Extending Social Health Protection in the Asia-Pacific Region:*

Progress and challenges

Asia-Pacific Regional High-Level Meeting on Socially Inclusive Strategies to Extend Social Security Coverage

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1: Global Patterns of access to health services and approaches to health financing

1.1 The importance of access to health services

Good health is a central outcome of development and is valuable in itself. This is recognized by all United Nations Member States in their commitments to the Millennium Development Goals (MDGs), three of which (Goals 4, 5 and 6) deal explicitly with improving health conditions, while three others (Goals 1, 7 and 8) can be considered to be health related (see table 1). Consequently, improving access to health services is a critical element of development, for two reasons:

First, effective access to health services is instrumental in enabling societies and individuals to achieve better health and to realize their full potential. Although achievement of better health is influenced by factors outside the health system, such as nutrition, education and gender relations, the provision of and access to health services are key to achieving overall health improvements. For example, it is well established that maternal mortality cannot be brought down to low levels without ensuring access to hospital-based health services offering essential obstetric care; provision of directly observed treatment, short course (DOTS) for the treatment of tuberculosis (TB) is contingent on the existence of a well-functioning health system and availability of health staff to manage and monitor the treatment; similarly, reducing death rates from malaria requires the provision of effective treatment to those suffering from the disease.

Second, lack of access to affordable health services can impose heavy burdens on families, leading to economic insecurity, impoverishment and poverty. It was the recognition of this reality that historically motivated countries such as Germany, Japan and Sri Lanka to take measures to expand coverage of health services.

Table 1 Health and health-related MDGs and health indicators

Goal 1:	**Eradicate extreme poverty and hunger**
Goal 4:	**Reduce child mortality** • Under-five mortality rate • Infant mortality rate • Proportion of 1-year-old children immunized against measles
Goal 5: Improve maternal health	 • Maternal mortality rate • Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	 • HIV prevalence among young people aged 15–24 • Condom use rate of the contraceptive prevalence rate • Number of children orphaned by HIV/AIDS • Prevalence and death rates associated with malaria • Proportion of population in malaria risk areas using effective malaria prevention and treatment measures • Proportion of TB cases detected and cured under DOTS • Prevalence and death rates associated with TB
Goal 7: Ensure environmental sustainability	
Goal 8: Develop a global partnership for development	

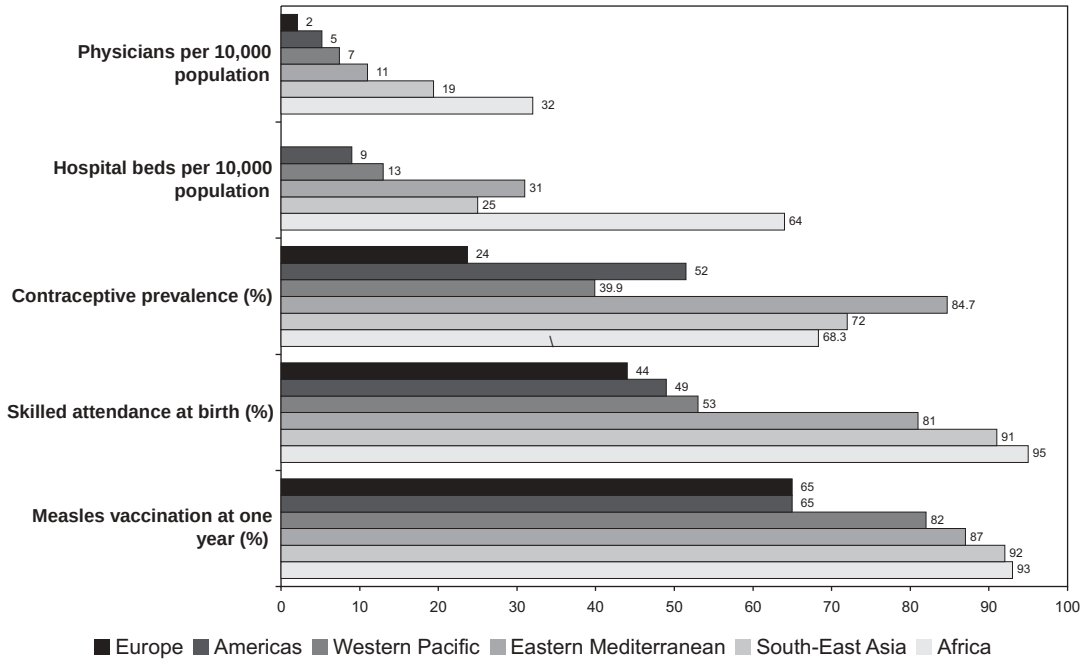
Note: MDGs requiring or implying improvements in access to health services are shaded.

1.2 Global patterns of access to health services

Access to health services varies greatly between and within countries: in advanced economies it is close to adequate and universal and in poor countries often, though not always, inadequate and unequal. However, quantifying these differences is neither straightforward nor easy. If we consider access as implying the notion that all individuals are able to make sufficient use of and benefit from appropriate and acceptable health-care services when they are ill and in need of those services, then measuring such access is not easy. For example, statistics on the physical provision of services can be misleading since they do not tell us how economic barriers may prevent people from using such services. The same per capita indicators of the availability of clinics can imply quite different levels of access in a geographically dispersed population such as Mongolia's from those in a densely populated region such as Java. Similarly, indicators showing equal use of services by people in different economic circumstances are not sufficient, because they do not tell us whether the equal use of services is adequate in relation to the differences in actual need for services. Moreover, simply asking people about their need for services can be misleading, because awareness of the need for services is partially dependent on knowledge and norms, which can vary between individuals and populations.

While recognizing the limitations of generally available indicators, it should be noted that most indicators point to consistent differences between regions across the world. This is illustrated in figure 1, which is based on WHO data and regional classification. In general, levels of physical provision of health-care inputs, such as hospital beds and health workers, are highest in the advanced economies of Europe and the Americas and lowest in Africa and South-East Asia. These translate into significant differences in the frequency of use of health services. Reliable and comparable data on how often the average person is able to access health services is unfortunately not routinely collected. However, for a more specific indicator such as skilled attendance at birth, access is close to universal in the developed economies of Europe, the Americas and the Pacific region, relatively high in much of East Asia, and under 50 per cent in most of Africa and South Asia. Similar patterns are also seen in the use of modern contraceptives and provision of child immunizations (e.g., measles vaccination).

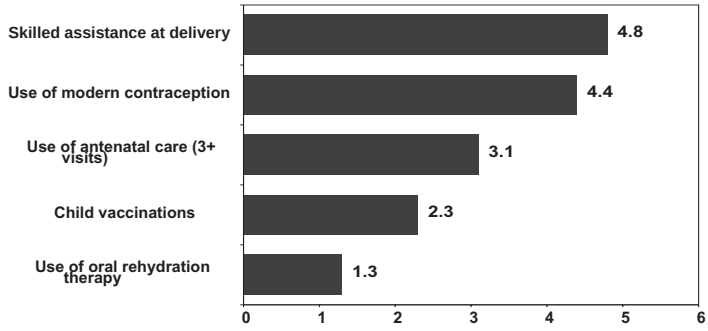
Figure 1 Indicators of access to health services, selected regions, latest available years



Source: WHO (2007).

Such regional and country averages mask significant variations in access between rich and poor within a country. In the developed countries of Europe, the Americas and East Asia, levels of use of health-care services vary only modestly, if at all, between those at different ends of the income range. The overall rate of use of services in the poorest households in these countries is usually higher than in the richest households, although the differentials may in many cases still not be sufficient in relation to differences in sickness between rich and poor (van Doorslaer et al., 2000). For the most part, physical access to health services is good for all income groups. In the world's poorest developing countries, on the other hand, there are significant disparities between rich and poor. For many indicators, such as use of skilled birth attendance or use of modern medical treatment when ill, the disparities between the richest and poorest quintiles can be as much as fourfold or higher (figure 2), although many developing countries the world over have managed to show that even at low levels of per capita income it is possible to substantially reduce or even eliminate such disparities.

Figure 2 Inequalities in use of services a verage rich/poor ratio, Demographic Health Surveys 1991-2002



Source: D.R. Gwatkin, S. Rutstein, K. Johnson, E.A. Suliman, and A. Wagstaff, *Initial Country-Level Information about Socioeconomic Differences in Health, Nutrition, and Population*, Volumes I and II (World Bank, Washington, DC, November 2003).

1.3 Global patterns in health-care financing

The level and nature of health-care financing is an important influence - although not the only or predominant one - on levels of access to health-care services in different countries. The mode of financing has implications for (i) the amount of financial resources that are mobilized, (ii) how efficiently these resources are translated into access to and provision of services, (iii) how well financial resources are pooled, and (iv) how access to services is distributed within the population.

The per capita level of health-care expenditure is closely related to the level of per capita income, with the share of national health expenditure in relation to gross domestic product (GDP) increasing with per capita income. In the advanced, high-income economies of Europe, the Americas and East Asia health spending averages US$ 2,000–6,000 per capita, or 8–16 per cent of GDP. In the poorest, low-income countries, which are mostly in Africa, South Asia and parts of South-East Asia, health spending is typically in the range of US$ 20–40 per capita, or 3–5 per cent of GDP, although donor assistance in some countries can push spending much higher. Spending in most middle-income countries (e.g., in Latin America, the Middle East and South-East Asia) is situated between these levels.

Broadly speaking, countries use five main modes of financing to pay for health-care services: (i) out-of-pocket payment by households, (ii) general revenue tax financing, (iii) social health insurance, (iv) voluntary or private health insurance, and (v) community-based health insurance. These mechanisms all differ in the extent to which they achieve *risk pooling*, which is the collection and management of financial resources so that large unpredictable individual financial

risks due to health-care needs become predictable and are distributed among all members of the risk pool. In practice, general revenue tax financing and then social health insurance achieve the most risk pooling. Out-of-pocket financing involves no risk pooling.

The more developed a country, the more likely it is to use financing mechanisms with high levels of risk pooling as the predominant method of financing (table 2). In fact, in the past century, the need to increase the effectiveness and coverage of risk protection has been the most important policy motivation in reforming health-care systems in the advanced economies of Europe and the developed world in general. In the advanced, developed economies, general revenue and social insurance financing account for 80–95 per cent of total health-care financing; there are a few exceptions, such as the Republic of Korea, Singapore and the United States, where they account for only 40–50 per cent of financing. In most poor countries, out-of-pocket financing is a major source of financing and can account for 20–85 per cent of total financing. In middle-income developing countries, with higher per capita income out-of-pocket financing generally gives way to financing by general revenue taxation and social health insurance, although the exact mix varies considerably between countries. With the exception of the United States, in no country does private insurance account for a significant share of financing, and in almost all countries it accounts for less than 2 per cent of total financing. Community-based health insurance was historically the precursor to many social health insurance programmes in countries such as Germany, Japan and the Republic of Korea. Today it is found only in a few poor countries, in particular in China and some African countries; however, with the exception of China, it usually does not contribute a substantial share of financing.

Table 2 Level and composition of health expenditures in low-, middle- and high-income countries worldwide, population-weighted averages, 2002

Income level	Per capita health expenditure (US$)	Total health expenditure (% of GDP)	Public spending (% of total)	Social insurance spending (% of public)	Private spending (% of total)
Low	30	5.3	29	6	71
Lower-middle	82	5.6	42	36	58
Upper-middle	310	6.2	56	53	44
High	3 039	10.4	65	44	35

Source: Gottret and Schieber (2006).

2: Current status of health-care coverage and financing in countries of the Asia-Pacific REgion

The Asia-Pacific region is characterized by considerable variations in geography, economic development and historical legacies. There is corresponding diversity in the development of health systems, and wide variations exist in the levels of coverage, risk protection and financing. It encompasses greater variation in this respect than any other region in the world, with circumstances ranging from those seen in Cambodia and Nepal to those found in Australia and Japan.

2.1 Access to health services and risk protection

Access to health services varies greatly in the region and is clearly linked to differences in overall health performance. In the advanced economies such as Australia, Hong Kong (China), Japan and New Zealand, health outcomes are among the best in the developed world, and these are

associated with high levels of access to health services with good levels of risk protection. Two indicators of the level of access in these countries are that the average person is able to visit a qualified physician 616 times a year, and the number of hospital beds per 1,000 population is more than 3.5 (OECD, 2005). Access to services in these economies is broadly equitable, although some disparities exist in the Republic of Korea and possibly in Singapore (Wagstaff, 2005).

Making an accurate assessment of the level of access in the rest of the region is not easy because at present there is no system to compile systematic data on health services for the region's non-OECD economies. Nevertheless, the available indicators show that in several middle-income economies (Fiji, Malaysia, Sri Lanka, Thailand, Tonga) and in a few low-income ones (Kyrgyzstan, Mongolia, Viet Nam) the population enjoys relatively high levels of access to basic and most intermediate health-care services, although high-technology services may be accessible only to a few. In these countries, levels of use of health services are much higher than in most other developing economies, although usually not as high as in high-income countries: the per capita visit rate to physicians averages 46, and the supply of hospital beds 24 per 1,000 population (WHO, 2007). For key basic health interventions, such as skilled birth attendance and immunization coverage, the indicators in these countries are also close to universal (>90 per cent). Extreme inequalities in use of health care between rich and poor are not typical, and in some of these countries, such as Malaysia and Sri Lanka, equity in health care use is high (Rannan-Eliya and Somanathan, 2006).

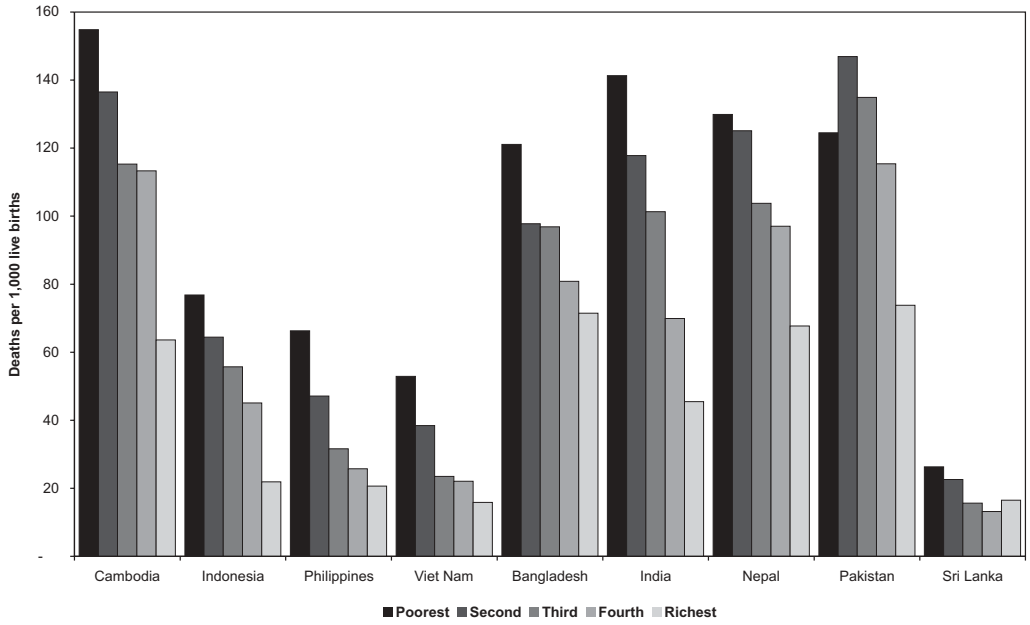
In the remaining countries of the region, considerable disparities exist in access to services, and large numbers of people lack adequate access, as shown in table 3. Access is poor in the low-income countries of South Asia, the Mekong region and some parts of China, particularly the inland western provinces. Access to most services is the worst in Afghanistan, Bangladesh, Cambodia, Nepal, Pakistan and Papua New Guinea, and in some northern states in India. In these countries, the average person makes 13 visits per year to a physician, and there are fewer than two hospital beds per 1,000 population. Most mothers give birth without skilled care, and coverage of basic preventive health interventions is too low to ensure effective protection. In countries where access to services is inadequate, considerable inequalities in access between rich and poor are the norm, and health outcomes show similarly large disparities. This is most clearly seen in access to maternal, child and population services; the available survey data shows that differentials in outcomes between the poorest and richest quintiles can be as much as four- or fivefold (figure 3).

Table 3 Health service coverage indicators in selected Asia and Pacific countries (as percentage of respective population group), 2002 2003

Country	Attended births	Measles immunization	DPT3 immunization	Contraceptive prevalence	DOTS detection	DOTS cure
Afghanistan	14	50	54	5	18	87
Pakistan	23	61	67	28	17	77
Cambodia	32	65	69	24	60	92
Bangladesh	14	77	85	54	33	84
Nepal	11	75	78	39	60	86
India	43	67	70	47	47	87
Indonesia	68	72	70	60	33	86
Philippines	60	80	79	49	68	88
China	97	84	90	87	43	93
Viet Nam	85	93	99	78	86	92
Thailand	99	94	96	72	72	74
Sri Lanka	97	99	99	70	70	81
Malaysia	97	92	96	55	69	76

Note: Countries are listed in ascending order of levels of access to services.
Source: WHO (2005a, 2005b) and WHO statistics.

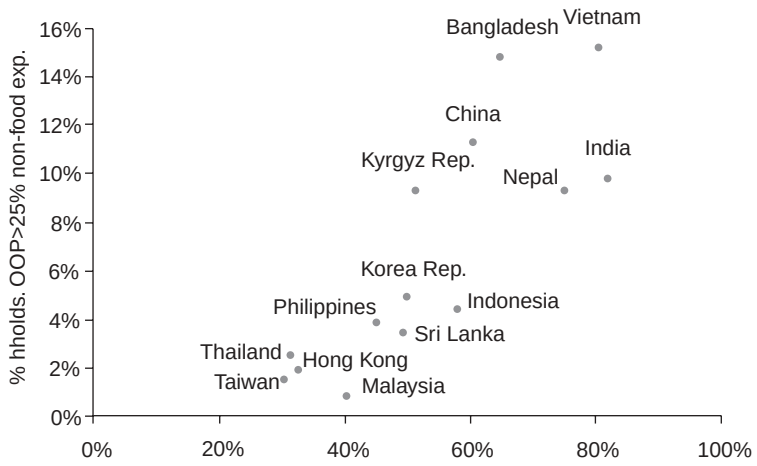
Figure 3Under-five mortality rate by income quintile, selected Asian countries, latest available years



Source: Analysis of various demographic health surveys (DHS) as published by the World Bank, and analysis by IHP staff of Sri Lanka DHS data.

The other important dimension of access is the extent to which health systems protect people against the financial risks of costly health-care treatment, which if severe enough can be catastrophic for households. Research by the Equitap collaboration has shown that performance varies substantially within the region (van Doorslaer et al., 2007). In the high-income economies such as Australia, Hong Kong (China), Japan and New Zealand, risk protection is good, and exposure to catastrophic expenses as a result of illness is very rare. However, the Republic of Korea and possibly Singapore (Wagstaff, 2005) are an exception in the high-income group, in that the incidence of catastrophic expenses is as high as in some poorer middle- and low-income economies. In general, risk protection is weaker in countries with lower levels of per capita GDP, but is clearly negatively correlated with the extent to which health-care financing relies on out-of-pocket financing (figure 4). Nevertheless, even within this context, some poorer countries in the region, notably Malaysia, Sri Lanka and Thailand, do quite well in ensuring effective risk protection despite significant levels of out-of-pocket financing. At the same time, a few countries that perform relatively well in terms of overall access to services (e.g., Viet Nam) do poorly in terms of risk protection.

Figure 4 Incidence of catastrophic health expenditures against reliance on out-of-pocket (OOP) financing, selected Asia-Pacific countries, data for years up to 2005



Source: van Doorslaer et al. (2007).

It is worth noting that although the generally richer countries of East and South-East Asia do better in terms of access, such performance is not simply an outcome of better economic growth. The examples of economies such as Sri Lanka or Viet Nam show that even at low incomes countries can substantially mitigate the problems of poverty and access and expand access to health services.

2.2 Levels and mechanisms of health-care financing

Lower levels of health expenditure help to explain lower levels of health service coverage in the region's poorer economies. The countries with the lowest level of coverage (e.g., Afghanistan, Bangladesh, Nepal, Pakistan) tend to spend less than US$ 1216 per capita, taking into account both public and private spending (table 4). However, aggregate levels of health spending do not provide the full explanation: the mode of financing and provision of health-care services also matters, and the effectiveness of risk pooling particularly so. For example, China, India and Sri Lanka spend similar amounts per capita (~US$ 3055) but achieve quite different levels of access and risk protection. Likewise, Cambodia and Viet Nam spend similar amounts on health, but coverage is much better in Viet Nam.

Table 4 Health expenditure in selected Asia-Pacific countries, population-weighted averages, 2002

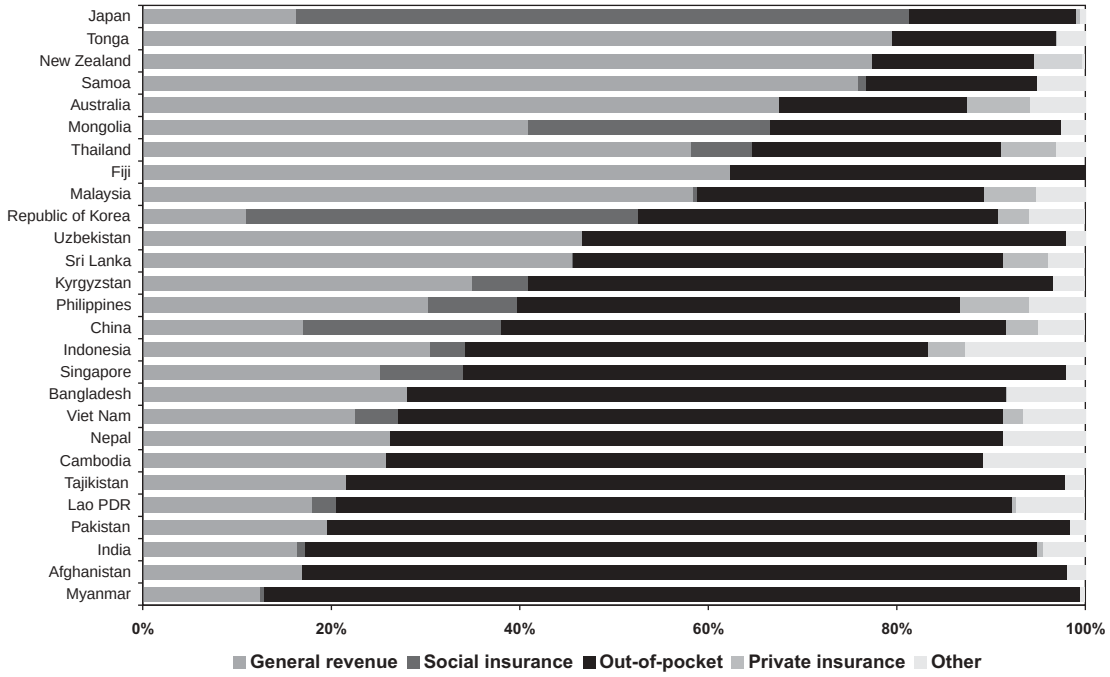
Country	Publicly financed health spending (% of total)	Privately financed health spending (% of total)	Health spending (as % of GDP)	Per capita spending (US$)
Afghanistan	-	-	8.0	14
Bangladesh[a]	25	75	3.4	12
Cambodia[b]	35	65	6.4	23
China	36	64	5.5	54
India	21	79	6.1	29
Indonesia	36	64	3.2	30
Malaysia	55	45	3.7	143
Nepal	27	73	5.2	12
Pakistan	35	65	3.2	16
Philippines	42	58	3.0	29
Sri Lanka	45	55	3.6	31
Thailand[a]	56	44	3.1	63
Viet Nam	29	71	5.2	23

[a] 2001 figures [b] 2004 figures

Source: Asia-Pacific NHA Network (APNHAN) correspondents, WHO statistics and author s estimates as cited in Walford et al. (2006).

WHO statistics reveal the contrast in modes of financing in the region (see figure 5). In the richest economies (e.g., Australia, Japan, New Zealand) and in a few Pacific States (e.g., Samoa) health care is financed primarily from public sources (>75 per cent), with out-of-pocket financing accounting for less than 20 per cent of total spending and private insurance representing an even smaller share. In most of these countries public financing is almost exclusively from general revenue sources, but in Japan social health insurance predominates. Where general revenue financing dominates, most service provision is through public systems that integrate financing and delivery, with public sector providers being funded from government budgets and with minimal patient charges, although public funding of private provision is significant in Australia. In Japan, where social health insurance dominates, most general revenue financing is mobilized through the social health insurance system, and most provision is by private providers. In all these countries access to health services and risk protection are good, and both poor and rich have access to publicly financed services.

Figure 5 Sources of health-care financing in selected Asia-Pacific countries, 2004



Note: Countries are listed in descending order of reliance on public financing (general revenue plus social insurance).
Source: WHO (2007).

In a second band of economies, public financing still dominates, although to a lesser extent, accounting for 45 to 75 per cent of total financing (e.g., Malaysia, Sri Lanka, Thailand). With the exception of Mongolia (low income), the Republic of Korea and Hong Kong (China) (high income), these are all middle-income economies. Coverage of health services is higher than in most developing countries and inequities in access are modest, although not as small as in Australia or Japan. Similarly, risk protection is better than in most developing countries but not as good as in the first group discussed above. In most of this second group, public financing is purely from general revenues (e.g., Fiji, Hong Kong (China), Malaysia, Sri Lanka) and is used to pay public providers, who are accessible to all citizens; a parallel private sector is funded by generally richer citizens who choose to opt out of the public sector. In the three countries which use social health insurance, namely, the Republic of Korea, Mongolia and Thailand, the schemes are universal in coverage and financed from a mix of social health insurance contributions and general revenue subsidies, the latter accounting for more than half of the schemes' financing base in Mongolia and Thailand. In these three countries it is possible for private providers to be paid by the social health insurance programmes, with public providers predominating in Mongolia and private ones in the Republic of Korea. Private financing does exist in these systems but it comprises mostly out-of-pocket financing of co-payments that the insurance schemes may require, or is used to purchase services not covered by the insurance schemes, such as medicines or high-technology services.

In a further group of countries (Afghanistan, Cambodia, India, Myanmar, Pakistan), most of which are among the region's poorest, out-of-pocket financing tends to predominate, accounting for more than 60 per cent of total financing, while public financing represents only 15 to 25 per cent of total health expenditure. Public financing is almost exclusively from general revenue taxation and is used to directly fund public services, reflecting the countries' severe difficulties in extending social health insurance mechanisms. In these economies, private financing almost

exclusively comprises out-of-pocket payments, and this is used to pay mostly for private treatment. In all of these countries, the heavy reliance on out-of-pocket financing is associated with weak risk protection and poor access to basic health-care services, with large inequities in access, particularly in respect of hospital services.

In regard to the extent of public financing, several countries lie between the second and third groups of countries mentioned above. In these countries, public financing generally represents between 2545 per cent of total expenditures, with out-of-pocket financing accounting for half or more of overall spending. The bulk of public financing is generated through general revenue, but several countries supplement this with social health insurance. This is most clearly the case in China, Philippines and Viet Nam, where social health insurance schemes cover parts, but not all, of the population, and operate mostly by paying the charges levied by government hospitals. In these countries, access to health care is a problem for large numbers of people, either because of lack of insurance coverage or high levels of co-payments with insurance, and risk protection is often weak.

3: Approaches to extending Social Health protection coverage

3.1 Defining social health protection coverage

We can define social health protection coverage to comprise two central elements:

(i) Arrangements for the financing and provision of health services such that all covered persons are able to access and benefit from essential health care when they are sick and to receive preventive health-care services when appropriate.

(ii) Arrangements for the financing and provision of health services such that no household is forced to make impoverishing payments in order to receive a basic minimum level of acceptable health services when ill.

Both of these elements can be empirically assessed to some extent. Indicators of the first include the overall volume of health-care services used by the population, the lack of significant inequalities in use of services between rich and poor (for an illustration, see figure 2), which would imply barriers to access, and high levels of coverage by essential preventive health measures (see table 3). An indicator of the second element would be the frequency of households that experience catastrophic or impoverishing expenditures in order to obtain medical treatment (see figure 4).

All countries start with low levels of coverage and access to health services. To varying extents, they then expand coverage and increase social health protection to their populations. In the Asia-Pacific region, the richest economies have been the most successful and most of them have achieved universal coverage, but at all income levels there are countries that perform significantly better than their peers and that have substantially ensured effective social health protection for their populations. This shows that achieving high levels of social health protection is not wholly dependent on GDP per capita (ILO, 2007a). While economic development is a key facilitator, regional and global experience demonstrates that the way in which health-care systems are organized and financed is just as important.

It is also important to note the imbalance in the less developed economies between those segments of the population living and working in the formal economy and the much larger numbers found in the informal economy (or "unorganized sector"), with the consequent exacerbation of the difficulties in financing health care and providing access to services.

The special nature of the health care needed in relation to maternity, and the importance of improving maternity indicators in many developing countries, has resulted in a growing trend (as seen in India, for example) towards special and separate schemes of finance for this category of care.

3.2 General approaches to financing coverage

In considering the different national approaches to extending coverage for social health protection, three aspects of the health-care system are most important: (i) financing and its organization, (ii) macro-organization of provision, and (iii) incentives for providers and patients. Of these, financing is most critical and most influential in determining the level of overall health protection. As noted earlier, countries use five mechanisms of financing to pay for health-care services: (i) out-of-pocket payment by households, (ii) general revenue tax financing, (iii) social health insurance, (iv) voluntary or private health insurance, and (v) community-based health insurance. The financing approach what mix of these are used and how they are combined with the delivery side determines how well risks are pooled and who can afford to access services, what services are made available to the poor and to workers in the informal economy, how efficient the system is, and the overall level of service provision (Hsiao, 2000).

Before discussing the major approaches to financing coverage, it is useful to note the implications of financing health care using solely out-of-pocket financing. This was the prevalent approach in all countries prior to the twentieth century. Such an approach leads to a situation where access to health care is related to ability to pay, so that access is better for the wealthier while those without financial resources are unable to access services. In addition, as sickness is an infrequent event, it can mean that individuals or families who experience a sudden serious illness face an urgent need for large, catastrophic and impoverishing expenditures in order to access care. Families obliged to finance health care on an out-of-pocket basis all too often sell their land, or their farming tools, thus getting caught in a downward spiral of indebtedness. Alternatively, many households in such a situation of financial hardship will simply not use any care services, relying on either self-treatment or no treatment at all. In this scenario, the prevalence of out-of-pocket financing implies a high degree of financial insecurity for most families and large inequalities in access to and use of health care.

All organized financing mechanisms can improve on this by pooling risks and health-care expenses across individuals, thus increasing financial security and overall access to care. However, their actual performance will often depend on the details of their implementation and other factors.

In general, countries use four different approaches to pool risks and expand access to coverage:

(i) Tax-funded, integrated health services
(ii) Social health insurance
(iii) Community health insurance
(iv) Private or voluntary insurance

Each of these can be and usually is combined with others; their effectiveness has depended on the details of their design and on the broader features of each country's economic and social conditions (Gottret and Schieber, 2006).

3.3 Tax-funded, integrated health services

Tax-funded, integrated health services are the commonest approach to extending coverage globally and in the Asia-Pacific region as well. In this approach, public financing is obtained

through general revenue tax financing, with the funding being used to finance government-operated health-care services which are made available to all citizens on a universal basis at zero or minimal price. The approach is integrated in the sense that public financing and provision are combined in a single institutional system.

This approach is often called the Beveridge model as it is most closely identified with the system established in the United Kingdom in the 1940s, although similar systems were established earlier in New Zealand and the Soviet Union, and much older examples existed in Sri Lanka (Rannan-Eliya and de Mel, 1997). A historical characteristic of this approach is that the public sector providers are usually funded on the basis of budgets (possibly on a per-person, or "capitation", basis), and not on the basis of payments for specific services delivered, although following reforms in the past two decades in New Zealand and Hong Kong (China), variations on this approach have emerged in advanced economies. The approach is common in developed countries (e.g., Canada, New Zealand, United Kingdom), where it has been effective in achieving universal coverage. It has also been widely adopted in developing countries (e.g., Bangladesh, Jamaica, Zambia, with a wide variety of characteristics), but in most of them universal coverage is yet to be achieved.

Strengths and weaknesses of tax-funded, integrated health services

These systems have several strengths, including:

(i) *Universality of coverage.* The systems provide services that all citizens are eligible to use, so in theory access is not linked to ability to make contributions, membership of specified groups, or ability to pay.

(ii) *Wide risk pooling.* Because these systems (usually) levy minimal charges at the point of treatment and spread the expense of health-care services across all taxpayers, they achieve the highest degree of risk pooling, in theory across the whole population.

(iii) *Large revenue-raising potential.* Taxation provides a broad revenue base, larger than that of social insurance.

(iv) *Equitable sharing of financial costs.* Taxation, especially direct taxation, is generally the most progressive form of health-care financing in that it imposes a greater share of all payments on wealthier persons than on poorer ones (van Doorslaer, 1993; O'Donnell et al., 2005).

(v) *Simplicity of operation.* Direct government provision of services and taxation make the least demands on state administrative capacities and are thus feasible even in the poorest countries.

On the other hand, such systems can present significant problems, especially in the setting of developing countries:

(i) *Unstable and inadequate funding.* Health services have to compete with other sectors for available public financing, and in poor countries tax resources are often constrained by the difficulties in mobilizing tax revenues. However, in advanced economies there is no evidence that this approach leads to under-funding (Hsiao, 2000).

(ii) *Inequity in the benefits of government services.* In many developing countries, available government services are used more by the rich than the poor. This is usually associated with underfunding and low levels of supply, with rich people better able to access available services, either because of their ability to pay for access or their proximity to service provision. In these situations, universality of coverage exists only on paper.

(iii) *Inefficient and unresponsive health-care delivery.* These systems are often criticized as being inefficient in their use of resources and not responsive to the demands of patients because of the lack of financial incentives faced by providers. However, it should be

noted that there is no empirical evidence to substantiate the view that public sector provision is more inefficient than the alternative private provision.

Critical issues in extending coverage with tax-funded, integrated health services

Although these systems have been successful in achieving universal coverage in advanced economies, in many developing countries they have failed to do so. A common reason is the inability of governments in poor countries to mobilize sufficient and stable tax financing to ensure sufficient levels of health-care provision enabling all citizens to have reasonable access to services, reflected in uneven geographical outreach and low quality of care. Other reasons that can come into play include inadequate targeting of limited resources to the poor who are in most need of coverage, and inefficiencies in delivery. For developing countries which use this approach, the critical challenges are usually how to mobilize sufficient funding to make the system work and how to target the limited government services that can be funded so that poor people benefit equitably.

3.4 Social health insurance

Social health insurance involves the collection, generally mandatory, of contributions from designated segments of the population and the pooling of these contributions in independent funds that are then used to pay for services on behalf of the insured population. In social insurance systems, the mandatory payments typically take the form of compulsory payroll levies (paid either by employers or employees, or both), and health-care services are provided either from government or private providers, or both. An important feature of this approach is that making contributions is linked to eligibility to receive benefits, although in most social insurance systems some categories of people may receive coverage without having to make contributions.

The social insurance model originated in Germany in the nineteenth century, and is often called the Bismarckian model. It is used by many developed countries and is also commonly found in middle-income economies (e.g., Brazil, Republic of Korea, Tunisia). It is less common in the poorest countries, where social insurance contributions are even harder to raise in significant amounts than general revenue taxes. One important modification of the original German approach must also be noted. Over time, many social insurance systems, including almost all in developed countries, have added general revenue taxes as an additional source of revenue. This has been necessary in order to extend coverage to those outside the formal economy who cannot easily make contributions. In a few countries, social insurance is in fact completely funded from general revenue transfers (e.g., Armenia, Lithuania).

Strengths and weaknesses of social health insurance

Social health insurance systems have several strengths. These include:

(i) *Significant revenue-raising potential.* Because contributions are directly linked to benefits, it is often argued that for raising financing social insurance schemes are politically a more acceptable mechanism than increasing general revenue taxation.

(ii) *More stable funding.* Since social insurance funds do not have to compete with other sectoral budgets, these schemes may provide a more stable level of funding for health-care services when competition for fiscal resources is intense.

(iii) *Wide risk pooling.* Social insurance schemes distribute risk across all contributors and are thus effective mechanisms to pool risks. However, they are not as effective as general revenue mechanisms.

(iv) *Equitable sharing of financial costs*. After taxation, social health insurance is the second most progressive form of health-care financing as it imposes a greater share of all payments on wealthier persons than on poorer ones (van Doorslaer, 1993; O'Donnell et al., 2005).

(v) *Potential for using financial incentives to stimulate greater responsiveness by providers*. Since in most schemes financing is not directly linked to provision, it is possible to link payments directly to service delivery and thus incentivize providers to be more responsive.

On the other hand, social health insurance approaches can face significant problems, particularly in developing countries:

(i) *Limitations to extending coverage to the poor and to the non-formal economy*. Most social health insurance schemes start by covering formal economy workers, from whom it is easiest to collect contributions. However, most schemes in poor countries have found it very difficult to extend coverage to other groups because of the difficulties in collecting contributions, and this usually results in such schemes only benefiting the richer segments of the population.

(ii) *Negative labour market costs*. Although insurance contributions can appear to be more acceptable than taxation, in practice they can themselves cause problems because workers may choose to remain in the informal economy to avoid payments, or the actual level of payments can increase relative labour costs during periods of recession.

(iii) *Capacity constraints in management*. Insurance systems can be quite complex to run, especially if providers must be contracted for delivering services. The necessary management and technical capacities to run such systems properly often do not exist in the poorest countries.

(iv) *Poor cost control and macroeconomic inefficiency*. Many countries at all income levels have faced difficulties in controlling the overall cost of insurance systems, particularly because of the incentives they often give providers to increase the supply of services.

Critical issues in extending coverage with social health insurance

Although social health insurance is used to ensure universal coverage in many developed countries, no poor countries and only a few middle-income ones have been able to achieve this. The main challenge in developing countries has been the difficulty in mobilizing contributions from the non-formal economy, which in these countries may comprise the majority of the population. This problem is not insurmountable, but the most effective solution has been to use general revenue taxation to subsidize or pay completely the contributions for the non-formal economy. In Mongolia, for example, more than 60 per cent of the social health insurance fund is paid from general revenue taxation. However, this can realistically mean that social health insurance will not provide a complete solution for poor countries, which are currently constrained by their inability to mobilize adequate tax revenues. Other challenges facing them include developing the administrative and technical capacities to manage insurance systems, ensuring that adequate health service delivery infrastructure exists in poor or rural areas to translate insurance coverage into actual health coverage, and devising ways in which costs can be effectively managed once social health insurance is instituted.

3.5 Community health insurance

Community health insurance is a form of collective health insurance. It differs from social health insurance in that it generally involves voluntary membership, and control is carried out by community organizations and not by the State or state agencies features associated with the type of arrangement generally known as micro-insurance. Membership is related to a shared residence

or to affiliation to social groups with some degree of self-organization, which may include specific occupations. Historically, forms of community health insurance were important in many European countries and Japan: they were the first forms of health-care financing that shared risks within groups, and in turn provided the precursors for the establishment of social health insurance.

Today, community health insurance is found only as a vehicle for marginal aspects of provision in any of the developed countries, and is generally used for larger-scale provision only in the poorer developing countries of Latin America, Africa and Asia. Community health insurance can take highly diverse forms but it generally operates in countries where those living and working in the informal economy or the rural sector typically must incur out-of-pocket costs in order to obtain health care, and where these groups lack access to other forms of insurance. This diversity makes it difficult to obtain comparable (or reliable) statistics on community health insurance schemes.

Strengths and weaknesses of community health insurance

The evidence on the contribution of community health insurance to health-care financing and access is limited, owing to the scarcity of statistics (Ekman, 2004; Gottret and Schieber, 2006). Some evaluations (Jakab and Krishnan, 2004), but not all (Ekman, 2004), suggest that in low-income settings some schemes have contributed towards overall financing and improved access for poor people. If it does have a positive impact it is only as a complement that fills the gaps in other organized financing schemes. This leads some to suggest that community health insurance may perform a useful introductory role as an interim step in the expansion of social health insurance, but a substantial body of evidence in support of this notion is lacking (Gottret and Schieber, 2006). However, studies show that compared with out-of-pocket financing, community health insurance has the capacity to reduce costs for households by 30 per cent or more (ILO, 2007b). A concrete positive example is emerging in Ghana, where the National Health Insurance System that was introduced in 2003 has developed to embrace a confederation of about 140 District Mutual Health insurance schemes, which by now covers around 50 per cent of the total population.

In Asia, with the exception of some schemes in India, community health insurance schemes have not proven able in practice to cover large numbers of people. The available evidence indicates that even in countries where it is significant, community health insurance typically covers only a small proportion (<10 per cent) of the population (Ekman, 2004). Moreover, the small size of most schemes and their tendency to be confined to low-income populations means that risk pooling is limited and the volume of financing mobilized relatively small, resulting in limited protection for their mostly poor members. If the schemes operate on a stand-alone basis, their often very informal nature also means that they typically fail to demonstrate sustainability, ability to counter adverse selection, or to manage large-scale expansion.

Critical issues in extending coverage with community health insurance

A study by ILO/STEP (2002) concluded that relatively few community health insurance schemes are very effective in terms of impact on health outcomes, health-care utilization and financial protection. While they typically operate in poorer communities, a further study (Sinha et al., 2006) found that the spread of membership is limited; it seems that schemes have not generally succeeded in engaging a very wide range (from the poor to the better-off) of participants. Thus while these schemes may perform an important role in filling gaps in situations where formal systems do not provide full coverage, they do not appear to be a solution for achieving full coverage. It is important to understand the situations where these schemes can play a useful role,

marginal as it may be, and to develop strategies to ensure that they are better able to reach the poorest as well as engaging those who are less poor.

3.6 Private or voluntary health insurance

This type of health insurance is a private sector-organized and provided form of health insurance. It differs from social health insurance in that enrolment is voluntary, although individuals may obtain coverage either on a personal basis or as workers in a covered company. Private insurance does provide risk pooling and this can be substantial if the risk groups are large. It generally only covers large numbers of people in developed countries: it is the predominant form of coverage in the United States (coverage ~60 per cent), and in many other developed countries it provides higher-income workers with coverage that supplements the main public schemes.

Strengths and weaknesses of private health insurance

The most common positive role of private health insurance is to allow individuals to pay for services that are not covered by public schemes. Examples range from providing access to elective surgery in private hospitals in the United Kingdom to paying the co-payments required by social health insurance schemes in Taiwan (China). Other contributions that have been suggested by some include the potential for private insurance to stimulate innovations in financing and management of private providers.

In practice, however, private health insurance has been quite ineffective as a means for achieving widespread coverage. Major reasons include the difficulty that these schemes have in controlling moral hazard (by both providers and patients) and adverse selection, as well as high administrative costs (often more than 30 per cent of total financing raised). The first two problems generally restrict affordable coverage to large groups, such as companies, and to the healthiest segments of the population, excluding the elderly and the chronically sick. Private insurance has also been ineffective in most countries in controlling price inflation, and in the case of the United States so ineffective that the expansion of private health insurance coverage in the second part of the last century did not result in any lowering of out-of-pocket costs of the average patient (Feldstein, 1981).

In developing countries, the smaller size of the formal economy and weaker financial markets have generally limited coverage of private health insurance to between 2 and 5 per cent of the population, and less than 5 per cent of overall health-care financing. Strong adverse selection effects have also often eliminated the market for many types of coverage, with items such as maternal care or routine outpatient treatment often not being insurable in many countries.

4: Effectiveness of current approaches in the Asia-Pacific region

All countries in the region have endorsed the MDG declaration with its various commitments to improving health coverage, as well as earlier international commitments for achieving health for all, such as the WHO Alma Ata agreement of 1978 to place primary care in the centre of national health policies, and relevant ILO Conventions. These imply a widespread and shared aspiration in the Asia-Pacific region to work towards universal access to health services and effective social health protection for all the population. This is reflected at the national level in the policy declarations and frameworks of nearly all countries (UNESCAP, 2007).

However, only a few countries in the region have been completely or largely successful in realizing these goals. As discussed in Chapter 2, in many of the region's poorest countries the majority of the population continues to lack effective coverage, and in many middle-income countries large segments of the population live in the same situation. Despite this, the successes and the failures provide important pointers to what is likely to work in extending coverage further.

4.1 Approaches that have failed in extending coverage

Before turning to examine the successful approaches more closely, it is useful to consider briefly what approaches have failed, or have not achieved success to date.

Exempting the poor from user fees for public services

User fees are charges that are levied for accessing publicly provided services. In most countries in the region user fees are levied in the public sector, at least for some services. In fact, in many countries public health-care systems were initially developed with a reliance on user fees as a major source of financing (e.g., China, Indonesia, Thailand). As elsewhere in the world, such fees when significant have reduced access by the poor to health care and increased inequalities in access, because the poor have less capacity to pay and because demand for services by the poor is more affected by price barriers than demand by the non-poor (Gertler and van der Gaag, 1990). Consequently, most countries have attempted to improve access and coverage for the poor by exempting them from user fees. This has been done either by applying a means test at the point of care in the health-care facility (e.g., Hong Kong (China), Malaysia, Sri Lanka) or by pre-identifying poor households and distributing them cards or vouchers entitling them to an exemption (e.g., Thailand, Indonesia, Bangladesh).

Unfortunately, as elsewhere in the world (Creese and Kutzin, 1995; Gottret and Schieber, 2006), such approaches have not demonstrated significant success in extending coverage in the region when the level of user fees has been significant. In Indonesia, for example, the widespread distribution of free health cards exempting patients from fees, targeted at low-income households, has not significantly diminished overall inequalities in health-care use, and there is some evidence that health cards disproportionately benefited the non-poor (Somanathan, 2006). In Thailand, a similar scheme, known as the Voluntary Health Card Scheme, was successively developed from the early 1980s and eventually covered one-fifth of the population, but despite many revisions it too failed to reduce inequalities in access between the poor and non-poor, and was not effective in reaching the poor in urban areas (Tangcharoensathien et al., 2005). Its failure was a major reason that persuaded Thai policy-makers to replace all such schemes with the universal "30 Baht" scheme.

In the region as a whole, no country has been able to substantially extend coverage to most of its poor population through a strategy of reliance on user fees for financing facilities, and targeting the poor with exemptions from the fees by using means testing. The major problem has been the difficulty and cost of operating mechanisms that identify the genuine poor accurately but also do not exclude large numbers of the poor. Although there have been and there continue to be examples of success in individual projects for different schemes, none have demonstrated viability when scaled up to national level.

Social health insurance with no general revenue subsidy

Many countries in the region have attempted to expand social health insurance schemes to the poor, to rural residents and to the informal economy without utilizing general revenue tax subsidies. Since many people in these groups typically lack the financial capacity to make regular

contributions and given the lack of administrative mechanisms for collecting contributions from the informal economy, such efforts have had to rely on voluntary enrolment. Despite some notable if modest successes in extending outreach, the overall picture is one in which the lack of capacity to pay, and also limited awareness of the benefits, have constrained expansions in coverage. Most poor people have been unable or unwilling to participate, and have not benefited. This has been true both in the most advanced economies of the region, such as Japan prior to the 1960s and the Republic of Korea in the 1970s, as well as more recently in poorer ones such as Thailand and China (WHO, 2005c).

Community health insurance without integration with state programmes and financing

To date, community health insurance in the region has not generally proved effective in achieving universal and sustained coverage of poor populations. It is worth noting, however, one historical and one recent example showing at least partial success. In Japan, voluntary community health insurance was established in the early nineteenth century and by the 1920s covered several rural areas. However, without financial support from the government its coverage remained limited, and was substantially expanded only from the 1930s, after the government intervened by directly organizing community insurance and providing general revenue budgetary support. In China, in the past two decades, the government has attempted to fill the void in rural areas caused by the collapse of the original Cooperative Medical Scheme (CMS) in 1978, by fostering the development of community health insurance schemes.[1] However, these schemes have failed to cover the poorest areas owing to the fact that social solidarity and community social resources are lowest there, and to cover the poorest households in other areas as they are the ones least able to afford coverage (Wang et al., 2005). In addition, risk protection has been weak even for those covered by the schemes.

4.2 Approaches that have succeeded in extending coverage

The regional and global experience is consistent in demonstrating that at every level of economic development it is possible to achieve high levels of coverage with appropriate policies. In practice, on the basis of available indicators (Rannan-Eliya and Somanathan, 2006; UNESCAP, 2007) only a few countries (or sub-national regions) in Asia and the Pacific can be regarded as having achieved high or universal coverage of social health protection to date:

- **Developing economies**: Sri Lanka, Thailand, Malaysia, Mongolia, Samoa, Tonga, Brunei Darussalam.
- **Developed economies**: Japan, Australia, New Zealand, Republic of Korea, Hong Kong (China), Taiwan (China).

If we examine how these successes have been achieved, it is clear that in practice countries have used one of two alternative approaches. They can be categorized into two groups according to which one of the two approaches they have adopted (UNESCAP, 2007):

- **Integrated national health services funded by general revenue taxation, with or without significant private provision available for those who wish to voluntarily pay**: Sri Lanka, Malaysia, Brunei Darussalam, Samoa, Tonga, Hong Kong (China), Australia, New Zealand.
- **Predominant reliance on social insurance financing supported by general revenue subsidies to extend access to public and private services**: Japan, Republic of Korea, Taiwan (China), Mongolia, Thailand.

[1] A large-scale, national initiative to build a social insurance scheme for the rural population began in 2003.

A critical feature common to both approaches is the contribution of general revenue taxation. In the first approach this directly finances government-provided services, while in the second it has proven vital to ensure that those groups who cannot (or will not) contribute for coverage are adequately covered.

However, it is important to note that while all the regional successes have relied on one of the two approaches, neither approach has been successful in every country where it has been attempted. This experience of success and failure is instructive, and provides important lessons.

4.3 Tax-funded, integrated health services

This approach is common in developing countries of the region, where it was often a legacy of colonial rule (e.g., India, Sri Lanka, Malaysia, Papua New Guinea), and also owing to its general administrative simplicity. Its evident advantage is that the services provided are in principle available to all citizens regardless of income. In practice, however, this often does not translate into reality and as discussed in Chapter 2 this approach frequently fails to deliver on its promise.

The classic examples of this approach to achieving universal coverage in developed economies are countries such as New Zealand and the United Kingdom. In these countries, the overall level of health-care provision is high enough to ensure that all the population has effective access to health care, with tax financing accounting for more than 85 per cent of all health-care financing and provision. However, almost no developing country has been able to replicate this. The critical difference is that developing economies lack the fiscal capacity to finance such a high percentage of overall funding for such a high level of services. To understand why, contrast the tax financing of 69 per cent of GDP available for health care in the developed country systems with the 12 per cent that is feasible in developing countries. The significant volume of demand for services in developing countries that cannot be met by tax financing must be met by private financing and private provision. Consequently, in most developing countries that attempt to apply this model, private expenditures account for 4075 per cent of total health-care financing and provision. It is this inadequate level of tax financing and public provision that then leads to the lack of coverage and inequalities in access. The rich are usually better able than the poor to access limited public services, and so in many countries they benefit preferentially from government service provision, leaving the poor excluded and inadequately covered. Although means testing access to services would in theory solve this problem, it is typically not feasible because the very factors that prevent governments of developing countries from raising significant amounts of revenue from income tax, i.e., their inability to accurately identify higher incomes, also militate against successful means testing (Besley and Coate, 1991).

In this situation, the critical challenges to extending coverage with this approach are:

(i) Maintaining the principle of universal access, i.e., no means testing, while at the same time targeting tax financed services effectively to the poor.
(ii) Achieving high levels of government service provision despite limited tax funding.

Some countries (e.g., Malaysia, Samoa and Sri Lanka) appear to have solved the targeting problem in similar ways (UNESCAP, 2007). In these countries, public services are used at a proportionately high level by the poor, while the non-poor opt out of the public sector and make much higher use, proportionately, of voluntarily financed private services. In contrast, in other countries the rich tend to make use of a comparatively greater mix of both public and private services. How countries reach such positions is not yet adequately explained in the literature, but likely reasons include development of highly dispersed government health service

infrastructures ensuring close physical access to the rural poor, maintaining some minimum quality levels in the public sector, the absence of significant user charges in public facilities, and a public sector culture that seeks to welcome the poor. In all these countries, governments have taken a pragmatic approach to the existence of private provision, but have also been strongly committed to reducing existing barriers that prevent poor people from accessing free government services. This has usually been driven by an acceptance that access to public (and private) services is an extension of citizens' political rights. In addition, it would seem that effective public service management enables these countries to achieve high levels of service delivery despite limited spending.

The successes in the region suggest that in order to successfully extend coverage with this approach, countries need to:

(i) stress the principle of universal access to public services, and support this by either abolishing or minimizing user fees in public facilities;

(ii) sustain a political commitment to continuously expand their government health-care delivery systems and reduce barriers to access for the poor, with particular emphasis on ensuring wide geographical coverage in rural areas, which may require highly dispersed service networks;

(iii) permit private sector provision and financing to operate alongside the public sector, with an implicit or explicit policy of encouraging the non-poor to voluntarily use private services;

(iv) be able to strengthen public sector management, and constantly improve efficiency and quality in public service delivery, so that limited budgets are translated into high levels of acceptable services for the poor;

(v) accept the linkage between citizenship and the right to have access to adequate government health-care services.

Another distinctive feature of these success stories is worth noting, namely, the fact that most of the countries concerned allocate an exceptionally large share of their public budgets to hospital services (>65 per cent in Hong Kong (China), Malaysia, Samoa and Sri Lanka). This facilitates effective coverage of the poor because hospital care is where risk protection needs are the greatest, and because it translates into high levels of investment in the institutional delivery system that is critical to achieving adequate levels of maternal care.

4.4 Social health insurance supported by general revenue subsidies

Several countries in the region have established social health insurance schemes with the goal of achieving universal coverage (e.g., China, Japan, Indonesia, Mongolia, Philippines, Viet Nam), but few have succeeded. The most critical challenge has been extending coverage beyond the formal economy population, for whom contributions are affordable and feasible to collect. In all the countries that have been partially or completely successful, e.g., Japan, Republic of Korea, Mongolia, governments have had to play a critical role (UNESCAP, 2007; WHO, 2005c) in the following:

(i) Finance from general revenue taxation and by cross-subsidies from the contributions of those in the formal economy;

(ii) Exert compulsion to enrol segments of the population in order to achieve high levels of coverage;

(iii) Manage in a planned and sustained manner the gradual expansion of coverage.

Regional experiences indicate that implementing such a strategy requires a high degree of government commitment to set priorities (ILO, 2007a) and to sustain the necessary commitment over a long period so as to prevent the expansion process from stalling. With the exception of Taiwan (China), where it took two years, achieving universal coverage with social health insurance has taken countries in the region between 12 and 30 years; however, it should be pointed out that in most European countries it took considerably longer.

Government commitment has proven a prerequisite to extend social health insurance coverage for two broad reasons. First, no country has been able to expand social health insurance in one step from zero coverage to the whole population. Successful countries have all started by first establishing schemes for segments of the population, usually formal economy workers and government employees. These population groups are typically covered on a contributory basis, with some degree of state-enforced compulsion. Extending coverage beyond these groups usually requires developing alternative mechanisms and scheme designs, and a sustained commitment to incrementally increase coverage group by group. In addition, the technical and administrative capacity to run social insurance systems must be developed, knowing that in the poorest countries the necessary skills and human resources are initially usually lacking. In Japan and the Republic of Korea coverage was gradually extended to most of the workforce as the economy and national capacity developed, with different schemes tailored for the circumstances of each segment of the labour force. This requires flexibility in policies and also the capacity to consider different approaches. Second, extension to the remaining segments of the population invariably requires the government to be willing to contribute general revenue subsidies and also necessitates effective policies to control and share costs in the national system. In Mongolia, for example, to achieve coverage levels of 80 per cent or more, it was necessary for general revenue contributions to pay for more than 60 per cent of the overall insurance fund receipts. At the same time, governments in most countries have had to ensure that the risk pools are broadened sufficiently so that better-off beneficiaries cross-subsidize the worst off.

The successes in the region suggest that in order for countries to successfully extend coverage with this approach, the following are important enabling or facilitating factors:

(i) High degree of government commitment to extending coverage to the non-formal economy.
(ii) Willingness to combine a purely contributory insurance mechanism with financing from general revenues to pay for the contributions of the non-formal economy.
(iii) Good economic growth that can help keep the fiscal and wage costs low during expansion.
(iv) High levels of state administrative capacity to effectively enforce the collection of contributions.
(v) Strong social and political commitment to the notion of social solidarity and sharing of risks through a common insurance system.

5: Key lessons and a strategy suggested by the ilo

The subject of health-care financing has in recent years risen strongly on the policy agenda of many, if not most, countries in the Asia-Pacific region. This is evidenced by a variety of major initiatives, not least in China (the insurance scheme for the rural populace now reaching some 700 million people) and in India (social insurance scheme designed for workers in the unorganized

sector). It is therefore timely to review the available experience as to what works and what seems less successful.

5.1 Key lessons of achieving universal health-care coverage in the Asia-Pacific region

Broadly, it is clear that successful extension of population coverage depends on using a range of instruments and approaches in appropriate combinations. Several specific lessons can be identified from a recent review (UNESCAP, 2007) of successful experience in the Asia-Pacific region and elsewhere:

(i) Countries which have achieved universal coverage have done so by focusing predominantly on one of two approaches using the tax-financed national health services model (Sri Lanka, Malaysia and Samoa) or the social insurance approach (Japan, Republic of Korea and perhaps Mongolia).

(ii) No country has, however, relied purely on one approach social insurance has had to be combined with tax financing and in some places community insurance, and in the poorer countries tax-financed health services have had to be complemented by private financing and provision.

(iii) The administrative and managerial requirements for successful implementation of social insurance approaches may be lacking in the poorest countries, and the successes in these cases are associated generally with the tax-financed approach.

(iv) Whichever approach is adopted, making coverage of poor populations a reality requires significant tax financing by the government, either in the form of direct budgetary support to free government health-care facilities or in the form of tax contributions to social insurance funds in place of premium payments by the poor.

(v) None of the successful countries has achieved universal coverage using explicitly targeted mechanisms, and all emphasize universalism and solidarity in entitlements and access to services or insurance coverage. Where targeting does take place, as in Malaysia and Sri Lanka, it tends to be informal rather than explicit.

(vi) Universal coverage must involve both a reduction in price barriers faced by the poor, whether they be official prices or co-payments, as well as actual physical supply of services to ensure that the poor are not prevented by distance from accessing services.

(vii) Economic development, in particular its tendency to lead to the expansion of formal economy employment and strengthening of government capacity, is an important precondition for successful implementation of a social insurance strategy to achieve universal coverage.

(viii) Countries which have achieved universal health care provide a full range of services in the covered package, and have not attempted to do so by restricting the package only to low-cost, cost-effective services of a very basic nature.

5.2 A strategy suggested by the ILO

Successful countries have often learned from international experience when designing and building their systems, although always choosing locally appropriate solutions and strategies. While one can probably identify a theoretically best health financing system that could provide universal and equal access to good quality health care, reality shows that such a system does not exist anywhere, nor has it ever existed. Universal tax-financed schemes wrestle regularly with the intricacies and risks of national budget processes that may lead to underfunding or wrong

resource allocations, and with the difficulties of motivating salaried providers. In no developing country has universal coverage been achieved by relying solely on tax-financed provision: resource constraints have required some balance to be maintained with other forms of financing and provision, including out-of-pocket financing and private provision. Social health insurance schemes seem to struggle regularly with cost increases and are able to reach out to the poor and to people in the informal economy only with substantial tax financing in the form of general revenue subsidies. Community insurance schemes face similar outreach problems, and these are compounded by sustainability problems if the schemes are not supported by national subsidies and eventually integrated with national programmes. Countries everywhere are mixing pure forms of health financing into specific national mixtures that develop over time. It appears that it is time to replace reliance on theoretically "pure" models by a truly pragmatic approach to health financing.

Based on such observations, the ILO's recent policy consultation paper on health protection (ILO, 2007a) drew the following conclusion from the various strengths and weaknesses of alternative health financing systems:

Worldwide experience and evidence show that there is no single right model for providing social health protection or one single pathway towards achieving universal coverage. In most cases, social protection evolves over many years and often decades according to historical and economic developments, social and cultural values, institutional settings and political willingness and stewardship. However, the way in which countries combine the various functions of resource generating, risk pooling, health-care delivery and financing is not neutral regarding efficiency and equity of health systems. Furthermore, most national health financing systems are based on multiple financing options that cover disjunct or even overlapping subgroups of the population while others remain uncovered.

The overall objective of national policies in social health protection should be to develop a pragmatic strategy aimed at rationalizing the use of various health financing mechanisms with a view to achieving universal coverage and equal access for all.

It is suggested here that countries develop their strategies towards universal coverage by:

- first, taking stock of all existing financing mechanisms in the country;
- next, assessing the remaining access deficits;
- then recognizing the need for government funding to reach the poorest groups; and
- ultimately, developing a strategy for expanding coverage which fills gaps in an efficient and effective way.

The State should play a pivotal, active role as facilitator and promoter in this context and define the operational space for each subsystem. Its facilitative role must, regardless of the primary financing strategy adopted, include the willingness to contribute general revenue financing to ensure that the poor and those in the informal economy are covered. This entails developing an inclusive legal framework and ensuring adequate funding and comprehensive benefits.

The framework should regulate, where relevant, voluntary private health insurance, including community-based schemes, consider regulations to ascertain good governance and effective protection, and identify an appropriate contributory role for private financing and provision that supports the overall goal of extending coverage. This framework should incorporate a rights-based approach to social health protection that refers in particular to the objective to include the uncovered part of the population in line with their needs and capacity to pay. The ILO also advocates a strong role for the social partners, particularly through social dialogue and broad

participation in policy processes, and governance of schemes, including the social partners, civil society, the insured and other stakeholders in social health protection.

When developing the coverage strategy, all options in regard to financing mechanisms including all forms of compulsory and voluntary schemes, for-profit and non-profit schemes, public and private schemes ranging from national health services to community-based schemes and out-of-pocket financing should be considered, if they contribute in the given national context to achieving universal coverage and equal access to essential services for the whole population. At the same time, countries should bear in mind that almost all countries which have succeeded in achieving universal coverage have done so by adopting just one of two predominant approaches, both of which require some level of general revenue financing.

The coverage strategy should aim to integrate the different financing and provision mechanisms on a coherent basis, so that each subsystem that contributes to universal coverage national and social health insurance schemes, tax-financed government provision, community-based insurance, and so on operates within a clearly defined scope of competence and coverage. The objectives of the coverage plan thus comprise:

- determining mechanisms that in combination cover all population subgroups;
- determining the rules governing the financing mechanisms for each subsystem and the financial linkages between them (also as financial risk equalization between different subsystems, if any);
- developing adequate benefit packages and related financial protection in each subsystem;
- maximizing institutional and administrative efficiency in each subsystem and the system as a whole;
- determining the time frame in which universal coverage should be reached.

When coverage is being incrementally expanded, the strategic plan should ideally include an overall national health budget which identifies and projects, on a national basis, the total social resources, such as taxes, contributions and premiums, available to finance health care, estimating the expenditure requirements of the different subsystems in such a way that the process of achieving affordable universal coverage and access can be planned, implemented and accelerated in a realistic manner.

An approach to applying pluralistic financing mechanisms simultaneously to achieve the stepwise extension of effective social health protection coverage through national health services, social health insurance, community-based insurance and mandated private health insurance is the most promising strategy for attaining universal coverage. It represents an integrated approach, respects existing coverage and financing arrangements, and can be adjusted to the specific social and economic context of each country.

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