FLOW OF PRESENTATION

- SOCIAL SECURITY
- NATIONAL HEALTH FINANCING MECHANISM
  - SCOPE
  - EXPERIENCE OF OTHER COUNTRIES
  - SUSTAINABLE FINANCING
  - CONCLUSION

SOCIAL SECURITY - ILO DEFINITION

The protection which society provides for its members through a series of public measures. Against the economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earning resulting from sickness, maternity, employment injury, unemployment, invalidity, old age and death; the provision of medical care; and the provision of subsidies for families with children.

OBJECTIVES OF SOCIAL SECURITY

To promote health and prevent illness

To provide compensation for income loss

To create living condition which will satisfy the general needs of the population and the social need of:

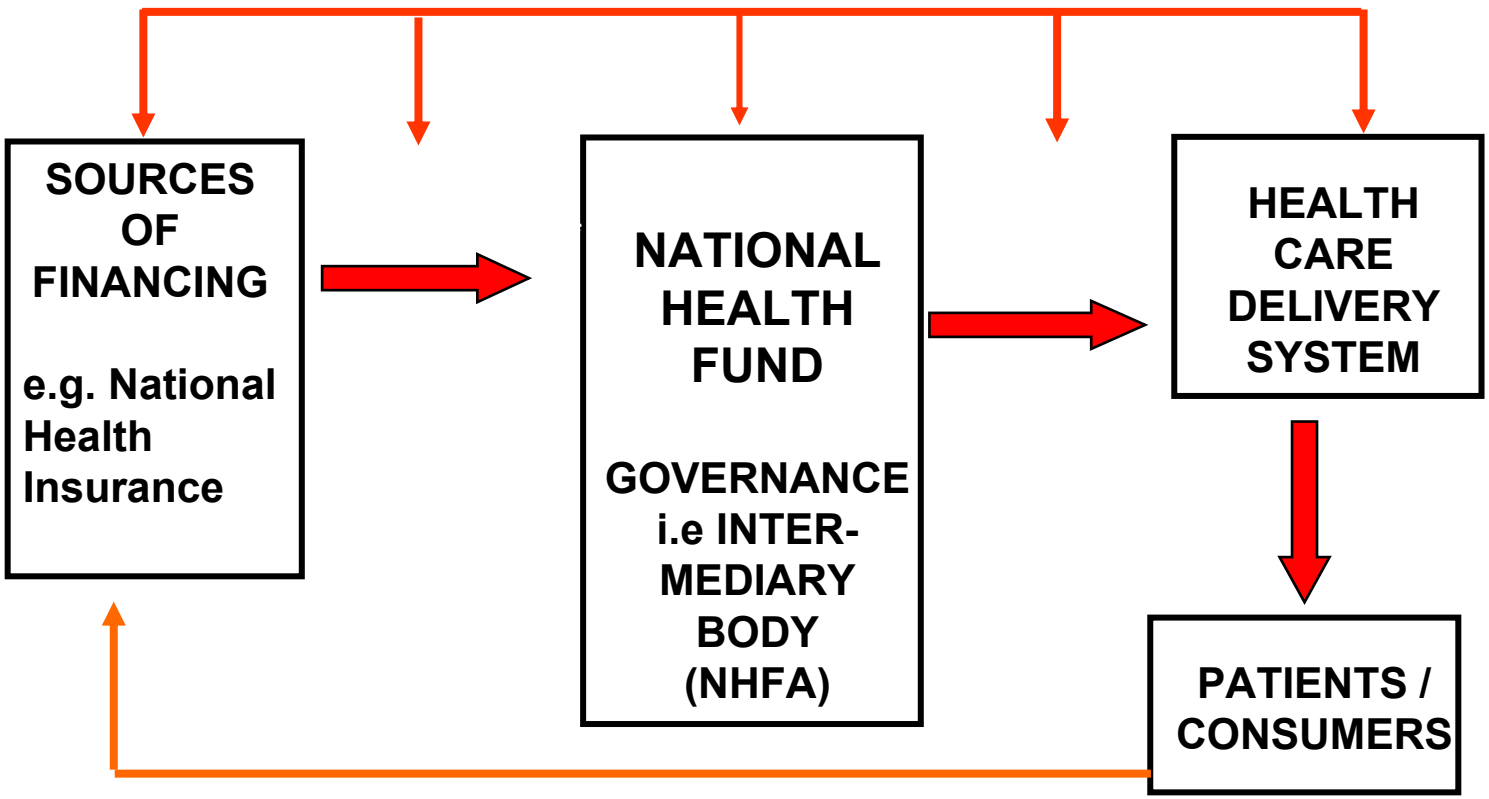
- the elderly
- the disabled
- children

SOCIAL SECURITY BENEFIT

1. Medical care benefit
2. Sickness cash benefit
3. Maternity benefit
4. Employment injury benefit
5. Old age benefit
6. Invalidity benefit
7. Survivors benefit
8. Unemployment benefit
9. Family benefit

NATIONAL HEALTH FINANCING MECHANISM

NATIONAL HEALTHCARE FINANCING MECHANISM: SCOPE



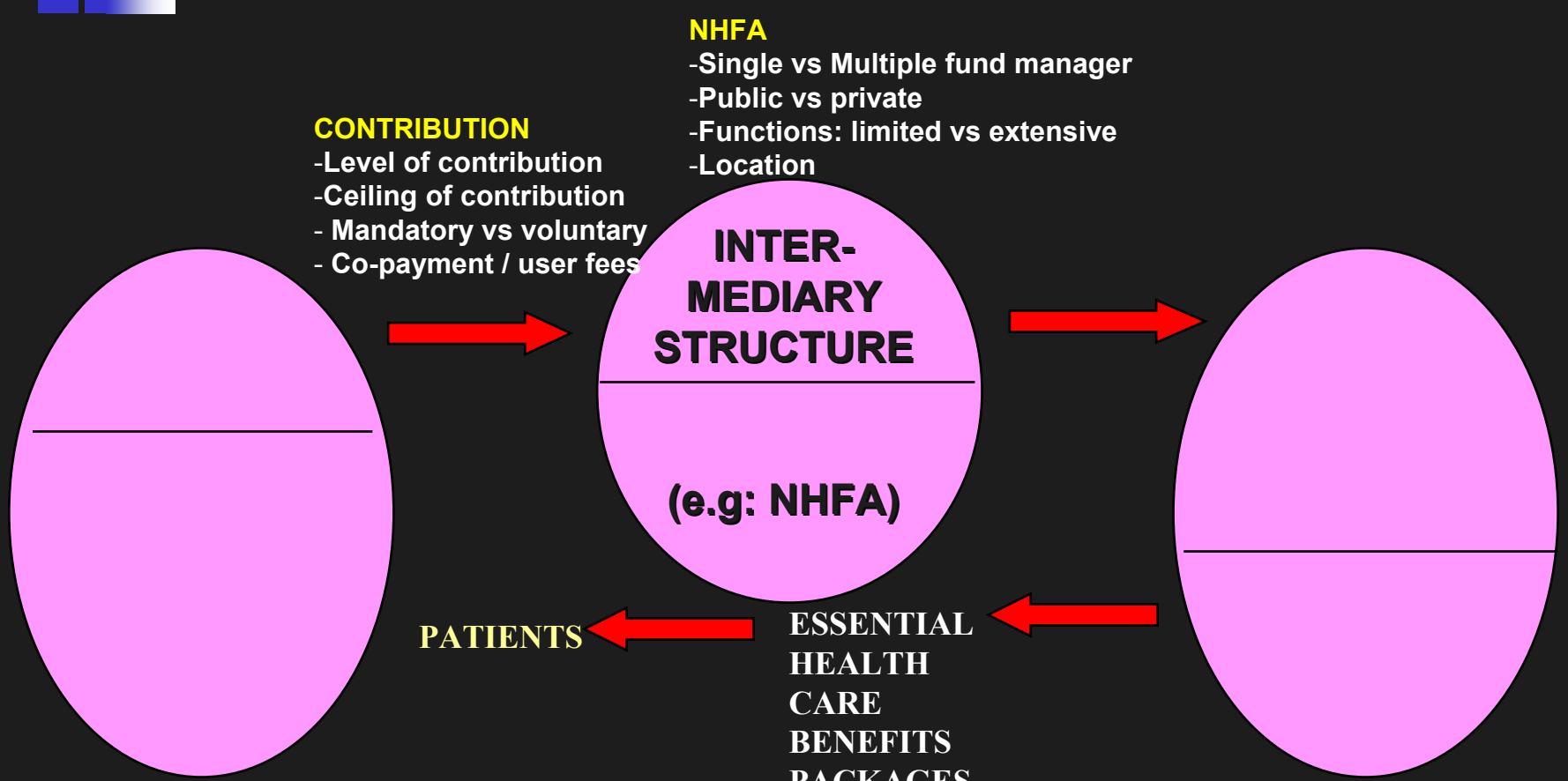
FUTURE HEALTH SYSTEM

SOURCES OF FINANCING

- General Taxation
  - UK
  - Most developing countries depends on taxation
- Social Health Insurance
  - Taiwan, Korea, Japan, Thailand
- Medical Savings Account
  - Singapore
  - (Hong Kong, South Africa, China)
- Community Financing
  - Cambodia, Laos, Vietnam, Sub-Saharan Africa
  - Cooperative Medical Scheme: China
- Private Insurance
  - Many developing countries e.g USA
- Others
  - National Lottery: UK
  - Loans: South American and Sub-Saharan Africa

WHAT IS THE NATIONAL HEALTH CARE FINANCING IS ABOUT ?

..each section needs time for explanation….



ESSENTIAL HEALTH CARE PACKAGES what?...

- Essential vs optional
  (mandatory vs voluntary)

- Coverage
  - limited vs comprehensive
  - generous including TCM
  - wellness or illness focus

- Integration - pb & pv
  - primary, secondary, tertiary

- implication on cost - supplier-induced demand
  - moral hazard

HEALTH CARE PROVIDER PAYMENT MECHANISM (PPM)

WHY THE PPM IS IMPORTANT?

- **It is a major instrument for cost containment because :**
  - **Health care providers are primarily interested in maximising income**
  - **Providers' clinical behaviour is significantly influenced by payment mechanism (i.e. incentives & risks to them)**
  - **Providers can induce demand**
  - **Providers have strong monopolistic power to set price**
- **A well-designed PPM should also be able to increase:**
  - **Quality**
  - **Efficiency**
  - **Accessibility**

Healthcare Providers Payment Mechanisms

...have both strengths & weaknesses and implication on:
accessibility, resource availability, quality, efficiency, cost escalation, etc

- **Prospective Payment**
  - **Capitation**
  - **Case-Mix/DRGs Reimbursement**
  - **Global Budget**
- **Retrospective Payment**
  - **Fee-for-Service**
  - **Per diem**
  - **Per itemised bill**

PROVER PAYMENT MECHANISM: Policy Goal Trade-offs

Greater Efficiency	Greater Patient Risk Selection	Higher Quality	High cost escalation
Total capitation	Total capitation	Case payment	FFS
Case payment	Case payment	FFS	Per diem
Salary, per diem	Per diem	Per diem	DRG
FFS	FFS, Salary	Capitation	Capitation
Less Efficiency	Less Patient Risk Selection	Lower Quality	Cost
Control			

OTHER COUNTRIES EXPERIENCE-1

UNITED STATES

Private Health Insurance, MCOs, MSA, other private : 37.1%
Individual - Out-out-pocket : 17.4%
18% had no insurance coverage of any kind (1996)
Premiums for private health insurance are skyrocketing, the number of people covered by insurance is falling
Private health insurance weaknesses: Moral hazard & supplier induced demand, adverse selection
Health expenditure : 13.7% GDP (1997)
Integration in health ...

NATIONAL HEALTH INSURANCE LESSONS LEARNT-2

GERMANY

- Introduced: 1893
- Coverage: 90% population
- Total health expenditure: 10% of GDP (WHR 2000)
- Key features:
  - Multiple fund managers (420) – public and private , mandatory
  - Fee-for-service (FFS)

To contain rising health care costs

-Health Care Reform Act introduced (1988/93): Changes in health benefits packages and provider payment mechanism

OTHER COUNTRIES EXPERIENCE-3

CHINA

- ✓ Total health expenditure has risen since its market-oriented economic reform began in 1978
- ✓ To contain cost : co-payment (1980s) -demand side control
- ✓ Cost escalation continued due to supply side factor:
  - adoption of new technologies
  - fee-for-service payment mechanism to hospitals
  - supplier induced demand, over-consumption of drugs, etc

JAPAN

- ✓ Social health insurance - multiple fund managers
- ✓ Fee-for-services (modified), > curative
- ✓ Perdiem: ALOS - long

SOUTH KOREA

- ✓ National health insurance with multiple fund managers
- ✓ Universal coverage to 97% population
- ✓ High co-payment - limit the access

OTHER COUNTRIES EXPERIENCE-4

CHILE

- **Mandatory health insurance scheme: choose either (i) Public scheme (FONASA) or (ii) Private scheme (ISPARE)**
- **FONASA: covered 2/3, spent US$ 200 per capita, admin. cost 4%**
- **ISAPRE : covered 1/3, spent US$ 300 per capita, admin. cost 20%**
  mainly rich people, premium is higher for the elderly
  24% patients still receive services in public facilities

SINGAPORE

- **Compulsory saving (Medisave) : 1984 +**
- Backup voluntary private insurance for chronic conditions (MEDISHIELD) : 1990 +
  - **Premium : S$ 12 –S$ 1,200/year. Deductible : S$500 -$4,000. Co-payment : 20%**
- Government contributions for the poor (Medifund): 1993 +
- **- (household with 2 adults & 3 children earning < S$ 1,400 per month**
- **Eldercare (2000), Eldershield (2001)**
- **Corporatisation / restructuring of hospitals (including Woodbridge Psychiatric Hospital)**

OTHER COUNTRIES EXPERIENCE-5

TAIWAN

- ✓ Universal health insurance / single fund manager– low admin. cost
- ✓ Generous essential health care packages and fee-for-service payment
- ✓ High customer satisfaction
- ✓ To contain rising health care costs
  - Reforming provider payment mechanism to global budgeting and strengthening quality assurance

➢ THAILAND

- ✓ Multiple health insurance / fund managers.
- ✓ Benefits not uniform between funds
- ✓ The poor still unable to get access to health care
- ✓ To contain rising health care costs and to improve equity
  - Will introduce universal national health insurance (single fund)
  - Introduced DRG provider payment mechanism
  - 30 Baht system was introduced

Health Insurance in Indonesia :
Social Health Insurance Scheme

Item	Askes	Jamsostek
Groups mandated	Civil servants, ret. CS, ret. military personnel, veterans	**Private employers w/ =>10 employees or pay salary > 1 mill Rp per month**
Contribution /premium	2% of basic salary. No ceilings	**3% salary for bachelor. 6% salary for married employees.Ceiling 1 mill Rp per month**
Contributor	Employees 100%	Employers 100%
Carriers / Fund manager	PT Askes, for profit	PT Jamsostek, for profit

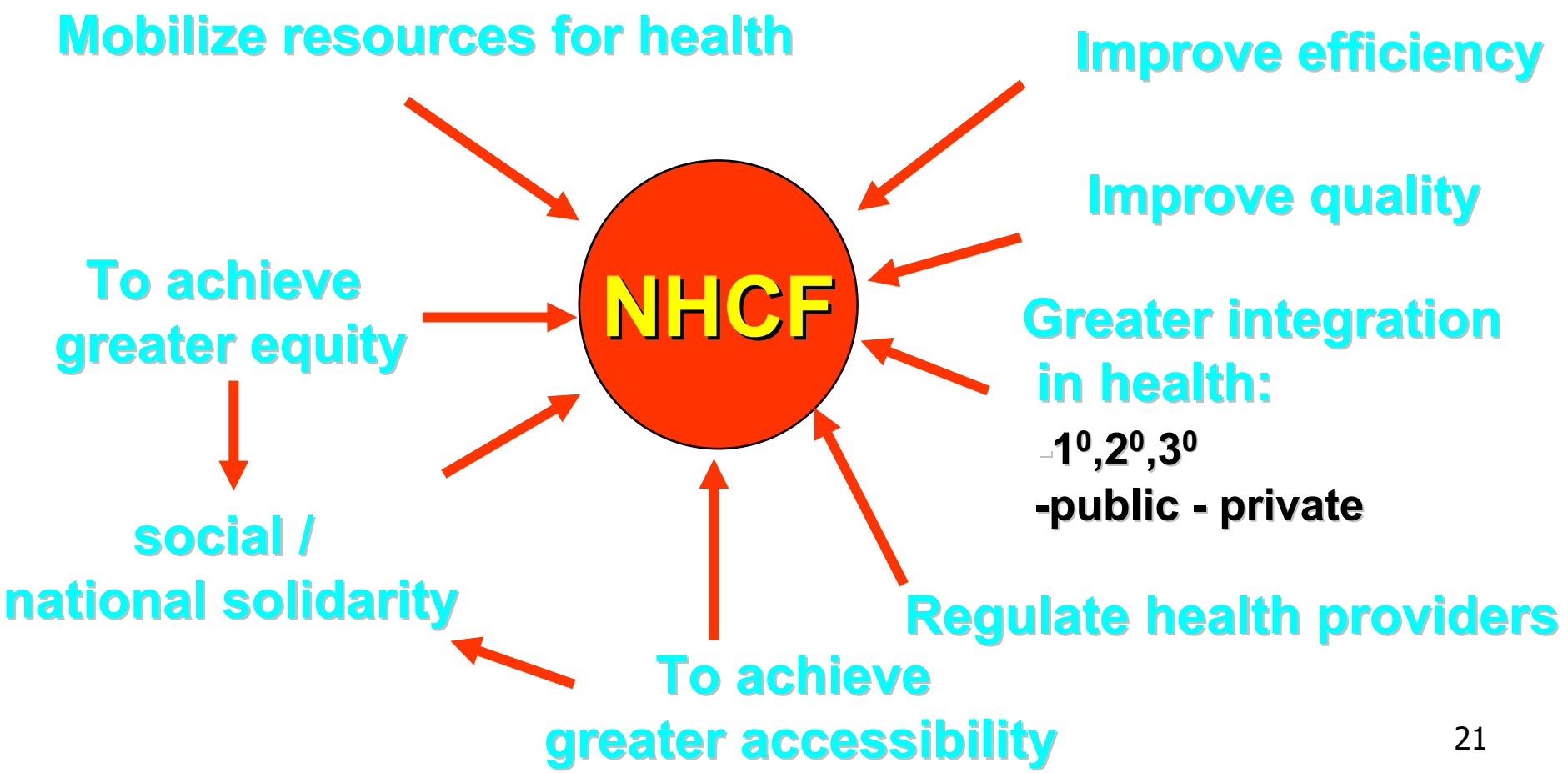
LEVEL & CEILING OF CONTRIBUTION-1

- UK
  - Employee - 10%: employer 11% of income (2002)
- TAIWAN
  - Set at 6% but remained at 4.25% of the monthly salary
  - Proportion – varies
- HONG KONG (Health Protection Accounts)
  - 1% to 2% of earning
- SOUTH KOREA
  - 2% to 8% of monthly income
  - Civil servants – 4.2% and government 4.2%
  - Self employed – 7%
- THAILAND
  - 5 major form of health insurance (covers 76% population)
    - Of the scheme (Social Security Scheme employer + employer contribute 1.5% of income respectively)
  - OOP (24% of population)
  - 30 Bhat scheme introduced

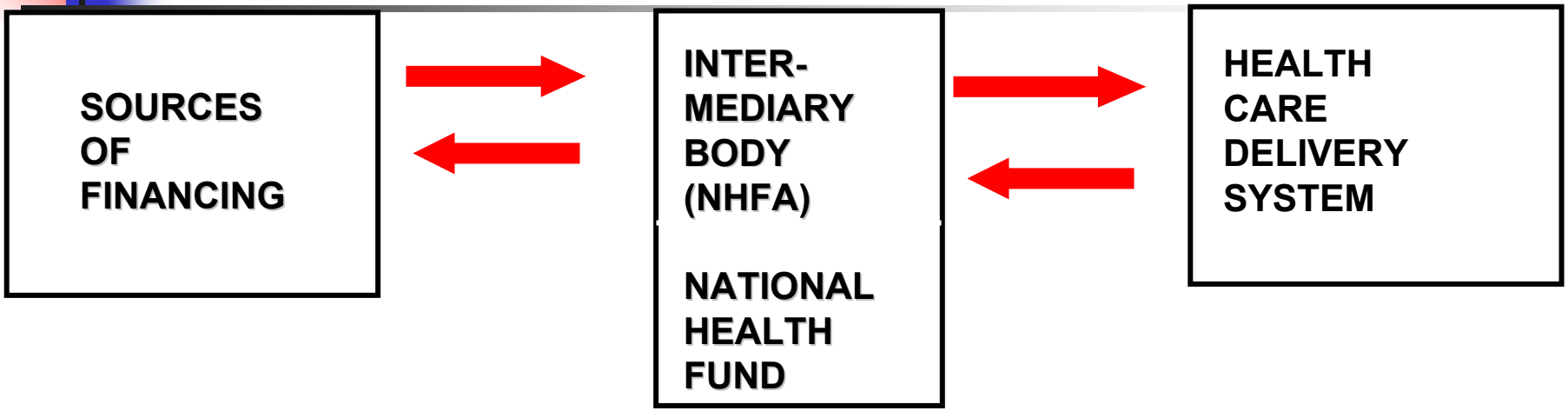
LEVEL & CEILING OF CONTRIBUTION-2

- **PHILIPPINES**
  - Employee & employer , same contribution – 1.25%
  - Ceiling of contribution – 3000 pesos
- **AUSTRALIA**
  - Medicare – 1.5% of taxable income
- **FRANCE**
  - Employee 1.55% (1975) – 6.8% (1995)
  - Employer 2.5% (1975) – 12.8% (1995)
- **GERMANY**
  - Varies: 7-16% of worker's gross wage (1990)
- **SINGAPORE**
  - 1997 (BEFORE ECONOMIC CRISIS) – both employer & employer contribute 20% to CPF.
  - 6-8 % from CPF channeled to Medisave.

OBJECTIVE OF NATIONAL HEALTH CARE FINANCING



COST CONTROL MEASURES



i. Control the demand side of health services

ii. Control the supply side

Through monitoring, evaluation, regulation and enforcement

Issues in Health Care Financing

- **Issue on Demand Side**
  - **Ability to pay**
  - **Willingness to pay**
  - **Exemption mechanisms**
  - **Moral hazards of consumers**
  - **Adverse Selection**
  - **Benefit package**
  - **Consumers satisfaction**
  - **Community vs Risk ratings**

Issues in Health Care Financing

- **Issue on Supply Side**
  - **Provider payment mechanisms**
  - **Moral hazards of providers**
    - **risk selection - cream skimming**
  - **Providers satisfaction**
  - **Administrative cost**

SUSTAINABLE HEALTH CARE FINANCING

NO.	CRITERIA	ELEMENTS
	Level of Funding / Resources	Amount Reliability Effect on other mechanism
2	Efficiency	Technical Allocative Administrative Quality. Treatment efficiency
3	Equity	Distribution of benefits Distribution of burdens
4	Acceptability	Consumer acceptability Acceptability of professional organisations Political acceptability
5	Health impact	Change in health status Outcome
6	Regulation	Control demand. Control supply. Separation of provider, purchaser/funder.

Adapted from: Evaluation of Recent Changes in the Financing of Health Services, WHO, 1993

CONCLUSION
- 6 PRINCIPLES OF LJUBLJIANA CHARTER ON HEALTH REFORM

1. Driven by values
2. Targeted on health
3. Centred on people
4. Focused on quality
5. Based on sound financing
6. Oriented towards primary health care