



H N P D I S C U S S I O N P A P E R

Towards Universal Health Care Coverage

A Goal-oriented Framework for Policy Analysis

Joseph Kutzin

July 2000



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1. Introduction1. Introduction1. Introduction

Health care in the United Kingdom is funded mainly from general tax revenues, and providers are paid from territorial health authorities of the National Health Service. In the Netherlands, health care is funded mainly from compulsory contributions by employers and employees to social insurance “sickness” funds and voluntary contributions to private insurance companies, both of which in turn pay providers. In both countries, virtually the entire population enjoys access to needed health care and is shielded from the risk of incurring expenditures that would otherwise be high enough to impoverish some individuals or families. In other words, the health care systems of both countries provide the *function of health insurance* (access to care with financial risk protection) to their populations, albeit with different institutional and organizational arrangements for the mobilization and allocation of resources. Analyzing policy options in terms of the extent to which this “insurance function” is enhanced offers a useful way to operationalize the goal of universal coverage, unfettered by an attachment to any particular organizational form of health insurance.

This paper was motivated by the perception that, with respect to health care¹ financing, there is frequently a confusion between policy tools and policy objectives. This has certainly been the case with many reforms involving health insurance, where the focus has been on establishing or refining insurance *schemes*, while the effects of these on the efficiency and equity of the broader *system* are either assumed or neglected entirely. The simple point emphasized here is the importance of distinguishing between the ends and means of health policy in general, and of health insurance in particular.

It is not particularly original or helpful to offer a reminder not to confuse the ends and means of policy. For more effective policy analysis, it is necessary to specify explicitly the objectives of policy and provide a tool for moving systems towards those objectives. In an attempt to do so, the paper provides an operational definition of “universal coverage” and a conceptual framework that is driven by the explicit normative proposition that the pursuit of universal coverage is desirable. The framework is proposed as a tool for (1) descriptive analysis of the main functions and interactions within an existing health care system and (2) identification and assessment of policy options to move towards universal coverage. An objective of this paper is to promote the idea that progress towards this goal requires a comprehensive approach involving coordination among multiple aspects of health care systems rather than an approach aimed at reforms in specific bits of the system in isolation from each other. Appropriate policies for progressing towards universal coverage require an orientation toward this goal, but the starting point for any change is the existing organization and institutional arrangements of a health

¹ The scope of this paper is limited to personal health care services (curative and preventive interventions delivered to individuals), rather than ‘health services’ more broadly. This is an explicit choice to keep the analysis relevant to the issues of access to care and financial risk protection. This should not be interpreted as denying the importance of ‘public health’ interventions (e.g. vector control, anti-pollution measures) and non-health system interventions that contribute to health (e.g. girls’ education).

care system. The use of this framework also leads to the conclusion that there are many policy levers available to governments to enhance the insurance function, even in contexts in which macroeconomic circumstances limit the scope for additional resource mobilization. Thus, expanding and strengthening insurance protection is not just a question of the level of finance. Enhancing the insurance function of health systems requires that policy makers recognize the importance of *managing* the system, not just funding it.

This paper begins by presenting key concepts and definitions, leading to the specification of a policy objective with respect to universal health care coverage. This is followed by the conceptual framework intended to help countries to identify a coordinated set of policies to move towards universal coverage. The next three sections incorporate lessons from country experience into a review of the various elements of the framework. The paper concludes with a review of selected key policy issues and directions for future research.

2. Concepts and policy objectives2. Concepts and policy objectives2. Concepts and policy objectives

Universal coverage with the health care insurance function may be defined as physical and financial access to necessary health care of good quality for all persons in a society. It implies protection against the risk that if expensive (relative to an individual's or family's means) health care services are needed, services of adequate quality will be physically accessible, and the costs of these services will not prevent persons from using them or impoverish their families. Defined in this way, the extent of *protection* is an important determinant of performance *vis-a-vis* broad health and social welfare policy objectives, because it entails *quality of care* (a means for improving the health status of the population), *equity in access to effective care* (a means to reduce inequality in health status), and *protection against the risk of impoverishment* as a consequence of health care costs.

Because "universal coverage" reflects a certain level of protection or *coverage*, it can be considered a determinant rather than a final objective of policy. There are two ways in which it is useful to think of it as an objective, however. First, it is often considered a political objective because it reflects notions of equity that are considered to be important in many countries. Second, and more generally, it is argued here that coverage is so closely linked to the broader policy objectives that progress on the latter requires progress towards universality. In other words, improving access, equity and risk protection with respect to health care services requires a stronger insurance function. Therefore, a policy objective for health care systems should be to strengthen, or enhance, the insurance function for the population.

The notion of "enhancing" the insurance function can be made more precise with an extension of the concepts of coverage:

- ☞ *depth* of coverage, meaning the extent to which services are available to people without exposure to out-of-pocket payment (i.e. the degree of cost sharing required to obtain various services), and
- ☞ *breadth* of coverage, meaning the proportion of the total population that has effective access and financial risk protection.

Thus, enhancing the insurance function can be described as *deepening* and/or *broadening* effective service and population coverage. This specification of the policy objective of universal health care coverage suggests that “universal coverage” is a relative rather than an absolute concept. Even if 100% breadth of population coverage is attained, there is always scope for expanding depth of coverage, by including additional services in the benefit package or increasing coverage/reducing cost sharing for the existing package.

Expansion of the depth and breadth of coverage is limited by the availability of resources and the efficiency with which resources are allocated and managed. Consideration of these issues together enables the specification of a generic public policy objective for health care reform:

- ☞ **achieving universal access to health care with financial risk protection *at the least cost possible***, or alternatively
- ☞ **expanding the depth and breadth of coverage *to the maximum extent possible for a given level of resources***.

The concepts of depth and breadth of coverage are illustrated by the experience of the Republic of Korea. From 1977 to 1989, the entire population became covered under the National Health Insurance system. Although the achievement of *universal breadth* was an impressive feat, a closer look suggests that Korea still needs to expand coverage, i.e. depth. Official cost sharing requirements for outpatient care (ranging from 30 to 55% of fees, plus a flat deductible) and for inpatient care (20% of fees) are steep, additional “special” payments are often made in hospitals to see more experienced doctors, there is an upper limit on the number of days of care covered by insurance, and many expensive services are excluded from coverage. Out-of-pocket payments accounted for an estimated 65% of total spending on personal health care services in 1992 (Yang 1997). Despite having achieved “universal coverage” with “National Health Insurance”, therefore, the specific features of their health insurance system suggest that Korean citizens do not really have equal access to health care and financial protection against the potentially high costs of severe illness or injury or long-term chronic illness.

This functional approach to insurance takes the perspective of the individual citizen or family rather than an institutional perspective based on membership in an “insurance scheme”. If the social costs,

distributional effects and legal provisions associated with providing the coverage are the same, public policy should be indifferent to whether the function of insurance is mediated through independent firms or within government systems. Based on this, another fundamental concept underpinning this paper is that while *insurance as a function is a policy objective, insurance as any specific set of organizational arrangements is not*.

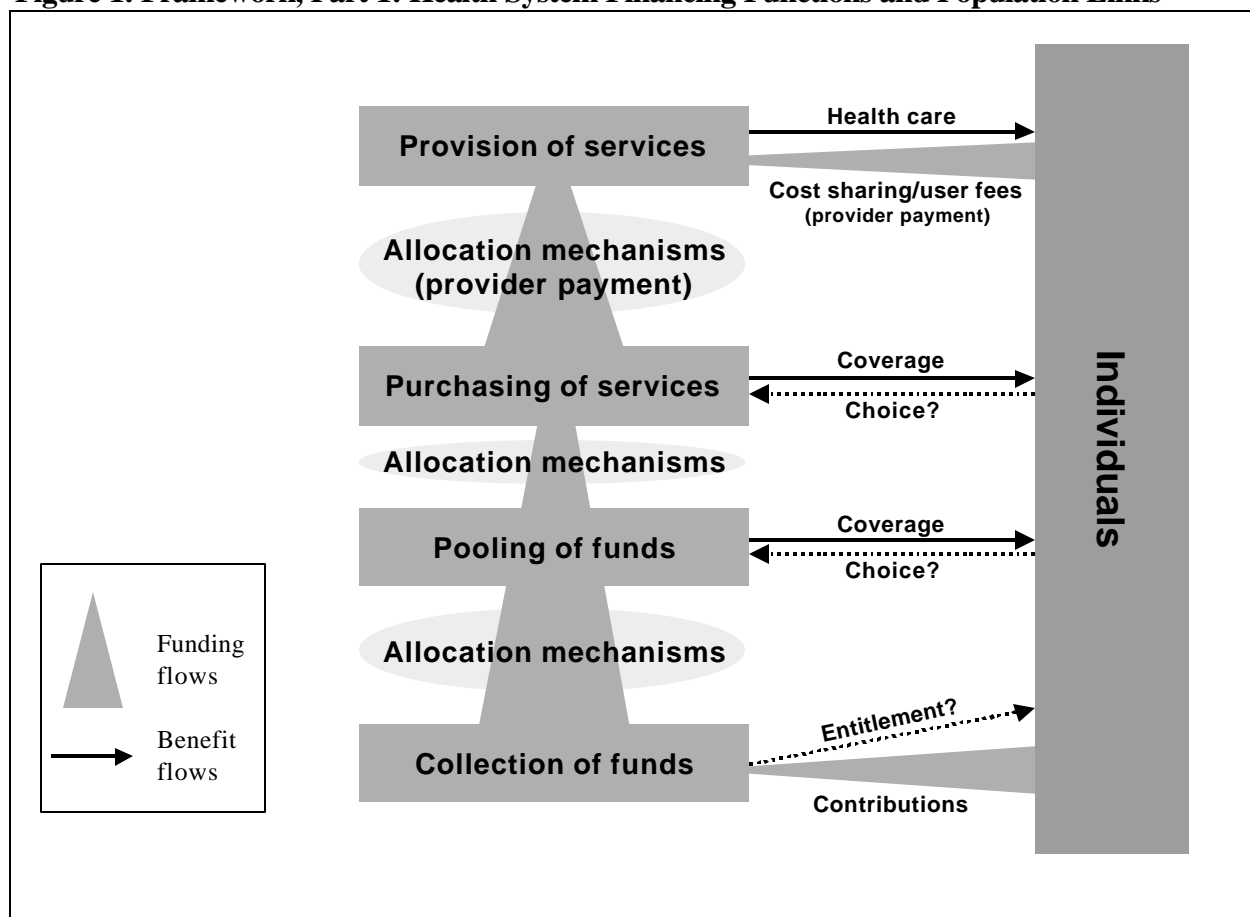
The last sentence suggests that though this public policy objective is proposed to be applicable everywhere, there is no ‘blueprint’ for how to achieve it. The means by which countries can make progress towards this objective should differ, given differences in a number of contextual factors. It is proposed, however, that policy makers use this objective as a basis for defining criteria to evaluate alternative reform strategies, assessing specific policies according to the extent, efficiency and equity with which they enhance the insurance function. This objective provides a concrete direction for policy change, but the ‘starting point’ for reform in any country is its existing organizational structure and resource allocation mechanisms for health care, as well as the broader context of economic, cultural and political factors. Hence, sensible reform requires that policy makers have a clear conceptual understanding of the features of their health systems. The next four sections of this paper provide a framework for this.

3. Conceptual framework3. Conceptual framework3. Conceptual framework

Often, health systems are described by their predominant source of funding (e.g. social health insurance “Bismarck” systems, general tax-funded “Beveridge” systems). As many countries have introduced significant reforms without altering the source of funds for health care, however, there is growing recognition that the source of funds need not determine the organizational structure of the sector, the mechanisms by which resources are allocated, nor the precision with which entitlement to benefits is specified. Hence, terms like “tax-funded systems” or “social insurance systems” are no longer adequate descriptors of systems; *traditional thinking* about health insurance imposes unnecessary limits on the range of policy choices open to countries. Even more sophisticated typologies of entire health care systems (see, for example, OECD 1992, in which seven models are identified) are not easily or usefully applied to countries in which finance, organization and population coverage are fragmented. Such fragmentation is more characteristic of low and middle income countries (and one high income country, the United States). The typology created by Londoño and Frenk (1997) of health system models in Latin American countries is more useful because it recognizes explicitly and incorporates this fragmentation. While building on their analytic approach, the purpose of this paper is not to create a typology to classify the health systems of different countries. It is, instead, to facilitate national level policy analysis by enabling a comprehensive description of a health care system and the identification of reform options to enhance the insurance function efficiently. For this purpose, there is a need for a generic framework to conceptualize the disaggregated components of health financing sources, resource allocation mechanisms and associated organizational and institutional arrangements.

Given this need, the conceptual framework depicted in Figure 1 is proposed as a tool for *descriptive analysis of the existing situation* in a country's health system with respect to health care financing and resource allocation, and equally as a tool to assist the *identification and preliminary assessment of policy options*.² It is not proposed as a tool to assist with the classification of entire country health care systems. The aim is to help to clarify the policy levers that are available to broaden and deepen the insurance function as efficiently as possible, while also highlighting the interactions of various policies and the need for a comprehensive rather than a piecemeal approach to reform.

Figure 1. Framework, Part 1: Health System Financing Functions and Population Links



The central column of the figure depicts the flow of “pooled” funds in the health system from sources to service providers. In this framework, pooled funds include those resources that can be *organized* on behalf of groups of people or the entire population, meaning all funds other than out-of-pocket

² In addition to the paper by Londoño and Frenk (1997), the proposed framework has roots in previous work, developed independently and at different points in time, by Barnum (1993) and Saltman (1994; 1995). An extension of the framework is presented later in the paper.

payments by individuals to providers. The concept depicted is actually a *functional* flow of funds, in the sense that money is not necessarily transferred across four separate organizational entities in all systems, but the various *functions* depicted do occur, even if these are not explicit or even recognized. The functions related to financial flows (reflected in the four rectangles in this column) include the collection of funds for health care, the accumulation (“pooling”) and allocation (“purchasing”) of these funds to health care providers on behalf of part or all of the population, and the provision of health care services to individuals. The three ovals depict the mechanisms for resource allocation between these different functions. These include the allocation of funds from their initial collection point to the intermediary organization(s) responsible for pooling them, the allocation from pooling organizations to purchasers, and the allocation of funds from purchasers to providers (i.e. provider payment).

The arrows in Figure 1 depict links between each of these health system functions and the population or individuals within the population. While these are explained in the next sections, it is worth emphasizing that of these links, the main policies that affect the depth and breadth of coverage provided to the entire population are signified by the arrows between “individuals” and the “provision of services”. These are the service benefits to which all or parts of the population are entitled and have effective access, and related policies and practices with respect to user fees or cost sharing (i.e. for those services not funded entirely from pooled sources and for which people must pay directly, either officially or “under-the-table”).

The figure is a model that attempts to provide a generic depiction of functions that can be applied in a wide variety of country contexts. In particular, the focus on generic functions rather than specific organizations or institutions is meant to capture critical features of all health care systems while recognizing the great diversity of settings in which these functions are implemented. In some cases, for example, the functions of collection, pooling, purchasing and provision are internalized within a single organizational entity or unit (e.g. social insurance funds that collect their own contributions and have their own provider units, fully integrated privately funded Health Maintenance Organizations that use their own hospitals and salaried providers). In other cases, collection, pooling and purchasing may be done by a single entity, with services provided by other organizations (e.g. voluntary health insurers that are distinct from the public or private sector providers from which they purchase services). Many different combinations of functional integration and separation exist, even within the same country. Moreover, within any of these functions there may be a *market*, with different entities competing to collect, pool, purchase and/or provide services, and there may also be competition between ‘networks’ of organizations providing several of these functions. Hence, the framework is a simplification of a multi-dimensional array of institutional and organizational arrangements that are possible, but oriented to a set of critical functions that occur in all settings.

In the next sections of the paper, various elements of the framework are analyzed in greater depth, indicating the ways in which each is relevant to the objective of universal coverage and the issues that

must be understood for a country to develop a coordinated set of policies towards this end. As a part of this, important lessons from country experience are highlighted.

4. Finance and Resource Allocation Functions4. Finance and Resource Allocation Functions

4.1 Collection: Sources of funds and contribution methods4.1 Collection Sources of funds and contribution methods

While recognizing that apart from external donors, the population (including individuals and corporate entities) is the initial source of all funds (as shown by the “Contributions” arrow in Figure 1), Table 1 categorizes the sources of pooled funds for the health care system, adapting the classification scheme used for National Health Accounts (Berman and Thompson 1999). In most countries, at least two of these sources are significant.

The most direct way to increase the level of pooled resources is through an increase in the allocation of public revenues for health care, either through a reallocation of public expenditures from other sectors, an increase in the overall level of public revenues, or an increase in compulsory contributions for health care. None of these options is easy, especially for low and middle income countries. Typically, the

political possibility for mobilizing a significant increase in resources through reallocation of a relatively fixed overall government budget is quite limited. The evidence summarized in Table 2 indicates that, on average, lower income countries are at a disadvantage when it comes to trying to increase the level of funds available from public sources. As noted by Schieber and Maeda (1997), the ability to raise public revenues tends to increase with a country’s income level, with low income countries raising less than half of the revenues (as a percent of GDP) than high income countries.

Zambia provides an excellent illustration of this resource mobilization constraint. Excluding donor funds, the Government of Zambia’s 1998 budget allocated about 14% of public resources to the Ministry of Health, a substantial increase over the 11.6% share received in 1994. Real GDP remained roughly constant over this period, but total public revenues as a percent of GDP fell from 22.4% (IMF 1999) to

Table 1. Sources of pooled health revenues

General government expenditures
↳ central government general revenues
↳ central government earmarked revenues
↳ local government revenues (mainly general)
Employers and firms
↳ compulsory contributions to insurance funds
↳ voluntary contributions to insurance funds
Individuals and households
↳ compulsory contributions to insurance or health savings funds
↳ voluntary contributions to insurance or health savings funds
Other
↳ official development assistance
↳ NGOs

Table 2. Public sector revenues as a percent of GDP

Region/income group	Mean	Median	Range		Number of observations
			Minimum	Maximum	
East Asia & Pacific	23	20	8	37	11
Europe & Central Asia	39	41	12	60	13
Latin America & Caribbean	24	25	8	42	21
Middle East & North Africa	32	31	12	48	10
South Asia	27	20	10	47	6
Sub-Saharan Africa	26	22	11	63	20
Developing countries	28	26	8	63	76
Industrial countries	45	44	31	62	21
Low income	20	19	8	44	22
Middle income	31	30	8	63	54
High income	42	44	12	62	24

Reproduced, slightly modified, from: Schieber and Maeda 1997, p.15. Data are for most recent year between 1990 and 1995.

an estimated 19.2% (Republic of Zambia 1998). Lack of economic growth and low public revenue collections have meant that even though the MOH increased its share of the government budget considerably, real allocations to the MOH declined to less than half their 1994 level.

For countries seeking to initiate or expand contributions for health care through compulsory insurance contributions, macroeconomic and labor market conditions are critical contextual factors (Ensor 1999).

If macroeconomic conditions are favorable, there may be scope for new types of resource mobilization schemes. If the economy is in recession and the level and growth of the proportion of the population in formal sector employment are low, it is difficult and potentially harmful to impose or increase “social insurance” taxes for health care. The same is true for policies to “encourage” (i.e. subsidize) employers and individuals to purchase voluntary insurance. Moreover, policies that tie insurance coverage (voluntary or compulsory) to the place of employment can have undesired macroeconomic effects by creating distortions in the labor market.

There are other issues for government to consider as part of an attempt to increase revenues through the introduction or expansion of compulsory or voluntary insurance schemes. In particular, when people

make an explicit contribution to an insurance scheme, they are entitled to a specific benefit in return.³ In most countries, it is not feasible to sever the link between a defined contribution and a defined benefit, because this would undermine any incentive to contribute (in a voluntary model) and induce political resistance from the contributors in a compulsory system. This is a potential constraint on equity, however, because those who are able to contribute will receive better benefits than the rest of the population. It may also have other implications because these contributions are usually associated with the creation of new organizations for pooling funds, paying providers, and in some cases, even for providing services. While often viewed as a means to inject new resources into the health sector, social health insurance contributions typically engender a full-fledged “scheme”, resulting in new costs as well as new revenues. Thus, where entitlement depends on insurance contributions (rather than citizenship, for example), universal breadth of coverage cannot be achieved unless government is willing to fund the ‘premiums’ of non-contributors (Ensor 1993), and the insurance function will not be administered efficiently (from the perspective of the entire system) unless the implementation of pooling, purchasing and (sometimes) provision for members of the scheme is well-coordinated with the implementation of these functions for the rest of the population. These issues are discussed in further detail in Sections 5.1 and 6.

While health sector decision makers, especially in poor countries, will continue to emphasize their need for more resources, it is essential to recognize that the main *factors that affect the level of funding for health care are largely outside of their immediate control*. Thus, investing a lot of time and effort seeking ways to raise more funds is unlikely to yield significant benefits. Instead, the greater proportion of their efforts should seek to ensure that the means that are within their control for improving the equity and efficiency of the system are exploited fully.

4.2 Pooling of health care revenues

Simply put, “pooling” refers to the accumulation of health care revenues on behalf of a population. In Figure 1, the arrow from “pooling of funds” to “individuals” signifies the *coverage* for health service costs for the population on whose behalf the funds are pooled (for groups or the entire population by one or several pooling organizations). The dotted line going in the other direction indicates that in some cases, individuals can choose their pooling organization. Table 3 provides examples of pooling organizations and methods used to allocate financial resources to or among them. From a policy perspective, it is often useful to consider these together. With voluntary contributions to health insurance funds, for example, the collection and pooling functions are implemented by the same organizational entity, and the allocation from collection to pooling is internalized within it. In this context, the contribution mechanism (e.g. premium payments by employers and employees) is also the method for

³ The presence or absence of a connection between contributions and entitlement is reflected by the dotted line in the lower right-hand part of Figure 1. For more on this, see Ensor 1993.

allocating to the pooling organization (note the overlaps between Tables 1 and 3). The discussion below begins with voluntary insurance and moves to examples characterized by greater levels of state involvement.

In their analysis of the dynamics of private health insurance markets, Chollet and Lewis (1997) note that all systems of voluntary purchase of insurance suffer from the problem of *adverse selection*. Because individuals have better knowledge of their own health status and potential need for health care than insurers, and because those who expect to use health services are more interested in buying insurance coverage, persons who seek to purchase health insurance voluntarily tend to be costlier to insure than the average person in the population. Consequently, private insurers have developed techniques to limit adverse selection or its financial effects.

These measures--including underwriting,⁵ tiered rating,⁶ durational rating,⁷ limiting coverage to members of groups formed for reasons other than to buy insurance coverage, excluding pre-existing conditions from coverage, excluding certain high-cost

Table 3. Examples of pooling organizations and mechanisms for allocating to/among them⁴

Pooling organizations	Allocation mechanisms
Ministry of Health ↳ central ↳ decentralized units (provincial, district health authorities)	Government (central or local) revenues ↳ historical patterns related to infrastructure or utilization ↳ ‘needs-based’ weighted capitation formula
Local government health department	↳ subsidize premium payment for participation of otherwise uninsured
Area Health Boards	
Social health insurance fund(s)	Earmarked/compulsory contributions ↳ percent of salary or income
Private insurance companies	↳ risk-adjusted allocation to insurers, usually with consumer choice of insurance fund
Employers as “self-insuring” firms	↳ “opting out”, with or without risk adjustment
Member-owned “mutual” insurers	
Fundholding providers and provider-based insurance schemes	Voluntary contributions ↳ individual risk- or community-rated premium payments

⁴ The allocations can be from the collecting agency (e.g. Ministry of Finance) to the pooling agency (e.g. Ministry of Health), from the initial source of funds to the pooling agency (e.g. private insurers that implement collection and pooling together), or from one pool to others (e.g. allocation from a central pool to competing or geographically-based pooling organizations through a risk adjustment process).

⁵ This is described as “the practice of evaluating individual health status and either rejecting potential buyers who are deemed to pose exceedingly high risk or placing them in plans with other people who represent approximately the same risk” (Chollet and Lewis 1997, p.82).

⁶ Setting premiums in direct relation to the expected health care costs of each insured individual or group (Chollet and Lewis 1997).

⁷ Charging more for renewal of the insurance contract than the initial enrollment premium (Chollet and Lewis 1997).

services from coverage, and patient cost sharing--have one thing in common: *in an attempt to ensure the financial viability of a particular insurance scheme, they detract from the depth and breadth of the insurance function for the population as a whole.*⁸

Without strong government involvement to reduce the consequences of adverse selection, the incentives in a competitive voluntary insurance market will lead to a segmentation of the population into different risk pools, which, among other problems, will make it increasingly difficult to finance the premiums of persons in sicker pools on a purely private basis. Over time, this may lead to a progressive ‘de-insurance’ of the population, especially in systems characterized by a ‘mature’ competitive health insurance market. This conclusion appears to be supported by the experience of the United States, the only industrialized country that relies primarily on a competitive voluntary insurance market. Between 1987 and 1995, the share of the nonelderly population covered by voluntary health insurance fell from 75.9% to 70.7% (analysis of US Current Population Survey data, summarized in EBRI (1997)), even though this was a period of strong economic growth and job creation, when employment-based insurance coverage might otherwise have been expected to grow.

Whilst the above may appear as an argument against relying on voluntary insurance, it is meant merely to signal some of the issues likely to arise with the development and growth of such markets. For many low income countries, expanded reliance on voluntary insurance affiliation may constitute an improvement over the alternative: out-of-pocket payment (given the relatively low levels of public resources mobilized in these countries as summarized in Table 2). In this context, policies to introduce or expand voluntary prepayment arrangements must be considered (Atim *et al.* 1998; Bennett *et al.* 1998; Bloom and Tang 1999; Dror and Jacquier 1999; Kaddar and Galland, eds. 1997). As noted in Section 2 above, however, the creation of a voluntary insurance scheme or market is not an inherent policy objective; such schemes should be analyzed with respect to how they contribute to or detract from the insurance objective for the health system as a whole.

Several countries that mobilize resources for health insurance through compulsory contributions by employers and employees have introduced changes in the way that resources are allocated to their insurance funds, whereas others have not. Chile is an example of the latter. In 1981, Chile enacted a reform that allowed high income people to “opt out” (i.e. choose to not contribute) of the national social insurance fund (FONASA) and choose among a number of competing private individual risk-based insurers (ISAPREs). This resulted in the creation of two different health care systems, largely differentiated by income and other individual risk characteristics of the population. As implemented in Chile, opting out eroded ‘solidarity’ (i.e. cross-subsidies from the rich to the poor and from the healthy to the sick) within the sector. Moreover, the potential reallocation of FONASA resources in favor of the higher risk (largely also poor) population made possible by the shift of people to private insurers did

⁸ Moreover, many of these techniques also involve considerable administrative costs that produce no systemic benefits in terms of access, quality or income protection.

not happen. In 1990, per capita expenditures on FONASA members were about US\$65, as compared to US\$250 for ISAPRE members. This difference is substantial, especially when the different risk profiles of the two population groups is considered. Moreover, when an ISAPRE ‘dumps’ a member who has become very high cost, FONASA must absorb the costs of this health care. As the implicit “insurer of last resort”, the poorer FONASA program subsidizes the richer ISAPREs. The problems created by ‘opting out’ in terms of equity and the efficiency of the insurance function for the population as a whole are clear; however, the ISAPRE beneficiaries seem to be quite satisfied with the system, as suggested by the evidence that all who have the opportunity to opt out do so (Baeza 1998).

Unlike Chile, other countries (e.g. Argentina, Colombia, Germany, Israel, and the Netherlands) have combined the introduction or expansion of consumer choice of fund with a formula to adjust the amount of revenue received by each fund for the relative health care risk of its enrollees. Implementing this “risk adjustment” procedure requires the creation of a new organization to pool health revenues on behalf of the entire covered population and then to allocate these funds to the competing health insurers according to the number of people choosing each fund, with the amounts for each enrollee adjusted according to the risk adjustment formula. This combination of reforms has multiple objectives:

- 👉 improving equity by attempting to match the resources received by each fund with the health care needs (rather than the income, for example) of its enrollees,
- 👉 improving consumer satisfaction through expanded choice, and
- 👉 improving sectoral efficiency through competition among funds, while reducing their incentive to devote efforts to selecting preferred risks.

Some successes with these measures have been documented. For example, prior to the introduction of risk adjustment with expanded choice of “sickness fund” in Germany in 1994, the financing system was inequitable because each fund had to set contribution rates to cover a standard package of benefits. Funds with a sicker mix of enrollees therefore had higher contribution rates, which meant that, on average, poorer and older persons paid a higher percentage of their income than did richer and younger persons. The introduction of risk adjustment with an expansion of consumer choice of “sickness fund” has led to a notable decrease in the contribution rates of some funds serving relatively high risk populations (Chinitz *et al.* 1998).

Despite some observed benefits from risk adjustment, this mechanism is technically complex and not well developed in actual use as yet. Most countries using this are only basing the adjustment on demographic variables (age and sex) which have been found to explain only about 1% of the variance in individual health expenditures (see studies summarized in Baeza and Cabezas 1999). Thus, the expected benefits of this mechanism should not be overestimated, especially with respect to the ability to curtail risk selection behavior by competing insurers.

For public budget funds that have been allocated to a Ministry of Health⁹ or that have been allocated to local governments and from there to the ‘local MOH’, funds may be distributed directly to service providers, or there may be an intermediary organization, such as a provincial or district health administration or board, charged with accumulating funds from the MOH and allocating these health care resources on behalf of a defined population.¹⁰ In an attempt to improve equity in the distribution of public funds, several countries have introduced or strengthened these intermediary organizations and changed the basis for determining the size of their budgets, so that resource flows more closely reflect population needs rather than historical patterns of utilization or infrastructure development. For example, the United Kingdom (OECD 1992) and Zambia (Choongo *et al.* 1995) introduced changes to allocate public funds to local health authorities or boards based on the relative size of the population living in the area, with these per capita allocations adjusted (‘weighted’) for various indicators of relative health care resource needs (e.g. population density, percent living below the poverty line, etc.).

Needs-weighted population-based allocation formulae for distributing budget funds to territorial health authorities or boards are conceptually similar to ‘risk adjustment’ formulae for redistributing prepaid contributions to insurance funds. The purpose of each is to ensure that the pooling organization has the ‘right’ level of funds to finance the defined benefit package for its ‘risk pool’. Risk adjustment of contributions to insurance funds may serve the further purpose (not needed with general revenue financing or fixed nationwide payroll tax rates) of trying to improve equity in the finance of care by reducing differences in contribution rates that relate to the expected health care risk of the contributors.

4.3 Purchasing and provider payment

In general terms, “purchasing” means the transfer of pooled resources to service providers on behalf of the population for which the funds were pooled. Together, (as indicated by the arrows in Figure 1) pooling and purchasing embody the function of *coverage* for a defined population. Table 4 gives examples of purchasing organizations. Frequently, the purchasing and pooling functions are implemented by the same organization. This is reflected in the overlap of the examples provided in Tables 3 and 4.

“Provider payment” refers to the *mechanisms* used to allocate resources to providers. These allocation mechanisms (summarized in Table 5) generate incentives that can affect the behavior of service providers. As suggested by the table, within each type of payment method can be a number of

⁹ The framework does not address, specifically, the process by which general public revenues are allocated to the health sector. In other words, this analysis does not address how a Ministry of Finance determines the size of the budget for a Ministry of Health.

¹⁰ One implication of this is that potential problems associated with “fragmentation” of pools are not limited to systems of voluntary insurance or even compulsory social insurance with multiple funds. Issues arising from fragmentation of pools can, and often do, arise within “Ministry of Health” systems.

variations that provide different incentives. In a capitation-based system of provider payment, the “steering mechanism” for the payment may be consumer choice, whereby consumers decide with which provider they will enroll, and the funding from the allocating organization follows that choice. Alternatively, the capitation payment could be simply assigned to providers according to the size of the population in its catchment area. In this case, capitation is virtually indistinguishable from a population-based budget allocation. Or, as was initially the case with Thailand’s Social Security health insurance scheme, the enrollment choice was made by employers on behalf of their employees, and this decision steered the flow of funds to providers (Tangcharoensathien *et al.* 1999). Saltman (1995) also notes that a contract can be negotiated between purchasers and providers that specifies the provider payment method, including a fee schedule, where relevant. In this case, the negotiated contract is the steering mechanism for the provider payment method. In fact, most countries use mixed methods of provider payment, often with the explicit intention of countering some of the adverse incentives of “pure” systems of provider payment (Barnum *et al.* 1995).

The payment methods and other actions of purchasers have important implications for the coverage and efficiency of the insurance function of health care systems. Two sets of broad policy questions that need to be addressed with respect to the purchasing function are:

- ☞ What is their role with respect to the providers of care? Are they passive financial intermediaries, or do they use their financial power to promote improved quality and efficiency in the delivery of health care?
- ☞ What is the market structure of purchasing organizations? Is there a ‘single payer’ covering the population in a defined geographic area? Are there multiple insurers, and if so, do they compete for ‘market share’, or are persons assigned to them in a non-competitive system? In the public sector, is there an organizational unit with explicit responsibility for purchasing?¹¹

Table 4. Examples of purchasing organizations

Ministry of Health
☞ central
☞ decentralized units (e.g. provincial or district health departments)
Local government health authority
Area Health Boards
Social health insurance fund(s)
Private insurance funds
Health “plans”
Employers
Member-owned “mutual” insurers
Fundholding providers

¹¹ Many of the questions on market structure also apply to pooling institutions.

Role of the purchaser: specific functions associated with allocations to providers

In many countries, the focus of reform could be put usefully on the specific activities carried out by the intermediary(ies). Evidence from both developing (Kutzin and Barnum 1992) and industrialized countries (Saltman and Figueras 1997) indicates that, largely as a result of information asymmetries that give providers powerful influence over consumer demand for health care, incentives and regulations oriented towards the supply side of the market (e.g. provider payment methods) are far more powerful policy tools than those oriented solely towards the demand side (e.g. user charges to limit excess consumption due to the effects of *moral hazard*). Thus, a critical factor for the performance of health care systems is the extent to which purchasers use their financial power actively to encourage providers to pursue efficiency and quality in service delivery. To the extent that purchasers are simply financial intermediaries, paying providers without attaching meaningful conditions on their performance, the result is invariably provider-led cost escalation, often accompanied by potentially harmful expansion of unnecessary service delivery (as in China (Liu and Mills 1999) and Korea (Yang 1997), for example). An alternative likely to be more consistent with health policy objectives would be for purchasers to use their financial power to promote efficient and high quality service delivery.

Table 5. Provider payment methods and incentives

Payment method type	When price or budget defined	When payment made	Basis or unit for price/budget	Payment 'steered' by	Treatment incentives
Budgets (line item and global)	prospectively	prospectively	inputs or all services of provider for a given period	various criteria, e.g. negotiated contracts, patient volume, physical capacity, etc.	underprovide, shift (refer) patients to other providers
Salaries	prospectively	prospectively	staff time (hours worked)	contract	underprovide, refer to other providers
Capitation without fundholding for referral services	prospectively	prospectively	expected cost of covered services from capitated provider for each person per period	consumer choice or size of population in catchment area	enroll healthy people; under-provide and refer, mitigated by re-enrollment process
Capitation with fundholding	prospectively	prospectively	expected cost of all covered services for each person per period	consumer choice or size of population in catchment area	enroll healthy people
Case-based payment	prospectively	retrospectively	treatment comprising bundle of services, most commonly a hospitalization	fee schedule codified in regulation or contract; patient choice of provider	increase volume of less severe patients in each case category; decrease services per case
Fee-for-service according to fee schedule	prospectively	retrospectively	each agreed service item or input	fee schedule codified in regulation or contract; patient choice of provider	increase patient volume and services per case
Fee-for-service, no fee schedule (or informal)	retrospectively	retrospectively	each item of service provided	patient choice of provider; negotiation between provider and patient	increase total volume of services provided
Mixed, e.g. salary plus fee-for-service	depends on specific mix	depends on specific mix	depends on specific mix	depends on specific mix	depends on specific mix

Sources: Barnum *et al.* 1995; Bloor and Maynard 1998; Saltman 1994

Such *active purchasing* can take several forms but essentially means allocating resources to providers using mechanisms that place conditions on the performance of providers, hopefully in a way that promotes the sectoral objectives of quality and efficiency. Therefore, critical conditions for the effectiveness of these mechanisms (which Kane (1995) calls the “elements of managed care”) are information systems to provide data to both purchasers and providers in a timely manner and management skills and systems to use this information to improve performance. Specific categories of active purchasing mechanisms include:

- ☞ *financial incentives* (provider payment methods, such as those summarized in Table 5), that usually shift some of the financial risk for patient care costs to providers and/or are targeted to achieving specific cost control or quality objectives;
- ☞ including non-emergency specialty services in the benefit package only if patients have been referred by a primary care *gatekeeper*;
- ☞ *managing choice* by pre-qualifying a group of “participating” primary care providers from which beneficiaries can choose, with services (apart from emergency and referral) obtained from other providers not covered (i.e. not paid for) by the purchaser;
- ☞ *contracting* by the purchaser only with *selected* providers (in contexts in which the provider market is competitive), requiring them to cooperate with certain utilization controls and provide services for a discounted price or fee schedule, in return for an expected high volume of patients;
- ☞ maintaining *profiles* of individual providers for monitoring and providing feedback to them on their treatment, referral and prescribing practices and costs; and
- ☞ intervention by the purchaser in clinical decisions to reduce inappropriate services and improve quality in the process and outcome of care through various forms of *utilization review* (UR), including *prior authorization* of elective admissions or specialized ambulatory procedures (under the oxymoronic name of “prospective review”), review undertaken during a hospitalization (“concurrent review”), and “retrospective review” of payment claims to compare the process of care with *standard treatment protocols*, and denying payment if clinical management is found to have been inadequate.

Unless guided explicitly by public health policy considerations and an awareness of market failures in the patient/provider interaction, however, the administrative procedures used by purchasers can easily get ‘out of control’. As noted by Saltman (1998), this seems to be happening in the United States, where commercial managed care firms are guided by the short-term financial interests of their owners in a market that lacks the regulatory framework needed to ensure/encourage purchasing decisions to be made in the public interest. In response to some of the perceived abuses of “managed care” (i.e. the actions of these companies, especially the denial of certain services and other interventions into the medical care decision-making process), many state governments and the national government are evolving a patchwork of regulations to promote quality, access and patient’s rights (Paterson *et al.* 1999; GAO 1999; Scanlon 1999; Pollitz *et al.* 1998).

The description of the active purchasing functions as the “elements of managed care” does not imply that they can exist only in a commercial insurance context, however. Many of these features, such as the use

of primary care gatekeepers and fixed budgets, existed in West European health systems for many years before the rhetoric of “managed care” became popularized in the United States (Saltman and Figueras 1998). As shown in the examples below, aspects of active purchasing can be found in low income countries as well. To date, these exist within particular insurance schemes serving relatively small numbers of people, rather than as features of the broader health system. These experiences are encouraging nevertheless.

In Tanzania, an umbrella organization (UMASIDA) of five informal sector groups in Dar es Salaam has created a contributory health insurance scheme for its members. To control costs and promote improved quality, UMASIDA uses selective contracting, provider profiles, utilization review and treatment protocols. For example, faced with a total of about 400 private primary care providers in the city, the UMASIDA groups have developed criteria for provider selection, such as the availability of a qualified medical officer and nurses, availability of a mix of services for women and children, competent laboratories able to perform at least five tests for conditions related to common diseases in Tanzania, proper record keeping procedures, and agreement to prescribe only items on Tanzania’s essential drug list (EDL). The scheme managers review claims for accuracy before reimbursement, and also check patient records to monitor provider prescribing patterns. In at least one case, a contract was terminated with a provider due to a failure to maintain quality and cost standards, including prescribing outside the EDL, polypharmacy, failure of the medical officer to be present on a daily basis, and a rise in consultation fees that was not agreed with the UMASIDA group (Kiwara 1997). Similarly in India, the health insurance scheme for the Self-Employed Women’s Association (SEWA) is using its purchasing power to improve quality and control costs, particularly through the use of provider profiles and utilization review. SEWA analyzes claims data to identify clinics that provide care at affordable prices and encourages its members to use these, while at the same time ‘blacklisting’ fraudulent doctors (Bennett *et al.* 1998).

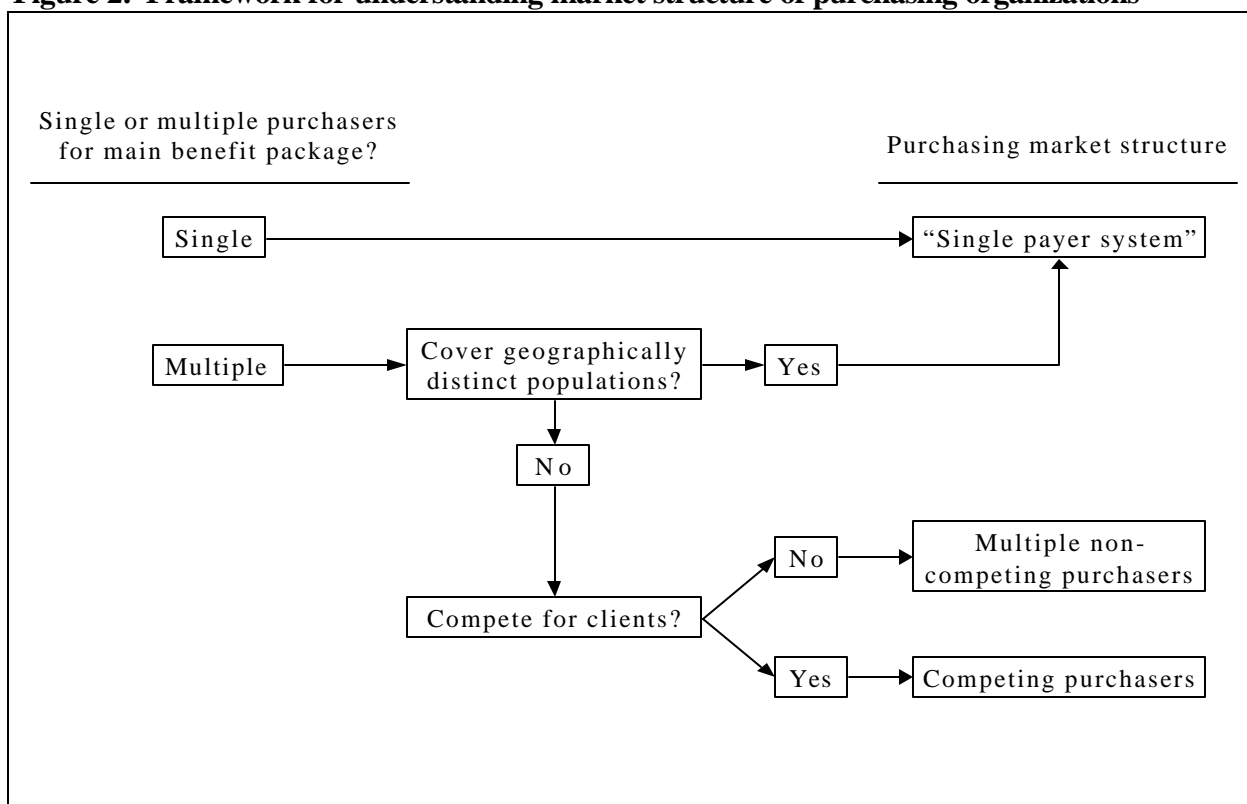
Based on the experience of West European countries, Saltman and Figueras (1998) have suggested that many of the active purchasing features can have positive effects for the health system if purchasers can be held publicly accountable for their decisions. While the health insurance schemes of UMASIDA and SEWA are not publicly accountable, as member-owned schemes they are at least accountable to their members. This may contribute to the importance that these schemes attach to both quality and cost control. Strengthening local accountability mechanisms figures high on the list of policy recommendations for reforms of community financing in China as well (Bloom and Tang 1999). The experience of the United States suggests, conversely, that where there is no such accountability to either the public or to just the covered population, the administrative actions of individual pooling and purchasing organizations may be a threat to system-wide efficiency, equity and quality. While these experiences suggest the importance of accountability as a determinant of the effects of active purchasing, there is a need for considerably more research on this topic. The evidence is not yet conclusive with regard to which specific purchasing measures are socially beneficial, at what cost, and under what

conditions, nor on the extent to which accountability (and the form in which it is exercised) affects the consequences of these measures.

Market structure

As suggested by Figure 2, the organization of purchasers in any health system can be categorized according to the numbers of these organizations and the extent to which they compete with each other. Some health systems are described as “single payer”. Canada is frequently cited as an example of a single payer system, even though it has a different purchaser in each of its provinces (the provincial insurance fund). This suggests that a definition of “single payer” (or single purchaser) is needed for clarification. It is useful to think of this as a single purchaser for the main service package on behalf of the entire population living in a defined geographic area. Hence, Canada has a single purchaser for each province. Similarly, Sweden has a single purchaser in each of its counties (the County Council), and

Figure 2. Framework for understanding market structure of purchasing organizations



Zambia has a single purchaser for primary and first referral care in each district (the District Health Boards) and one national purchaser for higher level hospital services (the Central Board of Health). In Costa Rica, there is a single purchaser of health care services for the entire population of the country (the Social Security Fund).

Many countries have more than one significant purchaser of services covering different groups of people in the same (or overlapping) geographic areas. Some have a small number of purchasers, and there is no competition between them (people are assigned to one or the other). In Mexico, for example, there are two main purchasers, the Social Security Institute and the Ministry of Health, and they serve different populations within the same geographic areas. In Thailand, there are more purchasers (5 statutory insurance funds), but they do not compete for enrollees. Until fairly recently, Germany and Argentina were characterized by a multiple (hundreds), non-competing insurance market. Alternatively, the United States and Switzerland have multiple competing insurers and purchasers. Some countries, such as South Africa and Jamaica, have a small but still important competitive insurance market in addition to the main publicly financed system. While Figure 2 provides a simplified classification scheme for summarizing purchaser market structure, in reality there are nuances and variations within each of these categories. It is essential that policy makers understand the details and implications of their own market structure if reforms are to proceed from a sensible starting point.

Country experience and certain elements of market failures in the health sector suggest a number of reasons why understanding the market structure of purchasers is important for informing the kinds of measures governments can take to promote accountable active purchasing, as described in the previous sub-section. There would seem to be theoretical advantages to a single payer system (either a public sector entity or a tightly regulated but independent 'quasi-public' agency, such as a social insurance fund) because a monopsony purchaser of services on behalf of the population could use its financial power to ensure that service delivery occurs in line with the objectives of efficiency and high quality. A single payer can offer a coherent set of incentives to providers, whereas the existence of multiple organizations that pay the same providers, as in the United States, can lead to diluted incentives and strategic (and socially unproductive) behavior by providers. Examples of the latter include "cost shifting"--adjusting prices charged to different purchasers for the same service (Brooks *et al.* 1999; Clement 1997), or manipulating the costs of care (and thus treatment practices) for persons with the same clinical condition but different levels of insurance coverage (Dor and Farley 1996)--and increasing the supply of services to patients covered by one scheme in response to changes in the payment system of another scheme (Yip 1998; Fahs 1992). In addition, the need to monitor and regulate the actions of multiple insurers means that the administrative costs of the *system* will be high, even if some individual insurers are efficiently run.

Conversely, a case can also be made for multiple competing purchasers. Competition might be expected to lead to a better match between consumer preferences, purchasing arrangements and benefit packages. It is also likely to facilitate a greater degree of experimentation in payment methods and other purchasing features. Moreover, despite the potential advantages of having one powerful and publicly accountable purchaser to generate appropriate incentives to providers, single payer systems (or more precisely, systems in which purchasers are not subject to competitive pressures) are not without problems, both conceptually and in practice. In particular, based on the experience of social insurance funds in many Latin American countries, Baeza (1998) notes that, in the absence of any real

competition, many of these funds have become poorly performing bureaucracies. He identifies a number of reforms that could be implemented to improve the performance of these agencies, including the use of incentives to encourage the fund to improve its services and be responsive to its clients (i.e. the population), ensure independence of the fund from the government to minimize political influence over resource allocation decisions, give the citizens/clients more power relative to both the purchaser and providers, and make the fund accountable to the general public while simultaneously limiting the influence of well-organized interest groups (e.g. politicians, unions, etc.). Baeza suggests that Latin American countries with single payer systems have done no better at implementing these kinds of reforms than have countries trying to regulate competing insurers in the public interest.

Irrespective of whatever is theoretically correct, the starting point for policy analysis and reform in any particular country is the existing system. In countries in which multiple (often private) insurance funds exist, the appropriate and realistic role for government is to improve its regulatory framework and ability, rather than to try and dismantle the insurance industry (Chollet and Lewis 1997). Thus, the issue for any country is not about the theoretically best method of organization (whether that is with a single payer or otherwise), but rather, given the existing market structure of purchasers in a country, what is the appropriate direction for policy changes that will facilitate active purchasing that is publicly accountable, or at least accountable to the population covered by each purchaser.

In countries with multiple non-competing purchasers, reform options include enabling the purchasers/insurers to compete or restructuring the system to move towards a single payer approach. As noted in the previous section on pooling, a number of industrialized and middle income countries (e.g. Argentina, Colombia, Germany, Israel, the Netherlands) with previously overlapping but non-competing purchasers are attempting to introduce consumer choice of fund coupled with risk adjustment of premiums to reduce incentives for risk selection. Alternatively, in countries such as Mexico and Thailand, with a small number of non-competing funds, reforms have been proposed to move towards a single payer system. In each case, the contexts and nature of the problems to be addressed are different.

In Argentina, for example, market structure (more than 300 non-competing insurance funds) contributed to inefficiencies and inequities in the health system due to the very small memberships of some funds, weak management, excess staffing, unequal revenue bases of different funds, wide variation in benefit packages and inadequate redistribution of resources across funds. Many of the efficiency problems in particular were attributed to the lack of competitive pressures facing individual insurance funds, and recent reforms have introduced consumer choice of funds, risk adjustment of premiums received by the funds, and a strengthened regulatory regime (World Bank 1997). In Mexico, there are two main non-competing purchasers, the Social Security Institute and Ministry of Health. In fact, the purchaser in each is only one part of separate, non-competing and geographically overlapping “health systems” with their own health care providers serving their “own” populations. As summarized by Frenk (1995), this segmentation of the population in the same geographic area into different vertically integrated health

systems has generated a number of problems, including wasteful duplication of functions and inefficient scale of provision of some services, lack of responsiveness by the monopolistic organizations (MOH and Social Security) controlling each system, and a burden of out-of-pocket payments on persons covered by (and contributing to) one system but who seek care in another. The reforms proposed to improve equity and efficiency included doing away with the vertically integrated systems, making the Social Security Institute the single insurer for the entire population, and simultaneously introducing competition among providers (FUNSALUD 1995). These changes have not been implemented.

In many low income countries, the government (usually through the health ministry) is the main organization that pays providers from pooled revenues, even though most health spending is unpooled (i.e. out-of-pocket). While these countries could be characterized as having “single payer” systems,¹² many do not have an identified agency with explicit responsibility for ensuring that the funds allocated to health care providers are, at least to some extent, tied to the performance of these providers. While this is primarily a question of the purchasing function rather than the market structure, there may be a link between reforms to strengthen purchasing within the publicly funded health system and the introduction of new organizational entities (e.g. Zambia’s introduction of the Central Board of Health and District Health Boards as purchasers).

While it is conceptually feasible to create this “purchaser-provider split” by changing the responsibilities and resource allocation mechanisms within and between existing public sector organizations, this has been difficult to put into practice. For example, as part of its reform plans, the Kyrgyz Republic attempted to pool all of the health budget revenues for primary care at the oblast (province) level which were previously distributed from the rayon (district) level, with the intention of then paying primary care providers (“Family Group Practices”) on a capitation basis. This was implemented on a pilot basis in one oblast in 1998 but reversed in 1999 (Adams *et al.* 1999). Reforms in provider payment are continuing, but a new organization, the Mandatory Health Insurance Fund (MHIF), has taken the lead in introducing these. The MHIF has recently been placed under the authority of the health ministry and, with the elimination of the Oblast Health Departments in early 2000, is set to become the single payer for entire system, receiving funds from general revenues as well as from payroll taxes.

While the reforms in the Kyrgyz Republic and Zambia are innovative and would enable the process of purchasing to be changed from historical patterns of allocation within the public sector, it is far too early to reach conclusions regarding the effectiveness of these changes. They have introduced a purchaser-provider split using public revenues, but they face the challenge of trying to introduce a “purchasing”

¹² In fact, because responsibility for allocating resources to provider units is often divided among different parts of the system, it may be more appropriate to characterize these systems as having multiple, non-competing purchasers. In Ghana, for example, government health facilities are allocated funds from several sources: the central government is responsible for allocating salaries directly to health workers in all public facilities, regional health administrations allocate non-salary operating budgets to public hospitals, and district health administrations allocate non-salary operating budgets to health centers (Nyonator and Kutzin 1999).

mentality into what have been historically highly bureaucratic systems. Moreover, rules governing the use of general tax revenues in many countries (e.g. strict line item budgets) limit the flexibility with which public sector purchasers can allocate to providers. Hence, while it is *conceptually* possible to introduce a purchaser/provider split in the public sector, it may be very difficult to implement this in *practice*. Baeza (1998) notes that instituting a purchaser/provider split within the public sector of several Latin American countries has had very minimal effects to date, which is attributed in part to the rigid cost structures and the lack of management flexibility in public provider units. A discussion of related market structure issues in service provision is included in the next section.

4.4 Provision of services

As with pooling and purchasing, understanding the market structure of service provision is essential for designing appropriate reforms to encourage efficiency and strengthen the insurance function. The distribution of providers is also critical for the attainment of universal coverage, since people living in underserved areas cannot be said to be effectively insured. Important sets of policy questions with respect to the insurance function are:

Table 6. Examples of service provider organizations

<p>Primary (first contact) care, secondary and tertiary care providers, pharmacies, laboratories, etc.</p> <ul style="list-style-type: none"> ☞ government or insurer-owned providers, with varying degrees of managerial autonomy ☞ private (or otherwise independent) providers contracted by system ☞ independent providers, without contracts ☞ individual practitioners, single-specialty group practices, and multi-specialty groups ☞ networks of providers linked by ownership or contract

4.4 Provision of services

- ☞ Are there different providers affiliated to each different purchasing organization, segmenting the population into different, vertically integrated health subsystems? To what extent is the structure of service provision competitive or monopolistic? How does this vary in different markets within the country (e.g. urban and rural), and for different kinds of services (e.g. primary care, inpatient care, drugs, etc.)?
- ☞ How much autonomy do managers of provider units have, especially with respect to staff? Does this differ significantly between the public and private sectors?
- ☞ What is the distribution of service providers? Are there parts of the country that have no effective access to health care? Are there particular population groups (e.g. those who are not members of a statutory insurance scheme) with very limited access to health care?

Market structure

Understanding the market structure of health care service provision is essential for developing appropriate and comprehensive reforms to enhance the insurance function. Thus, it is useful to describe, for the health system as a whole or for each insurance subsystem (scheme), whether each purchaser (if there are more than one) has its own providers in an exclusive relationship (i.e. vertical integration), or if

the same providers can receive payment (and patients) from different purchasers. For example, does the social health insurance scheme have its own hospitals that only serve its own beneficiaries? This situation is characteristic of a *segmented* health system (Londoño and Frenk 1997) in which the different social groups in the population are served by parallel, vertically integrated systems for revenue collection, pooling, purchasing, and provision of health care. Alternatively, do allocating organizations contract with independent providers? Are publicly owned facilities organized by level of government, so that, for example, provincial hospitals are funded through provincial governments and district hospitals and health centers are funded through district governments? Answers to these questions will give an indication of the nature of the relationship between payers, providers, and populations in various geographic markets.

Based on analysis of the existing market structure, the appropriateness of market vs. planning approaches to reform should not be an ideological decision but rather one based on an assessment of the specific mix of approaches that is most likely to yield improvements in efficiency, quality and equity. In general, the supply of primary curative care services will be more competitive than referral and specialized care.¹³ Where there is a relatively large number of primary care providers (GPs, for example) in a relatively small geographic area, it may be appropriate to use consumer choice or selective contracting by the purchaser with GPs as the basis for allocating funds to providers. In non-competitive markets for particular services, these options are unlikely to be a useful mechanism for steering provider payments because no real choice exists. The analysis of the market structure of service provision may also suggest opportunities for system-wide efficiency and equity gains by enabling a shift from an organization of provision based on scheme membership to a more population-based system.

Autonomy of provider units

Many lessons about the effects of reforms, especially those involving changes in the ways that providers are paid, are drawn from countries in which most service provision occurs in private or otherwise independent organizations. Where providers are predominantly ‘owned’ by the public sector, the lessons drawn from other contexts may not apply because of the constraints on managers usually associated with these forms of ownership. However, many countries have introduced or are considering reforms to increase the managerial autonomy of publicly owned provider units (mainly hospitals) in order to simulate the flexibility of independent firms and, in some cases, expose them to competitive pressures. Harding and Preker (2000) describe a continuum of organizational types and reforms, ranging from budgetary units for which all resource related decisions are made by the government, to autonomous, corporatized and fully privatized units, with the scope for resource-related decisions increasingly given to the facility’s managers, management boards, or new owners (in the case of privatization). The framework is useful, but evidence on the effects of these reforms remains limited.

¹³ Competition for some hospital services exists but is mostly driven by providers (physicians as agents for their patients), not consumers.

Only a handful of cases have been analyzed in a systematic manner (Govindaraj and Chawla 1996), and even these provide very little information on the interaction of autonomy reforms with other measures.

Baeza (1998) notes that provider payment reforms have not always been accompanied by provider autonomy reforms in Latin America. For example, both Chile and Costa Rica have implemented (nationally or on a pilot basis) case-based payment systems for public (in the case of Chile) or social security (in the case of Costa Rica) hospitals, but the expected benefits of each have been limited by the constraints facing managers with respect to the capacity to adjust their cost structures in response to the new incentives. In general, if public providers are to compete effectively with private providers in a reformed environment, then reforms to increase managerial flexibility within the public sector are needed. This requires going beyond the health sector and making the case to those responsible for overall reform of the public sector. If the experiences where countries (e.g. Argentina) have granted autonomy to formerly public hospitals do not prove successful at leveling the playing field with private hospitals, Baeza suggests that creating a purchaser-provider split in the public sector may be ineffective at generating efficiency gains. This might mean that the *ownership* of providers does matter, in practical if not necessarily conceptual terms. This may bring the issue of privatization of service provision onto the policy agenda in a new way, provided the context is appropriate and that it is part of a more comprehensive reform effort.

Distribution of providers

The distribution of providers directly affects access to care and thus the breadth of the insurance function. This is because a promise of financial protection is meaningless if people do not have reasonable physical access to primary care, emergency services, or necessary referral care. Therefore, analysis of the existing insurance function and proposals for reform must include an assessment of the geographic distribution of providers, irrespective of whether or not individuals happen to be members of an identifiable insurance scheme. In Costa Rica, for example, poorer persons who were ostensibly covered by the social security health insurance system suffered from very long waiting times that limited their access to primary care. The solution to this was not to expand financial protection (to which they were already entitled) but to establish 800 basic health teams to provide comprehensive primary care (Salas Chaves 1995). Thus, the insurance function was enhanced by expanding the availability of services.

5. Benefit package and out-of-pocket payment: opposite sides of the coin

As noted earlier, the direct links between individuals (as patients) and service providers--health care and out-of-pocket payment--are of central importance to policy objectives. Thus, policies on the design of benefit packages and cost sharing/user fees are essential elements of a universal coverage strategy. Operationally, it is useful to conceptualize the benefit package not simply as a list of services

to which the population (or beneficiaries of an insurance scheme) is entitled, but as those services, and means of accessing services, for which the purchaser will pay from pooled funds. This definition implies that *services not included in this package are those for which direct out-of-pocket payment by users is required to fully or partially finance their provision* (i.e. fully or partially covered services). This definition is useful for looking at the financing of the health care system in a comprehensive manner, with fees/cost sharing viewed as a part of the entire financing system rather than just an isolated tool for raising revenues or deterring demand. Moreover, as identified explicitly in Figure 1, the role of out-of-pocket payments as part of “provider payment” also needs to be taken into account for policy and planning.

The composition of the benefit package, including the level of cost sharing, is a reflection of the *depth* of effective insurance coverage. Key sets of policy questions with respect to this are:

- ☞ What is the basis for determining entitlement to benefits? Is there a common benefit package for the entire population or a mandated minimum package to which the entire population is entitled and has access? Alternatively, are different insurers/purchasers free to determine their own packages?
- ☞ Is policy on user fees related explicitly to the benefit package? Are fees designed to promote efficiency through appropriate use of the referral system? Are there provisions to enable access for low income persons who would otherwise be deterred from necessary service use as a consequence of fees?
- ☞ How should package/fee policy differ for services with different “economic” characteristics?
- ☞ What is the nature of the services covered by the system or scheme(s)? To what extent is the package comprehensive, catastrophic, or based on an assessment of the relative cost-effectiveness of medical care interventions? Where people can make use of more than one benefit package (e.g. entitlement to a publicly financed system plus membership in a private insurance scheme), how well do the different packages ‘fit’ to provide efficient insurance protection?
- ☞ How important are formal and/or informal out-of-pocket expenditures as contributors to provider payment? How do such direct payments from patients interact with purchasing methods from pooled funds and affect the environment of incentives facing providers?

5.1 Entitlement to benefits5.1 Entitlement to benefits5.1 Entitlement to benefits

As noted in the discussion of revenue collection in Section 4.1, the way that the health care system (or schemes within the system) is financed sometimes determines the entitlement of the population to benefits (Ensor 1993). Health care systems funded from general tax revenues tend to offer benefits to the entire population (citizenship entitles people to benefits). However, in many middle and low income countries, such coverage through general tax revenues is only theoretical for parts of the population that lack effective physical and financial access to services of adequate quality. Hence, what in several

countries is a constitutional guarantee of access to all is in fact an empty promise, or at least an unfulfilled one.

In countries that have schemes involving either voluntary or compulsory contributions to an insurance fund, such contributions by or on behalf of individuals or families usually determine their entitlement to benefits. This is problematic in countries where a large percentage of families have no one working in the formal sector of the economy. Where most are contributing and where there is a broad social consensus favoring universality, there may not be much resistance to provisions made to include the poorest in the system (as in many OECD countries, for example). However, where a contributory scheme would include a minority (though still significant number) of families, it is very difficult to offer the same benefit to non-contributors, as this would dilute the willingness of workers and employers to contribute.

There are some exceptions to the contribution-entitlement link. In China, the “Government Insurance Scheme” is funded out of general revenues and entitles civil servants and university students to free medical care (WHO 1995). Thus, there is a generous benefit for part of the population that is not linked to any specific contribution. In Costa Rica, it is estimated that contributions are made to the social security health insurance system for about 85% of the population. In the 1980s, the government decided to make social security-funded health services available to the entire population, meaning that about 15% of the population receives the entitlement without a defined contribution (Salas Chaves 1995). Similarly in the Kyrgyz Republic, over 40% of the beneficiaries of the Compulsory Medical Insurance program in 1998 were pensioners and unemployed persons who did not make financial contributions to the scheme. Although contributions were supposed to be made on their behalf through budgetary transfers, most (nearly 80%) of the scheme’s revenues came from employer contributions (on behalf of formal sector workers). Contributors cross-subsidized non-contributors (or, more precisely, relieved pressure on government funds): 70% of insured patients in 1998 were pensioners (Government of the Kyrgyz Republic 1999).

5.2 Role of direct payment by patients

Direct payment by patients (i.e. user fees, cost sharing) is conceptually linked to the concept of the benefit package. If a service is “fully covered”, there is no requirement for patient payment at the time of use. If a service is “partially covered”, then patients have to pay something at the time of use (“cost sharing”), but not the full costs. “Uncovered” services are those which have to be financed entirely by the user if they are to be provided at all. With these definitions, it becomes clear that the depth of risk protection for health care can be assessed, in large part, by the extent to which people have to pay for care at the time of use. As noted in Section 2, the National Health Insurance system of the Republic of Korea has very high levels of explicit cost sharing for services in the benefit package, entirely excludes from coverage many expensive high technology services, and also has an unknown level of informal

payments. Thus, while Korea has made a remarkable achievement in extending the National Health Insurance scheme to the entire population, the protection offered to the population is quite limited (Yang 1997). Insurance coverage in Korea is *broad* but not very *deep*.

Examining policies on patient cost sharing in health systems and schemes gives insight into the extent to which people are protected against out-of-pocket expenditures in case of severe illness. Two particular features give an indication of whether catastrophic financial protection is offered: a “benefit maximum” or an “out-of-pocket maximum”. A benefit maximum means that there is a defined limit on the amount of health care costs that will be paid from pooled funds by the purchaser, leaving individuals at risk for expenditures above this amount. An out-of-pocket maximum, conversely, defines a limit on the total out-of-pocket payments for which individuals are responsible, with all the costs of care over this amount paid for from pooled funds. In West European countries, there is either no cost sharing or an effective out-of-pocket maximum for inpatient care, meaning that populations are financially protected against the risk of high-cost health care (Kutzin 1998). In many other countries and specific insurance schemes, there is either no out-of-pocket maximum or there is a defined benefit maximum, leaving even “covered” persons at risk for a substantial level of out-of-pocket expenditure in case of serious or prolonged illness.

When reviewing the role of user fees in health systems or schemes, therefore, it is important to identify whether these are designed and implemented as part of a coordinated and comprehensive system of financing and targeted incentives, or whether they are simply used as an isolated instrument for raising revenue from users. Used appropriately, cost sharing can be an essential part of the active purchasing function. To promote use of a hierarchical referral system, many health systems and schemes require that persons first seek care from a defined primary care provider. This provider is intended to be a gatekeeper to higher level referral services. This gatekeeper function is strengthened if it is backed by a policy to charge high fees to persons who bypass the gatekeeper (for non-emergency services) and self-refer to high cost services. In such a system, the benefit package can be defined as including referral services if these are authorized by the primary care gatekeeper, but excluding the same higher-level services if the patient self-refers. By conceptualizing the benefit package not only as a list of services, but also as the *means* by which the services are accessed, it becomes a potential policy instrument for demand management.

5.3 Demand characteristics of different kinds of services

It is important to recognize that health care contains a mix of services with different economic characteristics (Preker and Feachem 1995). Some personal services provide health benefits that accrue solely (or largely) to the individual receiving them (“purely private goods”, such as aspirin for a headache or setting a broken bone), while others have broader benefits (“mixed goods”, such as immunizations and communicable disease treatment). An important input into the design of appropriate policies has to

do not with the distribution of the benefits from particular services, however, but rather whether the *demand* for the service is determined primarily by the consumer or is heavily influenced by the provider.

In general, the demand for first-contact, primary care services is largely consumer-driven, since the contact with the health care system is motivated by the individual who is seeking care. However, the demand for referral and specialized care is usually provider-driven, because the provider's greater knowledge about the nature of illness and the types of treatments available puts him/her in a position to identify the need for specialized or referral services on behalf of the sick person, who rarely has such knowledge. Consequently, the potential role of cost sharing as a tool to limit "unnecessary use" of services due to moral hazard (i.e. greater consumption of covered services than would have occurred in the absence of coverage) is far greater for primary care than for referral services.

While "supplier-induced demand" is not always negative (indeed, one of the important functions of providers is to identify the need for specific diagnostic and therapeutic services), it is the central factor explaining the cost escalating effect of fee-for-service reimbursement, despite the presence of cost sharing (co-payments) in many health systems. A belief that incentives to providers affect both the supply and demand sides of the market is the basis for suggesting that reforms aimed at changing incentives to providers have a much greater impact on efficiency than do those aimed primarily at consumers, such as patient cost sharing (Kutzin and Barnum 1992; Kutzin 1998; Saltman and Figueras 1997). These factors need to be considered in the design of policies to encourage efficient, effective and equitable use of resources for specific kinds of health care services.

5.4 Services in the benefit package

In low and middle income countries, the issue of the benefit package to be guaranteed by health systems has received intense attention since the publication of the *World Development Report 1993* (World Bank 1993). Among other things, this report promoted the idea that countries should define, *publicly fund*, and ensure delivery of an "essential package" of clinical health services based on an analysis of the relative cost-effectiveness of interventions. This recommendation has been very influential at the international level and has generated considerable debate (e.g. Hammer and Berman 1995; McGreevey et al. 1996; Kutzin 1996; Söderlund 1998). In terms of practical implementation, however, as Söderlund (1998) notes, "the development of packages of entitlements based wholly or mainly on cost-effectiveness has yet to be seen at a national level anywhere in the world" (p.201). In political terms, limiting explicitly the services to be available to a large segment of the population has proven to be quite difficult.

The main concern of a conceptual nature raised with the recommendation has to do with the implications of allocating public funds on the basis of intervention cost-effectiveness in countries that lack privately-funded health insurance for protection against the risk of high-cost illness. Where no other source of insurance protection exists, targeting public expenditures to the most cost-effective interventions will

leave people at financial risk for unanticipated high-cost medical care, thereby ignoring “the insurance function of health policy” (Hammer and Berman 1995, p.38). A “catastrophic” funding strategy may be unworkable, however, in low income settings where even expenditures for basic services may constitute a high percentage of household income and thus prove to be a substantial barrier to access. In this context, the contents of an “essential” package are likely to be very similar to a “catastrophic” package.¹⁴ In any event, it may be useful to refine the strategy of *WDR93* by thinking of the “essential package” not as a “benefit package” (as defined here), but rather as those services which the government should ensure that the health system is able to deliver to the entire population (but not necessarily fully finance for the entire population).

The validity of the arguments in favor of an “essential package” or a “catastrophic package” cannot be addressed in isolation from the other elements of the health system and an understanding of the market structures of poolers, purchasers and providers. For example, without active purchasing to control unnecessary use of specialized care, public funding of a hospital-based “catastrophic package” is likely to lead to excessive and medically unnecessary use of expensive care. Moreover, the role of an explicit benefit package is different in different health systems. While packages may have multiple objectives, they are either part of plans to (a) ration scarce public funds, or (b) regulate or manage competition among insurers (Söderlund 1998). Thus, the analysis of the existing benefit package, and options for reform, need to be considered in the light of the comprehensive system of financing, allocation mechanisms, associated organizational and institutional features, and the national regulatory framework and capacity.

When considering the possibility of implementing new schemes or changing the benefit packages of existing schemes, an assessment should be made of how well such changes will enhance the overall insurance function in the country. For example, if formal sector employees already have good financial access to private sources of primary care financed through direct out-of-pocket payment, setting up a scheme for them covering an “essential package” of cost-effective interventions will do little to enhance *functional* insurance coverage (i.e. breadth and depth) for the population as a whole. The creation of a scheme for a relatively well-off part of the population that provides comprehensive protection for both low cost and high cost health care represents a good example of how countries can confuse policy objectives and policy tools. By focusing on getting people into an “insurance scheme”, the objectives of expanding access and financial protection may be lost as policy makers focus on “insuring” that part of the population least in need of more coverage. This kind of problem has occurred in many low income countries with relatively small percentages of the population in formal employment, generally resulting in a greater concentration of public and private spending on health care for the (relatively) wealthy (Kutzin 1997). Countries should thus be wary of implementing schemes offering comprehensive or “essential” packages for relatively well-off parts of the population who can afford to pay for primary curative care, since all they really need is catastrophic protection. Comprehensive schemes may only be warranted for

¹⁴ I am grateful to Christian Baeza for this insight.

this part of the population if they include sufficient ‘active purchasing’ functions to improve efficiency in the health care system, or, similarly, if they are designed as a means to move a greater share of the population into an ‘organized’ system of first contact and referral care.

One interesting model of potentially well-coordinated benefit packages involves combining schemes for individual savings (or very limited community risk pooling) to pay for relatively low cost services with a “backup” insurance arrangement protecting against the cost of financially catastrophic health care. The only country with an explicit combination of savings and insurance schemes with coordinated benefit packages is Singapore (Nichols *et al.* 1997). While the specifics of the “Singapore model” may not be widely applicable, the concept of combining different arrangements for the population to insure against different kinds of risks may be worth considering. In particular, in contexts (e.g. rural areas of some countries) where there is not great expressed demand for broad-based risk pooling (Bennett *et al.* 1998), it may be feasible to combine public budget funding of high cost services with limited community risk sharing or individual savings (e.g. through ‘health cards’ entitling users to a fixed number of health center visits) to cover health care costs that are low in absolute terms but still significant for relatively poor persons who experience fluctuations in cash incomes over the course of a year. Establishing coordination of the benefit packages covered by different purchasers is not without problems, however, since this creates strong incentives for providers (and purchasers) to ‘shift’ costs. Thus, it is essential that reforms to coordinate benefit packages among different purchasers include active purchasing mechanisms (e.g. pre-admission certification) to limit cost-shifting behavior or mitigate its effects.

5.5 Out-of-pocket payment and provider payment

Most discussion and analysis of provider payment focuses on methods used by third-party purchasers to allocate pooled financial resources to providers. Direct payment by patients is considered as a part of policy, but in terms of “cost sharing” as a tool for demand management. In many parts of the world, however, these direct payments comprise a substantial share of provider incomes. In this context, it is important to address provider incentives inherent in direct payment as part of a comprehensive policy analysis. This task is complicated because, in many health systems, payments made directly to providers are ‘informal’ or ‘under-the-table’. By their very nature, it is difficult to capture information on such payments.

As with payments from pooled funds, provider behavior can be affected by the incentives of fee-for-service payments directly from patients. For example, in county general hospitals in Shandong Province, China, most patients are not covered by insurance and thus pay for care directly at the time of service use. These revenues are used to pay cash bonuses to hospital-based physicians, with the level of bonus related to the quantity of services and revenue generated by each physician. A review of patient records from six of these hospitals over a ten-year period for two tracer conditions revealed a

substantial amount of unnecessary service provision, especially for drugs and professional services (Liu and Mills 1999).

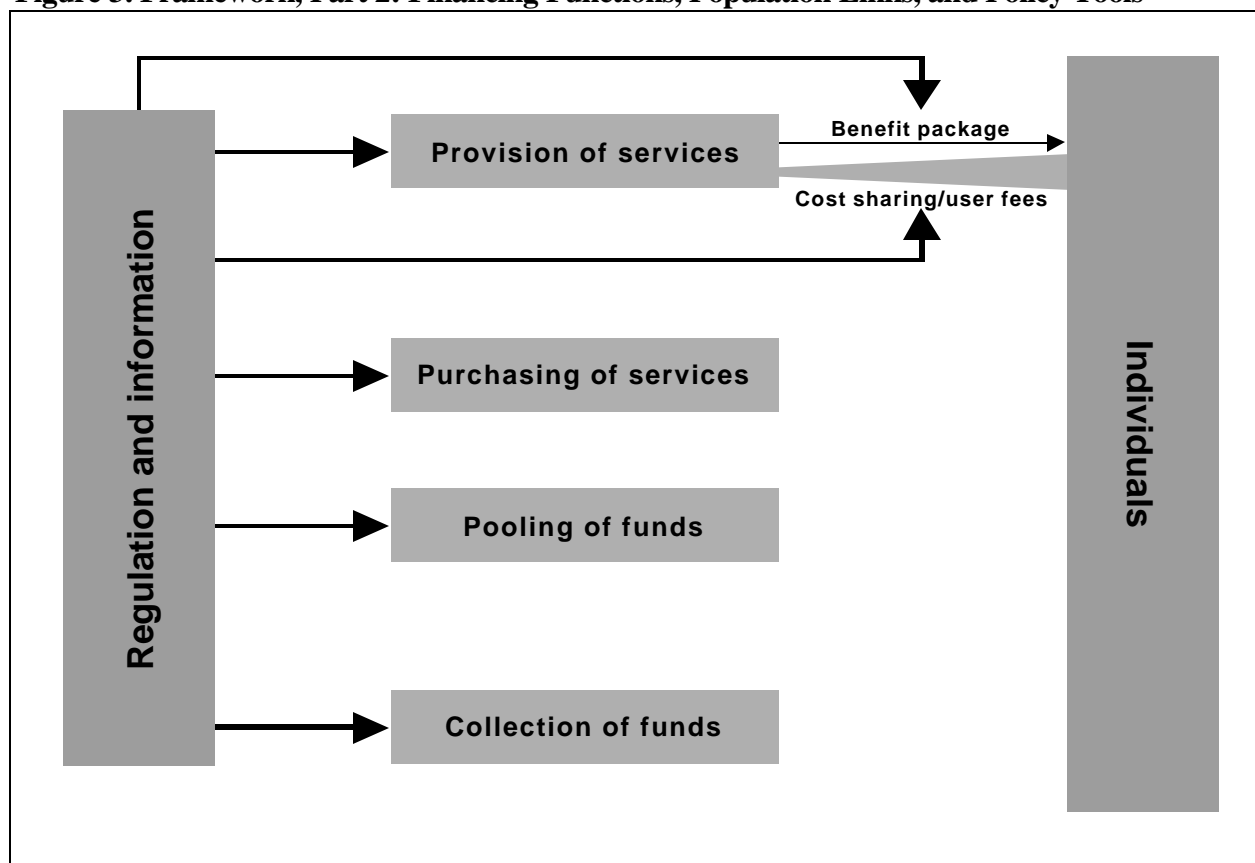
Based on their assessment of experience in China and the countries of the former Soviet Union (FSU), Ensor and Savelyeva (1998) suggest that providers will emphasize provision of services “that have a visible and sophisticated appearance” (p.47) because there is greater user willingness to pay for these and, therefore, they are likely to generate considerable income for the provider. Another concern raised by these authors is that the failure to account for the provider incentives inherent in direct (and informal) payment can limit the effectiveness of the provider payment reforms being implemented in many FSU countries. If, as they note, most physician income comes from fee-for-service payments made directly by patients, the introduction of capitation payments from pooled sources (as in Kazakhstan and the Kyrgyz Republic) may not affect provider behavior in the expected manner.

6. Regulation and information to improve policy outcomes

To this point, the conceptual framework has focused on key aspects of the health system that need to be considered in the analysis and reform of policies to improve access and risk protection in an efficient manner. These aspects include the four critical functions in financing and resource allocation--collection, pooling, purchasing, and provision--and the ‘mirror image’ policies on the benefit package(s) to be financed from pooled funds and out-of-pocket payment. The framework is incomplete, however. Although issues relating to the regulatory environment have been mentioned, the role of regulation and information as policy tools to enhance the insurance function of health systems needs to be addressed more fully. Figure 3 provides an outline of the overall conceptual framework that incorporates these important tools for implementing public policy. Of course, the range of available policy tools extends beyond regulation and the provision of information. As categorized by Musgrove (1996) in order of increasing intrusion into private decisions and actions, the instruments for public intervention in the health sector include:

- 👉 provision of *information* to the population, providers, insurers, purchasers, etc.;
- 👉 *regulation* of how activities may be undertaken in the health system, often in concert with financial incentives;
- 👉 *mandating* specific actions by private firms or individuals;
- 👉 *financing* health care or insurance coverage with public funds; and
- 👉 *provision* of services in the public sector by civil service staff.

Figure 3. Framework, Part 2: Financing Functions, Population Links, and Policy Tools



For each function, issues arising in a variety of circumstances, including public *provision*¹⁵ and *finance*, were explored earlier in the paper and will not be repeated here. Instead, the focus is on critical issues in regulation (broadly interpreted to include mandates) and information provision that apply to each of the functions and policy on benefits and fees. It is useful to think of each of the functions as a “market”, meaning that each is characterized by suppliers and demanders of the function (even in non-competitive contexts). The purpose of regulation and information provision is to enable each of these markets to function better, with “better” defined in terms of the health policy objective identified at the beginning of the paper: efficiently expanding depth and breadth of coverage. Londoño and Frenk (1997) refer to this as “modulation”, and this section of the paper draws heavily on their work. Table 7 provides examples of these informational and regulatory measures.

As noted by Londoño and Frenk (1997), the effectiveness with which these functions are implemented (if at all), as well as the way in which their implementation is organized, have important implications for the performance of the health care system. While usually associated with government (as instruments of

¹⁵ In this context, “provision” implies not only provision of health care, but also provision of the collection, pooling, and purchasing functions by public sector organizations employing civil service staff.

public policy), it is possible for some of these functions to be implemented by one or several public or private entities. Thus, as with the other functions in the health system, it is important to address the content and market structure of regulatory and informational interventions.

Issues of market structure are less ambiguous here than with the other functions, however. It is in the interests of the system for regulatory and informational activities to be carried out for the population as a whole (e.g. by one insurer or by the MOH on behalf of entire system) so as not to dilute the effectiveness of these functions or limit the benefits to members of particular schemes. Of course, different agencies or firms (or branches of the same agency or firm) could implement the regulations in different geographic areas, but a common set of measures and messages should

Table 7. Examples of regulation and information across health system functions

Functions/ policies	Information provision	Regulation
Collection	<ul style="list-style-type: none"> ☞ informing exempted persons of their rights/entitlements 	<ul style="list-style-type: none"> ☞ tax treatment of health insurance and health care contributions ☞ caps on social insurance contributions ☞ exemptions from contribution
Pooling	<ul style="list-style-type: none"> ☞ development and dissemination of standard minimum benefit package ☞ consumer guidelines to assist with choice among competing insurers ☞ development of risk adjustment method 	<ul style="list-style-type: none"> ☞ “qualifying” insurers by requiring they offer at least standard package as basis for competition ☞ standards for marketing health plans ☞ restrictions on underwriting; open enrollment periods
Purchasing	<ul style="list-style-type: none"> ☞ standardized criteria for assessing health plan performance ☞ standardization of data systems to be used to inform purchasing ☞ dissemination of standards and lessons for effective purchasing to “community-based” insurance funds 	<ul style="list-style-type: none"> ☞ consumer protection mechanisms, such as administrative or legal channels to appeal individual purchasing decisions ☞ requirement for second opinion for denials of certain services
Provision	<ul style="list-style-type: none"> ☞ development and dissemination of standard treatment protocols and essential drug lists ☞ technology assessment ☞ dissemination of information on provider performance 	<ul style="list-style-type: none"> ☞ licensing, certification, accreditation ☞ rules governing technology acquisition ☞ consumer protection, such as right to seek redress for malpractice
Benefits/ fees	<ul style="list-style-type: none"> ☞ dissemination of exemption categories and entitlements to defined package of services ☞ definition of explicit benefit package 	<ul style="list-style-type: none"> ☞ “plain language” requirements on marketing of benefits and rules governing use of services

apply. If each insurer has its own technology assessment policy and drug formulary, for example, this yields higher than needed administrative costs (from the perspective of the entire system), exacerbates inequalities across populations covered by different schemes, and induces cost shifting by providers according to the rules of the scheme by which patients are covered. The absence of these functions means that providers are free to obtain whatever equipment or drugs they deem necessary or marketable. The dilution of these functions across several schemes may result, for example, in over-investment (from the perspective of the entire population) in high technology medical equipment. Thus, there should be an attempt to shift the design of these functions to the broad system level on behalf of the entire population as a part of the reform package.

This is a major part of the argument made in proposals to reform Mexico's health care system (FUNSALUD 1995). Part of the critique of existing arrangements was that there were entirely separate health care systems for different social groups of the population (insured, uninsured poor, and uninsured middle class), with parallel structures for the implementation of each health system function, including regulatory functions. In recognition of the waste and inequity caused by this, the recommendation was to integrate various functions on behalf of the population as a whole, with the modulation/regulation function to be played by the Ministry of Health. This suggestion is central to the "structured pluralism" (Londoño and Frenk 1997) argument for separating the responsibilities for key health system functions to be performed on behalf of the entire population, rather than having each of the main agencies or subsectors (e.g. Ministry of Health, social insurance agency, private sector) taking on all of the functions for the different social groups that they serve.

As suggested by the preponderance of examples in Table 7, an important area for which rules need to be set in many countries is with regard to a competitive voluntary insurance market. The enforcement of a clear set of regulations on the insurance industry is necessary to set the "rules of the game" for "managed competition" to promote expanded coverage in countries that rely on competing insurers as their pooling organizations for health care. Types of measures that need to be enforced include restricting the practice of underwriting, requiring all insurance plans to cover, at minimum, a defined basic benefit package to improve comparability and thus facilitate informed choice by consumers, defining an 'open enrollment' period when people are free to choose a new insurer or re-enroll in their existing one, and risk adjusting the premiums received by any insurer to further limit the practice and consequences of preferred risk selection. The broad objective of this package of measures is to motivate or induce insurers to compete on the basis of the quality and cost of the services that they offer, rather than to compete by attempting to register young, healthy people who are likely to be less expensive to insure.

Establishing the appropriate framework for this "managed competition" among insurance funds has proven elusive, even for the few developed countries that have attempted to do so. For example, the Netherlands has tried to put in place a system of regulations needed to maintain equity in financing and promote efficiency through competing insurers, but the challenges have proven so great that they have not been willing to implement the reforms that they have been planning since 1987 (Chinitz *et al.* 1998; Saltman 1995). Moreover, as noted by Chollet and Lewis (1997), many middle income countries (e.g. Brazil, South Africa, Turkey, Uruguay) have done a poor job of regulating the private health insurance industry in the public interest. This is not just a 'technical' failure. As the failure of the United States to adopt the Clinton universal health plan demonstrates, the kinds of regulatory changes and restrictions needed to structure competition among insurers in the interests of efficiency and equity can pose (or be perceived to pose) a threat to powerful interest groups in society, thereby engendering significant political resistance. These experiences suggest that countries that rely on a competitive insurance

market will face tremendous challenges in making efficient progress towards the goal of universal coverage.

It is not intended to go into detail with respect to other specific regulatory and informational measures like essential drug lists, prescribing protocols, or technology assessment, for which good reference material exists (e.g. Bennett *et al.* 1997; Banta and Luce 1993). The point made here is that an analysis of the insurance function in a country should include a description of these functions. This would include an assessment of *what* functions are being performed, *how well* they are being performed and *who* (what organization(s)) is performing them. As mentioned above, the effectiveness of these functions for the system as a whole is diluted when they are carried out by multiple actors by or on behalf of individual schemes. The effectiveness of these measures in enhancing efficiency in the health system depends on the capacity of governments to define and implement (or ‘contract in’ this capacity) essential regulatory and informational functions.

7. Conclusions: priority issues for enhancing the insurance function

The framework presented in this paper is proposed as a tool for descriptive analysis of the key functions and interactions within an existing health care system and for identification and assessment of policy options to move towards universal health care coverage. The ‘tour’ of the components of the health care system provided above suggests that the depth and breadth of the insurance function in a country depend on more than one element of policy. One of the objectives of this framework is to promote the idea that progress towards the goal of universal coverage at the least cost possible requires a comprehensive approach involving coordination among multiple aspects of health care systems rather than an approach aimed at reforms in these aspects in isolation from each other. Appropriate policies with respect to enhancing the insurance function require an orientation toward this goal, with the clear understanding that the ‘achievement’ of specific organizational reforms, such as the creation of an insurance scheme, is a means rather than an end of policy. However, the starting point for goal-oriented reform is the existing institutional and organizational arrangements of the health care system. The framework also suggests that even where macroeconomic circumstances limit the scope for additional resource mobilization, there are many policy levers available to governments to enhance the insurance function. Thus, insurance is not just a question of the level of finance. Enhancing the insurance function of health systems requires policy makers recognize the importance of *managing* the system, not just funding it.

The paper concludes by identifying some key issues with respect to the insurance function of health care systems. It is not meant as a comprehensive review; instead, some messages believed to be very important are highlighted.

7.1 Market structures at function and system levels

Market structure issues have been stressed in many aspects of the paper, in particular with respect to the pooling, purchasing, provision and even regulatory functions. Part of the discussion of market structure for each of these functions included references to issues that cut across functions. For example, the appropriateness of any method of provider payment cannot be divorced from the market context of service providers and intermediaries. To the extent that there are multiple purchasers setting their own incentives but paying the same providers, the collective potential of provider payment reforms is reduced, given the potential for providers to shift costs across patients according to the payment rules of a particular purchaser. This not only weakens the effect of specific payment incentives on provider behavior, it also results in resources being used by providers for a socially unproductive administrative effort to strategize the management of costs according to the rules of each insurer. Similarly, the design of provider payment reforms must be informed by an understanding of the service provider market, and in particular, the capacity of providers to respond to the payment incentives.

This suggests the importance of understanding the market structure of entire health care systems as well as of each specific function. Indeed, as noted in Section 3, this has been the focus of previous attempts to create typologies of health systems. The conceptual approach used by Londoño and Frenk (1997) to summarize Latin American health systems is perhaps the most useful of these because of its explicit recognition of the fragmented arrangements found in most countries of the world. The main features of their approach include an analysis of the extent to which health system functions are integrated or separated, and the extent to which populations are segregated (often by design) into different health systems or are covered under a common system. Although their definitions of the specific health system functions differ somewhat from those used here, their mapping of the functions can be adapted easily to reflect a range of possible combinations of integration and separation across collection, pooling, purchasing, provision, and regulation. Adapting their approach and combining it with that presented here enables country health system analysis to include a comprehensive assessment of market structure issues for an entire health system and for each of the functions of the health system.

To facilitate understanding of health care system functions, resource allocation mechanisms, and their interactions, “mapping” the organizations and flow of funds is an indispensable descriptive tool. This approach (an extension of the technique used in Barnum’s 1993 presentation) involves turning the ‘central column’ of Figure 1 on its side and replacing the contents with the actual organizations and allocation mechanisms used in the country being analyzed. An example is a picture of the flow of funds within the health system of the Volta Region of Ghana (see Nyonator and Kutzin 1999). This depiction helped the authors to identify a specific reform option to reduce the problems of access and income protection posed by user fees in the Region. While the option itself was not original (develop small-scale risk pooling mechanisms, such as community-based prepayment schemes), the map of the flow of funds suggested how such schemes might be incorporated as an *explicit instrument* of policy and how

flows of public funds would need to be re-directed if these are to be used to explicitly subsidize the participation of low income persons. This option was thus differentiated from most such schemes, which have developed without much reference to the rest of the health system, often as a response to the failure of the system to meet local needs (Bennett *et al.* 1998). Londoño and Frenk (1997) also provide visual depictions of market structures within and across health system functions for stylized models of health systems, and these can be adapted and usefully applied to the specific features of any country.

7.2 Costs and benefits in administering the insurance function

The issue of administrative costs has appeared in various points in the paper, most notably in the discussions of market contexts of poolers and purchasers. The emphasis given to ‘active purchasing’ in Section 4.3 suggests that it is not desirable to focus simply on minimizing administrative costs; some administrative actions can contribute to health system objectives. Thus, it is useful to analyze various administrative features in terms of both their costs and their contributions to the system. Using the definitions and concepts proposed at the beginning of the paper, this can be phrased as analyzing the costs and benefits of administering the insurance function of the health system.

The benefits of certain administrative functions depend on how well they are performed, and analysis of this must be done on a country-by-country, system-by-system basis. However, many administrative activities undertaken in health systems are “pure costs”, that is, they make no contribution to the depth and breadth of coverage. Examples of these have been discussed in the paper, and broad responses to them are summarized in Table 8. In summary, these tend to aspects of strategic behavior by individuals and organizations that extract private benefits from the system without making a net addition to coverage. No moral judgment is implied; very often, this behavior is simply a product of the market context in which the individuals and organizations are found. In general (but not exclusively), the scope for this strategic behavior is greatest in systems with multiple pooling and purchasing organizations. Policy makers need to respond to these challenges by first recognizing their own context and identifying the strategic behavior likely to arise. This can be followed by appropriate policy responses, ranging

Table 8. Administrative issues to be addressed in health care systems

Function	Administrative issues
Collection	Avoid undue diversion of attention of health authorities on schemes to increase health revenues, especially in low growth economies
Pooling	Minimize system-wide investments in underwriting and related risk selection activities
Purchasing	Promote accountability, transparency, and knowledge among population and providers
Provision	Minimize cost-shifting and other behaviors to ‘game’ payment systems

from regulatory actions or incentives to a more radical re-design of the system, if this is politically feasible.

7.3 Schemes vs. systems: avoid confusing ends and means

As noted in the introduction to this paper, expanding the breadth and depth of coverage at the least cost possible is a policy objective, but the use of any particular set of institutional and organizational arrangements to achieve this is not. Another way to say this is that the objectives of policy relate to the entire population and thus the overall health care system; insurance ‘schemes’ (and reforms related to them) should be assessed in terms of how the schemes contribute to the system-wide insurance objective. As noted above, for example, many of the actions taken by insurers in a competitive market to enhance the financial viability of their schemes (e.g. underwriting, coverage exclusions) can be in direct conflict with the objectives of the health care system as a whole. Thus, policies that can improve the efficiency and sustainability of individual insurance schemes can, at the same time, have negative consequences for the efficiency and sustainability with which the entire health care system pursues the goal of universal coverage.

This does not mean that schemes and systems are necessarily in conflict. The challenge to governments is to create the conditions for schemes to contribute to system objectives (Bloom and Tang 1999). By identifying the existing institutional/organizational arrangements and financial flows for health care, policy makers can see more clearly how various sources of funds can be channeled to *complementary* purposes, rather than being isolated into overlapping yet self-contained subsystems. With a good understanding of the various elements of the framework, the role of schemes can be defined or modified, with corresponding changes in government policies, to serve overall system objectives in an efficient manner. Thus, for example, benefit packages can be made complementary, and certain administrative functions can be shared across schemes or managed jointly with the public system. Schemes can also be directed or encouraged to make use of government-supported policies with respect to essential drugs, treatment protocols, technology assessment, etc.

A challenge facing many low and middle income countries is how to transfer various features of active purchasing, as illustrated by the UMASIDA and SEWA schemes, into the broader health system that is intended to serve the majority of the population. One possibility that may be worth exploring in the future is that public subsidies for health care may be better channeled to the *purchase* of health services on behalf of the population rather than directly to health facilities. This may be particularly true in urban areas characterized by a rapidly expanding number of private providers. In this context, strengthening purchasing on behalf of the population may have a better chance of promoting public policy objectives than relying on government’s traditional regulatory mechanisms, which are often ineffective in poor countries.

7.4 Efficiency is essential for equity7.4 Efficiency is essential for equity7.4 Efficiency is essential for equity

Universal coverage is fundamentally a reflection of the policy objectives of equity in access to care and of financial risk protection. Very often, the objectives of equity and efficiency are portrayed as being in conflict. Efficiency is an objective in its own right, but it is worth noting that where the scope for mobilizing additional resources for health care services (from any source) is limited, improving efficiency in the administration of the insurance function is also a means, perhaps the only means, by which coverage can be broadened, thereby increasing equity of access. In other words, measures that improve the efficiency of the system also can be good for equity, and a deterioration in efficiency almost always causes a deterioration in access for the poor. This is especially true in contexts where the real level of funding for health care is either stagnant or declining. Thus, the kinds of inefficiencies that have been associated with the fee-for-service reimbursement mechanisms in the Korean or Chinese health insurance systems, for example, mean that the resources of the health care system are skewed to a greater extent in favor of relatively well-off people. Where higher levels of finance are unlikely to be forthcoming, the only way to make more resources available for re-distribution is through efficiency gains. Again, however, efficiency needs to be assessed from the perspective of the system rather than that of individual schemes.

7.5 Measuring coverage7.5 Measuring coverage7.5 Measuring coverage

Defining insurance as a function rather than as membership in a scheme raises questions of measurement: how can a country determine the proportion of its population that is *effectively covered*, and how can changes in this coverage be assessed over time? If insurance is defined as participation in a scheme, measurement simply involves calculating the percentage of the population in schemes. This neglects the possibilities that (1) persons who are in a scheme may not be effectively covered, and (2) persons not in a scheme may be effectively covered. What is needed is a way to measure both the breadth and depth of coverage, and it may not be possible to capture these two elements in a single index measure (i.e. percent “covered”).

Since the insurance function is concerned with access to effective services and financial protection, methods are needed to measure each of these. This poses many difficulties, one of which is that conceptually, there are many degrees of access and protection; they are not discrete variables. Measures of access will need to include assessments of physical and financial access to care. In terms of physical access, it may be possible for countries to examine access to key ‘tracer’ services, such as basic primary care, emergency services (e.g. emergency obstetric services), and referral hospitals. Financial access can probably best be measured with the help of data on care seeking behavior and out-of-pocket health care expenditures derived from household surveys, although indirect information gleaned from health facilities (e.g. changes in the number of people exempted from fees) may be of some use. It will also be necessary to have a consistent definition of what constitutes “good” or

“adequate” health care. Financial risk protection may be examined at the policy level (e.g. is there an out-of-pocket maximum?), but the analysis of actual financial risk protection also needs to involve analysis of household survey data showing, for example, changes over time in the percentage of total household expenditure devoted to health care, in the distribution of financial risks for health care expenditures (see Pradhan and Prescott 1999), and in the level (in absolute terms or relative to income) at which the financial risk for health care expenditures is ‘truncated’, if at all.

The challenge in measuring coverage will be to develop reasonably low cost and accurate methods. The potential payoff from such work is great, because it would shift the analytic focus from measuring the implementation of reform instruments to measuring the effects of these instruments on health system objectives.

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