries are increasingly turning their attention to the issues of universal health coverage, financial protection, and health system efficiency. These objectives require an overhaul of the current financing structures—a prospect that raises technical, institutional, and political challenges. This chapter summarizes common issues confronting middle-income countries and offers viable alternatives for health financing reforms. It first reviews the background of health financing systems in middle-income countries and their financing priorities. Secondly, it describes issues specific to each of the three financing functions: collecting revenue, pooling risk, and purchasing services. Finally, it discusses the need for governance and regulations to support financing functions.

This overview of health financing challenges yields these policy recommendations for middle-income countries:

- Efficient revenue mobilization should be a top priority for health, because funding must be sustainable and must match long-term needs.
- Domestic revenues and funding sources will need to supply the bulk of financing.
- Tax-raising ability should increase and resources should be mobilized equitably and efficiently for health, possibly through better payroll collection, tax reform, or other structural reforms.
- Increased risk pooling is needed to improve allocative efficiency, equity, and financial protection. This would entail increasing the pooling of out-of-pocket health spending—estimated to compose about 40 percent of total health spending—as well as integrating informal sector workers into coverage schemes.
- Risk pools should be consolidated to provide maximum financial protection and universal coverage. The associated benefits are greater purchasing power and efficiency through lower transaction costs.

- An appropriate package of benefits should be designed for covered populations, because the level of benefits affects the efficiency of risk pooling and resource allocation as well as the degree of financial protection. Standard or minimum benefit packages should have the right mix of coverage breadth and depth, so that trade-offs among the goals of universal coverage, financial protection, health outcomes, and cost containment are well balanced.
- Health spending should be parsimonious so that coverage can be expanded to more people. Overall efficiency in the health system can be increased by reforming procedures for purchasing services and by instituting incentive-based payment mechanisms. Furthermore, payment policies should be in line with overall cost containment and cost-effectiveness objectives.
- The specific form of health insurance scheme, whether based on a national health service system, social health insurance, or a private health insurance model (or some combination of the three), is less important than ensuring that the scheme focuses on improving revenue collection, risk pooling, and service purchasing. Depending on the context, a combination of insurance schemes may be necessary to accomplish the dual goals of universal coverage and financial protection.
- Lessons and best practices from the health-financing reform experiences of middle-income countries, especially those that address ways to overcome institutional impediments, are valuable for low-income countries as their economies grow. Development partners should document such experiences to expand global knowledge.
- The international community should not overlook the disparities in the health status of different populations within middle-income countries, a situation that also prevails in low-income countries and some high-income countries.

Commonality and variations in health systems

Middle-income countries, as defined by the *World Bank Atlas* method, are countries with 2003 gross national income (GNI) per capita of \$766–\$9,385 (\$3,035 is the dividing line between lower-middle-income and upper-middle-income economies) (World Bank 2005). In general, middle-income countries are diversified and well integrated within the world economy. Compared with low-income countries, they tend to have a greater institutional and administrative capacity for economic growth and for the introduction, implementation, and management of social programs. Many have achieved measurable results in reducing poverty and providing basic health services.

Nonetheless, poverty and income inequality are still common (Linn 2001). For example, approximately 28 percent of Thailand's population, 18 percent of Turkey and Mexico's, and 17 percent of Brazil's still live on less than \$2 a day. In the education, employment, and social security sectors, many middle-income

countries are lagging behind. In Latin America, only 60 percent of the population is enrolled in secondary education, and 10 percent of adults are illiterate. High unemployment rates and social exclusions are widespread throughout middle-income countries (Linn 2001). These social challenges provide the context for any discussion of these countries' desire to achieve equity in health.

Because of their economic situation, middle-income countries have the capability to provide essential public health services and deliver basic primary care, usually through a combination of public and private delivery systems. Their current health expenditures average some 6 percent of GDP. In addition, with the exception of some countries in Eastern Europe, middle-income countries rely on high levels of out-of-pocket expenditures to fund their health systems. Out-of-pocket payments are estimated to account for some 50 percent of total health expenditures in lower-middle-income countries and about 35 percent in upper-middle-income countries (see chapter 1).

Health financing arrangements in middle-income countries vary widely by geographic region and cultural context. A variety of health reform efforts—with varying approaches—are under way in this cluster of countries as well. But at present, the predominant features of the countries' health financing systems are influenced by the historical dynamics of institutional development in each region. The distinctions are worth noting because the evolution of current frameworks and institutions strongly depend on their historical, cultural, and political genesis. In turn, this backdrop continues to frame (at least to some degree) the challenges faced by and the policy solutions considered in each country.

The modern health care systems of the middle-income countries of Eastern Europe and Central Asia largely began with a preexisting Semashko model system (a centrally planned national health services entity similar to that found in the former Soviet Union) (Langenbrunner and Adeyi 2004). The financing structures within such systems were grossly inefficient, because of misalignment between the budget and the demand for services (Langenbrunner 2005). Although such systems achieved good results for communicable diseases, they were less successful for noncommunicable diseases. After the fall of Communism in the early 1990s, middle-income countries in the region, such as Estonia, Hungary, Poland, Romania, and the Russian Federation, immediately moved to revamp their health financing structures. Today, most countries in Eastern Europe and Central Asia have organizational and financing structures that can be traced to Bismarck's social insurance model. However, their health funding has in many cases been adversely affected by economic downturns, and the transition to more market-based systems has been slow (Langenbrunner 2005).

In the Latin America and the Caribbean region, middle-income countries have developed a mix of arrangements to finance health care—social health insurance, private health insurance, and national health service systems. The current structures

evolved from the corporatist relations between workers and the state that developed as Latin American political elites consolidated their power at the end of the nineteenth century (Savedoff 2005). Workers in the public and formal sectors were first incorporated into Bismarck-style social health insurance entities. Later, between 1940 and the 1960s, other groups, including the poor and the uninsured, were covered through national health services (Baeza and Packard forthcoming). These different financing arrangements coexist to varying degrees in Latin America and the Caribbean, ranging from an even split between the national health service system and social health insurance coverage in Mexico to a predominantly social health insurance model in Argentina (Baeza and Packard forthcoming).

Most countries in the Middle East and North African region are middle-income countries, and their financing systems are built on a combination of the national health service system and social health insurance models (Schieber 2004). Some countries, such as Bahrain, Lebanon, Morocco, Saudi Arabia, and Tunisia, have a rapidly expanding private health insurance sector, and more countries seem to be following this trend (Sekhri and Savedoff 2005). However, a few places are involved in conflict situations, in particular, Iraq and the West Bank and Gaza. Given the political instability in the region, reforming health financing is not currently a principal concern for many of these countries (Raad 2005).

Middle-income countries in the East Asia and Pacific region are politically and socially diverse. Traditionally, social health insurance has not been as developed in this region as in Eastern Europe or Latin America (Saadah 2005). Despite their diversity, however, many of these countries share the common trait of having achieved the so-called economic miracle within the past 25 years. They have used the additional resources to make major investments in their health systems. Many systems are in transition, and a few economies (such as the Republic of Korea and Taiwan, China) have already achieved universal coverage.

Common health financing challenges

Despite their regional differences, middle-income countries have similar health financing priorities and goals: universal coverage, financial protection, and efficiency. These priorities spring from pressures facing health systems in the form of cost increases due to demographic, epidemiological, and technological change; large out-of-pocket payments; inequitable and ineffective health financing systems; and inefficiencies in the health care systems.

Demographic and epidemiological transitions

Currently, the overall health outcomes in middle-income countries are fair, and life expectancies are catching up with those in high-income economies. But like high-income countries, middle-income countries are experiencing aging demographics and an increasing burden of noncommunicable diseases (WHO 2003). Additionally, the demand for expensive technologies and pharmaceuticals is projected to

rise with income levels. In the face of demographic, epidemiological, and technological pressures, middle-income countries are expected to spend more on health than their current commitment of some 6 percent of GDP.

Large out-of-pocket expenditures

As shown in chapter 1, out-of-pocket expenditures have contributed some 50 percent of total health spending in lower-middle-income countries and around 35 percent in upper-middle-income countries, considerably higher than in high-income countries. Out-of-pocket spending consists of official fees charged by service providers; user charges for publicly provided services and consumables, such as drugs and medical supplies; or under-the-table payments as gifts for services.

Out-of-pocket expenditures are estimated to be more than 50 percent of all health expenditures in Kazakhstan and the Arab Republic of Egypt (Langenbrunner 2005; WHO 2005), and approximately 40 percent in Latin America and the Caribbean (Baeza and Packard forthcoming). In East Asia and Pacific, such expenditures account for an even higher share of total health spending (Sekhri and Savedoff 2005; WHO data). The impoverishing effect of direct out-of-pocket spending for medical services has been described in recent country surveys, including Russia (2004), Kazakhstan (2004), Argentina (2004), Chile (2000), and Peru (2002) (Baeza and Packard forthcoming; Langenbrunner 2005). In Latin America, those relying heavily on out-of-pocket expenditures as the main source of health care financing have become poorer as a result of illnesses than those with any kind of health insurance.

Inequitable and ineffective financing systems

In middle-income countries the disparate expenditure patterns across income groups are as significant as the high proportion of out-of-pocket payments. Lower income groups pay more toward health care as a percentage of household resources than do high-income groups. They are more at risk of falling into poverty as a result of prolonged health events because they have fewer household resources and less safety net protection through private health insurance (Baeza and Packard forthcoming).

This biased distribution of household out-of-pocket spending on health care exposes the health financing systems' failure to provide adequate financial protection to certain segments of the population in middle-income countries. Hence, the lack of universal coverage and financial protection are symptoms of ineffective financing instruments and the misalignment of policy incentives in these countries. Furthermore, implementing universal coverage would require middle-income countries to increase health spending, demographically adjusted, to levels closer to those in OECD countries, most of which currently offer universal coverage. To move beyond the status quo, middle-income countries need to better mobilize resources and use existing resources more efficiently.

System inefficiencies

Many financing systems in middle-income countries are fraught with duplication and inefficiencies. Fragmentation of health systems often precludes consistent policy focus and incentives for efficiency on both risk pooling and purchasing grounds. From Latin America to the Middle East and Eastern Europe, there are many organizations pooling resources and allocating health spending. The list of actors includes social health insurance organizations, central and local governments, health authorities, the military and security agencies, and commercial insurers. For example, there are 29 public agencies in Egypt managing health financing with service provisions linked to specific schemes.

Often, the efficiency of public providers is also problematic. Many local hospitals have occupancy rates below 50 percent (Gericke 2004). Similarly, post-Communist countries inherited excess capacity in health care facilities and personnel, as well as rigid budget allocation processes. Many countries have not been able to redesign essential benefits and streamline service delivery (Langenbrunner 2005). Although the region has had many financing reforms, a fragmented incentive structure has undermined the outcomes and the effectiveness of health care delivery systems (Langenbrunner 2005).

Revenue mobilization

As middle-income countries attempt to strengthen financing instruments for better revenue mobilization, risk pooling, and purchasing of services, they will have to overcome many structural and implementation obstacles. Challenges include insufficient public resources allocated to health and limits on the government's ability to increase the amount and share of public revenues devoted to health, together with a lack of sustainable financing sources, thereby affecting fiscal sustainability. Risks also need to be pooled more effectively. This could be done by expanding the size of the pool and reducing fragmentation across the system, for example, or by other means. Finally, to improve service purchasing, countries will need to improve the structure of their defined benefit package or covered services and implement appropriate provider payment incentives. In evaluating the array of possible solutions to financing issues, the merits and drawbacks of each option are reviewed in detail.

Allocating more public resources to health

Compared with high-income countries, most middle-income countries devote far fewer resources to health care and more of what they do spend comes from non-public sources. As discussed in chapter 1, high-income countries spend about \$3,000 per capita (population-weighted) on health each year, almost 10 times as much as upper-middle-income countries (which spend \$309) and more than 36 times as much as lower-middle-income countries (which spend \$82). At the same time, public sources account for 65 percent of health expenditures in high-income

countries, but 56 percent in upper-middle-income countries and 42 percent in lower-middle-income countries. The high level of out-of-pocket spending by average households, a phenomenon found in most Latin American, East Asian, Middle Eastern, and Central Asian countries, is another sign of insufficient risk pooling and public funding for health.

Why is public funding allocated to health care insufficient in these countries? A primary reason is the state of the economy. For instance, Georgia, Kazakhstan, Poland, and Russia have seen their overall public funding for health decrease during the 1990s, as the Eastern Europe and Central Asia region as a whole suffered an economic downturn (Langenbrunner 2005). In countries where GDP growth is slow, such as Ecuador and Peru, public spending on health is understandably limited. By contrast, in the East Asia and the Pacific region, where economic growth has been very strong, some economies have been able to fund social health insurance through general revenues and expand coverage to the entire population (Republic of Korea and Taiwan, China).

Other factors contributing to the lack of public resources are weak or inefficient revenue collection systems and a heavy reliance on payroll taxes, which present many challenges, as discussed below. In a number of countries, the government also offers guarantees for the debt of health insurance funds. Thus, when health insurance runs a deficit or becomes insolvent, as in Argentina or Russia, governments must cover the costs. Given that low-income people generally do not have social health insurance, subsidizing social insurance with general revenues in this fashion may prove regressive.

Finding new sources of financing

Like low- and high-income countries, middle-income countries may choose from or combine the revenue sources of payroll taxes, general taxation, and even to some extent private insurance to fund their health financing systems. The question of which source is most appropriate depends on a country's infrastructure, socioeconomic situation, and political context. Policy makers should assess the strengths and weaknesses of each source and determine whether their country meets or is capable of meeting the enabling conditions for each option (chapter 3).

Payroll contributions. Compulsory payroll contribution systems were introduced at the end of the nineteenth century, along with social health insurance schemes. These contributions are generally shared between employers and employees, with some variation in the distribution. Contribution rates in middle-income countries fall within a wide range, from as low as 2 percent to as high as 18 percent.¹ In general, rates tend to be higher in Eastern Europe than elsewhere (Langenbrunner and Adeyi 2004).

In addition to weighing the pros and cons of a payroll-based revenue source, as discussed in depth in chapters 2 and 3, middle-income countries must also assess the feasibility of implementing such a system. Experiences from countries relying on

payroll taxes suggest that the following enabling conditions are necessary: a growing economy, a large formal labor market, an administrative capacity for collection, a good regulatory and oversight structure, and an appropriate incentive structure.

The middle-income countries that chose payroll taxes as the primary funding source have a large percentage of their working-age population employed in the formal sector, which constitutes the government's revenue base (Ensor and Thompson 1998). In Eastern Europe, payroll taxes are the predominant source of funding, financing much of the health care costs in Estonia, the Czech Republic, Hungary, and Slovakia (Langenbrunner 2005). In these countries, state enterprises and civil service institutions are large formal sector employers and are a reliable source of payroll contributions. In addition, the shift to payroll contributions (away from general revenue-based funding) offered a way for these countries to break with their Soviet-era past and reduce the role of the state. Payroll taxes also play a prominent role in Argentina, Chile, and the Republic of Korea. In Latin America and the Caribbean, labor unions representing a large share of the formal workforce are actively involved in collecting and managing health insurance contributions, as seen in Argentina's *Obras Sociales* (ILO 2001).

Middle-income countries that have successfully used payroll taxes also share the structural characteristics of strong administrative and regulatory oversight, which facilitate collection. For instance, good record-keeping systems are available to register workers and to enforce collection, especially in the former communist states. As a group, these countries tend to have greater bureaucratic institutional capacity than many lower-middle-income countries. Therefore, collection rates are higher, and the related processes are more efficient in these countries.

Finally, middle-income countries choosing the payroll option must have reasonable rates of contribution and incentives for a majority of the population to participate in payroll contribution mechanisms. Despite their significant payroll deductions for social security and health insurance, the Eastern European countries are committed to the system of universal coverage and continue to value solidarity.

Countries that have difficulties meeting the enabling conditions for successful implementation of payroll contributions may need to reconsider plans to rely heavily on such payments. Middle-income countries in the lower income group, such as Ecuador and Peru, may not have a large enough economy or enough growth to support the expansion of health coverage beyond basic services. In Latin American countries where the informal segment of the labor market is growing, a largely payroll-based system is not likely to be feasible or sustainable. The revenue base is too small to be the sole source of health funding for the entire population. In such circumstances, many countries use general taxes to subsidize or supplement payroll sources.

Similarly, studies have shown that payroll contributions have a negative impact on the labor market in Latin America and the Caribbean by increasing tax evasion

and reducing the size of formal labor market (Baeza and Packard forthcoming). Finally, experiences from Albania, Kazakhstan, Romania, and Russia show that payroll-based revenues fell short of expectations because of common operational challenges, weak tax collection systems, and less developed regulatory capacity (Langenbrunner 2005). Unless these middle-income countries expand revenue collection efforts into the informal sectors and improve their administrative capacity, they may be better off pursuing alternative sources for health financing.

General taxation. Many of the pros and cons of this revenue source were discussed in chapters 2 and 3. Countries relying on general taxation, or wishing to rely on it more heavily, in funding their health systems must consider whether they have some key enabling conditions that facilitate revenue mobilization through general taxation: a growing economy, sound administrative capacity, and an appropriate tax structure and incentives.

A growing economy is important for general revenue collection, as it is for payroll contributions, because as income levels improve, so do tax contributions. But more important, the administrative capacity to raise taxes is crucial for sustainability. For instance, middle-income countries in Latin America and the Caribbean have collected much less in total taxes, relative to their per capita income, than the European countries (Baeza and Packard forthcoming, figure 5.5). These countries also need appropriate tax structures and incentives, including clear rules and transparency. There is a high level of inequality in wealth and power within middle-income countries (Anderson and others 2003). Many governments have been unable to sufficiently tax the wealthy elites in their societies, as is also the case in low-income countries. Furthermore, the growing informal sector in some middle-income countries complicates efforts to collect both general taxes and payroll taxes. In countries that increasingly rely on indirect taxes, the system is generally regressive and hurts the poor. Thus, tax reforms may be necessary to introduce a progressive structure and the right incentives for participation.

A number of middle-income countries, such as Ecuador, Kazakhstan, Lithuania, Malaysia, and Ukraine, rely primarily on general revenue as their health financing source. Others are contemplating shifting to general revenues, including Chile, Mexico, and Russia. Among the high-income countries, Spain has changed to general revenues. Most middle-income countries have the infrastructure to raise general taxes, although some countries have more capacity than others. Yet, they must first improve the tax structure and the efficiency of collection.

For countries using a mixed funding base or contemplating a switch to general revenue funding, an incremental approach may be in order. Countries such as Argentina, Colombia, and Mexico, where less than 15 percent of health expenditures are financed through general revenues, may want to build up the tax base first by increasing collections from nonpoor informal workers and the wealthy (Baeza and Packard forthcoming).

Private health insurance premiums. Private health insurance premiums are increasingly becoming an alternative source of financing in developing countries. As with all funding sources, countries must carefully weigh the advantages and drawbacks of this approach. To take advantage of private resources alongside government funding for health care, middle-income countries should consider the following enabling conditions: a substantial middle-class population, a capacity for regulatory oversight and management, viable financial markets and institutions to invest reserves, and the availability of other funding sources for health care.

Since private health insurance caters primarily to paying customers, the existence of a middle class is a prerequisite to its development. In East Asia, Latin America, and the Middle East, where the level of out-of-pocket health payments is substantial and where middle-class populations are growing, private health insurance is becoming more popular (Sekhri and Savedoff 2005). With the exception of the Eastern Europe and Central Asian region, private health insurance accounts for more than 5 percent of health expenditures in 19 middle-income countries. In Brazil, Chile, Namibia, South Africa, and Uruguay, it exceeds 20 percent of total health spending (Sekhri and Savedoff 2005). Nonetheless, it still remains a minority source of health funding in all countries across the world, except for the United States (Tapay and Colombo 2004).

Regulatory oversight and management skills are necessary to ensure that all parties in private health insurance systems carry out their fiduciary responsibilities. Despite their significant presence in many middle-income countries, private health insurance markets are still largely unregulated. The lack of regulation, management skill, and actuarial sophistication contributed to the failures of private sector-based reforms in Latin America and Eastern Europe. The extent of and possibility for risk selection within private insurance markets is less studied in developing countries, although it is already well documented in several high-income countries (Newhouse 1998).

A viable financial market is also a precondition to the development of private insurance entities. The reserves from premiums collected must be invested to ensure profits over resource outlays; this profit stream is critical for the sustainability of private entities. In East Asia and the Middle East, a growing private insurance market parallels healthy development in the financial sector over the past decade (World Bank 2005). In Latin America and Eastern Europe, weaker financial markets hinder the development of a private insurance industry.

Of course, middle-income countries cannot rely solely on private health insurance premiums to fund their health systems. Other publicly funded insurance programs must be available to serve as a safety net for those who cannot afford private insurance. Across the world, the most common forms of private insurance serve a supplementary or complementary coverage role. In most countries where private health insurance flourishes, social health insurance or national health services have the prominent roles. A number of middle-income countries, including

Brazil, Chile, Indonesia, Mexico, the Philippines, and Uruguay, have integrated private insurance into their health financing systems (Sekhri and Savedoff 2005).

Risk pooling

Regardless of funding sources, governments also need effective methods to pool risks (see chapters 2 and 3). Currently, risk pooling arrangements are imperfect, with segmented or fragmented risk pools. Although debates continue about the most appropriate risk pooling arrangements, the experiences of countries that were able to expand coverage suggest that increased risk pooling and better equity-related, distributional subsidies are critical to success.

Expanding coverage and resources

Many middle-income countries are concerned about the failure of their pooling arrangements to cover vulnerable and disadvantaged groups. Furthermore, the failure to pool out-of-pocket payments has prevented middle-income countries from harnessing the substantial private resources that are needed to extend risk pooling and provide improved financial protection.

Reducing risk segmentation

An important concern with current pooling arrangements is risk segmentation, whereby health risks are spread unevenly across different pools.² Without the ability to cross-subsidize across pools, segmentation can result in an excess of financial resources for some pools and less than adequate funding for others. Transferring funds between pools can help adjust for potential shortfalls in each fund. However, this procedure substantially increases administrative costs and inefficiencies. Furthermore, those who are not covered by social insurance pools typically have higher health risks than those who have insurance, as many studies have found in high-income countries (Newhouse 1998). These uninsured populations tend to use national health service delivery systems, so that the government often finances the health care of a higher proportion of high-risk individuals than do the other financing mechanisms.

The sheer number of pools and the complexities involved in cross-subsidies often contribute to regional inequities in funding levels, as in Bosnia and Herzegovina, Poland, Romania, and Russia, where revenue collection processes for health are decentralized. Most funds are collected and allocated by local governments, and risk pooling rests at the local level. As a result, thousands of risk pools coexist.

Furthermore, most middle-income countries do not have the regulatory capacity to ensure transparency of fund transfers. Without such oversight, mismanagement and misallocation of resources are likely. In Kazakhstan, corruption resulted in the disappearance of millions of dollars in health insurance funds. Because of such corruption and other mismanagement issues, Kazakhstan's payroll revenue system was replaced in 1999 by general budget financing, a simpler process.

Changing risk pooling arrangements

Many recent reforms of risk pooling arrangements occurred in response to challenges relating to risk selection and lack of financial protection. Box 8.1 describes successful reforms in the Republic of Korea and Taiwan, China. Most of the innovations that are suitable for middle-income countries are built on three basic mechanisms: creating a single pool through a national health service system, expanding pooling through social health insurance reforms and payroll contribution, and reducing the fragmentation of pools.

Creating a single pool through a national health service system. Some countries are considering shifting from a social health insurance model to a general tax-funded national health service system, as Spain did in the mid-1990s. This trend is facilitated by some countries' desire to use public financing instruments that are more broadly based than payroll taxes. Among middle-income countries, Costa Rica successfully merged its national health service and social health insurance systems in the mid-1990s.

Policy makers considering such a shift, however, will likely need to convince the public that the quality of the services provided under a national health service system will match that of the current social health insurance system or private health insurance plans. It will also be more feasible if there is fiscal, technical, and political support. Consequently, many reforms of national health services have concentrated on improving the efficiency of service delivery and deepening the benefit package, rather than on enlarging the pool or reducing fragmentation of the pools.

Expanding pooling through social health insurance reforms and payroll contributions. Social health insurance is the main risk pooling arrangement in many middle-income countries in Latin America, Eastern Europe, and the Middle East. One of the most important advantages underlying social health insurance reforms for expanding universal coverage is the existence of pooling funds (sometimes a single large fund) that allow newly enrolled individuals and groups to take advantage of existing risk and income cross-subsidization mechanisms (chapter 3) rather than creating new pools. The organizational and institutional capacity in social health insurance systems also provides an important foundation from which countries can expand coverage to new populations. The reality, however, is that social health insurance schemes usually cover a relatively small proportion of the total population in these countries. Their structural capacity to reach the informal sector and the poor are limited because of their link with formal employment. Therefore, specific reforms and innovations in middle-income countries have focused on expanding coverage to informal sector workers and the poor.

Innovations to extend social protection in health include: opening voluntary affiliation to self-employed and informal workers; providing public subsidies to

BOX 8.1 *Republic of Korea and Taiwan, China—from fragmentation to universal coverage through social health insurance reforms*

The Republic of Korea and Taiwan, China are models of social health insurance reform successfully implemented to achieve universal coverage.

Republic of Korea

In 1989 the Republic of Korea legislated universal health insurance, successfully completing a health care reform process that took more than a decade. At the core of this process was the introduction of progressive innovations in the initially small and shallow social security–based health coverage system to extend its reach to all workers and their families, in both the formal and the informal sector. The process was greatly facilitated by a period of important economic growth.

In 1977, Korea had only 8.8 percent of the population covered by formal social security insurance (Peabody, Lee, and Bickel 1995). That year two programs were established: the Free and Subsidized Medical Aid Program, for people whose income was below a certain level, and a medical insurance program that provided coverage for individuals and their immediate families working in enterprises of 500 people or more. In the next major step two years later, coverage was expanded to enterprises with 300 or more people and to civil servants and teachers in private schools. In 1981, coverage was extended to enterprises employing 100 or more people and in the following three years to firms with as few as 16 employees. This process was largely made feasible by an unprecedented period of prosperity for the smaller businesses that were directly and indirectly benefiting from an economic process of clear expansion and macroeconomic stability.

By the end of 1984, 16.7 million people, or 41.3 percent of the population, had medical insurance. By 1988, the government had

expanded medical insurance coverage in rural areas to almost 7.5 million more people. Ten years after beginning the first reforms, approximately 33.1 million people, or almost 79 percent of the population, received medical insurance benefits. At that time, the number of those not receiving medical insurance benefits totaled almost 9 million people, mostly independent small business owners in urban areas. In July 1989, however, Seoul extended medical insurance to cover these self-employed urban workers, so that the medical insurance system extended to almost all Koreans.

Taiwan, China

In 1995 Taiwan's public authorities introduced legislation to create a mandatory national health insurance scheme. At the time only half of the population was covered by a social security scheme. At first, the process seemed extremely rapid, given the fact that one year later 92 percent of the population was covered. However, the process had started more than a decade before through the Council for Economic Planning and Development (CEPD). The first planning stage took two years of studies and the original proposal included a project to phase in the nationwide insurance program progressively until reaching universal coverage by 2000.

The first pilot project for the expansion started with well-organized farmers' groups in 1987. Political events in the first half of the 1990s created a strong political incentive to give priority to the fast expansion of social security to the whole population. A careful analysis of the pilot projects and the lessons learned from the farmers' experiences and studies on trends of health expenditures allowed for the legislation to be introduced in 1995 (ILO/STEP 2002).

social health insurance systems to enroll the poor, or subsidizing premiums for poor self-employed or informal workers; mandatory universal participation; and expanding the pool through the integration of private health insurance.

- *Opening coverage to self-employed and informal workers through voluntary affiliation.* This innovative method has been tried by the Mexican Social Security Institute (IMSS) in Mexico, the National Health Fund (FONASA) in Chile, and by many others, but has met with limited success (Bitran and others 2000; IMSS 2003). There are some major obstacles to this innovation. Its voluntary nature, together with a typically flat rate contribution, may encourage more high-risk enrollees to join, resulting in adverse selection and potential financial loss for the social insurance system. Another issue particular to Latin America and the Caribbean is the high cost of “bundled” contributions (payment of joint contributions for pension and health)—and consequently the perceived gap between benefits and contributions—which may drive away potential participants. Moreover, even if enrollment is opened to informal and self-employed workers, the poorest among them may not be able to afford the contributions and therefore will not join.
- *Subsidizing the social health insurance systems to help the poor pay premiums.* Some reforms aim at assisting the self-employed and informal sector workers to join the existing social health insurance schemes by helping them overcome financial obstacles. Government subsidies have been granted to FONASA in Chile and the Costa Rican Social Security Organization for this reason. In another approach, the Colombia Subsidized Mandatory Health Plan (POS-S; see box 8.2) and the Indigent Program³ of PhilHealth in the Philippines provided premium subsidies to the poor (Alamiro and Weber 2002).
- *Implementing mandatory universal participation.* Some middle-income countries have passed laws requiring mandatory universal participation. Successful cases include gradual expansion to the whole population in the Republic of Korea and the Samara region within the Russian Federation, as well as in Taiwan, China, and less ambitious programs such as an incremental expansion to cover more dependants of the contributing members in Panama (see box 8.1 for more details on the Republic of Korea and Taiwan, China).
- *Expanding the pool through the integration of private health insurance.* In the past 20 years middle-income countries have seen two main reforms of private health insurance: facilitation and promotion of voluntary health insurance, including formalized competition, and integration of regulated private insurance into the social security system.

The debate on whether harnessing private health insurance contributes to or damages middle-income countries’ chances of achieving universal coverage has focused on whether countries can take advantage of the benefits of health insurance competition and avoid the associated efficiency and equity problems. The technical

and institutional feasibility of specific financial, regulatory, and organizational reforms (risk adjustment mechanisms, risk equalization, and solidarity funds, among others) is at the core of this debate. Such reforms can be implemented only if the transaction costs do not offset the benefits of competition and privatization (Coase 1937; Williamson 1985; Baeza and Cabezas 1998; Newhouse 1998).

The literature provides some evidence of problems that have followed the introduction of private health insurance and competition in the insurance market in some countries (Londoño and Frenk Mora 1997; Sheshinski and López-Calva 1998). Problems such as risk selection and underservice have been studied intensively and have been discussed in previous chapters (Arrow 1963; Rothschild and Stiglitz 1976; Laffont 1990; Milgrom and Roberts 1992; Hsiao 1994, 1995).

It is not clear whether middle-income countries can reduce—or eliminate—risk selection, segmentation, and equity problems within systems with competing multiple health insurers. Although there is not enough evidence on the effectiveness of introducing competition when coupled with adequate regulation and incentive frameworks, it is clear that introducing private health insurance competition within social health insurance systems without the necessary regulations, solidarity, and risk adjustment mechanisms can have severe negative consequences. Efficiency and equity may suffer, as evidenced in the health insurance reforms in Chile in the early 1980s (Baeza and Muñoz 1999).

Reducing the fragmentation of pools. To reduce the risk fragmentation and segmentation presented by multiple pools, middle-income countries face the strategic decision of whether to pursue a single or a “virtual” pooling arrangement. Although in reality there are multiple pools, a “virtual pool” system functions like a single pool by allowing cross-subsidization among member pools and subjecting them to the same rules. More efficient cross-subsidies across income groups and health risks can be achieved by merging smaller pools into larger pools or, in some cases, into a national pool. Creating a single large risk pool is ultimately better than multiple pools for spreading risk and improving equity through subsidies, as explained previously. Disadvantages of the virtual pool arrangement, when compared with a single pool, include the more complex regulations and incentives needed to counterbalance adverse selection. Such procedures can result in high transaction costs to society, but most of all, many middle-income countries are not well-equipped technologically or institutionally to deal with the challenge.

Some countries have a single pool arrangement and others have the virtual pool or multipool arrangement. Those with a single pool include Costa Rica and Poland. These middle-income countries have expanded risk pools to include the entire population, independent of the type of insurance schemes employed. Middle-income countries that have virtual pools include Brazil, Chile (virtual pool integration), and Colombia (comprehensive multipool, as described in box 8.2) (Londoño 1996; Bitran and others 2000).

BOX 8.2 *Colombia—reducing fragmentation among health coverage schemes*

Colombia is by far the best example among middle-income countries of the integration of private sector participation into the social health insurance system. Its 1993 reform mandated radical changes in risk pooling and health insurance, including participation of private sector entities in social health insurance and demand-side subsidization of social health insurance contributions. The new law separated the financing and provision of services across the health sector (except in the publicly managed fund). Private entities and providers are able, together with their public counterparts, to provide services for payroll-tax contributors (who pay 11 percent of their salary) and subsidy-eligible citizens. Participants can select their health insurer and providers.

The law also established mandatory universal coverage for the population, which receives two kinds of basic coverage, depending on their income. Payroll-tax contributors have access to a minimum level of coverage, defined as the Contributive Mandatory Health Plan (*Plan Obligatorio de Salud—POS*) and nonpayroll-tax contributors, or subsidy-eligible citizens, have access to the Subsidized Mandatory Health Plan (*Plan Obligatorio Subsidiado de Salud—POS-S*). Payroll-tax contributors can purchase additional coverage from for-profit health insurance institutions (*Empresas Promotoras de Salud—EPS*) (Yepes 2001). The new system creates solidarity among payroll-tax payers through a fund that collects all payroll-tax contributions and then distributes resources on a per capita basis using a demographic risk adjustment mechanism (based on age and sex). The system is regulated through a regulatory agency under the Ministry of Health (Londoño 1996; Restrepo Trujillo 1997).

A main objective was to maintain solidarity and equity within the system while intro-

ducing competition and choice. The system has a redistribution fund, which uses a demographically based risk-adjusted capitation. The fund collects all contributions from payroll and general taxes and distributes the capitation to all insurance agencies. There are strong conceptual and empirical reasons to believe that the risk adjustment mechanism does not prevent enough selection behavior on the part of insurers and that the specific design of the package and the solidarity fund provides strong incentives for participants to avoid contributing or to contribute below the desired levels.

Unfortunately, there has been little evaluation of the potential or current selection problems in the Colombian system. There is some evidence that the subsidized portion of the system positively affected financial protection for the covered population. Yet, there is no evidence regarding the impact on health status and utilization of services. However, there is ample evidence of significant fiscal sustainability problems, due mostly to declining contributions resulting from perverse incentives relating to contributions and significant difficulties in transitioning from historical supply financing to demand-side financing within the public sector. At the core of the transition problem has been the great difficulty in overcoming the rigidities of public providers and ensuring their financial sustainability in the presence of the demand-side subsidy.

Colombians are on the brink of a major restructuring of their previous reforms in an effort to resolve the perverse incentives affecting contribution levels and to encourage public providers to be more flexible in the way they manage resources. Expected savings should make it possible to adjust the cost structure in the way needed to accommodate demand-side financing.

Yet, policy debates on alternatives in this area tend to go beyond technical issues to reflect cultural and historic backgrounds of a country. The virtual pool strategy is more feasible in middle-income countries with coexisting, multiple coverage pools. It is difficult, especially from a political perspective, to merge all the pools and restructure the associated and distinctive collection and distribution systems.

For example, local governments in Kazakhstan and Russia have been unwilling to transfer funds to a health insurance system and lose control of a large portion of their health budget. Furthermore, a single pool, in particular a national pool in the form of national health service, would introduce a type of “public monopoly” in health, which may not be palatable in countries struggling to move away from the centralized public systems of the Soviet era. National health service systems typically confront significant efficiency problems, including governance challenges and problems relating to capture by health sector unions, because of their role in the direct provision of services. Thus, a debate on the efficiency of single pooling versus virtual pooling schemes ought to include consideration of the microefficiency limitations of public monopolies (Schieber and others forthcoming).

Although the performance of the two approaches has not been assessed, the trend among middle-income countries is to enlarge the risk pool size and reduce the number of pools. There have been recent initiatives in Eastern Europe and Central Asia to merge risk pools. Estonia has consolidated the number of pools from 22 to 7, while Romania has reduced them from 14 to 6. Russia is deliberating on a federally pooled health insurance system, while Kazakhstan and Uzbekistan are pooling general revenues at the territorial level, similar to the Canadian system. In the Baltic states, the Czech Republic, Hungary, Slovakia, and Slovenia, risk pooling is even more consolidated, with social health insurers controlling more than 70 percent of public health care funds (Langenbrunner 2005).

Purchasing services

The World Health Organization (WHO 2000) identified strategic purchasing as a central function for improving health system performance, and many countries have embraced the general principles of strategic purchasing in their health reforms. Yet, among middle-income countries, the progression from a simple, retrospective provider payment system toward strategic purchasing arrangements has been slow and uneven. In most developing countries, including middle-income countries, elements of passive purchasing still dominate and present challenges to financial protection and health care service efficiency.

Making purchasing strategic

Reforms in health service purchasing generally seek to address some of the following: the design of the standard benefit package, the fragmented pooling system, and the organizational incentives. Some reforms, particularly in Eastern Europe,

have improved the health care service purchasing function as it relates to the incentives under provider payment schemes and the quality of services.

Benefit package affects purchasing efficiency and financial protection. A benefit package—a set of services covered by health insurance under specified conditions—sets the risk limits and standards for adequate financial protection. Experiences from economies that have successfully expanded risk pooling, such as Costa Rica, the Republic of Korea, and Taiwan, China demonstrate that it is important to develop an explicit benefit package, regardless of the kind of insurance model.

For most middle-income countries in Eastern Europe and Latin America, concerns about the design of the health care benefits package relate more to the depth of the coverage than to its breadth. A direct comparison between two government insurance programs in Chile indicates that the National Health Fund (FONASA), which concentrates on insuring impoverishing events, provides better financial protection for low-income populations than Institute of Public Health and Preventive Medicine (ISAPRE), which insures mostly frequent and low-cost events, has high deductibles, and excludes preexisting conditions (Baeza and Packard forthcoming). Those who are covered by a “deeper” package do not fall into poverty as often as those with the “shallower” package. And as people have become impoverished, they have had to disenroll from ISAPRE, undermining the objective of social insurance. In Latin American health reforms, there is therefore an increasing push to establish an explicit entitlement to a specific benefit package. Colombia (1994), Chile (1996 and 2003), Mexico (2003), and Argentina (2003) have introduced a standard benefit package as an entitlement even for services covered under the national health service.

By contrast, efforts in Eastern Europe and Central Asia to define a basic benefit package have been largely unsuccessful. The difficulties are often related to lack of expertise, information, or political will (Langenbrunner 2005).

Low risk pooling and fragmentation affect purchasing efficiency. Another factor affecting efficiency at the purchasing level is the low level of risk pooling in middle-income countries. Without pooling, a government has less control over service delivery strategy, and less purchasing power with which to negotiate with providers. In addition, a fragmented system may subject different services or delivery mechanisms to different and possibly conflicting incentives, distorting the health services market. For example, the former Soviet states did not start out with a pooling mechanism when their centralized model changed to social insurance. Revenues from general, payroll, and other taxation flowed down directly to providers and purchasers at the local level through the previous line-item budget allocation process (Langenbrunner 2005). Adding to the complexity, different funding sources financed different functional categories of expenditures; for example, there were different funding sources for capital investments and operational

costs. Such a disjointed approach prevents transparency, reduces efficiency gains at the service purchasing level, and raises transaction costs.

Organizational issues affect purchasing efficiency. Organizational and management problems also contribute to inefficiencies in service purchasing. The most apparent problems have been associated with a lack of adequate and predictable funding, autonomy for providers, timely information, and technical and managerial skills. Countries in Eastern Europe and Central Asia often prefer highly technical solutions, which can add to, rather than ameliorate, existing challenges. For example, Kazakhstan has geographic resource allocation formulas with 100 or more variables, and some countries have complex provider payment systems (some regions in Russia have 55,000 diagnostic payment groups), some of which are even more complicated than those in OECD countries (Zhuganov, Vagner, and Zhuganov 1994). These systems suffer from new administrative burdens, and the signals they send to providers are often too complicated to achieve a meaningful behavioral response.

Changing service purchasing arrangements

There is no comprehensive account of the types of purchasing entities in place in middle-income countries, nor of their impact. There are examples of single-payer mandatory health insurance funds acting as sole purchasers (Baltic states, Bulgaria, Costa Rica, Hungary, the Kyrgyz Republic, Romania, and Slovenia) or multiple health insurers acting as third-party payers (Argentina, Colombia, Czech Republic, Russia, and Slovakia). There are also examples of contracting taking place without a new separate third-party purchaser apart from the ministry of health. In Kazakhstan, the law requires that all levels of government contract with providers through special units (“Densaolik”) that are inheritors of the collapsed mandatory health insurance fund (Duran, Sheiman, and Schneider 2004). Detailed accounts of the reform experiences in Estonia and Slovenia are described in boxes 8.3 and 8.4.

Reforms to separate purchasers from providers. Some middle-income countries have undertaken initiatives to separate purchasers from providers, improve services by linking plans and priorities to resource allocations, shift to more cost-effective interventions, and move care across boundaries (such as, from in-patient to out-patient care). Purchasing, in this sense, is an alternative way to plan and better meet population health needs and consumer expectations. It seeks to improve providers’ performance by giving purchasers financial incentives and monitoring tools to increase provider responsiveness and efficiency, facilitate decentralization of management and the devolution of decision making, allow providers to focus on the efficient production of services as determined by the purchaser, introduce competition among providers, and use market mechanisms

BOX 8.3 *Estonia—successful reform in financing, purchasing, and payment methods*

Estonia's reform of its health financing and delivery systems during the transition of the early 1990s is perhaps the most successful in the Eastern Europe and Central Asia region over that period. Success is attributed to two measures: institutional capacity and government commitment.

The government established a national health insurance in 1991, financed through a 13 percent wage tax that includes sick and disability funding (Jesse 2000). The initial insurance law established semi-autonomous funds in each county (district). Estonia consolidated 22 pools into 7 over time, and in 2000, created the unitary Central Health Insurance Agency. The fund is now adequately staffed and equipped and has a full-range of planning and operating systems. Responsibility for revenue collection has been transferred to the government's tax bureau, and compliance is high, thanks largely to a relatively small informal sector. The health insurance fund functions like public insurance funds in many OECD countries and serves as an example for other countries in the region.

Purchasing reforms were also initiated, particularly in the areas of provider payment

and service contracting. Payments for family doctors are based on a mix of capitation and fees for priority services such as immunization. The capitation payment constitutes more than 70 percent of the total payment and is adjusted by age groups. There is also an allowance for capital investments and for distance from hospitals. Outpatient specialists are subject to a fee schedule with an overall cap.

Family practitioners have undertaken limited fund-holding functions since 1998. In 2002 they received a virtual budget representing just under 20 percent of the total capitation fee, with which they can purchase selected clinical and diagnostic services. These include minor surgery and physiotherapy, common endoscopic procedures, x-rays, and biochemical tests. Parts of family practice and some other system features were privatized.

Contracts with hospitals are capped, and case-mix adjusters have been developed. The hospital payment system evolved from line-item budgets, to per diem, to simple case-mix adjusters with fee-for-service for some services, and most recently diagnostic-related groups.¹ The diagnostic-related groups are scheduled to

(Continues)

to increase efficiency (Figueras, Jakubowski, and Robinson 2001). Since 1990, most health reforms in Latin America, including those in Argentina, Brazil, Chile (FONASA), Colombia, Costa Rica (Social Security reform), Mexico, and Peru (Baeza and Packard forthcoming), have included some elements that sought to strengthen the purchaser-provider compact.

Innovations in contracting. There have also been innovations in purchasing methods. Over the past decade, a wide range of contract-like models for purchasing services have been developed in several middle-income countries in Eastern Europe, Latin America, and the Middle East. The rationale of such a “contract” is to introduce some form of accountability that is often lacking under state-run or public sector entities. Contracting is applied to a selection of providers (hospitals and clinics), staffing of physicians and nurses, and individual services or benefit packages, and it often includes terms relating to quality assurance programs and performance enhancement. However, the countries in Eastern Europe and Central

BOX 8.3 (continued)

be phased in over several years to achieve 30 percent phase-in by 2005. Payment methods for capital and long-term care are also being developed. From 1990 to 2000, average length of stay decreased a significant 47 percent to less than seven days, but admissions rose 10 percent because of payment incentives.

An aggressive rationalization strategy of hospitals also played an important role. A facility master plan was developed in the 1990s to consolidate vertical specialty hospitals under the old Soviet model into larger network facilities with autonomy to develop community governing boards. The networks progressively downsized within their own capacities and budgets. The total number of facilities was reduced from 115 to 67 between 1993 and 2001, with the target of 13 regional hospitals by 2015. Overall, beds decreased 38 percent between 1990 and 2000.

Estonia benefited from a cadre of well-trained and enthusiastic leaders who pushed for sweeping reforms. Donor countries such as Finland and Sweden appeared to have positively influenced Estonia in developing a reform agenda and provided blueprints for delivery system planning. Furthermore, the

World Bank's Estonia health project supported staff training and development, improved accounting and management information systems, and contributed to further refinements in the payment system to stronger incentives for efficiency and quality of care.

Improvements in the economy and employment and the implementation of new regulations seemed to have contributed to the success. Continued macroeconomic stability plus further efforts to improve efficiency bode well for the system's financial sustainability.

¹ Diagnosis-related groups (DRGs) are a classification of the types of hospital cases into groups expected to use similar levels of hospital resources. The U.S. Medicare system uses this classification to pay for in-patient hospital care. The groups are based on diagnoses, procedures, age, sex, and the presence of complications or comorbidities. Comparisons among different DRG versions should be made with caution because criteria are revised periodically (Agency for Health Care Research and Quality 2004).

Asia use contracting primarily to encourage new directions and delivery targets, not as a legal covenant. As such, these contracts tended to be “soft” agreements, rather than legally binding documents. Nevertheless, many countries continue to push for more performance-based contracting, as Romania has with primary care physicians (Vladescu and Radulescu 2001).

Innovations with provider payment mechanisms. There have also been innovations in provider payments, mainly by changing incentives for hospitals and physicians. Traditional hospital provider payment mechanisms are being converted to different methods, such as per diem, per case, or diagnostic-related groups (DRGs) for hospitals. Similarly, in several Baltic states, primary-care fund-holding arrangements and physician capitation have evolved to include a variety of models, such as direct payment to doctors or payment through facilities, “carving-out” priority services, or bonus add-ons for specific purposes. Specialist payments are managed through a separate insurance fund.

BOX 8.4 *Slovenia—improvement in financing, payment methods, and quality of care*

Slovenia established a national health insurance scheme in 1993, with a payroll tax rate of 13.25 percent. Since 2000 Slovenia has been engaged in reforms aiming at cost-containment, access, and quality of care. Improvements have included health financing reforms such as changes in the coverage and structure of copayments under the Basic Benefits Package and the introduction and management of supplementary health insurance; payment reforms covering primary, secondary, tertiary, long-term, and palliative care; and quality of care improvements. An evidence-based approach was adopted in the design of the reforms, and implementation was assisted by the World Bank–financed health sector management project (2000–4).

Voluntary supplementary insurance was introduced to cover copayments for mandatory social health insurance. Because the flat contribution rate for the supplementary insurance is relatively low and the copayments for many items in the mandatory package are quite high (such as, for pharmaceuticals), most citizens (more than 90 percent) have purchased supplementary insurance. As such, it is a steady and secure form of extra income for the health sector. But supplementary health insurance is beginning to show some drawbacks. It is somewhat regressive due to the flat rate premiums, and it has diminished the utilization control mechanism inherent in co-payments. Supplementary health insurance covering copayments has been found to increase patient utilization of discretionary services and publicly funded services, as in France and the United States.

Slovenia has accomplished major reforms in its health information systems,

which provide a building block for developing more sophisticated payment and utilization management systems. The system uses smart cards that collect health information at the individual level. The creation of minimum standards on information architecture and datasets may have benefited from the European Union (EU) standards. The next step is diagnosis data linking use with data for providers, facilities, and costs. Such a comprehensive system will help to improve the process for payment, quality, and management.

As part of the reform to improve the quality of care, Slovenia has involved its medical community in developing clinical pathways or standard-of-care guidelines. A comprehensive system for quality improvement of health services is also under way. Some examples include voluntary reporting of sentinel events at the national level; a national manual on the methodology of clinical practice guidelines development; and (within the hospital setting) clinical pathways development, facility accreditation, a manual for self-assessment, indicators development, and health promotion projects in collaboration with WHO.

Slovenia has achieved reform success due to several favorable factors. It has been aided by excellent institutional, managerial, and administrative capacity within the Slovenian Ministry of Health, which led the process and mastered the difficult technical aspects of the process. The country's impending EU membership also helped promote a results orientation and ensure sustainability. Finally, the country has involved stakeholders in quality standards agreements and in the evaluation and updating of health systems.

Strategic purchasing coupled with new provider payment incentives has increased efficiency to some extent, but there are unintended consequences. Strict capitation models have been shown to decrease use of preventive services and cause providers to underserve patients, as seen in Kazakhstan (Langenbrunner and Adeyi 2004). Per diem and per case payments have been known to induce excess service consumption and cost increases by driving up the volume of cases.

Some middle-income countries in Eastern Europe and the former Soviet Union are shifting their focus to the next financing challenges: cost containment.

Reforms to introduce internal markets. These include introduction of purchasing-provider splits, public-private purchasing, provider payment reform, and decentralization. These reforms attempt to address barriers to the extension of coverage that stem mainly from microinefficiency problems in public providers' production of services and seek to establish a more user-oriented incentive framework for providers (Enthoven 1985).

Along with purchasing reforms occurring within the social insurance systems, three key elements seem to be common to the introduction of internal markets. First, a new relationship between the purchasing organization and individual providers or networks of providers must be established. In this relationship the demand for health services is separated from supply using price mechanisms, provider payment mechanisms, or contractual and quasi-contractual arrangements. Second, the correct incentive environment for providers, especially the correct price signals, must be set. This environment includes provider payment reforms shifting historical supply-side financing of line-item budgets to more mixed demand and supply-side financing payment mechanisms (or at least "money follows the patient" mechanisms) linked to the production of services, but also containing elements of risk sharing between purchasers and providers through mechanisms such as global budgets, capitation, or DRGs. Third, successful implementation of provider payment reforms will necessitate significant flexibility in resource management by public service providers. They need to be able to adapt their service production functions and cost structures to the continuing evolution of price signals determined by the new payment mechanisms and competition with private providers. This includes diverse forms of hospital autonomy, including corporatization and privatization.

Evidence on the impact of provider-purchaser splits on microefficiency in low- and middle-income countries is still evolving, as there have been significant restrictions on the full implementation and functioning of such splits. This is often due to the difficulties public providers face in adjusting their cost structures without major, accompanying reforms to public sector management, particularly personnel management.

Initial provider payment reforms assumed that managers of public providers would receive and understand the price signals in the new payment mechanisms; know how to respond and be willing to act accordingly, despite other organizational and institutional incentives; and have adequate legal and administrative flexibility to make the right changes. It also assumed that political authorities in the sector and the government would be willing and able to deal with the political problems associated with such flexibility (Baeza 1998). Experience over the past 15 years has increasingly demonstrated that these conditions have often been missing. Effective institutional reforms must be implemented in tandem with

purchasing reforms, particularly those providing increased flexibility to manage personnel. In addition, a necessary condition for provider payment reforms—effective modernization of the public sector management and civil services statutes—has been missing from most health sector reform efforts.

Other considerations

In addition to the three financing functions previously discussed, middle-income countries are well aware that other institutional considerations are essential to the success of their health financing systems: strengthened health care provider infrastructure, timely information to the public, improved governance through policy incentives to insurers and providers, and strong regulatory oversight of private sector insurance and delivery. These issues are explored and discussed in other chapters.

The success stories described in this chapter suggest that a clearly defined benefit package, in concert with reforms aimed at enlarging risk pools, plays a critical role in achieving greater inclusion through solidarity in health care financing (potentially increasing financial protection) and in increasing access to needed health care services. Improving provider incentives through effective purchasing arrangements is also an important part of successful reforms.

Annex 8.1 Summary of recent health reforms in middle-income countries

TABLE A8.1 Summary of recent health reforms in middle-income countries

Type of reform	Specific reform	Country	Features
Strengthening the purchaser-provider compact in national health service and social security	Purchasing-provider split	Uruguay (1998)	Strengthening of ASSE (State Health Services Administration) as the purchasing agency
		Argentina (1997)	Salta and Mendoza health sector reforms in the late 1990s
		Chile (1981–97)	Creation of <i>FONASA</i> in the early 1980s and its consolidation as the public sector purchasing agency in the late 1990s
		Colombia (1994)	
		Slovenia	
	Estonia		
	Public provider payment reforms	Costa Rica (1995)	Payment reforms within the <i>Caja Costarricense de Seguro Social</i>
		Chile (1985–92)	Municipal primary health care capitation and <i>FONASA</i> -NHSS payment reforms
		Brazil (1985)	Contracting and payment reforms for contracting with private providers
		Nicaragua (1998)	Budget decentralization and performance agreements
Introducing public-private competition	Private-public competition for mandated health insurance	Chile (1985)	ISAPREs
		Colombia (1994)	EPSs
		Estonia	
	Demand-side subsidy for insurance	Colombia (1994)	Subsidized modality in the social health insurance reform
	Public-private competition for the provision of publicly financed health services	Chile (1985)	<i>FONASA</i> voucher system
Argentina (Salta, 2001)		Outsourcing public hospital management to the private sector (Hospital Materno-Infantil)	
Re-converting public providers	Direct community participation in governance of public providers	Panama (1999)	San Miguelito Hospital
		Perú (1994)	CLASS
		Bolivia (1994)	Decentralization to municipal level for maternal and child insurance
	Public hospital autonomy	Argentina (1994)	
		Colombia (1994)	
		Uruguay (1998)	
		Panama (1999)	
		Chile (2003)	

(Continues)

TABLE A8.1 Summary of recent health reforms in middle-income countries (*Continued*)

Type of reform	Specific reform	Country	Features
Enlarge risk pools		Costa Rica	
		Chile	
		Poland	
		Estonia	
		Czech Republic	
		Brazil	
		Egypt, Arab Rep. of	
		Taiwan, China	
		Korea, Rep.	
Define benefit package		Colombia	
		Argentina	
		Chile	
		Mexico	
		Uruguay	
		Bolivia	
		Brazil	
Integrate private insurance		Philippines	
		Colombia	
		Chile	
		Slovenia	
Revenue base shift		Kazakhstan	
		Russia	
Universal coverage		Chile	
		Peru	
		Ecuador	
		Costa Rica	
		Argentina	
		Bolivia	
		Uruguay	
		Russia (Samara Region)	
Expand national health service		Brazil	
		Mexico	

Source: Authors' compilation.

Endnotes

1. Because of the bundling of pension and health insurance premiums, contributions can amount to as much as 40 percent of total wages, as in Argentina.
2. This chapter uses the terms “risk fragmentation” and “risk segmentation.” In the literature, these terms sometimes have somewhat different meanings; risk fragmentation is often used to refer to the existence of multiple risk pools, whereas risk segmentation is used to refer to the existence of uneven risk distributions between or among pools. The use of the terms in this chapter seeks to mirror the common usage in the literature.
3. “The main pro-poor program of PhilHealth is the Indigent Program (‘IP’) or ‘Medicare para sa Masa’(MpM).” (Almario and others 2002).

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