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A Framework for Determining the Extent of Public Financing of Programs and Services

by

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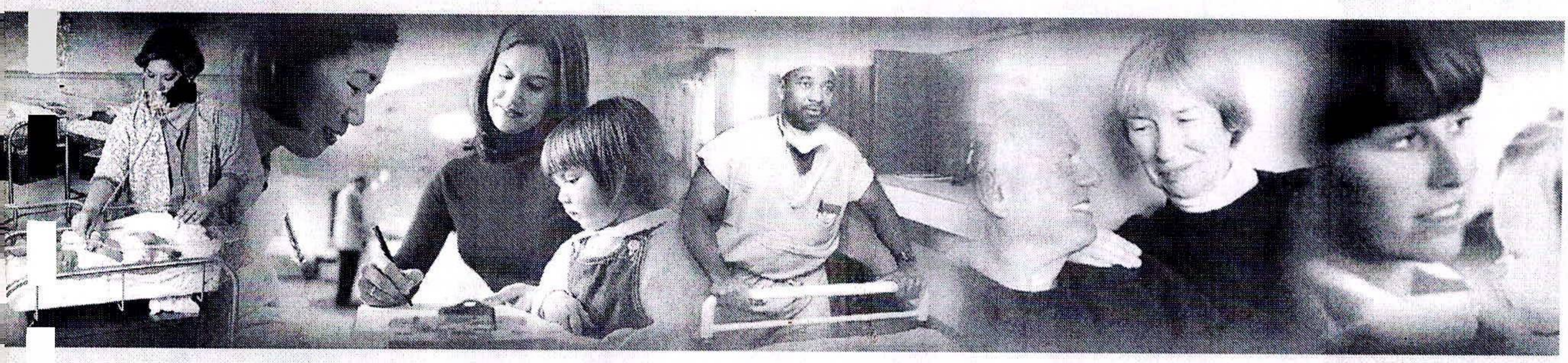

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Highlights

- The goal of a sustainable, high-quality, universal health care system must involve an examination of how public health care funding is allocated and whether the money is "well spent."

- The central concept of the *Canada Health Act* (CHA), medical necessity, has not been officially determined, therefore, the extent of public insurance varies from province to province. Only the governments of Alberta and Quebec have stated that they will establish an expert panel to review and make decisions on which health services and treatments are publicly insured.

- Most industrialized countries have been dealing explicitly with the rationing of health care services for years. The methods range from attempting to draft a specific list of services (Oregon) to determining guidelines for rationing decisions (New Zealand).

- The delisting of health services is unlikely to produce substantial savings to the government.

- While the mix of public and private financing has been associated with health inequities, the more likely connection is between health status and being insured at all, publicly or privately.

- In terms of access, quality and health system performance, Canada ranks better than some countries and worse than others. There is no clear public or private financing demarcation.

- The process of deciding which health services to publicly fund should begin with a discussion of the relative importance of the system's goals. Then there must be a reasoned approach to determining which services or programs are considered. The evaluation process should incorporate cost-effectiveness analysis and consider the relevance of the service to the health system's goals. The public should be involved in priority setting.

Executive Summary

The Conference Board of Canada estimates that public health expenditures are projected to rise from 31.1 percent in 2000 to 42.0 percent by 2020 as a share of total provincial and territorial government revenues, reducing the funding available for other social programs and government initiatives. As well, several other analysts and organizations are concerned about the financial pressures on the health care system: advances in technology, new pharmaceuticals, population aging, etc. In this context, the goal of the Commission on the Future of Health Care in Canada for a sustainable, high-quality and universal health care system must involve an examination of how public health care funding is allocated and whether the money is "well spent."

In general, hospital and physician services are publicly funded, as required by the *Canada Health Act* (CHA). However, the central concept of the CHA, medical necessity, has not been officially defined, therefore, the extent of public insurance varies from province to province. For example, only some provinces cover the services of non-physician health care providers, only some cover hearing aids for certain age groups and coverage of prescription drugs varies. This may not be problematic in and of itself but it begs the question as to whether it is desirable and/or feasible to develop a more structured framework for deciding on the nature and extent of public health care financing. Thus far, only the governments of Alberta and Quebec have stated an intention to establish a permanent expert panel to review and make decisions on which health services and treatments are publicly funded.

This paper examines the question of public funding from a macro-level perspective. First, it provides an overview of which health care services are currently paid for by the public and private sectors in Canada and describes how several other countries deal with financing issues. Then it discusses how the source of funding for services is related to the quality, accessibility and cost of services. Finally, it proposes a general framework for public funding decisions.

How Do Other Countries Determine Public Financing Arrangements?

Many other industrialized countries have been dealing explicitly with the rationing of health care services for years. The methods vary from drafting a specific list of services with public involvement (Oregon), to having a national committee make the main decisions with some public input (United States, United Kingdom and Australia), to a system in which the government makes the decisions with little public input (Singapore), to the use of guidelines (New Zealand).

All countries have found that setting health care priorities cannot be done systematically from cost-benefit analysis alone. As well, the delisting of health services is unlikely to produce substantial savings.

Access, Quality, Cost and Public Health Care Funding

While many analysts believe that it is the mix of public and private financing that causes health inequities, the more likely connection is between health status and being insured at all, publicly or privately. There are differences in the use of health care services by the insured and the uninsured, and in their health outcomes. But there are numerous studies showing that health status and access to the medical system are not necessarily correlated, and that health status is related more to income, education and access to public health programs such as immunization, screening, etc.

In terms of access, quality and overall health system performance, Canada ranks better than some countries and worse than others. Canada spends more than most industrialized countries on health care, but it is unclear what effect this greater expenditure has on Canadians' health status.

Framework for Determining Extent of Public Financing

1. Clarify the Purpose of the Health System

Before discussing what health services the public sector should fund, there needs to be agreement on the relative importance of the health system's goals: maximize the amount of health in society, treat disease, meet health care needs or ensure equality in health status. As well, there are interventions that maintain function at high cost, interventions that are mainly used to enhance quality of life, heroic but marginally effective technologies, emerging advances in genetic diagnosis and treatment, and numerous socio-economic factors that have been associated with health status, such as housing, income and education.

2. Decide Which Services to Evaluate

Decision makers/funders should ask the following questions about program and service trade-offs before heading into the evaluation stage:

1. *What is it?* Interventions (e.g., heart transplant) and medical and diagnostic technologies vary in practice/method, function and effects.

2. *What is it for?* Services must be considered in terms of public policy goals and values. At issue may not be the effectiveness of the service but less tangible concerns about the medicalization of problems or the legitimacy of recipients' needs.

3. *How is it situated?* Interventions may be interdependent; restricting one may affect the other.

4. *Whose is it?* Lobbyists/constituencies may influence the assessment process.

5. *Who is it for?* Services/technologies may work better in particular populations.

3. *Evaluate Cost-Effectiveness and Relevance of Programs and Services*

Some form of cost-effectiveness analysis should be used to determine which health care services to cover publicly, balancing the need for rigor against the limitations of the current state of medical knowledge. The relevance of particular services to a health system's goals must also be established. For example, U.K. decision makers have decided that the National Health Service (NHS) is not obliged to subsidize a lifestyle drug such as Viagra for everyone who might benefit from it; they have determined that Viagra, in most cases, is not *relevant* to a publicly funded, universal service.

4. *Involve the Public*

Priorities are set at many levels: federal and provincial governments set priorities and budgets; funding is allocated between geographical areas and specialties; which services, how they are delivered and to whom must be decided; and there are decisions about how much to spend on individual patients. These issues raise a number of areas for potential public involvement in decision making, including in the definition of the values of the system and which groups or treatments receive priority. Individuals (patients, providers and those directly affected by the policy/choices) must have the right to challenge any rationing decisions.

Introduction

Public sector spending accounts for almost 73 percent of total spending on health and represents about 30 percent of governments' total revenues in Canada. (Canadian Institute for Health Information 2001; Conference Board of Canada 2001) The Conference Board of Canada estimates that public health expenditures are projected to rise from 31.1 percent in 2000 to 42.0 percent by 2020 as a share of total provincial and territorial government revenues, reducing the funding available for other social programs and government initiatives. (Conference Board of Canada 2001) As well, several other analysts and research organizations are concerned about the financial pressures on the current health care system: advances in technology, new pharmaceuticals, population aging, etc. (Baxter 2002; Standing Senate Committee April 2002; Baxter and Ramlo 1998; and Canadian Institute of Actuaries 2001 and 1995) In this context, the goal of the Commission on the Future of Health Care in Canada for a sustainable, high-quality and universal health care system must involve an examination of how public health care funding is allocated and whether the money is "well spent."

In general, hospital and physician services are government-funded, as required by the *Canada Health Act* (CHA). However, the central concept of the CHA, medical necessity, has not been officially defined, and what is publicly insured varies from province to province, even for services provided in-hospital, such as certain prosthetic devices and crutches, for example. (Prince Edward Island Department of Health and Social Services 2001) This may not be problematic in and of itself but it begs the question as to whether it is desirable and/or feasible to develop a more structured framework for making health care financing decisions.

This paper examines this question from a macro-level perspective. First, it provides an overview of which health care services are currently paid for by the public and private sectors in Canada and describes how several other countries deal with financing issues. Then it discusses how public funding of services is related to the quality, accessibility and cost of services. Finally, it proposes a general framework for public funding decisions.

Government Funding of Health Care Services

The Financing of Health Care in Canada

Total health care spending in Canada is projected to have been almost $96 billion in 2000 and more than $102 billion in 2001. The public sector share of health spending has risen from 70.2 percent in 1997 to 72.6 percent in 2001. (Canadian Institute for Health Information 2001) Table 1 outlines the basic structure of health care financing in Canada.

Most provinces cover only a portion of the fees charged by chiropractors and other non-physician health care providers. Only some provinces cover hearing aids for certain age groups and coverage of prescription drugs varies. Most provincial insurance plans do not cover acupuncture, naturopathy, cosmetic surgery, physical examinations for employment or insurance purposes and sterilization reversals. With respect to these differences, a paper by the National Forum on Health asked: What is the proper way for provincial insurance plans to define "medically necessary"? What standards of evidence should govern decisions about insuring or not insuring services? (National Forum on Health 1995)

Table 1
The Financing of Health Care Services in Canada

Service	Method(s) of financing
Hospitals	100 percent public financing for medically necessary services; private payment for upgraded accommodation or non-medically necessary services provided in hospitals
Private clinics	Privately funded for services not considered medically necessary
Long-term care	Mixed
Home care	Partial public coverage provided in most provinces
Physicians	100 percent public for medically necessary services; majority is paid fee-for-service, with some salary and capitation payments; private payment for non-medically necessary services
Other health care professionals	Mainly private (insurance and out-of-pocket); some services covered by provincial plans for long-term care or home care
Prescription drugs	Mixed: drugs within hospitals covered by government-allocated hospital budgets; provincial plans pay for a large percentage of drugs dispensed outside hospitals; coverage is typically limited to target populations; balance funded privately
Non-prescription drugs	Private
Dental/optometry care	Mainly private; some provincial plans cover some services for children and seniors
Alternative medicine	Mainly private; limited coverage by some provincial plans
Ambulance services	Partial public coverage in some provinces; special programs for residents in remote areas
Public health programs	Public
First Nations health	Public directly delivers some services

Sources: El Feki 1998, 38; National Forum on Health 1995; Newfoundland Department of Health and Community Services 1999; Prince Edward Island Department of Health and Social Services 2001; Government of New Brunswick 2002; Nova Scotia Department of Health 2001; Government of Quebec 2001; Ontario Ministry of Health and Long-Term Care 2000; Manitoba Health 2002; Saskatchewan Health 2000; Alberta Health and Wellness 2002; British Columbia Ministry of Health 2002.

Since the Forum, there has not been much movement toward answering these questions and building a framework for determining core services. However, there have been many methods proposed and a few provinces have said they are now going to be seriously examining this issue.

Most recently, the government of Alberta accepted all the recommendations for reform proposed by an advisory council. The council states that the CHA was never designed to cover the full range of health care services now available, but, over the years, many new treatments and technologies have been added to the list of insured services. Generally, decisions involve assessment of the technology, analysis of the impact, expert consultations, government review, development of legislation if necessary, review by the legislature or government and implementation. Ultimately, the funding decision is made by the health minister or by the government collectively. (Premier's Advisory Council 2001)

As there likely will be continued pressure to add more treatments, programs and drugs to the list of insured services, the government needs to reconsider what gets insured and what does not, and decide what services could be funded in other ways. One of the council's proposals was to establish a permanent expert panel to review and make decisions on which health services and treatments are publicly funded. The expert panel will start by reviewing the broad categories of services currently provided and deciding which ones should be "grandfathered" for continued public funding. (Premier's Advisory Council 2001)

In Quebec, the Clair Commission also recommended the establishment of a permanent committee to review and decide which services to publicly insure. (Standing Senate Committee April 2002) Saskatchewan is also moving toward formalizing evidence-based funding of health care. In its 2001 action plan, it supports the formation of a quality council to advise government, develop evidence-based approaches and promote effective practices throughout the system. (Saskatchewan Health 2001)

A rationalization of services is not easy to achieve. Ontario's 1994 deinsurance initiative illustrates the variety of principles and interests that are involved in the process. The initiative was part of an agreement between the Ontario Medical Association (OMA) and the Ministry of Health to cut $20 million worth of services in order to keep within the budget allocated to the profession, which had been recently capped. The services for deinsurance were nominated by the OMA and the ministry, and reviewed by an ad hoc commission. Because the CHA requires that provinces insure all medically necessary care, the candidates for deinsurance had to seem "medically unnecessary" in some sense – cosmetic surgery, for example. Additionally, since deinsured services would be privatized, an existent or potential private market helped flag certain choices. It was a difficult process and there were attempts to include the public in the decision-making process. Nonetheless, even the chair of the commission that reviewed the candidates for deinsurance described the final selection as "bizarre." (Giacomini 1999, 728-730)

Some Methods Proposed for Priority Setting in Canada

John Williams and Michael Yeo, ethicists at the Canadian Medical Association, make a few general suggestions about priority setting in Canada:

- Regional boards and the federal and provincial governments should clarify the values and principles that guide their priority-setting work, as regards both the goals of health and health care and the means for attaining these goals.
- Decision making at all levels should be transparent and open to scrutiny.
- Public education programs should be developed to prepare the public to participate in priority setting and demand accountability from the decision makers. (Williams and Yeo 2000, 132)

The Canadian Medical Association Core and Comprehensiveness Project

The Canadian Medical Association (CMA) has constructed a decision-making framework on core (publicly funded) health care services. The association uses the terms core, basic and optional services, rather than medically necessary. The CMA believes that there are three key factors to making the decision: quality of care (effectiveness, appropriateness, efficiency, patient acceptance and safety), ethics (fairness, age, lifestyle, the identifiable patient versus the statistical patient and futility) and economics (cost-effectiveness analysis). The CMA states that an ethical process recognizes that decisions are made between patients and physicians, in the community or by society, and by governments. It advocates for public involvement in the decision-making process. (Wilson, Rowan and Henderson 1995; Walters and Morgan 1995; and Sawyer and Williams 1995) The CMA model was first used to make recommendations on three clinical issues: prostate specific antigen (PSA) screening, gastroplasty and the annual physical examination. (Deber et al. 1995, part 2)

The Four-Screen Model

The 1995 paper *The Public/Private Mix in Health Care*, by Deber et al., proposes a four-screen (Deber-Ross) model of prioritizing government health care financing decisions. Decisions about coverage are made as a function of four screens, with only those interventions passing an earlier screen considered at the next stage. Screen 1 (effectiveness) examines whether the intervention works. Screen 2 (appropriateness) incorporates information about the risks and benefits to particular individuals. Screen 3 (informed choice) incorporates the views of recipients of care and Screen 4 (public provision) asks whether a third party should pay for the intervention. This decision requires the consideration of such factors as cost minimization, social values and advancement of knowledge. (Deber et al. 1995, part 2)

The model begins at the level of the individual, but implementation is simplified if it is then aggregated to determine a global budget. Rather than list which procedures would be covered, the budget is based on an estimate that, for a given population, there should be approximately X hip replacements, Y cases of diabetes and Z with high blood pressure. This model presupposes reforms of the way in which health care is delivered in Canada. (Deber et al. 1995, part 2)

How Do Other Countries Determine Public Financing Arrangements?

In all countries, the government plays a significant role in the financing of health care. The programs and services that other countries publicly fund vary, as does the method by which these countries determine these financing arrangements. This section looks at what services are publicly covered in Australia, New Zealand, Singapore, the United Kingdom, and the United States, and how these coverage decisions are made.

Australia

The Commonwealth and state and territorial governments account for about 70 percent of health expenditures in Australia. The Commonwealth government is the primary public insurer of prescription drugs and physician services, and it funds some 50 percent of hospital expenditures. (Standing Senate Committee January 2002*a*, 8)

The Commonwealth government's Medicare program provides "free" treatment to Medicare patients in public hospitals, and free or subsidized treatment to patients treated by doctors (and optometrists or dentists for some services). Patients may insure with private organizations for the gap between the Medicare benefit (subsidy) and the fees. (Ramsay 2001)

Medicare pays benefits for services that are considered "clinically relevant," such as consultation fees for doctors, tests and exams by practitioners to treat illness, eye tests performed by optometrists, and most surgical and therapeutic procedures performed by doctors. Medicare does not cover such things as dental exams and treatment, ambulance services, home nursing, physiotherapy, chiropractic, glasses and contact lenses, hearing aids, prostheses, medicines and non-clinically necessary services. (Health Insurance Commission 2001)

In what it calls an effort to ease the financial burden on the public health system, the Commonwealth government has implemented reforms intended to improve the affordability of private health care and enhance choice for consumers. Specifically, among other measures, the government encourages the purchase of private health insurance with a 30 percent refundable tax credit. (Australian Department of Health and Aged Care 2000, 4) However, there is debate as to whether a public subsidy in the form of tax relief on the purchase of private *insurance* is an effective use of funds, in that it could cost governments more than it would save them. (Standing Senate Committee January 2002*a*, 11; Emmerson, Frayne and Goodman 2000, 31-32) As well, there are those who contend that private *insurance* or private *hospitals* result in longer queues in the public system. (Standing Senate Committee January 2002*a*, 11-12; Currie 2000)

The Commonwealth government's approach to Medicare is increasingly to fund interventions that are safe, clinically effective and cost-effective. During 2000-01, the Quality and Safety Council and the National Institute of Clinical Studies were contracted to examine a "whole of system" approach to quality and safety, focusing on best practice models for acute care and the treatment of a range of national health priority areas. Already, the Pharmaceutical Benefits and Medicare Services advisory committees recommend funding for services and medicines proven to be appropriate and effective. (Australian Department of Health and Aged Care 2000)

New Zealand

In 1998-99, the proportion of publicly funded health and disability support services accounted for around 77.5 percent of the total health expenditure in New Zealand. Individuals may also choose to use private health care services; the proportion of health expenditure financed privately has risen from 12.0 to 22.5 percent over the last two decades. (New Zealand Ministry of Health 2001*b*, 12-13)

Most New Zealanders are eligible for publicly funded health and disability services, as they are either permanent or long-term residents. Eligible people may receive free inpatient and outpatient public hospital services, subsidies on prescription items and a range of support services for people with disabilities. There is a fee-for-service system for primary care, although visits to the doctor and prescription items are generally free for children under age 6 and basic dental care for children is generally free until age 16. For people who have to make many doctor visits or who require a lot of medication, there is the possibility of getting a government subsidy. (New Zealand Ministry of Health 2001*a*)

In 2000, the central government transferred decision-making responsibilities to community-focused district health boards (DHBs). The central government provides broad guidelines on what services the DHBs must provide and national priorities have been identified in the New Zealand Health Strategy. (New Zealand Ministry of Health 2001*b*)

The national Health Funding Authority is expected to reflect the needs of users and is obliged to consult communities about its plans for the purchase of services. As well, the National Health Committee (NHC) was set up in 1992 to advise the government on the types of health and disability services that should be publicly funded and their relative priorities, given available resources. Over the years, the NHC has engaged the public in its work: there have been town hall meetings, focus groups and calls for submissions. The NHC even runs a consumer-training program in guidelines development. (Edgar 2000)

The philosophy behind the NHC's rationing process includes consideration of the effectiveness of the services, value-for-money, fairness in access and use of the services and consistency with communities' values. (Edgar 2000) Four assumptions underlie the NHC's work:

- Rationing of services is inevitable.
- The processes for making rationing decisions must be transparent.

- Communities must be involved – their values are essential when rationing decisions mean that not everyone will get all the health services they want.
- There are transparent tools – guidelines and priority criteria – that can help decision makers. (Edgar 2000, 186)

While there have been few well-designed research studies conducted on NHC initiatives, the committee still feels it important to continue learning how to make difficult choices. Even if total spending on health care were to double, decisions would still need to be made on the margins of funding and acceptance of the need to make such decisions is important. (Edgar 2000)

Singapore

Health services in Singapore are provided by three different ministries and by the private sector. In 1999, Singapore spent about 3 percent of GDP on health care in total; government health spending accounted for 0.8 percent of GDP. (Singapore Ministry of Health 2001, 10)

The Ministry of Health provides preventive, curative and rehabilitative services; formulates national health policies; co-ordinates planning and development between the public and private health sectors; and regulates health standards. (Singapore Ministry of Health 2001) The Singapore health care philosophy emphasizes the building of a healthy population through preventive health care programs and the promotion of healthy living. Immunization, health education in schools and dental services are free. (Hsiao 1995)

Primary health care is delivered at government outpatient polyclinics and private medical practitioners' clinics. There is an outpatient consultation fee, which includes medication. At the government polyclinics, all services are subsidized. (Hsiao 1995) However, co-payments apply even to most heavily subsidized hospital wards and are designed to limit demand by making patients cost-conscious. (Ham 1996)

To ensure that basic medical services are available to all Singaporeans, the government also subsidizes medical services at public hospitals and government clinics. The basic medical package is intended to reflect up-to-date medical practice that is cost-effective and of proven value. It excludes non-essential or cosmetic services, experimental drugs and procedures of unproven value. The goal of the system is to allocate resources in such a manner as to do the most good for the largest number of people. (Ham 1996)

Singaporeans are required by law to save for their medical expenses. Under the Medisave scheme, all working persons must set aside 6 to 8 percent of their income for a personal Medisave account. Singaporeans use the money in this account to help pay for any hospitalization costs they, or their immediate family, incur. In addition, there is Medishield, a voluntary insurance plan designed to help Singaporeans meet any medical expenses arising from a major accident or prolonged illness. Medishield reimbursements are based on a system of deductibles and co-insurance, and there are claim limits per policy year and per lifetime. Lastly, there is Medifund, an endowment fund set up by the government as a safety net to help low-income Singaporeans pay for their medical care. The amount of help given to a patient depends on individual circumstances and is decided upon by a committee at the hospital level. (Ramsay 2001)

The Singaporean government has also introduced low-cost community hospitals for the convalescent sick and elderly not requiring the more expensive care of the acute general hospitals. Health care services for the elderly are mostly run by voluntary welfare organizations that are subsidized by government. Most support services to the hospital and primary health care programs are found in both the public and private sectors. (Singapore Ministry of Health 2001)

United Kingdom

The National Health Service (NHS) is the main provider of health care in the United Kingdom. It is based on the ideal of universal coverage for all British citizens, paid for from general tax revenues. But initial cost estimates for the NHS were soon exceeded and fees were added for such services as prescriptions and dental care. (However, today, about 85 percent of prescriptions are dispensed to people who are exempt from the charges.) (British Medical Association [BMA] 1999)

About 11 percent of the U.K. population have private medical insurance. (Ramsay 2001) The number of people paying directly for elective surgery in the private sector accounts for about 19 percent of private treatment and the private sector also provides the majority of places in residential and nursing homes. (BMA 1999)

Despite cost pressures on the system, the NHS's 10-year modernization plan rejects the suggestion that the NHS should only cover a defined set of individual conditions or treatments:

> First, advocates of this position usually have great difficulty specifying what they would rule out. The sorts of treatments that commonly feature include varicose veins, wisdom teeth extraction or cosmetic procedures. The problem is that these sorts of services account for less than 0.5 percent of the NHS budget, and are not major cost-drivers for the future. Instead, the vast majority of spending – and spending increases – go on childbirth, elderly care and major conditions such as cancer, heart disease and mental health problems. (United Kingdom Department of Health 2001, chap. 3)

The other reason given in *The NHS Plan* for not restricting spending to a defined set of core services is that effectiveness is subjective: different patients under different circumstances can derive different benefits from the same treatment.

However, *The NHS Plan* acknowledges that priorities have to be determined. The National Institute for Clinical Excellence provides guidance on the clinical and cost-effectiveness of new and existing health technologies, including medications, with the aid of a Citizens Council. (United Kingdom Department of Health 2001) While the context for prioritizing decisions is national, many choices are made by local health authorities and, more often, rationing is done implicitly by individual physicians, using clinical judgment applied to the individual case. (BMA 1999)

United States

Medicare/Medicaid

In the United States, there are two main government health care programs. Medicare covers elderly Americans (aged 65 and over) and disabled Americans, and Medicaid provides health insurance and services for lower income Americans. Medicare covers more than 39 million Americans and Medicaid had 36 million recipients. (Health Care Financing Administration [HCFA] 2001*c*; 2001*a*) In 1997, the public sector in the United States accounted for 46.4 percent of total health care spending. (Ramsay 2001)

Medicare is a federal program that reimburses the elderly for their health care expenses. Of seniors, 98.6 percent were enrolled in Medicare and most elderly (70 percent) have both Medicare and additional private insurance for those costs not covered by the public program. (Ramsay 2001) Medicare Part A is hospital insurance that helps beneficiaries cover the costs of inpatient hospital care, critical access hospitals, skilled nursing facilities, hospice care and some home care. Medicare Part B is optional insurance and covers medically necessary doctors' services, outpatient hospital care and some services that Part A does not cover, such as the services of physical and occupational therapists. For both Medicare parts A and B, there are premiums, deductibles and co-payments.

State governments contribute to Medicaid, and also fund such things as public health services (e.g., immunizations and Native health), community-based services (e.g., mental health and substance abuse services), state university-based teaching hospitals and state employee health premiums. As Medicaid is a joint federal-state program, its benefits and eligibility requirements vary from state to state. Coverage is not available to all low-income people, but to those who are considered by the various state definitions to be "categorically" or "medically" needy; most states fund assistance programs for specified poor persons who do not qualify for Medicaid. (Standing Senate Committee January 2002*a*, 48) Nominal deductibles and cost-sharing may be imposed on some Medicaid recipients for certain services, however, there are some recipients who must be exempt from cost-sharing: pregnant women and children under 18 years of age, for example. (HCFA 2001*b*)

In general, basic Medicaid coverage must include inpatient and outpatient hospital services, physician services, surgical dental services, nursing facility services and home health care for some individuals, family planning services and supplies, rural clinic and ambulance services, laboratory and X-ray services and periodic screening. The most commonly covered optional services include clinic services, intermediate care facility/mentally ill services, optometrist services and eyeglasses, prescribed drugs, prosthetic devices and dental services. (HCFA 2001*b*)

It is the responsibility of the Health Care Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services, to track emerging technologies and patterns of care to determine the need to change national coverage policies. In making these decisions, the HCFA considers whether an item or service demonstrates medical benefit and added value (either in terms of more health benefits or lower cost) to what is already covered for the Medicare population. (HCFA 2001*d*) Part of the HCFA's approach is to use the Internet to inform people about how coverage decisions are made and the progress of each issue under coverage review. (HCFA 2001*e*)

Oregon

The Oregon Health Plan (OHP) provides insurance coverage for some one million low-income Oregonians, but it is estimated that about 400,000 people remain without health coverage. (Oregon Health Services Commission 2001)

The OHP is the only state Medicaid program that explicitly rations medical care, funding services using various measures of value. In broad terms, covered services include diagnosis, physician services, medical and dental check-ups, family planning services, maternity, prenatal and newborn care, prescriptions, hospital services, comfort care and hospices, dental services, alcohol and drug treatment, and mental health services. Services not covered are those for conditions that will get better on their own, conditions that have no useful treatment, treatments that are not generally effective, cosmetic surgeries, gender changes, treatment for infertility and weight-loss programs. (Office of Medical Assistance Programs 2001)

There is a priority list of 736 medical conditions and their related treatments. As of October 2001, the government funding line went up to and included 566 of these condition/treatment pairs. Table 2 gives an indication of the complexity of the funding list.

Table 2
Selected Services Covered by the Oregon Health Plan as of October 2001

Ranking	**Diagnosis**	**Treatment**
Government-funded services include the following:		
1	Severe/moderate head injury: hematoma/edema with loss of consciousness	Medical and surgical treatment
2	Type I diabetes mellitus	Medical therapy
565	Symptomatic urticaria	Medical therapy
566	Dysfunction of nasolacrimal system	Medical and surgical treatment
Government funding does not include the following:		
567	Chronic anal fissure, anal fistula	Sphincterectomy, fissurectomy, fistulectomy, medical therapy
568	Dental conditions (ex. broken appliances)	Periodontics and complex prosthetics
735	Spastic dysphonia	Medical therapy
736	Disorders of refraction and accommodation	Radial keratotomy

Source: Oregon Health Services Commission, 1 October 2001, *Prioritized List of Health Services*.

The impetus for Oregon to rank procedures came in 1987, when the state deinsured transplants for Medicaid patients. As a consequence, a boy needing a bone marrow transplant died before his family could raise enough private money for the procedure. The incident led to public outrage and a more systematic and evidence-informed method of rationing was deemed necessary.

The initial process involved ranking health services by their value to the community and their cost-effectiveness. Multiple rankings were required before the end result was achieved. In later stages, analysts ranked finer categories (eventually diagnosis-treatment pairs) according to an algorithm that used criteria including cost-effectiveness, public opinions of service types and health states, and expert opinions of the ranks produced. Eventually, 17 categories were developed and then ranked by a state-appointed Health Services Commission. They covered more than 10,000 medical procedures, which were reduced to 709 diagnosis-treatment pairs.

Oregon's efforts to rationalize the Medicaid benefit package met with lobbying by providers and consumers who wanted to protect their own favoured services from being rationed by the government. There was some success by lobbyists in proscribing or delaying the addition of particular services to the ranking list. For example, most psychiatric care was excluded from the ranking. The excluded services accounted for about 70 percent of Medicaid spending, leaving 30 percent of the budget to be controlled by the priority-setting process. (Giacomini 1999, 725-726) "Because Oregon [in the end] did not ration care based on cost-effectiveness, their basic benefits package fails to maximize health outcomes to Medicaid recipients." (Tengs 1996, 181)

The central idea behind the OHP was that, given fiscal limits, it is better to provide some health insurance for everyone rather than only covering some people for everything. However, the benefits package today is more generous than Oregon's old Medicaid system and the costs for the OHP have increased over the last decade. (Oregon Health Services Commission 2001)

Other U.S. states have tried alternative methods of expanding public coverage of health services to those who are uninsured. For example, Massachusetts expanded coverage with a basic option for the non-categorical needy called MassHealth. New York's Healthy New York package is for small businesses that do not provide health insurance for their employees and to working, uninsured individuals. Washington State's Basic Health Plan gives low-income Washingtonians a choice between a managed-care-style plan and a less managed plan with higher out-of-pocket costs. Minnesota's MinnesotaCare has a basic benefit that includes single adults without dependent children; initially offering only outpatient services, inpatient services for this population were recently added. (Oregon Health Services Commission 2001)

Despite such efforts, in 2000, 14 percent of Oregonians were uninsured, 9 percent of Massachusetts residents, 15 percent of New Yorkers, 14 percent of Washingtonians and 8 percent of Minnesotans; the national figure was 14 percent. (Kaiser Family Foundation 2002) As well, there is some evidence that programs to publicly insure low-income adults might not be increasing overall coverage but, rather, crowding out private. A study examining the expansion of public insurance in four states found that the programs in Oregon and Washington "resulted in a decline in the number of uninsured and very little crowding out of private insurance," whereas in Tennessee there was "a decrease in the number of both uninsured persons and privately insured persons" and, in Minnesota, there was "a decline in the number of privately insured persons and virtually no change in that of uninsured persons." (Kronick and Gilmer 2002, 225)

There seems to be no correlation between how much a state spends on health care and the extent of insurance coverage. State health care expenditures per capita for the United States averaged US$872.64 in 1999: Minnesota (US$807.83) and Oregon (US$774.18) spent less than the national average, while New York (US$1,615.64) and Massachusetts ($1,455.21) were the top two spenders in the country. (Kaiser Family Foundation 2002)

Lessons for Canada from the International Experience

Many other industrialized countries have been dealing explicitly with the rationing of health care services for years. The methods vary from drafting a specific list of services with public involvement (Oregon), to having a national committee make the main decisions with some public input (United States, United Kingdom and Australia), to the government making the decisions with little public input (Singapore), to the use of guidelines (New Zealand).

All countries have found that setting health care priorities cannot be done systematically from cost-benefit analysis alone. As well, the delisting of health services is unlikely to produce substantial savings. In both Oregon and New Zealand, explicit priority setting resulted in more services being covered rather than fewer. (Coulter and Ham 2001) In other countries, such as the Netherlands, services that have been delisted (long-term in-vitro fertilization, cosmetic surgery, eyeglasses, homeopathic drugs, dental care for those over age 18, and several other items) produced a savings of 4.5 percent to the government. (Williams 1997)

If major cost-savings are a goal of government, there must be more substantial reform than simply delisting certain services. The prioritizing process, however, is a good way for governments to finance and ensure universal access to those interventions that best meet the needs of the population:

> … it is also a matter of equity: in contrast to actuarial private insurance, where every purchaser buys the expected value of the health services needed, public finance is involuntary. It comes from the taxpayers who have a legitimate interest in meeting needs and thereby getting value for their money, but not necessarily in paying for wants. (Musgrove 1996, 56)

The rationale for encouraging democratic deliberation of rationing is that choices in health care involve moral issues and, more pragmatically, it is likely that legal challenges to rationing decisions will increase and this reinforces the need to make the decision-making process fair and transparent. (Coulter and Ham 2000)

Professor Norman Daniels of Tufts University believes that, to legitimize limit setting, there must be what he calls accountability for reasonableness, which demands public access to the reasons for priority-setting decisions and requires that fair-minded people consider these reasons relevant to meeting population health needs with limited resources. (Daniels 2000) According to Daniels, accountability for reasonableness requires four necessary (but not sufficient) conditions to be met:

- *Publicity*: decisions regarding coverage for new technologies (and other limit-setting decisions) and their rationales must be publicly accessible.
- *Reasonableness*: the rationales for coverage decisions should aim to provide a *reasonable* construal of how the organization should provide "value-for-money" in meeting the varied health needs of a defined population under reasonable resource constraints....
- *Appeals*: there is a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in light of further evidence or arguments.
- *Enforcement*: there is either voluntary or public regulation of the process to ensure that conditions 1-3 are met. (Daniels 2000, 92)

Access, Quality, Cost and Public Health Care Funding

One of the main purposes of a health care system is to improve the health of the population and, ideally, this is achieved by providing broad access to quality health care at a manageable cost. Since Canada's health care system is mainly publicly funded, it is necessary to discuss what is known about how public financing of services affects the accessibility, quality and cost of services. As well, there must be discussion of whether the method of financing health care matters in the pursuit of better population health status.

Deber et al. summarized conventional thought about the financing of health care for the National Forum on Health: "it is widely recognized that divorcing access to a comprehensive mix of health services from ability to pay inherent in public financing enhances equity. As one moves along the public/private continuum to include more private sector involvement, equity decreases. At the extreme, one has the U.S. system, in which a large proportion of the American public is either uninsured or underinsured for health care." (Deber et al. 1995, part 1)

The problem with this argument is that it implies that it is private sector involvement that decreases equity rather than the fact of being uninsured, publicly or privately. Being uninsured in the United States does not mean that you will be denied care when you need it.[1] As well, statistics show that many of the uninsured are only temporarily so. For example, the uninsured rate in Minnesota is about 8 percent, but it declines to 3.1 percent if one considers those Minnesotans who were uninsured for the entire year of 2001. (Minnesota Department of Health 2002)

However, there are differences in the use of health care services by the insured and the uninsured, and in their health outcomes. For example, uninsured children in the United States were 2.5 times as likely as children with health insurance to be without a recent visit to a physician in 1995-96. (National Center for Health Statistics 1999) As well, from an analysis of 125 peer-reviewed research papers, the Oregon Health Services Commission concluded that uninsurance is associated with increased mortality (e.g., diagnosis of disease at a late and incurable stage); more pain, disability and suffering (e.g., uninsured children are less likely to receive treatment for sore throats, earaches and asthma); and expensive care (e.g., the uninsured are more likely to use the emergency room for care). (Oregon Health Services Commission 2001)

Universal insurance, then, is a desirable goal. But there are myriad ways of insuring an entire population and basic health status measures, such as life expectancy and infant mortality, do not indicate that one method is particularly better or worse at reducing inequities in health. In Canada, for example, there is evidence of queue jumping for non-medical reasons and evidence that family physicians are not referring the sick and elderly as readily as they should for such treatments as kidney dialysis. (Gratzer 1999, 24 and 43) As well, in attempting to balance their fiscal situations, many provincial governments have delisted services, resulting in more people paying for needed services. If having to pay for care is inherently unfair to people with lower incomes, then this "cost-saving" measure represents increasing inequity in the Canadian system.

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[1] By law, neither public nor private hospitals are permitted to refuse treatment to an indigent patient. For more information, go to http://www.medlaw.com.

Access

In terms of access, there are many studies that seem to indicate that patients wait longer for care in Canada than in countries such as the United States, Sweden or Germany; but less time than patients in the United Kingdom and New Zealand.

A study in the 1980s found that Canadians waited longer than Americans for orthopaedic consultation and for surgery post-consultation. (Coyte et al. 1994) Research in the 1990s showed Canadians waiting longer than Germans and Americans for several cardiac procedures. (Collins-Nakai, Huysmans and Skully 1992) Another study found that, in 1992, Canadians generally waited longer for bypasses than Americans or Swedes, but less time than the British, (Carroll et al. 1995) and another study, conducted in 1998, indicated that Canadians had shorter waiting times than New Zealanders for bypasses. (Jackson, Doogue and Elliott 1999) Research at Dalhousie University found that proper follow-up and diagnosis for patients with gross hematuria (bloody urine) took longer in Canada than in the United States. (Moulton 1998)

A study conducted in the early 1990s by the Queen's Radiation Oncology Research Unit found that, for all but emergency care, Canadian patients waited longer for radiation treatment of cancer than their American counterparts, and longer than oncologists considered to be medically acceptable. (Mackillop 1994) A recent report on cancer care by the Cancer Advocacy Coalition warns that long waiting lists for radiation and the slow approval of new chemotherapy drugs have a negative impact on patient survival, and provides data showing that Canadian provinces tend to have higher cancer mortality rates than American states. (Cancer Advocacy Coalition 2001)

As well, the situation in Canada does not seem to be improving. A study of almost 30,000 breast surgery patient cases in Quebec found that the median waiting times between diagnosis and surgery rose from 29 days in 1992 to 42 days in 1998. (Mayo et al. 2001) An update of an audit by the Manitoba Centre for Health Policy and Evaluation of waiting times for eight non-urgent surgical procedures in Winnipeg from 1992 to 1997 found increases in the waiting times of six of the eight procedures, including breast tumor removal and carotid endarterectomies, from the 1992-93/1996-97 period to 1998-99. (Currie 2000) While the Manitoba authors do not draw any conclusions from the increase in waiting times, they note that the trend is of concern.

What should also be of concern to Canadians is that our system, which is intended to provide equal access to care, may not be succeeding in that area. One study shows that low-income Canadians are less likely to visit medical specialists (Dunlop, Coyte and McIsaac 2000), and others show low-income Canadians to have lower cardiac (Alter et al. 1999) and cancer (Mackillop et al. 1997) survival rates than Canadians with higher incomes.

In 2000, the Canadian Association of Radiologists released a report suggesting that 63 percent of X-ray equipment is out of date, as is the majority of diagnostic machinery in Canada. (Canadian Association of Radiologists 2000) Out of 25 OECD countries, Canada ranked 19th in terms of magnetic resonance imagers (MRIs) per million population. (Esmail 2001) Out of 23 OECD countries, Canada ranked 18th in terms of computed tomography scans per million population. (Esmail 2001) For health care services (hospital beds, physicians and other resources), Canada ranked 5th of 8 countries, having more resources available than the United Kingdom, Singapore and South Africa, but fewer than Germany, Switzerland, the United States and Australia. (Ramsay 2001)

At minimum, such findings bring into question the belief that a publicly funded health care system that prohibits the private financing of medically necessary services is necessarily better at providing greater and more equal access to health care than one that allows public and private funding of these services. There are problems in Canada and the United Kingdom with waiting lists and survival rates for certain illnesses, for example, but there are Americans who go without health care because of its cost.

A recent survey looked at patient views regarding access, quality and costs of care in Australia, Canada, New Zealand, the United Kingdom, and the United States. It found that the United Kingdom had the largest share of the population waiting four months or more for elective surgery, while Canada had the only statistically significant increase in the number of people waiting four months or more for treatment. However, Canadians and Britons were much less likely to report going without medical care because of costs than were adults in Australia, New Zealand and the United States. (Blendon et al. 2002)

Quality

There are few, if any, that can point to whether a publicly or privately funded health care system is better or worse for population health. For example, research by the Institute for Clinical Evaluative Sciences in 1999 concluded, after having examined some 18 studies of health outcomes in Canada and the United States, that "none of these studies proved that differences in health outcomes were due solely to differences in the health care systems of these two countries. As a result, formulation of a distinct hypothesis regarding the relationship(s) between quality of care of each distinct health care system and outcomes in comparison to each other is unlikely." (Szick et al. 1999, 17)

In the aforementioned five-country survey, respondents in all of the countries rated their physician care as excellent or very good. With respect to hospital care, a majority in every country except the United Kingdom rated the care they received as excellent or very good. Canadians and Americans with lower incomes were less likely than those with higher incomes to rate their care as excellent or very good; the opposite was true for Britons. (Blendon et al. 2002)

In *World Health Report 2000*, the World Health Organization (WHO) ranked the performance of health care systems around the world in trying to achieve three main goals: good health, responsiveness to the expectations of the population and fairness of financial contribution (how much people pay out-of-pocket). In the comparison of overall system performance, Canada ranked better than countries such as the United States and Australia but worse than France, Italy, Singapore, the United Kingdom, Germany and 20-plus other countries. (World Health Organization [WHO] 2000) Being a first attempt at ranking health systems, there are debatable methodological aspects of this report and, being a complex and lengthy report, it would be foolhardy to take the results as indicating that any one country's health care system was unambiguously better than another's. However, the ordering of the countries should at least cause people to question whether Canada's health care system as it stands should be sacrosanct, or if we cannot learn from how other countries organize their systems.

Cost

Deber et al., in their report to the National Forum on Health, state a common view in Canada:

> … from both international and Canadian evidence, [is the finding] that exclusive public financing of medically necessary care is also the most economically efficient method. Efficiency is increased through the state's monopsony power over the control of total budgets and over fee and salary negotiations with providers, and through minimizing cost shifting and risk selection. Case studies of Canadian experience reveal that cost escalation is higher in those areas of health care with greater roles for private financing (e.g. drugs, automobile insurance, travel health insurance) than those with public financing and monopsony control (e.g. hospitals).… The only justification for the mixed financing plans is that they may provide enhanced consumer and provider choice (liberty). (Deber et al. 1995)

While there is some evidence that governments can increase the efficiency of health care markets because there are social returns to health, asymmetric information and other market failures, there is little, if any, evidence that "exclusive" public financing of medically necessary services is the most economically efficient method. As well, there has been documentation of government failures that are as serious as market failures: poor public accountability, information asymmetry, abuse of monopoly power and failure to provide public goods. (Harding and Preker 2000)

Dr. Ake Blomqvist told the Standing Senate Committee on Social Affairs, Science and Technology, "if cost containment is a main objective, there would seem to be a prima facie case for extending public sector coverage to encompass a broader range of benefits, for example, by introducing a system of publicly funded Pharmacare, as suggested by the National Forum on Health." (Standing Senate Committee January 2002*a*, 68) While it is true that countries with publicly funded systems *may* be able to control costs by brute force – capping physicians' fees, closing hospitals and delisting services, for example – better than countries that rely more on private financing, they are not necessarily less expensive systems. Canada spends more on health care than most industrialized countries, all of which allow private sector financing of medically necessary services.

As well, a recent comparison published in the *British Medical Journal* of Britain's publicly funded National Health Service with California's private, nonprofit Kaiser Permanente found that the per capita costs of the two systems, adjusted for such aspects as differences in benefits and population characteristics, were similar to within 10 percent. But it also found that Kaiser members experienced more comprehensive and convenient primary care services and much more rapid access to specialist services and hospital admissions. Kaiser's superior access, quality and cost performance was attributed to better system integration, more efficient management of hospital use, the benefits of competition and greater investment in information technology. (Feachem, Sekhri and White 2002)

The struggles faced by Canada's health care system are numerous: waiting lists, emergency room back-ups, a lack of high-tech medical equipment, limits on newer pharmaceutical treatments and low provider morale. Many of these issues arise because health care in Canada is organized mainly as a function of government and, therefore, increasing health care costs is problematic. By continuing to demand "exclusive" public financing of medically necessary services in Canada, the federal government is potentially harming Canadians' health and hindering the future prospects of the health care sector. (Ramsay and Walker 1996) For reasons such as these, and not only for "enhanced consumer and provider choice," is there justification for mixed financing plans.

Public or Private Financing and Population Health Status

Beyond the Public-Private Debate: An Examination of Quality, Access and Cost in the Health-Care Systems of Eight Countries found that, of the many possible determinants of health, income per capita and literacy have the strongest relationship to health status. It also found immunization rates to be important. Given these findings, *Beyond the Public-Private Debate* concludes that government intervention should focus on (given scarce resources) assuring universal access to and the availability of preventive and basic primary care, even increasing their availability. Beyond this, governments should work to ensure that people who cannot afford to pay for medical services have access to care when they need it and, perhaps, governments should require their citizens to purchase health insurance for catastrophic events. (Ramsay 2001)

World Health Report 2000 states that "scientific and technical progress … explained almost half of the reduction in mortality between 1960 and 1990 in a sample of 115 low- and middle-income countries, while income growth explained less than 20 percent and increases in the educational level of adult females less than 40 percent." (WHO 2000, 9) With respect to developed countries, WHO's report claims that a large portion of the improvement in life expectancy in Europe has been due to modern medical care. But, it also says that health systems do little to improve health: studies have shown life expectancy to be correlated with income per capita but not to the numbers of doctors, hospital beds or health expenditure. And, WHO notes that, while "rich" people tend to benefit more from the use of hospital and primary care services, "the distribution of primary care is almost always more beneficial to the poor than hospital care…." (WHO 2000, 16)

Nonetheless, *World Health Report 2000* advocates for all countries – developed and developing – a universal, publicly financed health system that encompasses everything from road safety to prevention to surgery. For WHO, "the ideal is largely to disconnect a household's financial contribution to the health care system from its health risks and separate it almost entirely from the use of needed services." (WHO 2000, 36) However, there are extensive studies that show that completely disconnecting use and costs is not necessary to ensure people's good health.

One of the most comprehensive studies of health insurance is that of the RAND Corp. More than 7,000 non-elderly families from six regions of the United States were assigned to different insurance plans and monitored over a period of three to five years. All of the plans had a limit on out-of-pocket expenditure and ranged from free care (zero coinsurance) to a variety of user-pay plans (with different coinsurance rates for different services). Two of the findings were that the *total* expenditure for the high-coinsurance group (95 percent) was well below that of the free-care group and that the different levels of maximum out-of-pocket spending did not result in significant differences in medical use. (Ramsay 1998)

The RAND study concluded that the increased use of services by the free-care group had little or no measurable effect on the health status and there was no significant difference between the groups in the risk of dying or measures of pain and worry. In only one instance was the free-care plan better, and that was for low-income people with high blood pressure. However, the researchers note that a "one-time screening examination achieved most of the gain in blood pressure that free care achieved." (Gratzer 1999, 124-125)

While the RAND study implies that targeted public interventions might be preferable than universal coverage, other analyses discount the idea of targeting health spending on low-income individuals or even on specific diseases, believing the practice to be ineffective. (Deaton 2002) Princeton University Professor Angus Deaton writes, "it is time that the educational debate was more cognizant of health benefits. As for income, there is a very strong case in poor countries, and among the poor in rich countries, for whom nutrition, nutritional-linked disease and poor housing are important determinants of adult and child health … [that] a policy of income provision to the poor may well be more effective than spending the same amount of public funds on a weak health care delivery system." (Deaton 2002, 27-28) Another study discusses the "fact that many of the conditions driving the need for [acute care] are preventable ought to draw attention to policy opportunities for promoting health." (McGinnis, Williams-Russo and Knickman 2002, 78)

Results such as these explain why all other industrialized nations have some type of private financing of services that are considered medically necessary by the somewhat mutable Canadian standard. Austrian ambulatory patients pay a quarterly fee for physician services; inpatients pay a fixed fee for all medication. Belgium inpatients pay a fixed daily fee for all medication received. In Germany, patients pay a fixed "hotel" fee, but are exempt from other co-payments while in hospital. Switzerland has an annual deductible for ambulatory care and a fixed daily rate for inpatient stays. (National Economic Research Associates 2001)

Every country attempts to mitigate the potential harmful effects of such cost-sharing measures, which include a potential redistribution of income from the poor and sick to the healthy and wealthy, and the lower use of health services by and worse health status of people with lower incomes. There are many studies, going years back, showing that cost-sharing mechanisms, such as user fees, can negatively impact certain populations. (For example, Beck 1974, 1980; Roemer et al. 1975; Evans 1993; and Ramsay 1998)

Because of these types of concerns, an alternative to traditional forms of cost-sharing, and one which would maintain the integrity of the *Canada Health Act*'s five principles, has been recommended by some health care policy analysts and by Alberta's advisory council: medical savings accounts (MSAs). Proponents of this idea believe that transferring most of the coverage decisions to individuals and allowing an expanded role for the private sector will make the health care system more efficient and cost-effective at delivering care, while broadening coverage of services for all citizens. An in-depth discussion of the pros and cons of MSAs is beyond the scope of this paper, however, there are several detailed presentations on how MSAs work in other countries and how they could work in Canada. (For example, Standing Senate Committee January 2002*a*; Premier's Advisory Council on Health for Alberta 2001; Gratzer 1999; Litow and Muller 1998; Ramsay 1998; and Massaro and Wong 1996)

Framework for Determining Extent of Public Financing

1. Clarify the Purpose of the Health System

> A public health-care system is not there simply to maximize the amount of health in society (however we choose to measure health). It is not there merely to treat disease (however we choose to define disease). It is not there solely to meet health-care needs (however we choose to define health-care needs). And it is not there to ensure equality in health status (however we choose to conceptualize equality). The goal of a public health-care system is a complex composite of a range of goals … it becomes impossible to use a simple maximizing algorithm as a basis for the priority-setting system. (Holm 2000, 31-2)

There are interventions that maintain function at high cost (e.g., organ transplants), interventions that enhance quality of life (e.g., Viagra), heroic but marginally effective technologies (e.g., high-dose chemotherapy) and advances in genetic diagnosis and treatment. (Clancy and Danis 2000) As well, there are numerous non-medical factors that have been associated with health status, such as housing, income and education. There needs to be agreement on the priorities of the health system.

2. Decide Which Services to Evaluate

The rationing process produces trade-offs that cut along divisions created by budget structures (fee schedules), institutionalized interests (clinical specialties), ideology (personal versus collective responsibility for illness and care) and information (available evaluation research). (Giacomini 1999) Therefore, decision makers should consider the following questions about each trade-off before proceeding to the evaluation stage:

- *What is it?* Interventions and technologies with a given label (e.g., heart transplant, prenatal care) may have many manifestations of practice, function and effects.

- *What is it for?* At issue may not be the effectiveness of the service, but some less tractable question about the medicalization of problems or the legitimacy of recipients' needs. Services must be considered in terms of public policy goals and values.

- *How is it situated?* Interventions can be interdependent; restricting one may affect the other.

- *Whose is it?* Services/technologies have constituencies of innovators, marketers, users and beneficiaries who may influence the assessment contest, such as whether a technology is exempt from scrutiny, etc.

- *Who is it for?* The more narrowly defined a technology's boundaries, the more burden placed on users to supply the supporting structures that make it "work." For example, many innovations have not been tested on (or adapted to) women. (Giacomini 1999, 750-751)

3. Evaluate Cost-Effectiveness and Relevance of Programs and Services

Most countries use some form of cost-effectiveness analysis to determine which health care services to cover publicly. Increasingly, they are also evaluating the relevance of particular services to their system's goals.

> The most crucial – and controversial – question for evidence-based coverage policy concerns the adequacy of evidence.... One policy is to cover an intervention unless there is compelling evidence that it is more harmful than beneficial.... Another standard is the "best guess": cover if the preponderance of evidence, whether extensive or meagre, suggests that the technology is beneficial.... Judging the adequacy of evidence is often subjective.... (Garber 2001, 66-67)

In the United Kingdom, practitioners involved in the priority-setting process make a judgment about the effectiveness of an intervention if good quality evidence is unavailable. In New Zealand, consensus panels of expert professionals and community people are involved in decisions regarding the effectiveness of some treatments. (Edgar 2000) Most evidence-based coverage processes are flexible, balancing the need for rigor against the limitations of the state of medical knowledge. (Garber 2001)

Another concern is that priority-funding lists provide a very diverse mix of services from which it is often difficult to evaluate the implications in practice of the trade-offs presented. For example, Oregon covers services relating to treating diabetes, newborn care and medical therapy for psoriasis, but does not cover treatment of sexual dysfunction or treatment for cancers where the potential to improve survival is low. (Oregon Health Services Commission October 2001)

As well, cost-effectiveness criteria are not generally sufficient to determine whether to publicly insure a health service: lifestyle drugs, such as Viagra, are a case in point. Used to combat the symptoms of erectile dysfunction in men, Viagra has been shown to be effective. However, even if a very large number of patients benefited in terms of a higher quality of life, are Canadians willing to close a cardiac surgery unit in order to publicly fund Viagra? (Ferguson, 13 January 2002) In the United Kingdom, Viagra is only available from the NHS for certain clinical conditions. The U.K. decision makers have decided that the NHS is not obliged to subsidize this lifestyle drug for everyone who might benefit from it; they have determined that Viagra, in most cases, is not *relevant* to a publicly funded, universal service. (New 2000)

4. Involve the Public

Most Canadians strongly agree with the concept of a mainly publicly funded health care system and the principles of the *Canada Health Act*. However, Canadians' support for increased public spending on health care is conditional on the system being made more efficient, effective and accountable for how new spending will be used; there is support for reducing the scope of coverage if necessary. (Vail 2001) As well, 30 to 50 percent of Canadians are willing to consider options that allow increased private delivery and financing of health care to either preserve the public system or ensure access to quality care. (Vail 2001)

Another survey, reported in the *Medical Post*, found that Canadians are not interested in "dumping more money in to make the pie bigger," but "the idea that governments should fund all health services proven to improve health or quality of life received 90 percent approval." (Milne 2001) As to what these services should be, Canadians favoured diagnostic services, such as MRIs, acute care, long-term care, home and community care and illness prevention. Lower on the list were health promotion, prescription medications, end-of-life care and public health. (Milne 2001)

There are many potential areas for public involvement in the rationing process: the articulation of the ethos and values of the system, which health care services/treatments are publicly provided, which groups receive priority (e.g., elderly versus young) and the location of health service provision (e.g., institution versus community), for example. (Mullen 2000)

One challenge will be to educate citizens on the cost-effectiveness of various programs and services. As indicated by the *Medical Post* survey, many Canadians perceive universal access to acute care to be more valuable than access to public health. The importance of perception was evident in Oregon, where the initial deinsurance of organ transplantation was based on the popular belief that transplants are only marginally beneficial. Another common way of cursorily differentiating health care services is newness versus oldness: transplants and infertility treatments, for example, are included in almost every priority-setting exercise. (Giacomini 1999)

Another challenge will be to effectively manage the various lobby groups in Canada. Practitioners – chiropractors and massage therapists in British Columbia's most recent delisting exercise, for instance – have protested the move by governments to decrease public funding of the services they provide. Hospital employees have raised concerns over initiatives to privately provide auxiliary services. Physicians and hospitals have resisted attempts to cap their budgets. Residents have complained loudly when a hospital is closed in their area. These are but a few of the many groups that place demands on limited public sector funds.

The point to keep in mind is that the reasonableness and transparency of the approach to rationing are most important. The public can be involved in varying degrees but, at the least, the information and criteria on which the priority-setting decisions are based must be made publicly available. Once the funding decisions have been made – which procedures to cover or which practice guidelines to implement – individuals (patients, providers and those directly affected by the policy/choices) must have the right to challenge the decisions.

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Health Policy Challenges for India: Private Health Insurance and Lessons from the International Experience

by

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Health Policy Challenges for India: Private Health Insurance and Lessons from the International Experience

Ajay Mahal

1. Health Policy Challenges for India

1.1.1. India's Achievements in Health: Great Progress and Persistence of Problems

Over the last few decades, the Indian population has experienced great advances in its health situation. For instance, life expectancy at birth increased from 50 years in 1970 to an estimated 62 years in 1995 and is possibly even greater now. Infant mortality rates have fallen as well, from 137 per 1,000 live births in 1970 to 69 per 1,000 live births in 1991 (World Bank 1995). These are substantial improvements, but much remains to be done, relative to some its neighbors as well in terms of reducing differences in performance across states and socioeconomic groups. For instance, China has done much better, with its life expectancy at birth hovering around 70 years, and India's neighbour, Sri Lanka, has a life expectancy of nearly 73 years (World Bank 1997). Both countries have much lower infant mortality rates as well, and in the case of Sri Lanka, less than one-quarter that of India. Again, Kerala has infant mortality rates below those in China, but states such as Madhya Pradesh, Orissa and Rajasthan have infant mortality rates of well over 100 per 1,000 live births in rural areas (Dreze and Sen 1995; Mahal, Srivastava and Sanan 2000). Similarly, in rural India, the infant mortality rates among the top two income quintiles are nearly 34 - 50 per cent lower than the rates reported for the bottom two quintiles.[1] Substantial differences in life expectancies at birth are present across states and socio-economic groupings (Dreze and Sen 1995).

Another issue of concern is the growing prevalence of chronic illness in the Indian population, such as obesity, heart disease, diabetes, hypertension and the like. This has partly to do with changing dietary habits, from coarse grain to energy rich diets of meat, milk products, and sugar. It has also to do with an urban population growing at an average annual rate of growth of 3.2 per cent and sedentary lifestyles often characteristic

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[1] Author's estimate based on NCAER survey data.

of it (National Institute of Urban Affairs (NIUA) 2000, Popkin, Horton, Kim, Mahal and Shuigao 2001). Thus, the prevalence of diabetes rates were nearly three times higher among urban residents than among rural residents in 1995-96, the prevalence of heart disease 70 per cent higher, and the prevalence of hypertension more than double. With the urban population expected to grow further in the future, the emergence of chronic illnesses will have significant consequences on the financial costs of providing health care, as many illnesses are extremely expensive to treat (Mahal 2000a).

1.1.2. The Case for Government Intervention in the Health Sector

At any point in time, an individual's health status depends on a range of factors. These obviously include the endowment of health that an individual started out with – genetic aspects, as well as parental health. It will also depend on choices that various individuals, or their guardians make. These choices may relate to lifestyle factors, such as smoking and alcohol intake, frequency of exercise, the quality of nutrition, as well as on the access to good quality medical care when sick. The health status will also depend on exogenous events, such as the contraction of infectious diseases. The latter may, in turn, be dependent on the availability of clean water, sanitation facilities, the immunisation status of the individual, and so on. Economists often describe these relationships through the device of a "health production function" (Phelps 1997). Good health, in addition to the initial endowment, is determined by individual preferences, the socioeconomic circumstances that help shape those preferences (such as marital status, cultural and religious factors and education), incomes, and the prices of different items consumed by an individual, including health inputs and the quality of such inputs.

By influencing these choices the government may play quite a substantial role in improving health. For instance, many of the decisions that individuals take about health depend on the information that they possess about potential health impacts. To the extent that information is a public good, markets may fail to provide all the information relevant to healthy lifestyle choices to individual agents. Governments also intervene in situations where illnesses are very expensive to treat. Those who fall sick face the consequence of significant financial costs of treatment in the absence of insurance, with possible catastrophic effects on living standards. It is true that catastrophic illness, whose incidence is often uncertain for an individual, creates a demand for insurance among those who can afford it. Such insurance is, however, underprovided by the market. By providing subsidised health services, or health insurance, the government can influence the consumption of health care by those in need of it while mitigating the inequity enhancing effects of illness. Government intervention is also desirable on account of the asymmetry of information that prevails in the market for medical care—with doctors (perceived to be) having much better information about the status of a sick person than the person himself. This creates an incentive for doctors to provide more services to patients than may be medically necessary, and lower quality care. For these reasons, protecting children and adults against infectious diseases, promoting better quality of care, and ensuring that families and individuals do not face inordinate financial risks related to catastrophic illnesses, form key objectives of public health policy (see, for example, Lok Sabha 1985).

In influencing the choices that make for better health and lowered financial burden of ill health, the society is typically faced with *three* key challenges. The first has to do with controlling the cost incurred in the provision of health interventions that it supports – be it care, health care regulation, or provision of insurance -- given that resources are limited and face competing demands for their use. The second is to achieve an equitable distribution of the financial burden of ill health and morbidity. This is a direct consequence of the fact that societies are concerned not just about improvements in "average health" but also, especially, about the health and economic welfare of the socially and economically marginal groups in society. A third issue is to ensure the quality of medical care that is provided, because of its central importance to people who need care, and also because of its direct link to the cost-effectiveness of care provision.

1.2. Cost, Equity, and Quality of Medical Care in India: The Existing Situation

In light of the previous discussion, it is of interest to check whether the existing Indian health system adequately addresses the three challenges mentioned earlier. In particular we ask: (1) How costly and "cost-effective" is the Indian health system? (2) How equitable is it from the point of view of the burden of health care spending? And (3) does it provide high quality care?

1.2.1 Costs and Cost-Effectiveness of Care Provision

Three approaches can be used to examine the costs and cost-effectiveness of health care provision at the national level. We can look at aggregate achievements in health and compare these to the actual amounts spent on health, relative to those in other countries, while controlling for potential confounding variables. One example of this approach is to estimate the relationship, say between life expectancy and health expenditures per capita, and to then compare the efficacy of health expenditures across countries in terms of the gains in life expectancy at birth per dollar/rupee spent. This, unfortunately, is not a straightforward exercise, since life expectancy at birth is linked to levels of living and past health expenditures as well, data for which are not readily available for most countries, except in the case of developed ones. Moreover, the relationship is likely to be confounded by the fact that life expectancy at birth may itself influence health expenditures and per capita incomes, so that any careful estimation exercise would have to consider the problem of simultaneity (Bloom, Canning and Graham 2000).[2]

A second approach is to examine health expenditures in each country and assess whether these are too "high" or too "low", relative to the average expenditures figures for all countries, or to some predicted value from a regression linking health expenditures to say, per capita income. This approach takes as its starting point that, on an average the world expenditures on health are appropriate relative to any given level of per capita income, although individual countries may depart from this norm, in one direction or the other.

A third approach is to verify whether the existing composition of health spending in the country of interest could be modified so as to yield an increase in health outcome measures such as disability adjusted life years (DALYs), while leaving the magnitude of total health spending unchanged. If such realignment of resources were possible in India, one could argue that the country is spending "too much" on the existing level of health care. For the purpose of this brief introduction, we focus mainly on the second approach, while providing suggestive ideas for the other two.[3]

Consider the first method of comparing health outcomes with aggregate health spending. According to the most recent estimates, the aggregate of public sector and private sector health spending amounted to nearly 5.6 per cent of the gross domestic product (GDP) of India (World Bank 1997).[4] These estimates are certainly much higher, as a proportion of GDP, of aggregate health expenditures among India's neighbours such as Bangladesh with 2.4 per cent, China with 3.8 per cent, Pakistan with 3.5 per cent, and Sri Lanka with 1.9 per cent, respectively (World Bank 1997).[5] Given that both Sri Lanka and China are doing significantly better than India in terms of indicators such as infant mortality rate and life expectancy at birth, this indicates that health spending in India is not as cost-effective as among some of its neighbours.

We also compared India's health spending to what would be suggested by its income level, based on a regression of health expenditures per capita as a proportion of GDP, on income per capita. Using data on these variables for 109 countries, we find that India's estimated spending per capita in *circa* 1995 was about US$19.5, nearly 25 per cent higher than what the regression would predict.[6] This too, would point to Indians spending a "little too much" on health care, despite being low in absolute terms, when compared to the United States (US$3,828) and other developed countries. The key point here is that the health expenditures are high relative to what would be expected of a country at its level of development and health achievements. One possible reason could be that Indians

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[2] Moreover, the effects of health expenditures that focus on potentially fatal illnesses such as cancer and AIDS are unlikely to even be significant in influencing life expectancy.

[3] Musgrove (1996) did not find a particularly strong relationship between life expectancy (and infant mortality) and health expenditures. We believe that is probably on account of his not accounting for the biases introduced by simultaneity and omission of lagged health expenditures.

[4] With the public sector accounting for about 1.3 percentage points of this aggregate.

[5] Recent estimates constructed by the author tend to suggest a smaller level of health spending as a proportion of GDP in India, of about 4.5 per cent.

[6] The data are from the World Bank (1997).

are spending relatively more on curative care, compared to the more cost-effective preventive care[7] (World Bank 1995, p. viii).

This last idea points to the possibility of realigning health expenditures in India so as to yield greater benefits say in terms of measures such as quality and disability-adjusted life years (World Bank 1993). For instance, the poor utilisation of primary health facilities in India is partly owing to the low levels of quality of care that is provided in such facilities. These, in turn, are caused by and manifested in absenteeism among doctors and other medical personnel, lack of availability of drugs – themselves a consequence of poor incentives and low levels of accountability (World Bank 1995).

1.2.2 Equity in the Burden of Health Spending

The public sector in India offers heavily subsidised medical care to its citizens through a large network of government-operated facilities, to which access is ostensibly free. However, it is unable to cater to the needs of large sections of the population, since the bulk of total health spending – 75 per cent of the total – is accounted for by out-of-pocket expenses of households (World Bank 1995).

The extremely large burden of health care spending on households is problematic since it raises the possibility of a disproportionate economic burden on the poor sections of Indian society. In fact, a recent study by van Doorslaer et al. (1997) for OECD countries demonstrates that out-of-pocket payments for health are the most inequitable among the class of resources that could be used to finance health services – other, more equitable, examples being, social insurance taxes, direct taxes, and the like. Table 9.1 presents information on the distribution of the burden of out-of-pocket spending on inpatient and outpatient care by households, by per capita expenditure quintiles, from the 52nd round of the National Sample Survey (NSS). Given that the ratio of out-of-pocket spending as a proportion of mean expenditure is higher in the richer quintiles, it would seem that the

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[7] Cost-effectiveness narrowly defined, of course, needs to be balanced against the protection from risk of expensive illnesses, which may not be as "cost-effective". A focus only on outcome measures such as DALYs and QALYs would exclude the benefits in terms of risk protection that public subsidies for expensive illnesses (such as cancer and heart disease) provide, even if the cost-effectiveness of these illnesses is low, relative to say childhood diseases. (see Hammer and Berman 1995).

financial burden of health care is not too inequitably distributed.[8] There are, however, at least three reasons for caution.

First, measures of out-of-pocket spending on health do not take into account the losses owing to foregone income that result from poor health. If lost income were also to be included in our calculus, the financial burden of health increases quite substantially for the lower quintiles. Data in Table 9.1 illustrate this clearly – the numbers in parentheses show the ratio of out-of-pocket spending *plus* income losses from ailments to mean per capita expenditure in each quintile. Indeed, the burden of care from lost income is substantially higher (comprising 50 per cent to 70 per cent of out-of-pocket spending) for the poorest 20 per cent in comparison with the richest 20 per cent (16 per cent to 28 per cent of out-of-pocket spending.)

Second, the burden of out-of-pocket spending does not include the adverse effects on long-term health that might result from not seeking care in time. The poorest groups not only report fewer illnesses, but they obtain treatment for a smaller proportion of those reported, compared to the richest groups. This fact clearly emerges from the 1995-96 health survey undertaken by the National Sample Survey Organisation (NSSO 1998). The proportion of ailments that the poor get treated for is also lower in comparison to the rich. For instance, the people in the poorest rural quintile left about 25 per cent of their reported ailments untreated, compared to 10-15 per cent in the case of the richest quintile. The corresponding numbers for urban areas were 17 per cent and 9 per cent, respectively. The treatment data, together with the data on the financial burden of health spending, suggest a problem of access to health facilities for people living in rural areas as well.

A third aspect of concern is the distribution of public health subsidies. Despite a considerable desirable for "equity" in public policy documents, a recent study shows that public subsidies on health are distributed quite unequally across different socioeconomic groups in India (Mahal *et al.* 2000). At the all-India level, the share of the richest 20 per

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[8] To be sure, there are some rural-urban differences, but these occur mainly in the richer groups – with health spending by the upper quintiles in rural areas much higher, as a proportion of total consumption spending, than their counterparts in urban areas.

cent of the population in total public sector subsidies is nearly 31 per cent, nearly three times the share of the poorest 20 per cent of the population. The inequality was greater among the rural residents, where the share of the top 20 per cent in public subsidies was nearly four times that of the poorest 20 per cent. Urban areas enjoyed greater equality, in addition to enjoying a greater than proportional share in total subsidies. Mahal *et al.* (2000) find that 31 per cent of public subsidies on health accrued to urban residents, somewhat higher than their share in the total population of about 25 per cent. There were substantial differences in the degree of inequality, with southern states such as Kerala, Tamil Nadu and Andhra Pradesh, and the western states of Maharashtra and Gujarat enjoying a much more equal distribution than the states of northern India.

Some of this inequality in the allocation of public health subsidies can be explained by income-related differences in utilisation patterns of public facilities, with the rich using more care, if health care is a normal good. Moreover, large subsidies to the rich may be a *sine qua non* for continued public support to the health sector. If, however, promoting equity is a key objective of the state, there is no doubt that substantial scope for improvement remains, whether in terms of inter-state equity, or within state distributions of public subsidies.

1.2.3 Quality of care

A third key element of the health care system is the quality of care that its users are able to obtain. Quality refers to at least two different things. First, the level of competence with which an examination and/or treatment protocol is implemented – be it medical examinations, diagnostic tests, the quality of administered drugs and medical care generally. This type of *technical quality* is likely to depend on a host of factors including the level of medical training, market pressures to acquire requisite training, continuing education, infrastructure, and the regulatory set-up. Second is *personal quality* that has to do with provider attitudes towards patients, overall surroundings in which health care is provided, and the degree of attention that a patient receives (Harvard Team, The 2000).

Quality of medical inputs in India

There is an extensive literature summarizing the poor quality of health care currently available to seekers of health care in India. Consider first the care provided by the public sector. Patients, both rich and poor, tend to overwhelmingly favour the private sector over the "free" services provided by the public sector, when it comes to ambulatory care Administrative Staff College of India (ASCI) 1996; Mahal *et al.* 2000; World Bank 1995). This is corroborated by studies noting large shortfalls in personnel, equipment, and medicines in public facilities reported in primary health centres and sub-centres (Naylor *et al.* 1999; World Bank 1995). The situation is no better for workers with access to facilities under the Employees State Insurance Corporation (ESIC), well known for their unresponsive staff and poor equipment quality (ASCI 1996; Wadhawan 1987).

Unfortunately, the private sector also faces problems with respect to the quality of health care it provides. One study in Maharashtra found a large number of doctors who practised modern medicine without being qualified to do so, several hospitals that did not have even the basic infrastructure and personnel to carry out their functions, and operated without any licenses or registration (Nandraj and Duggal 1996). Other studies of private medical hospitals in Kolkata and Mumbai further confirm the poor state of private sector facilities, apart from highlighting the frequency of medically unnecessary procedures carried out on patients (Nandraj, Khot, and Menon 1999).

These problems with quality have to do with a lack of well-defined laws, and where such laws exist, their poor enforcement, whether on account of judicial delays or because of low levels of self-regulation by the medical community. Table 9.2 presents legislation related to the maintenance of quality standards in medical inputs such as drugs, medical personnel, and medical infrastructure. Typically, the legislation with respect to medical personnel involves the setting up of bodies (or councils) that oversee the maintenance of quality in new entrants to the profession, maintenance of membership records of the profession and, through codes of conduct and sanctions, maintenance of standards among existing members. Although quite widespread and covering all the Indian states, the record of these councils in ensuring continued good behaviour is quite poor (Jesani, Singhi and Prakash 1997). Moreover, there is other evidence of problems in that many practitioners of traditional systems practice modern (allopathic medicine) without any sanctions. There is no premium on continuing education or examination on those who already possess a medical degree.

The problem with quality control legislation is somewhat more acute in the case of health infrastructure. Until recently, the only relevant legislation was the Nursing Home Registration Act in a small group of states such as Delhi, Maharashtra and Bengal (Nandraj, Khot and Menon 1999).[9] The focus of these laws is primarily on registration of facilities, although the Delhi legislation specifies quality standards for these facilities (Nabhi Publications 2000, p. 12). In any event, the enforcement of even these laws has been poor; records of private facilities are generally incomplete and the few existing studies typically find substandard facilities, understaffing and low quality of care provision. There was no law with respect to diagnostic centres until recently (in fact, the Delhi Shops and Establishments Act specifically excludes medical facilities (Nabhi Publications 2000)). Now, however, at least in a proposed Delhi Private Medical Establishments "Act" (Aggarwal and Chaudhri 1998) would also seek to impose quality standards on diagnostic centres limited, of course, to the state of Delhi.

Consumer protection laws and their implementation

Even if quality related regulations against errant doctors and medical centres are not satisfactorily enforced by the government, quality can still be maintained if there exist a suitable set of laws on consumer protection, provided at least these are reasonably well implemented.

Table 9.3 summarises some of the major features of the law related to consumer protection in India. The two most common avenues for relief in the arena of medical care are the Consumer Protection Act and various civil courts (see, for example, Reddy 1997). Unfortunately, the Indian court system is not very effective, and by all accounts is

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[9] More recently, some states have begun taking steps to introduce fresh laws regarding private establishments (Aggarwal and Chaudhri 1998, Nandraj, Khot and Menon 1999).

characterised by lengthy delays and a massive backlog of cases.[10] It is thus not surprising that the various consumer commissions established under the Consumer Protection Act (COPRA) of 1986 have begun playing a key role in protecting consumer rights, in spite of their relatively recent origin. The main rationale for COPRA was it offering a quicker and cheaper way for consumers to address their grievances. A number of cases related to insurance and medical negligence have reached these courts (Aggarwal and Chaudhri 1998, Vats 1997). Recent evidence suggests that problems with backlogs have begun to occur in consumer courts as well, owing to an inadequacy of judges and the increase in the burden of cases (Bhat 1996a). Effective enforcement of malpractice laws against errant doctors has also been hampered by doctors' unwillingness to depose against their peers (Bhat 1996b; Jesani, Singhi and Prakash 1997).

1.3. Policy Challenges

Clearly major concerns exist in all three areas of health policy that have been highlighted earlier – in the overall costs of care, financial equity and the quality of care. A sustained improvement in these areas would play a significant role in advancing the primary goal of health policy – health, itself.

The government could essentially adopt one of two methods to address these issues. The first option is to *do nothing at all* beyond what it has already done. This, unfortunately, does not imply an unchanged situation. First, the Indian health sector would have to contend with the emergence of the private health insurance sector, given the passage of the Insurance Regulatory and Development Authority (IRDA) Bill. Second, over the longer run, it would have to contend with an aging population and the increasing burden of expensive chronic illnesses, such as cancer, diabetes and heart disease, with substantial implications for the health budgets of the poor and of the government.[11]

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[10] According to one estimate it would take nearly 324 years to clear the existing backlog! (Debroy 1999).

[11] Unfortunately, differences in definitions make it difficult to make comparisons with previous survey data to get a sense of the trends in key chronic diseases. As per the 52nd round data, self-reported estimates of prevalence rates (reference period of 15 days prior to the survey) were 26 per 100,000 for cancers/tumors in

In section 2 we assess the potential impact of the entry of private health insurance on the objectives of cost-containment, financial equity, and quality. The existing regulatory regime relating to private health insurance in India is also evaluated, and suggestions made for appropriate changes in it to ensure that private health insurance works to promote the various (intermediate) goals of health policy. We do not focus on the problem of the increasing prevalence of chronic illness, mainly because that calls for a whole new study, but note that it will serve only to highlight even further the importance of cost-containment, equity and health insurance.

If, as one suspects, the spread of the private health insurance sector, even a well-regulated one, is unable to address all of these policy challenges effectively, then other options will need to be considered. In its search for alternatives, India, in fact, is in the fortunate situation of being able to learn from a number of health system experiments that have taken place in different countries around the world. Some of the more interesting case studies have been the United Kingdom, Netherlands, Germany, Israel, Canada and Singapore.[12] In Section 3 of this report, we examine and evaluate these country experiences with process of reforms and outline their main lessons for Indian policymakers.

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rural areas and 28 per 100,000 in urban areas. For diabetes it was 48 per 100,000 and 145 per 100,000 for rural and urban residents, respectively (NSSO 1998, Table 3).

[12] There are many other countries, of course, that have undertaken reforms. We have chosen our set of countries to highlight the different types of reforms that have taken place.

Table 9.1. Distribution of out-of-pocket spending and income losses from ill-health: rural, urban, and all India, 1995-96

Per capita Expenditure Quintile	**Urban India**			**Rural India**			**All India**		
	Mean consumption expenditure (in Rs.)	*Per capita health spending (Rs.)*	*Health spending/ Consumption Expenditure*	*Mean consumption expenditure (in Rs.)*	*Per capita health spending (Rs.)*	*Health spending/ consumption expenditure*	*Mean consumption expenditure (in Rs.)*	*Per capita health spending (Rs.)*	*Health spending/ consumption expenditure*
I	2,807	121	0.043 (0.062)	2,085	95	0.045 (0.073)	2,177	101	0.046 (0.072)
II	4,060	232	0.057 (0.074)	2,810	138	0.049 (0.071)	2,991	168	0.056 (0.077)
III	5,266	301	0.057 (0.071)	3,423	194	0.057 (0.074)	3,726	187	0.050 (0.067)
IV	6,935	358	0.052 (0.061)	4,225	251	0.059 (0.078)	4,780	300	0.063 (0.082)
V	12,089	723	0.060 (0.069)	6,498	562	0.087 (0.111)	8,380	607	0.072 (0.088)

Note: Health spending refers only to expenditures on inpatient stays and outpatient treatments related to illness (i.e., pregnancies are excluded). Ratio in parentheses is (health spending *plus* income losses)÷mean per capita expenditure.
Source: Author's estimates based on National sample Survey (NSS) data, 52nd round (1995-96).

Table 9.2. Legislation related to standards in the health sector

Legislation	Objective	Powers and Functions	Quality Controls	Implementing/ Monitoring Authority
The Bureau of Indian Standards Act, 1986	Provide for the establishment of a bureau for the harmonious development of activities of standardisation, marking and quality certification of goods	Co-ordinate activities of any manufacturer or association or consumer(s) engaged in standardisation and improvement of quality Grant, renew, suspend or cancel licenses for use of standard mark. Inspect samples, establish laboratories for standardisation and quality control Address consumer complaints about quality of a product	Establish and publish Indian standards in relation to any article or process Specify a standard mark to be called the "Bureau of Indian Standards Certification Mark"	Bureau of Indian Standards
Drugs and Cosmetics Act, 1986	Quality control of drugs	Power to deem a drug misbranded, adulterated, spurious and to prohibit import, manufacture and sale of certain drugs	Define standards of quality, adulterated, misbranded and spurious drugs	Inspectors for this purpose appointed by central and state governments
Nursing Home Registration Acts (Delhi, Maharashtra, Bengal)	Registration of private hospitals	Maintain a register of private hospitals; may enter and inspect a nursing home; inspect any records; cancel registration if not meeting the provisions of the Act.	None specified	Municipal authority/ state government
Indian Medical Council Act/Nursing Council Act, 1947/Pharmacy Act 1948/Indian Medical Degrees Act 1916)	Create minimum and uniform quality standards	Various councils (medical, nursing, pharmacy, dental, Indian Systems): Give recognition to institutions that train medical personnel; maintain uniform standards; maintain registry; define code of conduct for doctors; take doctors off the rolls for violating code of ethics	May prescribe standard curricula for training of medical personnel; conditions for admission; examination standards	Indian Medical Association; medical/nursing/pharmacy councils of India and respective state councils.

Sources: Sunil Nandraj (personal communication); Aggarwal and Chaudhri (1998), Government of India (various).

Table 9.3. Selected list of legislation/rules linked to consumer protection in India

Legislation	Objective	Powers/Functions/Procedure	Monitoring/Implementing Authority
Consumer Protection Act, 1986	To protect consumers rights such as: 1. Protection from marketing of services hazardous to life 2. Right to be informed about quality, quantity, standard, price and purity for protection against unfair trade practices 3. Seek redressal against unfair trade practices or exploitation of consumers	A complaint under the Act can be made when there is a deficiency in services – any fault, shortcoming, inadequacy in quality of medical or insurance services, or if an excessively high price is being charged. To observe principles of natural justice and to award appropriately, compensation to consumers.	Central and state consumer councils 'promote' various objectives related to consumer rights District, state and national consumer commissions function as quasi-judicial forums to address consumer complaints. Orders of the National Commission can be appealed only in the Supreme Court.
Monopoly and Restrictive Trade Practices (MRTP) Act, 1969	Prevention of concentration of economic power, control of monopolies and prohibition of monopolistic and restrictive trade practices	Conduct inquiries into monopolistic and restrictive trade practices based on complaints by the government, own information, or a consumer, or an association or consumers or traders. Can award compensation for any loss or damage resulting from unfair trade practice.	Monopolies and Restrictive Trade Practices Commission.
Employees' State Insurance Act, 1948 (Section)	Address consumer (and other) complaints	Complaints about treatment received; benefits not received; eligibility, etc.	Medical Benefit Council, Medical Appeal Tribunal, Employees' Insurance Court
Central Government Health Scheme (CGHS) Rules	Address consumer (and other) complaints	Complaints about treatment received, benefits not received, eligibility, etc.	Internal dispute resolution mechanism
Arbitration and Conciliation Act, 1996	Address consumer (and other complaints) generally, but also GIC specifically	All complaints and demands for compensation	Arbitration Tribunal
Indian Contract Act 1872; Code of Civil (Criminal Procedure)	Consumer complaints	For breach of contract, deficiency in services, damages, dispute of facts, negligence and so on	Judicial system/courts

Drugs (Control) Act, 1950	Control over sale and price of drugs	Fix maximum prices and maximum quantities that may be sold General limitations on the quantity that may be possessed at any one time	Chief Commissioner, Drug Controller of India
Indian Medical Council Act, 1956	Defining a professional code of conduct	Taking doctors off the registry roles for violation of rules of conduct	State medical councils, Medical council of India

Sources: Aggarwal and Chaudhri (1998); Reddy (1997); Government of India (1999c); Bhat (1996a,b).

2. Private Health Insurance in India: An Assessment of its Impacts and Regulatory Issues

2.1. Introduction

The passage of the Insurance Regulatory and Development Authority (IRDA) Bill in the Indian Parliament marked the last phase in the move towards the privatisation of the insurance sector in India (*Asian Age* 1999, Government of India 1999a). Up till then, the provision of various types of formal insurance had been under the exclusive control of the public sector (Government of India 1999a-c). The Bill allows for the entry of private sector entities in the Indian insurance sector, including health insurance, and envisages the creation of a regulatory authority that would oversee the operations of various players in the insurance market (Government of India 1999a).

Whether the regulatory steps envisaged in the IRDA Bill, including especially the provision for entry of private firms, will influence the progress towards achieving India's health policy goals, and the likely direction that this effect will take is assessed here. The relevant policy goals for this purpose are assumed to be a health care system that is: not too costly, of good quality, and with an equitably distributed burden of health care spending.[13] Apart from indicating the implications of private health insurance for India, this section will also examine regulatory tools that can be utilised to address its adverse implications (if any) and takes account of its existing regulatory structure.

2.2. Private Health Insurance and Cost, Quality and Equity in Health Care

This section examines the theory and the evidence linking private health insurance to: (a) the aggregate cost of providing health care; (b) the quality of care provided by the health sector; and (c) equity in the financial burden of care and the distribution of public health subsidies.

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[13] Equity in health care can have many meanings including in terms of health outcomes, access to, and utilisation of health care facilities (Musgrove 1996). However, most of the measures are likely to be correlated with equity in the burden of health spending.

2.2.1. Private health insurance and aggregate costs of health care

In theory, the introduction of private health insurance can contribute to increasing the aggregate costs of health care in several different ways. Most of the arguments in favour of increasing health care costs due to private health insurance have to do with some disparity in the information available to parties involved in transactions in the health care and health insurance markets.

In interactions between health care providers, such as doctors and patients, it is a given that the former have much better information about their patients' health status and future course of treatment than the latter. This, together with the prospect of being ill and accompanying psychological costs and loss of earnings, makes the demand for health care fairly dependent on the course of treatment recommended by a physician. One consequence is that in a regime of pure indemnity insurance, providers have an incentive to provide more care than may be medically appropriate. For the same reason, the patient or, insurers for that matter, may be less willing to question the qualifications of the doctor as to his or her expertise (Arrow 1963, pp. 371-3).

The transaction between the insurer and the insured in the health market suffers from an asymmetric information problem as well. Once insured, an individual faces a reduced incentive to take precautions against poor health, much as a person with house fire insurance is likely to take less precaution in storing hazardous materials in her house. A sick person may also feel less compelled to control her consumption of health care and expensive diagnostic examinations if medical care costs are covered by insurance.

The arguments outlined above hold true *for any type of insurance regime*, public or private, so it is unclear on this basis alone whether costs are likely to be higher in a private insurance system in comparison to public sector dominated financing.[14] However, public sector operated insurance schemes, which typically involve dual functions of financing and provision of services involve a myriad restrictions on health care utilisation, especially referral to higher order care and overall budgetary limits.[15] In India, government employees covered under the Central Government Health Scheme (CGHS) cannot obtain reimbursements for private care unless appropriate referrals have been obtained from authorised medical practitioners or the Director of CGHS. A similar set of rules hold for the state supported Employees State Insurance Scheme (ESIS) for workers employed in the organised sector in India. Whether these schemes curtail use of expensive medical care depends on the presence of an effective referral process that curtails the usage of public facilities, or private care if permitted under the public scheme. Under the CGHS, only about 6 per cent of the total expenditure is accounted for by outside/private referrals suggesting that the process for external referrals may be effective in India (Garg 1999, p. 34).[16] However, this appears not to be the case for referrals *within* the public system where the utilisation patterns are biased towards public hospitals as against primary care facilities (World Bank 1995 and Mahal *et al.* 2000).

Managed care institutions, such as health maintenance organisations (HMOs) that have emerged in the private sector in other countries, combine the roles of the provider and the insurer and can, therefore, serve to cut costs. The cost-cutting mechanisms could include stricter referral processes, payments based on diagnostically related groups, capitation payments, and other methods of managing utilisation of health care services (Einthoven 1997; Phelps 1997). In the United States such systems covered nearly 60 per cent of the population in 1995, with the population coverage having expanded at rates of 12 per cent per annum during the previous decade (Einthoven 1997). Similar institutions can be found in many other countries including Israel, and on a miniscule scale, in India (Gupta *et al.* 1992; Chinitz 1995). There is some evidence to suggest that the emergence of HMOs has led to cost-containment in the United States (Phelps 1997).

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[14] Of course, in the existing scenario where the bulk of health expenditures in India are out-of-pocket, use may be limited much earlier by household or local community resources.

[15] A similar argument could hold for the private sector if increased costs lead to increased premiums and a smaller amount of insurance purchased than it would otherwise be.

[16] This does not rule out inequities arising in the sense that a small segment of the beneficiary pool may be using a disproportionately large amount of the external referrals.

To the extent that private insurance in the form of managed care can yield low-cost outcomes in comparison to a fee-for-service system, the relevant issue for policy makers and regulators is to devise methods to promote its emergence. At one level, such institutions might be thought to be a logical market outcome given their lower costs and no obvious declines in consumer satisfaction relative to fee-for-service systems. However, the experience of the United States suggests that such an outcome is not a fait accompli. HMOs faced stiff resistance from medical associations and legislatures until the 1970s and subsequently, much of this resistance was to do with the prevailing "guild free choice" model that supported the idea of free choice of health care providers by consumers (Einthoven 1997, pp.198-9). HMOs got a boost in the United States when laws were passed requiring employers to offer at least one HMO option to their employees and when the government began offering its own employees the option of such plans (Einthoven 1997, pp.212-3). Further evidence on this issue is available from the health reform experience of Chile where ISAPREs (private insurers) have functioned mainly as pure third-party payers (Baeza 1998; Ferreiro 1999).

A third form of information asymmetry common to insurance markets is the fact that individuals are likely to know much more about their health status and future needs than insurers. People expecting to incur significant health expenditures in the near future will figure disproportionately among those who choose to get insured. This causes profit-oriented private insurance companies to adopt procedures that are often expensive to weed out bad risks via *risk selection*. In Chile, for instance, whereas the population over 60 years accounts for 9.5 per cent of the country's population, the share of the 60 year-plus group in the population insured with private insurers was only 3.2 per cent, with the rest being covered by the public sector (Baeza 1998, p.18). Similarly, the average family size in Chile is four members, whereas the average among ISAPRE members is only 2.3 (Ferreiro 1999).

The "administrative" costs resulting from this risk selection can be quite high and usually passed on to customers in the form of higher loading charges.[17] Those unable to obtain

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[17] Loading charges can also include profit margins.

insurance at the higher premiums may then go back to the free public health system if the public system is open to all, or to out-of-pocket payments. In sum, overall health care costs would be higher than under a comparable public insurance system where membership into the insurance scheme may be compulsory for designated groups, unless outweighed by the inefficiencies of a public sector bureaucracy.[18] Regulatory methods to prevent risk selection must, per force, face up to the problem of adverse selection given its implications for the financial viability of an insurance company. Thus, market outcomes that lead to insuring large groups are desirable so that there is little to suspect a preponderance of poor risks in the applicant pool.[19] Indeed, larger groups face lower administrative costs. In the United States, loading charges (defined as (premiums/claims) less 1) typically range from 40 per cent for individual insurance to 5-8 per cent for group insurance (Phelps 1997, p.346; see also Table 9.6). In India, insurance plans offered by the General Insurance Corporation (GIC) offer discounts over individual premium rates that range from 15 per cent to 67 per cent for groups of size 50 thousand or more.[20]

Regulations that cap total overhead expenditure of insurance companies likely promote the administratively cheap group insurance business (Government of India 1999d).[21] Employment based group insurance can also be promoted by insurance contribution-linked tax benefits given to employers without corresponding tax liabilities for the employees (but not if premiums are paid by employees), as in the United States (Phelps 1997, pp.349-54).[22] In India, however, tax benefits can accrue both to employers and

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[18] One key exception to the argument that lower administration costs result from social insurance is a system where social insurance takes the form of a contribution into a national fund, payments out of which are made to various "private" entities to insure the contributors. In this case, risk selection by these entities would continue unless appropriate regulatory measures are adopted.

[19] With the assumption that the group insured was formed for reasons other than to seek health insurance.

[20] These are the rates for *Group Mediclaim Insurance* plans (communication with Rashmi Sharma, New India Insurance Company).

[21] Under the insurance rules of 1939, management expenses for "miscellaneous" insurance cannot exceed the *sum* of agent commissions (limited to 10 per cent of gross premiums) and a number ranging from 20-35 per cent of gross premiums depending on the volume of business. There are some exceptions for newly established companies, however (Government of India, 1999e, pp.21-23).

[22] This is likely to be the case if employers find it administratively costly to deal with individual insurance packages, e.g., if wage differentials based on insurance contributions were to be instituted. Individual policies account for only 6 per cent of the entire privately insured population in the United States (Phelps 1997, p.349).

employees depending on who pays the premium.[23] In this setting employer paid premiums may still be desirable as a means to promote group insurance if corporate tax rates are higher than personal income tax rates or if there are returns to scale to employers from administering group insurance.

In developing countries, there is one other information-related factor that could lead to high health care costs -- the financial health of health insurance companies. In the absence of minimum capital reserves and incomplete epidemiological information about the population, there is a risk that insurance companies could be guessing wrong and charging premiums that are much lower in comparison to the benefits offered in a competitive environment.[24] The problems would be exacerbated if get-rich quick companies were to invest their premium income in high-risk assets that are not aligned to insurance claim liabilities. The importance of health insurance and the dependence upon it of a significant (and often politically powerful) cross-section of the population means that the government is unlikely to accept even short-run scenarios where the companies can become bankrupt.[25] As a consequence the government or the insurance sector may incur additional amounts in expensive bailout packages for sick health insurance firms, creating a disincentive for individual firm managers to perform financially, since their downside risks are covered to some extent.

Worldwide, governments have sought to address these concerns by setting a minimum set of conditions relating to management and personnel, actuarial analyses, solvency, working capital and investment profile; and a system for dealing with liquidations/takeovers. In most cases, there is a national level regulator to oversee the implementation of these conditions.

2.2.2 Aggregate cost implications of private insurance: cross-country evidence

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[23] Communication with Mr. Sikandar Khan (Member of Income Tax Tribunal).

[24] The problem is likely to be exacerbated in an environment with many competitors so that scale economies in administering insurance may not be possible (see Baeza 1998; Musgrove 1996, p.54).

[25] The market would work by eliminating inefficient firms over time but in the case of insurance this may be a cost too high to bear for the government.

Cross-country data is examined here to check if increased health spending per capita is associated with increased private insurance, all else remaining the same. Information on per capita income, health care expenditures and private and public insurance coverage for about thirty-one developed and developing countries is used for this purpose (for details about the sample of countries and data sources, refer to Table 9.7). Of course, a macro-assessment of the cost impact of the private insurance sector using national level data is not straightforward since it is likely to be confounded by income effects, the type of public insurance available, the nature and implementation of regulations and the like. Our preliminary analysis does not rule out the possibility that private insurance may have a much smaller impact on health spending than one would suspect.

Column 1 of Table 9.7 reports the results of a regression of the natural log of health spending per capita on the proportion of population covered by private insurance. The magnitude of the coefficient suggests that health spending per capita is positively associated with the proportion of population covered by private insurance. Indeed, a one-percentage point increase in the proportion of population covered by private insurance is associated with a 7.8 per cent increase in the costs of health care per capita.

Health spending, however, depends on many factors including income. Increased income may also lead to increased demand for insurance, both public and private. Increased incomes may also lead to greater out-of-pocket health spending. Thus, at the very least, the regression analysis would have to control for the overall level of insurance (and/or income) in examining the impact of private health insurance. Doing so reduces the coefficient on the proportion of population covered by private insurance to *statistical insignificance* at the 5-per cent level and its magnitude becomes small in absolute terms. Indeed, column 2 of Table 9.7 indicates that an increase in the proportion of population covered by private insurance of one percentage point is associated now with only a 0.7 per cent increase in the costs of health care per capita, if variations in income are controlled for. The results remain unchanged even if we control for the type of health insurance coverage in operation – that is, whether it is an alternative, or merely a supplement to an existing system of public health insurance (see Table 9.7).

Is this result reasonable? The United States is often held as an outstanding example of a country with "very high costs" of health care, a fact that is often linked to its predominantly private health insurance system. In particular, the United States has a high spending on health per capita (US$3,828 in 1995) in comparison to other OECD countries, such as France (US$2,600), Japan (US$2,947), and especially the United Kingdom (US$1,205) and Canada (US$1,814) (World Bank 1997). On the other hand, it is worth noting that with some notable exceptions such as United Kingdom, the *rate of growth* of health care costs in the United States has often fallen below that of many of the OECD countries. California, a state with a long experience in managed care, experienced even lower rates of growth in health costs during the 1980s and 1990s.

On the flip side, it is worth noting that even though the coefficient on the proportion of population covered by private insurance is statistically insignificant, it is by no means small in terms of its implied effects on health spending. Indeed, holding income to be the same, an increase in the share of private health insurance from negligible levels to 50 per cent of the total population would increase the health expenditure per capita by as much as 35 per cent (not percentage points).

2.2.3. Quality of health care

In a free market, with no uncertainty about the outcomes of treatment, one can expect higher quality treatment to be undertaken (subject to the usual constraints) as fully informed consumers choose the most effective doctors and medical facilities ignoring the rest. However, a major problem in the health care market is precisely the uncertainty about outcomes on the part of the consumer of services. Alternatively, institutions might develop to label/certify doctors and health care facilities, without necessarily excluding them from service provision, so as to address this problem of lack of information with the consumer (see Phelps (1997) for examples from the United States). In this case, one would expect greater demand for certified personnel and facilities and the gradual sidelining of others not so certified. This depends on the extent to which the consuming public is capable of taking informed decisions and whether it considers the certifications credible. Finally, there could be licensure that excludes everyone other than those meeting certain standards from practicing medicine.

The contribution of an insurance scheme, whether public or private, to improving the quality of health care depends on whether the scheme is able to influence the process of labeling or licensure of medical personnel and facilities or the entry of highly skilled individuals in the health sector.

The increased provision of private insurance may increase the demand for health care and so push up its price. While this would improve opportunities for high-quality individuals who might have otherwise sought employment in other sectors, it would also increase the supply of low-skilled individuals into the health sector, unless appropriate screening takes place. Thus a mere increase in returns to health care provision in this sector may not increase average quality and may even reduce quality at the margin. This is already occurring in the guise of doctors with degrees in Indian systems of medicine practising modern (allopathic) medicine (Nandraj and Duggal 1996). Insurance companies could contribute to enhancing quality if, for example, they put quality-determined restrictions on the nature of expenses they would reimburse.[26] In the case of HMOs and other managed-care institutions, they could empanel only those doctors who meet certain qualifications and treatment guidelines (Einthoven 1997). By enhancing the returns of such doctors over that of others they could increase the demand for such qualifications over time. The same could presumably be done for institutions, such as hospitals and diagnostic centres. By restricting the use of unnecessary expensive care through guidelines for referrals and hospital stays, managed care could also promote cost-effective treatment guidelines.

Many of the steps that appear necessary may well occur in a market, without any prompting by regulatory authorities. There are, however, three areas of concern. First,

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[26] To some extent, this already exists under GIC plans. Under the *Jan Arogya Scheme* for instance, reimbursement for medical expenses depends on whether the medical facility used was registered with local authorities and had a qualified medical practitioner, in the sense of being registered with the appropriate provincial medical council (Rashmi Sharma, National Insurance Company of India).

arguments that hold for HMOs need not also hold for indemnity based insurance. In the case of indemnity insurance, an expansion in coverage if accompanied by an increase in demand for care induced by physicians and lack of resistance to it by private insurers and patients could lead to enhanced use of expensive care and diagnostics without any change in health outcomes. It also does not follow that an indemnity system would cater only to highly skilled personnel and institutions, especially if consumers of health care are unable to readily distinguish among plans and premiums charged by managed care institutions and indemnity-type insurance. Indeed indemnity type insurance might appear more consumer friendly by not putting restrictions on whom to consult and get treated by.

Even otherwise, effective competition from managed care organisations might be slow to emerge if there is resistance from associations of medical personnel, consumers and employers. The formation of panels and exclusive contracting with doctors, characteristic of managed care may be problematic if there are pre-existing laws against restrictive pricing practices. For instance, the General Insurance Corporation (GIC) is exempt from the provisions of the Monopoly and Restrictive Trade Practices (MRTP) Act (Government of India 1999h, pp. 5-8). To the extent that preferential treatment for panel doctors associated with HMOs can be interpreted as a form of restrictive trade practice, the MRTP Act would hinder the development of managed care in India, apart from giving GIC an unfair advantage in the insurance market.

Second, insurers in managed care type systems may sacrifice quality of care in exchange for lower costs by empanelling lower quality (and cheaper) doctors and facilities if there is a low level of quality awareness among consumers and if laws against malpractice do not exist or are poorly enforced.[27] One way around this would be regulation that promotes uniform benefits packages and information provision to consumers of care.

Third, if private health insurance leads to increased incomes among private providers of care, it may affect the quality of medical personnel available in public sector facilities, if replacements are not readily available. High returns in the private sector would lead to

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[27] For the generally poor state of the law on malpractice in India, see section below.

their exit from relatively low paying public sector jobs as well as reduce the number of new entrants into public sector jobs and there is some anecdotal evidence that this is already taking place (see Naylor *et al.* 1999, pp.4, 7).

2.2.4. Equity Implications of Private Health Insurance

The entry of private health insurance companies could worsen the distribution of the burden of health care spending for two reasons. First, private companies may find it profitable to undertake risk selection so as to insure low risk individuals and exclude the high risk ones from insurance.[28] This imposes a large financial burden on people who are likely to get sick and most in need of risk protection. In Chile, the ISAPREs (private managed care) insure a disproportionately large number of people in the economically well-off groups, leaving the worst-off to the public insurance system (Baeza 1998). In this sense, private insurance enhances inequity unless there is access to public services of reasonable quality as a last resort. If private insurance and subsequent private care expansion attract doctors and other skilled medical personnel away from public health facilities, it would imply the worsening of the quality of care available to precisely those who are denied this insurance. Second, if entry of private insurance raises the overall costs of health care for reasons discussed previously, patients who cannot afford to buy insurance would have to pay larger out-of-pocket amounts.

As against this, an expansion in private insurance could lead the better-off groups to consume high quality private care, thereby improving access to (somewhat) lower quality public sector facilities for the worse-off groups (see, for example, Besley and Coate 1991; Gertler and Sturm 1997). However, this requires the assumption that a shift out of public care by the rich is not only large but will also leave the magnitude of public expenditures unaffected. In a recent paper we simulated the effect of the spread of private health insurance on the usage of public facilities by the richest 20 per cent in the Indian population. Our main conclusion is that these effects are likely to be very small given that the rich benefit from substantial subsidies provided by the public sector, unless

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[28] Via exclusion conditions, tiered or durational rating (Chollet and Lewis 1997)

the quality differentials between the private and public sectors are very large and private insurance cheap (that is, with low administrative costs) (Mahal 2000b).

Internationally, the empirical evidence favours the view that inequality will worsen with private insurance. A recently completed study of OECD countries found that private insurance as a means of financing health care has fairly large adverse redistributive effects across income groups in countries where it plays a major role, such as the United States and Switzerland (van Doorslaer *et al.* 1999).

From a regulator's standpoint, steps to address inequality enhancing effects of private insurance may include limiting the number of insurance packages offered, together with some controls on prices, or linking the expansion of insurance business to a certain proportion of insurance business being undertaken among backward areas and communities. But this may end up harming the health and subsequent growth of the health insurance industry itself.

2.3. Health Insurance Regulation: Challenges for India

The main lessons from theoretical and empirical literature are essentially the following. In an ideal world with well-informed consumers who can evaluate alternative health care and insurance packages, with proper legal protection and affordable care, private insurance may not be harmful for cost and quality, although its impact could still be adverse from an equity point of view. The previous section also suggests that there are specific things the government could do to yield better outcomes. These include: steps to ensure financial stability of insurers, enhance consumer protection, control risk selection and strengthen legislation complementary to health insurance, such as malpractice law and accreditation. This section focuses on regulation that relates specifically to insurance and compares the standard approach worldwide with the regulatory system in India.[29]

2.3.1 Health Insurance Regulation: "Model" versus the situation in India

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[29] This section relies heavily on Chollet and Lewis (1997) and Tapay (1999).

In line with the preceding discussion, we will focus on the following five topics: (1) Financial requirements (for entry, operation and exit) (2) Consumer protection (3) Risk selection/fairness (underwriting, rating standards) (4) Benefits (5) Regulatory agency: overview. In each case, there is a general description of existing (or recommended) practices in other countries followed by a brief discussion of the relevant regulatory features in India.

Financial Stability

The key issue here is to balance the requirements of financial stability with that of enhanced competition, since very strict financial standards may leave few insurers in the market place and extreme competition of the "cut-throat" variety may lead to financial instability and bankruptcies (see, for example, Ranade and Ahuja 2000).

a. Capital and solvency requirements

The current regulatory practice is for insurers to meet minimum capital requirements *and* surplus (over liabilities) requirements, the latter known as the solvency margin. The first establishes a floor for insurers wishing to enter the market and remaining there. The second takes into account the insurer's size and risk profile. For example, the larger its estimated liabilities, the greater will be the surplus requirement. This is obviously a better indicator of the company's solvency than a system relying solely on some fixed minimum capital requirement.

In the United States, the trend is towards using a "risk-based capital standard" (RBC). The RBC formula takes consideration of possible risks from lower asset values, higher rates of morbidity and mortality, lower interest risk, and other business risks. In the European Union, the "solvency margin" is calculated as the higher of the claims basis (23-26 per cent of average claims in the last 3-7 years) or the premium basis (16-18 per cent of retained premiums).[30] A reduction is allowed for reinsurance, up to a maximum of 50 per cent of the solvency margin (European Community (EC) 1999). The limit on

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[30] Some countries use "gross" premiums to calculate solvency margins. This penalises companies that have reinsurance (Tapay 1999).

using reinsurance for calculating solvency margins is to avoid creating incentives for the insurer to take on more risk.

The Indian regulatory structure under the IRDA Bill has similar features. Under the 1938 Insurance Act, the solvency margin (assets *less* liabilities) was given as a percentage of retained/net premiums (gross premiums less reinsurance payments), of the order of 20 per cent (Government of India 1999d). The IRDA Bill of 1999 provides for a minimum lower bound of Rs. 50 crores for the solvency margin along with a requirement of 20 per cent of net premiums, or 30 per cent of the average of net incurred claims in the three preceding years (Government of India 1999d, p. 28). This is in addition to an entry requirement of a minimum capital of Rs 100 crores.[31] In this sense, many of the provisions of the IRDA Bill parallel the regulatory features of other countries and become even more alike as the regulatory authority acquires greater experience.

As in other countries there are a number of restrictions on the nature of investments that can be undertaken by an insurance company in India and the Insurance Act of 1938 sets these out in more detail in sections 27B and 28B (Government of India 1999d; Tapay 1999). The IRDA Bill also prohibits the investment of funds outside of India (inserted as Section 27C in the Insurance Act of 1938).

b. *Accounting and Auditing*

A second condition has to do with periodic reviews of an insurer's financial condition, including audits, submission of annual reports and so on. In the United States, insurance regulators have broad powers of changing the management and financial practices should the need arise (Chollet and Lewis, p.88). Establishing and evaluating the solvency status of an insurer requires a uniform set of accounting procedures and methods by which contracts issued by an insurer can be translated into assets and liabilities.

Under the Insurance Act of 1938 and the IRDA Bill the controller of insurance (now the Insurance Regulatory Development Authority) has wide powers just as in the United

States and elsewhere. These include auditing by qualified actuaries, periodic submission of reports, appointing directors or taking over management, requesting information and even shutting down the operations of the insurance company through a court order (Government of India 1999d,e).

c. Organisationsal restrictions

In many countries, insurers cannot undertake additional business that is not directly linked to insurance as, for example, banking. The main regulatory concern is that insolvency of one business may cause the insolvency of the other (Chollet and Lewis, 1997). An argument against this restriction is that given banks, insurance companies and stock markets essentially are markets that deal with risk, an artificial separation may neither be desirable in the interests of efficiency, nor feasible (Ranade and Ahuja, 2000). Restrictions may also include specifying some desirable citizenship or residency status, ownership in the insurance company, and experience with similar business elsewhere (see also EC 1999, p.6). Similar restrictions can be found in the Insurance Act, 1938, although there is no linkage to any specific industry or sector (Government of India 1999c).

d. Exit and Guaranty Fund

Exit rules are to ensure orderly exits from the market. The insurer who plans to leave the industry may have to give a timely notice to the regulator and submit plans for payment of all liabilities prior to the exit date. In the event of company insolvency, the practice often is that *all insurers* participate (contribute to) in the formation of a guaranty fund. The means of participation could be taxes on insurance premiums of the insurers. Generally, the fund does not pay out the full liabilities but only some portion of it to the insured. This is to address any problems of moral hazard on the part of insurers. While there is extensive discussion of liquidation of a company (voluntary or court

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[31] There is a 50 per cent upper limit on the amount of reinsurance that can be used to calculate net premiums for calculations of the solvency margin, just as in the European Community (GOI, 1999d).

ordered) under the Insurance Act of 1938, there is no mention of a guaranty fund under Indian law.[32]

Consumer Protection by the Regulatory Agency

Generally, insurance regulation with regard to consumer protection revolves around (a) the marketing and language of insurance contracts; and (b) the relationship between insurers and providers.

a. Marketing and language of insurance contracts

This category covers the language of insurance contracts so that it is easy to understand along with the terms used – benefits package, premium rate, deductibles, and so on. It also includes regulation relating to unfair trade practices, such as misrepresentation, discrimination, inducements, and failure to maintain records. Moreover, qualifications of insurance agents and their mode of functioning may also fall in this category. Tapay (1999) documents a case where the United States government prohibited agents from specifically looking for healthy patients to enroll.

The Insurance Act of 1938 addresses directly only two concerns relating to consumer protection. It does so first by detailing the procedure by which insurance agents are licensed including the requirement that they have not been previously convicted of "...criminal breach of trust, or cheating or forgery..." or of participating in "...fraud, dishonesty, or misrepresentation..." (Government of India 1999d, p. 62). Second, it imposes limitations on commissions that agents can be given or the incentives they can offer to clients while selling insurance (Government of India 1999d, pp.56-60). The IRDA Bill gives authority to the regulator to specify a code of conduct for agents but no further specifics are provided. It also allows for a tariff advisory committee to oversee premium rates, insurance plans and to prevent discrimination (Government of India 1999c, p. 9).

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[32] However, there appears to be some discussion about the setting up a guarantee fund in the IRDA (communication with T. Raghavan, *Business Standard*).

There is additional legislation that addresses consumer protection more forcefully. Indian consumers also have access to consumer courts under the Consumer Protection Act of 1986, protections under contract and tort law in the Code for Civil Procedure, and the Arbitration and Conciliation Act of 1996, but suffer from poor enforcement.

b. Relationship between insurers and providers

The primary objective of regulating this relation is to ensure that health care providers remain professionally independent of the insurers in a managed care system and not under undue pressure to avoid recommending expensive treatments. In the United States, regulations permit any provider to join a plan if he accepts its payment conditions, and also allows him to work with patients outside their plan (the provider cannot be locked in by managed care organisations).

Unfortunately, consumer protection laws in India have little to say on the relationship between the insurer and the provider. It may be that some of the practices described above could potentially fall into some version of "unfair trade practices" which belong in the realm of the Monopoly and Restrictive Trade Practices (MRTP) Act (Government of India 1999h). At the present time, there is no case law to support or dispute this assertion. The bulk of the existing case law deals with fraudulent claims or delays in clearing claims by the insurer (see, for example, Aggarwal and Chaudhri 1998).

Risk Selection/Fairness

Regulation in this area has taken two main forms in the United States: (a) restriction of underwriting/risk selection; and (b) restriction on prices based on health status.

a. Underwriting restrictions

These restrictions may involve a *guaranteed issue* of certain plans (or all plans) to all applicants, without regard to their risk profile. A variation on this may be *guaranteed renewal* where the insurer can underwrite applicants at the time of first issue but not on subsequent renewals. In case only a few select plans are subject to this restriction it will

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be the case that these plans will become much more expensive, if the risk composition of the plan determines its price. Of course, if all plans were subject to this restriction there would be the problem of adverse selection. Ways to get around this would be the exclusion of "pre-existing" conditions, or having open enrollment only at certain times of the year.

A variation of the restrictions noted in the previous paragraph is the *portability requirement*. These are often used along with pre-existing exclusion restrictions. For example, as long as a reasonable continuity is maintained in coverage a second insurer cannot impose a pre-existing exclusion on a person who has already exhausted a similar exclusion with another insurer. Other restrictions could relate to insurer requests for medical history, application forms for insurance coverage, and so on.

b. Community rating and rate review

Community rating is the requirement that premiums be based on some broad geographic or demographic criterion rather than on individual health status. This is likely to be somewhat inefficient since it involves a degree of cross-subsidy across participants.

Another approach to this is controlling the premium rates directly by requiring government approval for rate levels and increases. The normal method to do this is by examining "loss ratios" – the proportion of claims to premium income -- and putting a bound on them.[33]

By restricting risk selection, the expectation is that insurers will compete in quality and prices. However, this may be particularly problematic in countries newly opened to the private insurance sector, as problems of adverse selection could overwhelm the small number of companies who first enter the market. As in the previous section, there is currently no legislation in India that has specifics on underwriting restrictions. However, a tariff advisory committee and the IRDA have the power to issue guidelines relating to

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[33] A number of states in the U.S. have loss-ratio restrictions (Chollet and Lewis 1997).

non-discrimination and the "...control and regulation of rates, advantages, terms and conditions..." (Government of India 1999c, p. 9; Government of India 1999d).

Benefits

With regard to benefit packages there are two issues of interest: (a) a minimum package of services available to everyone; and (b) catastrophic insurance.

a. Uniform minimum benefits package

Given a uniform minimum benefits package that is accessible to all applicants, insurance companies would have a tendency to offer additional products to appeal to low risk applicants, or indulge in underwriting. Both options would increase costs and promote inequity – the latter by way of higher administration costs as well as increased premiums for the relatively more risky, and the former in terms of higher premiums for the sick. Thus, it would seem that the regulation on benefits package ought to accompany some sort of market "managing" regulation in the sense of Einthoven (1997) or Medici et al. (1997) that creates large buyers in the insurance market. The presence of large buyers could help enforce rules among insurers, in exchange for the volume of business they can bring. Examples of this are the social insurance schemes of the type in Netherlands and Israel (Chinitz 1995; West 1997; Ham 1997). In each case, a (uniform) basic package of services is provided by a set of sickness funds with compulsory enrolment in at least one of them. Funds from a central source follow the individual and there is some risk-adjusted capitation payment to curtail risk selection. As a consequence, there is increased likelihood of competition in quality and less of risk selection.

b. Catastrophic insurance and emergency care

These can only be covered through reinsurance of various kinds in view of the rarity with which they occur. Unfortunately, in developing countries, private reinsurance is typically difficult to obtain because of the poor quality of actuarial data on rare events (Chollet and Lewis 1997, p.94). Reinsurance could be promoted in the form of more relaxed solvency margin requirements as in the European Community.

There is no legislation in India relating to benefits packages of either type. The only pertinent statement is in the Insurance Act of 1938 stating that the Tariff Advisory Committee (and the Insurance Regulatory and Development Authority under the IRDA Bill will oversee rates, benefits and other activities of insurers. The IRDA Bill, however, allows both the entry of re-insurers in the Indian insurance market and relaxed solvency margin requirements (Government of India 1999c).

Regulatory Authority: Overview

There are two issues of relevance here: (a) What are the main functions of this authority? (Who does what?) (b) How will the authority be funded?

a. Main functions

The two main functions relate to market standards (including consumer protection) and to overseeing solvency and financial regulation. In the United States, the states have the primary responsibility for regulating insurance, including solvency and financial standards. In the European Union, supervisors in each country enforce country-specific market standards, but the financial standards are similar for all EU countries (Tapay 1999).

b. Funding

Funding could be obtained from sources such as a premium tax (about 2 per cent of annual premiums in the United States), allocation from general funds to the insurance department, a "dedicated funding system" whereby fees, fines and other income generated by it are placed in a separate fund.[34]

Unlike the previous two sections, the Insurance Act of 1938 and the IRDA Bill of 1999 have much to say on the nature and functions of the regulatory authority. In some cases, the authority is wielded directly by the so-called "controller of insurance" or the IRDA. In other cases, it is committees predominantly composed of insurers and headed by the controller. For details see Government of India (1999c,d). As per the Indian

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[34] In 1997, premium volume in life and health insurance was US$340 billion.

Constitution, the authority to regulate insurance is centralised in the IRDA and the central government, with little control by Indian states.[35] As to funding, the IRDA has the authority to levy fees or other charges to carry out its functions and can have access to grants from the central government.

The general picture that emerges is that legislation (existing and proposed) concerning health insurance in India is fairly comprehensive even in comparison to a model set of regulations when focusing on auditing, financial controls, investment guidelines and licensing regulations. There is much less regulatory focus, however, on the consumer of insurance products and on overall goals of health policy in the form of regulation that curbs risk selection, protects consumers, promotes HMOs and the like. To be sure, both the Insurance Act of 1938 and the IRDA Bill are sufficiently comprehensive (ambiguous!) to allow increased focus on these issues, yet problems remain. For instance, regulating the relationships between insurers and providers or controlling rates could have implications under the Monopoly and Restrictive Trade Practices (MRTP) Act and that is parliamentary legislation over which IRDA has no control.

2.4. Conclusion

In sum, the entry of private health insurance could have adverse implications for some of the goals of health policy, especially equity in the financial implications of ill health, and possibly costs of care. However, an informed consumer and a well-defined and implemented insurance regulation regime might be able to address some of the problems. There are areas where regulation with regard to health insurance would be clearly useful -- in instituting benefit packages, restrictions on risk-selection procedures, and addressing aspects of consumer protection.

Addressing these issues, however, requires meeting at least the following challenges. The first is the issue of enforcement of regulation. Even Consumer Protection Act of 1986 (COPRA) that was meant to address the rights of consumers through the establishment of special consumer courts has suffered from delays of various kinds (Bhat

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[35] Items 43 and 47 (Union list) of Schedule VII of the Indian Constitution (Government of India 1996).

1996a, *Hindu* 1999). There is, therefore, no reason *a priori* to expect that health insurance regulation enforcement would do any better. To be sure, as an independent regulator, the Insurance Regulatory and Development Authority (IRDA) would have much greater leeway in implementing its own guidelines – but the recent experience with a similar entity, the Telecommunications Regulatory Authority of India (TRAI), suggests that this is by no means certain.

Second, it is also the case that some of the regulatory changes envisaged in health insurance also appear to require, as a necessary condition, additional changes in the existing publicly financed and provided care. In particular, for uniform benefit packages to work and for competition to kick in among insurance companies, large buyer groups may have to be created on the pattern of the United States and various European countries. For a start, such buyer groups may have to be formed out of existing publicly operated schemes, such as the Central Government Health Scheme (CGHS) and the Employees State Insurance Corporation (ESIC). Both, unfortunately, fall out of the regulatory ambit of the IRDA.

Third, in so far as legislation on quality standards in health care provision is concerned, the IRDA faces an even greater challenge since many of the laws and their implementation are in the hands of individual states as a constitutional requirement. Moreover, all evidence indicates that these are incomplete in scope, poorly designed, and hardly ever implemented. This makes the design of insurance policy more difficult and suggests taking a comprehensive and long-term look at issues of health insurance and care provision in India.

It may be some time before these regulatory challenges can be met. The actual magnitude of these effects may well depend on the size of the insurance market that emerges and we believe that to be small. We estimate this market size to be INR 24 to 40 billion in terms of annual premium income in 1995-96 (Mahal 2000b). Even at twenty-four to forty times the existing magnitude of GIC business at the time, it amounts to only about 6 per cent of the then prevailing national levels of health spending.

Table 9.4. Administrative costs of operating health insurance programmes: a comparison of private and public insurers, selected countries

	Costs of administering insurance (as per cent of expenditures)	
Country	**Private**	**Public**
Chile	18.5	1.8
Sweden	n.a.	1.5-5.0
United Kingdom	n.a.	10.0 (GP fundholdings)
United States	5.5-40.0	2.1 (medicare)
India	20.0-32.0	5.0-14.6

Notes: For the United States, the range in the private sector reflects low costs for group insurance to high costs for individual insurance. For India the range in the private insurance represents the different experiences of the four subsidiaries of the General Insurance Corporation (GIC). For public sector insurance in India the lower bound for the range are the costs of CGHS and the upper bound for ESIS (Garg 1999). For Sweden, the range reflects public schemes operating in city councils and private doctors. GP = general practitioner.

Sources: Chile (Baeza 1998, Ferreiro 1999); India (Garg 1999b; communication with Anurag Kaul (New India Assurance Company)); Sweden (Rehnberg 1997); United States (Rehnberg 1997); United Kingdom (West 1997).

Table 9.5. Health spending per capita and private insurance coverage: cross-country regressions

	Dependent variable: Log health spending per capita (US$)			
Regressors	**(1)**	**(2)**	**(3)**	**(4)**
Constant	3.86 (0.35)	-5.02 (0.48)	-4.83 (0.48)	-4.83 (0.46)
Private health insurance coverage (% of population)	0.08 (0.01)		0.007 (0.004)	0.007 (0.005)
Log of per capita income (US$)		1.27 (0.06)	1.24 (0.06)	1.23 (0.06)
Dummy for type of private health insurance				-0.005 (0.180)
Sample size	31	31	31	31
R-squared	0.42	0.93	0.94	0.94

Notes: Robust standard errors reported in parentheses.

Type of private insurance: 1 for countries where private insurance is offered as an alternative to social insurance or public scheme; 0 for countries where private health insurance can only be offered as a supplement to a public insurance scheme.

Countries included in sample: Australia, Germany, Ireland, Netherlands, United Kingdom, United States (OECD); Argentina, Brazil, Chile, Colombia, Dominican Republic, Ecuador, Gautemala, Jamaica, Honduras, Mexico, Peru, Uruguay (Latin America and the Caribbean); Ivory Coast, Egypt, Jordan, Kenya, South Africa, Zimbabwe (Africa and the Middle East); India, Indonesia, Philippines, Sri Lanka, Thailand (Asia); and the Czech Republic.

Sources of Data: Chollet and Lewis (1997); World Bank (1997).

3. Lessons from the International Experience with Health System Reform

3.1. Introduction

Section 2 highlighted the potential consequences of the entry of private health insurance for the Indian health system. The main conclusions findings were first that the entry of private health insurance sector may not necessarily have large cost-increasing effects in the health sector, especially if appropriate regulatory structures were in place and enforced. The example of the United States notwithstanding, the international evidence on the association between costs of health care and private health insurance appears to be weak. A worrying factor, of course, was the generally poor state of the regulatory structure pertaining to the health sector in India. Second, it is unlikely that the entry of private health insurance would significantly worsen quality, although there is no reason to believe that it would lead to improved care. Needed is improved regulation and the implementation of regulation related to providers and medical technology – be it to fill in regulatory gaps related to medical infrastructure, continuing education, better implementation of regulation relating to accreditation, drug use or malpractice law. Of course, private health insurance may reduce the quality of medical personnel available to people who continue to use public services, if returns to private practice increase which can lead to an exodus of experienced medical personnel from the public sector.

Whether the equity worsening effects of the private insurance sector will be large, or small, depends very much on the size of the private health insurance sector and the continued presence of subsidized public facilities. If public expenditures continue to remain large, we would likely see large-scale selection by insurance companies in favor of healthier groups, as in Chile, followed by a reverting back of the sicker groups towards "universally" accessible public facilities. In this sense, the most visible short-term result of private health insurance entry would be little or no change in the public sector's burden of care, and pressures by the younger and healthier groups to reduce their contributions to public services. Coupled with departures of medical personnel, this would signal both a decline in quality and given competing fiscal demands on the government, a reduced role for the government. If so, private health insurance would have a long-run effect towards worsening inequalities in the burden of health spending. If the response is increased government spending (to counteract the declining contribution of younger members of the population) to address the needs of the sick and the poor, then the impact of private health insurance would have been to increase the financial burden on the government. It is, therefore, not surprising to see that countries with national level insurance systems have imposed various restrictions on plans offered by private insurers (e.g., Canada and the United Kingdom), or on people who leave the public system (e.g., Germany).

If, as we assess, private health insurance is unable to promote the major goals of health policy, it may be worthwhile to consider other ways to address problems with high costs, equity and quality of care. In this section we consider four such possibilities (health systems) and examine their functioning for outcomes of interest to Indian policy makers. These four cases are presented in the form of country experiences. These are as follows: (1) The United Kingdom (National Health Service) (2) Netherlands/Israel/Germany (Social Insurance) (3) Canada ("National" Health Insurance) (4) Singapore (Compulsory Insurance/Fee for Service/Medical savings)

3.2. Reasons for selecting these country experiences?

The main reason for considering these four cases is that they cover possibly the widest range of possibilities that can be analysed, given country experiences. Moreover, these examples serve to highlight different aspects of the Indian health system, which consists of a mix of private insurance supported care, tax-funded public services, wage-linked contribution schemes, and out-of-pocket payments to providers.

The *United Kingdom* offers a model of a system that is primarily centrally-funded by general revenues (along with some wage-linked payments) and one where, prior to the health reform of the 1990s), provision of care was an integral part of the functions of the government in the health sector. A major set of problems with the system in the United Kingdom, prior to the reform phase, was the existence of long waiting times for "non-urgent" hospital treatment, substantial variation in performance across regions, and a perception of non-responsiveness towards patient's needs (Chernichovsky 1995; Ham 1997). The same, although perhaps to a much greater degree, can be said of public health services accessed by the Indian population. *Canada* has a framework similar to the United Kingdom in terms of financing, but differs in the way fees for health care are set and the choices that consumers are able to exercise among providers. In the net, it offers interesting insights into ways to contain health care costs without sacrificing patient satisfaction.

Netherlands, *Israel* and *Germany* offer examples of health care systems that are built around compulsory wage-linked contributions into a fund (or funds) to be used for purchasing health care, or more precisely, purchasing health care insurance from competing insurers. These compulsory wage-linked contributions and the idea of an "insurance fund" have much in common with the Employees' State Insurance Scheme (ESIS) that currently operates in India (see Table 9.5). One similarity is in terms of the population covered. According to the most recent estimates, there are about 35 million beneficiaries under ESIS, more than double the population of Netherlands, and about 40 per cent of the population of Germany (Garg 1999b, World Bank 1997). ESIS also shares a feature, common to Germany and Netherlands (but not to Israel), where only employees earning below a certain level of income are required to join (Schwartz and Busse 1997; van de Ven 1997; Government of Israel 1999; Table 9.4). The ESIS is distinguished from the systems in these countries in two significant ways. First, it comprises an extremely small segment of the Indian population (about 3 per cent), compared to coverage rates ranging from 65 per cent to 96 per cent of total population in Germany, Israel and the Netherlands (Schwartz and Busse 1997; Government of Israel 1999; Government of Netherlands 1998). Second, health care under the ESIS is provided in-house – either at its own hospitals and care centres, or at public facilities, which is generally not the case for Netherlands and Germany, and for three out of four Israeli sickness funds. Given that there is much dissatisfaction with ESIS funded health services (Wadhawan 1987), there is the possibility of learning from the experiences of these three countries in terms of efficiency improvements, patient satisfaction and quality of care.

Singapore offers an example of how an "individually" oriented system that seeks to address the need for universal access, a high degree of choice with regard to providers, and a desire for cost containment might turn out. The central element of the Singapore model is an individual medical savings account (along with a catastrophic insurance scheme) to which working individuals contribute, and can be used to pay for their own inpatient care and expensive outpatient services (The Harvard Team 2000). The Singapore model, with its compulsory medical savings accounts, is relevant for India primarily because it is a relatively unique idea, echoes of which can be seen in the report on Old Age Social and Income Security (OASIS) recently presented to the Indian Ministry of Social Justice and Empowerment (Expert Committee 2000). The OASIS report suggests that such a scheme can be quite effective in meeting the social security needs of segments of the population living in far-flung and rural areas of India, and those who do not have regular incomes.

3.3. Country Experiences

The next four sections provide case studies of the four sets of country health systems.

3.3.1. United Kingdom

The United Kingdom provides an example of a system which, until 1990, was centrally funded and had its own network of services. Nearly ninety per cent of the public health expenditure was supported by general revenues, and the remainder by social insurance contributions (The Harvard Team 2000). Hospital and community services were under the control of the government and a network of General Practitioners (GPs) provided basic care on a capitation fee system. Private insurance was available but could only insure services not covered by the National Health Service (NHS) (Kutzin 1998). The system provided care at a much lower cost, taken as the ratio of health expenditures to GDP, compared to other OECD countries, yielding health outcomes in terms of life expectancy and infant mortality rates that were among the best in the world (see, for example, World Bank 1993). But there were concerns about long waiting lists for non-priority care, non-responsiveness to patients and variation in quality, that prompted a review of the system under the Thatcher government (Ham 1997).

Following a review of the National Health Services (NHS) ordered by the Thatcher government in the late 1980s, reforms in the NHS were approved by the British parliament in 1991. These reforms (compared to the pre-existing system) consisted of the following key elements:

1. *Financing (sources):* The basic structure of the sources of financing was left untouched. That is, general revenues continued to be the main source of funding for health services in the United Kingdom.
2. *Financing (allocation):* The method by which funding was allocated by the government was, however, changed in two ways: First, overall funding was distributed among district level health authorities in relation to the population in their area, after adjusting for age, sex and other health relevant factors. This was different from the previous method, where the allocation was based on services provided, irrespective of the residence of patients. The best way in which this could be replicated in the Indian context could be, instead of the central government providing funds to the All India Institute of Medical Sciences on the basis of the number of patients served, the same amount of funding could be distributed across Indian states, based on the population. The same argument would, of course, hold good for state level funding of hospitals in state capitals. Second, the district health authorities had to compete for funds, in a limited manner, with organizations of general practitioners (GP fund-holdings).[36] GP fund-holdings are essentially groups of practitioners who take responsibility for providing a range of services for patients enrolled with them in return for command over a budgeted amount given in advance depending upon the number of patients enrolled. These services typically include both those services traditionally provided by GPs but also hospital-based inpatient care. Starting initially with a limited set of services, some GP groups have been provided the entire budget

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[36] In the sense that funds given to GP fund-holdings were deducted from the budgets of the district health authorities (Ham 1997).

for the enrollees. Any amount left over at the end of the year in these funds could be kept by GPs. The setting up of GP fund-holdings was a voluntary exercise and a change from their previous function as a provider of GP services for a capitation payment.

3. *Separation of financing and provision in the NHS:* A third pillar of reform was the separation of the financing function of the NHS from that of providing services. Hospitals and community services that were previously under the control of the public health authorities were now spun off as semi-independent trusts, which now had to compete with each other and with private sector health institutions for government funds, whether allocated through district health authorities, or through GP fund-holders.

In theory, the reforms would have the following effects. By basing the allocation of central funds to districts on population-based measures, one impact would be the development of facilities and services closer to the people who need them. This should, all else the same, increase the efficiency of health spending and the level of patient satisfaction. Second, separating funding from provision by district health authorities, should ideally lead to a prioritization of scarce resources in line with the interests of the population in their districts, instead of being governed by provider interests.[37] This tendency would also be promoted by the competition for funding from GP-associations. Third, giving GPs control over the budget for inpatient care of patients would have the effect of a better control over (rationalization of) referrals to higher order facilities, and presumably, increased provision of primary services by GPs. There was the danger, of course, of GPs providing inadequate levels of care given the incentive of being able to keep the surpluses out of fund-holdings, or selecting better risks. This, however, was potentially addressed through regulating the purposes for which surplus funds could be used. Fourth, by promoting competition among providers, both NHS Trusts and private, the reforms would have the effect of increasing efficiency among the former public providers (reducing costs) and making them much more responsive to patients' needs. Finally, apart from the reasons mentioned above, patient satisfaction could be enhanced

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[37] Ham (1997) refers to this as "provider capture".

by the possibility of exercising choice with regard to inpatient care that might result from enhanced provider competition.

Given the short period that has elapsed since the introduction of reforms, it has proved difficult to provide anything more than qualitative evaluation of their effects. However, a few broad contours appear to be emerging. First, the changing rules for allocation of funds has affected the location of facilities in the expected direction – with declining numbers of facilities and consolidation in London and increased numbers in surrounding areas, presumably lowering the costs of service provision as well (Ham 1997). Second, there is some evidence of health authorities setting budgetary priorities and the types of health services needed, in consultation with GPs. Third, GPs have increasingly sought to provide a broader class of services, both primary and specialist care, at their clinics than they had previously done reflecting their concern for increased cost efficiency. Thus far there is little evidence of risk selection by them, although recent reforms have sought to prevent this by greatly increasing the membership of fund-holdings (The Harvard Team 2000). The evidence on greater patient choice among providers as a result of the reform is mixed. GP fund-holdings appear to have been much more responsive to patient needs compared to NHS trusts that have benefited from block contracts with district health authorities. On the other hand, there is some concern that increased contractual requirements and multiple contracts that have to be negotiated between different buyers and sellers of care has increased administrative burdens and costs (Ham 1997).

3.3.2. Germany/Israel/Netherlands

Unlike the United Kingdom, these three countries have a health system explicitly built round contributions to different competing insurers/sickness funds. In all three countries, coverage by these insurance funds is "compulsory", although the extent of coverage varies. For example, all residents of Israel must, per force, be enrolled in the national insurance scheme. Currently, 96 per cent of the Israeli population is covered (Government of Israel 1999). In Germany, the scheme allows the self-employed, and people above a certain income level to opt out – currently about 88 per cent of the population is covered under this scheme – 75 per cent compulsorily and 13 per cent voluntarily. The rest obtain private health insurance. The Dutch scheme is similar to the German in that it excludes the self-employed, people earning above a certain income level, and government officials. As a consequence, about 64 per cent of the population is covered, with the rest enrolled in private insurance or in government schemes. However, there is a compulsory element – catastrophic insurance is necessary for everyone, and contributions for this purpose are paid into a national fund (Government of Netherlands 1998; van de Ven 1997).

A key element of the health systems in three countries is the presence of multiple competing insurers. The precise format by which the contributions are paid to the insurers/sickness funds varies across these countries. In the case of Netherlands and Israel, employees and employers contribute directly into a central fund (Government of Israel 1999; Government of Netherlands 1998).[38] Then, depending on which sickness fund an individual chooses to enroll in, an amount is transferred from the central fund to the insurer on a risk-adjusted basis. Unlike Israel, however, Netherlands allows insurers to charge a flat rate premium from enrollees, constrained to be the same for all enrollees, which they can vary at their discretion (van de Ven 1997). In Germany, contributions are paid directly by individuals (and their employers) to the sickness funds by the enrollees. Until recently, there was little competition among the different insurers; of late, several national level sickness funds have begun competing with regional sickness funds (Schwartz and Busse 1997). The rate of contribution depends on projected expenditures and a balanced budget requirement, and varied between 9 per cent and 15 per cent in 1996 (Schwartz and Busse 1997; Chinitz, Preker and Wasem 1998). In the Netherlands, there are limited co-payments for certain types of care and drug expenses, subject to an upper limit -- in 1998, the co-payment was 20 per cent for certain classes of medical expenses, and subject to an annual limit of 200 NLG (dutch guilders). There was also a 20 per cent co-payment for drugs relative to a defined "reference price" (Government of

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[38] Wage and salary earners (and their employers) pay a proportion of their earnings up to an upper limit, whereas pension earners and the self-employed pay a "small" proportion of their pension earnings. A contributor can choose any of the four sick funds, which gets a risk-adjusted premium from the national insurance fund. All sick funds are obliged to offer a fairly comprehensive basic minimum service package. Furthermore, no price competition over the basic package is allowed (Government of Israel 1999).

Netherlands 1998).[39] In Germany too, there is a very limited co-payment for inpatient days of stay and a reference pricing based cost-sharing arrangement for drugs (Kutzin 1998).[40]

In all three countries, the basic package of services that the insurers have to provide to enrollees is pre-determined by the government.[41] However, the field over which the insurers can compete for enrollees varies across the three countries. Competition among insurers in Israel is guided solely on the basis of quality, with little scope for price competition over the basic package. Moreover, the number of sickness funds is fixed at four with no prospect of entry for others into the compulsory scheme. In the Netherlands, both quality and price competition is possible, owing to the existence of the flat rate premium that companies can charge to enrollees with respect to the basic package. It is also relatively easy for new firms to enter the sickness fund industry in the Netherlands, including for existing firms to provide services in regions where they do not currently operate. In Germany, for a long time, there was limited competition among sickness funds/insurers, many of which had only a local reach. More recently, competition has heated up with the increasing spread of national level sickness funds. Competition can be over both price and quality since the contribution rates depend on expected expenditures and a balanced budget requirement. Moreover, in all these countries insurers (including private insurers) can offer supplementary packages, available for voluntary purchase to their enrollees, at prices determined by the insurer.[42] This leads to a third possible arena over which insurers can compete.

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[39] By a reference price is meant the government-specified price for a class of drugs.

[40] There are, however, restrictions on pharmaceutical purchase.

[41] In the *Netherlands* these include medical and surgical treatment, obstetric care, limited dental care, pharmaceutical services, inpatient stays, aids and appliances, transport, maternity care, genetic testing, haemodialysis, rehabilitation, thrombosis prevention services and audiological services (Government of Netherlands 1998, pp.23-5). In *Israel*, these are medical diagnosis and treatment, preventive medicine, health education, inpatient care, surgery, transplants, limited dental care, transportation, medical services at the workplace, treatment for drug use and alcoholism, obstetrics and fertility treatment, medicines, and physiotherapy (Government of Israel 1999). Schemes in *Germany* include, in addition to these, cash benefits for sickness.

[42] In Israel, private insurers can offer a full package (including the basic one) (Kelter 1998).

Competition among insurers is only one element of these health care systems. A second key element, much in the mould of the reforms in National Health Services in the United Kingdom, is a focus on contractual relationships between providers and insurers, with an eye on provider competition. The objective of enhanced competition among physicians was explicitly pursued by the government of Netherlands, which in 1992 scrapped a law requiring insurers to compulsorily have contracts with all physicians in their region of operation. No such flexibility is currently available in the case of hospitals and rehabilitation centres, whose budgets insurers are obliged to fund. The size of the budget of these institutions is, however, fixed in consultation with insurer organisations. In Israel, the largest sickness fund owns its own provider facilities. By contrast, the other three sickness funds typically enter into contractual relationships with physicians and hospitals. Even this, however, ought to have an influence on the quality of services in the remaining sickness fund, if provider competition leads to better quality services by the other funds. Finally, in Germany the services are provided after a process of negotiation between provider associations and sickness funds. Till July 1998, the procedure was for sickness fund associations and physician associations to agree on a maximum budgeted amount, which was then allocated to individual physician members based on usage, and which could serve as a source of provider competition. Hospital budgets were similarly agreed upon with individual hospitals. However, after that period, these have been replaced by a fee schedule and a "target" volume of services (essentially a soft budget constraint). In each of these cases patients have a fairly substantial degree of choice across providers.

It is also worth noting that both the German and the Dutch governments have relied on various sorts of restrictions on prices charged by providers. During 1982-92 in the Netherlands, the governments specified a schedule of prices to be charged by providers, later dropped in the reforms (van de Ven 1997). Similarly, apart from directly specifying prices for specific types of hospital services, or the maximum budget size that could be negotiated for ambulatory care, the German government has, from time to time, stepped in if the provider organisations insisted on higher than "normal" amounts in their negotiations (Schwartz and Busse 1997).

As formulated, what are the likely implications of this structure for policy objectives of interest – such as cost of care, quality and equity? Competition among insurers for enrollees would suggest they would try to be responsive to consumers, in the sense of providing the best possible quality of service, both personal and technical, and at the least possible cost, given quality. Competition among insurers is promoted by five features of the system – multiple insurers, fixed package of basic services, people being able to choose which insurer to enrol with, funds following the enrollee in a capitation fee arrangement, and voluntary supplementary insurance.[43] Moreover, having enrolled, the fact that there is also substantial choice for patients among providers, means that in a regime where insurers contract with providers, patient choice of provider can determine whether or not an insurer contracts with that particular provider. Thus one might expect better service provision by providers. Finally, provider-insurer contracts that are based either on capitation fees and/or on prospective budgets would address concerns on cost-containment, apart from the fact that large insurers can obtain better deals from providers. In the Netherlands, with few exceptions, insurers are prohibited from providing health services directly (Government of Netherlands 1998, p.32). In sum, one might expect enhanced cost-containment, greater cost-effectiveness, and improved quality of care.

A key concern in these systems has to do with the possibility of risk-selection by competing insurers/sickness funds, much as in a setting with only private insurers. This problem is not overcome simply by mandating an insurer to enroll everyone who applies, or to have a uniform basic benefits package for all applicants. Such measures fail as long as the insurers have some method of being able to select – by choice of the contents and prices of the voluntary package, for example. In principle, risk-adjusted payments ought to be able to address this problem.[44] However, the situation could be problematic in the Netherlands and Israel if the risk-adjusted payments by the central funds are

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[43] Beginning 1996, the last majority of compulsory insurees in Germany can switch among 15 of the largest insurance funds on an annual basis (Chinitz, Preker and Wasem 1998; Schwartz and Busse 1997); in the Netherlands and Israel, switching is allowed among all registered funds once each year (Government of Netherlands 1998, p.23; Government of Israel 1999);

[44] Risk-adjusted payments in Netherlands currently account for gender, age, region and disability (van de Ven 1997); and in Israel for age (Chinitz 1995).

somehow unable to capture reasonably well the variation in costs of care across patients. In Germany, this could happen by regional or national sickness funds focusing on healthy patients, and by offering lower contribution rates to such patients.[45]

If risk-selection were common, this would have implications for the administrative costs of running the insurance schemes, and hence the overall costs of the health system. In each of these countries, the government has set up mechanisms to address this problem. In the Netherlands, the government uses two types of financial "adjustment" mechanisms to address this problem. First, at the end of each financial year, the budgeted amounts are adjusted across insurers so that those with higher costs in relation to budgets receive more – that is, resources move from funds with an "above-average budget balance to ...funds with a below-average budget balance." (Government of Netherlands 1998, p.30). Second, differences between costs and budgeted amounts for insurance funds are made up directly through payments from the central fund operated by the government. The payments under these two methods currently account for as much as 97 per cent of the gap between expenditures and budgets of individual insurance funds, so that there is hardly any incentive for the gains from insurer competition envisaged earlier! (van de Ven 1997).

In Germany, there was considerable variation in contribution rates across sickness funds – and funds with wealthier and healthier enrollees with much lower contribution rates. Beginning in the mid-1990s, however, regulatory mechanisms have been set in place so that the funds' revenues are adjusted according to age, sex, income, or whether enrollees received an invalidity pension (Chinitz, Preker and Wasem 1998; Schwartz and Busse 1997). In Israel, it is unclear how this problem would be addressed beyond making enrolment by sickness funds compulsory, since the risk-adjustment mechanism only includes age. Chinitz seems to suggest that this would be done mainly through the government budget (Chintz 1995).

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[45] Enrolment of healthier and younger populations would imply lower health costs per enrollee, and hence the strategy would be self-fulfilling.

One might expect the compulsory nature of the schemes and the contribution into a common fund at constant proportion of income to promote greater equity in terms of the financial burden of care as well, although some caution is in order. First, there are upper bounds on the amount of contributions that are to be made under the central fund/individual insurance funds. In the case of the Netherlands and Germany, these take the form of opt-out clauses for people with income above a certain threshold (Government of Netherlands 1998; Schwartz and Busse 1997). In Israel, the highest payment is explicitly set – at the specified *percentage contribution multiplied by four times the average wage* in the country (Government of Israel 1999). The fact that contributions are non-decreasing in income is desirable from the point of view of equity, but the limits and opt-out clauses allow some scope for inequity.

In each of the three countries, the experiences with some of the features of health systems are much too recent to permit a comprehensive analysis of their effects. Some indicative evidence is available, however. According to one expert, following the partial Dutch health reforms in the early 1990s, there was substantial internal reform within sickness funds. These included longer hours of service by the funds (including mobile offices), electronic data systems, developing different systems for delivery of drugs (mail-order), and replacement of administrative oriented heads of institutions by more entrepreneurial ones. In their dealings with providers, sickness funds were able to break down some of the seller-cartels and thereby reduce provider charges by substantial amounts. Moreover, providers themselves seem to be focusing more on quality cost-effectiveness – one indictor being the increasing introduction and use of cost-accounting procedures in health care institutions. Indeed, better information about costs is probably the first step in such an exercise (van de Ven 1997, p.93). There is also some evidence that the Israeli system, particularly after 1995, has promoted greater equity in terms of the burden of health spending.

In addition to the qualitative evidence, we can also compare national level information in these three countries with other developed nations that do not primarily rely on a social insurance system. According to the most recent statistics available health expenditures in

Germany, Israel and the Netherlands, taken as a share of GDP, were about 9.6 per cent, 7.7 per cent and 8.8 per cent, respectively. By contrast, Switzerland and the United States, which rely a lot more on private insurance, spent 9.6 per cent and 14.5 per cent of their GDP, respectively, on health. Countries, such as Canada and the United Kingdom, which use general revenues to fund their health care spent about 9.5 per cent and 6.9 per cent of their GDP on health (Chinitz 1995; The Harvard Team 2000; World Bank 1997). Health achievement measures, such as life expectancy and infant mortality rates, is negligible across this same set of countries – ranging between 77 and 79 years for life expectancy at birth, and between 6 and 8 per 1,000 live births, respectively (World Bank 1997). It thus appears that in terms of cost-containment and cost-effectiveness, countries with social insurance lie somewhere in between those that rely on private insurance and those depending on general revenues to finance health care, but as demonstrated in Section 2, cross-national regressions do not lend strong support to this hypothesis.[46]

More crucial is the relative performance of these different country systems in terms of equity. One recent study of OECD member countries points out that social insurance has generally been regressive in Netherlands and Germany, but the overall effects pale in comparison to the regressive implications of private insurance and direct out-of-pocket payments. On the other hand, general revenues are much more progressive, so that the United Kingdom comes out to be progressive overall, and United States and Switzerland with relatively high regressive health financing systems (Wagstaff and Doorslaer *et al.* 1996). Thus, in terms of equity in financing, social insurance appears to lie in between systems that rely on private health insurance/out-of-pocket spending and those that rely on general revenues.

3.3.3. Canada[47]

In the preamble to the Canada Health Act (1984), the Canadian Parliament recognized the importance of cooperation between "governments, health professionals, voluntary organisations, and individual Canadians.." and expressed a wish to "...encourage the

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[46] Moreover, Germany's relatively high costs of care in comparison to Netherlands and Israel may have to do with the poor integration of lower-levels of care with hospital-based care (Harvard Team, The 2000).

[47] This section relies heavily on The Harvard Team (2000).

development of health services...by assisting the provinces in meeting the costs thereof." (Government of Canada 1999, Chapter C-6).

Canada finances it national health insurance system through tax revenue with financial participation by both the provincial and federal governments. The insurance system itself is managed by provinces, with contribution of the national government typically taking the form of a lump-sum grant to each province (Harvard Team, The 2000). However, the *full* contribution is conditional, and depends on whether the health care support regime satisfies certain criteria. The relevant list of criteria includes the requirement that the health plan be administered on a non-profit basis by a public authority, that the health insurance plan be: comprehensive, universal in terms of population covered, portable, and ensure accessibility. The last requirement includes a statement that "must provide...services...on a basis that does not impede or preclude...whether by charges made to insured persons... reasonable access..." (Government of Canada 1999; Chapter C-6). Thus, patients are not required to give co-payments for medical services received, except in the case of purchasing drugs that do not belong to the class of "least cost alternatives". In the year 1997, the provinces covered about 60 per cent of their total health expenditures, and the federal government, the remainder.

The overall spending takes the form of expenditure caps set for hospital-based services and for physicians' services. Given these caps, rates are set for each unit of service (and specialty) by a process of bargaining within the medical associations of each province. Within this system, payment is by fee-for-service, which creates an incentive for doctors to oversupply services. This tendency is controlled by a centralized monitoring system – since all payments are routed through one provincial agency. As a consequence, doctors who appear to be violating the "norms" are brought to the notice of the medical association for appropriate disciplinary action.

The final key feature of the system is that patients have completely free choice of providers. There are some restrictions, in terms of certain services that are provided with delay (some forms of elective surgery) and others that are not covered (dental care). In general, however, there appears to be a high level of patient satisfaction with the Canadian health care system (Harvard Team, The 2000). It is also quite clear that given universal access and funding through general revenues, the system is also quite equitable. The one area of concern appears to be, and this was noted in the previous section, the high expenditure on health as a proportion of GDP – 9.5 per cent (Harvard Team, The 2000).[48] This is counter-balanced by two other factors. First, Canada is among the very few developed countries that have experienced a decline in their health spending as a proportion of GDP in the last few years (Harvard Team, The 2000, p.51). Second, it has done extraordinarily well in terms of indicators of life expectancy and infant mortality rates – 78 years and 6 per 1,000 live births, respectively.

3.3.4. Singapore

Singapore's health care financing and provision system is organized around four main pillars. The first is a medical savings scheme (Medisave) which is compulsory for all employees and the self-employed. Contributions to the scheme take place through the intermediary of the Central Provident Fund (CPF). Of the 40 per cent payroll tax deposited into the CPF, between 6-8 per cent is allocated to the Medisave scheme. Half of the payroll tax is borne by employers, and the other half by employees. The contributions are tax deductible and earn interest (Nichols, Prescott and Phua 1997). There is a maximum limit to which the balance in the *Medisave* account can accumulate, after which additional amounts go into a retirement fund. Amounts can be withdrawn from the Medisave account to pay for hospitalization expenses for the individual and his family, subject to caps for charges per hospital/day and surgery expenses. Expenses for ambulatory care cannot be charged to Medisave, although there are exceptions for expensive forms of ambulatory care.

In general, patients are allowed to freely choose among the many private and public providers.[49] Users of public services are required to make a co-payment at the time of consumption. The rate of co-payment varies by class of care, increasing as quality

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[48] The information on health expenditures per capita was read from Figure 9 (p.51) of The Harvard Team (2000).

[49] About 80 per cent of primary care, and 20 per cent of hospital based care is provided by the private sector (Phua 1997).

improves. At the lowest class, the co-payment rate is only 20 per cent. People who cannot afford care are subsidized from a common fund (see below).

A second pillar is the so-called Medishield. The main problem with Medisave was that inter-temporal pooling (i.e. savings over the lifetime of an individual) is unlikely to ever be sufficient to pay for truly catastrophic illnesses. This role was best undertaken by cross-sectional pooling of resources. The Medishield scheme involves the payments of age-adjusted premiums for catastrophic insurance coverage up to the age of 75 years. The premiums and other charges related to Medishield can be paid out of Medisave accumulations. The scheme has a large (initial) deductible, a 20 per cent co-payment rate, and annual as well as lifetime limits. This scheme is compulsory for employees and the self-employed, but voluntary for their dependents and all others.

A third key element of the scheme is a provision for the very poor, people who cannot afford care, even at the most subsidized rates. This led to the creation of the Medifund. The government provides support for this fund on a fairly periodic basis, and those seeking relief under this category can simply apply to the management of a public hospital (a "Medifund Committee" exists at each hospital) for the requisite benefits.

On the provision side, the government has sought to promote competition both by allowing patients a free choice among providers as well as by restructuring public hospitals. This has mainly involved their becoming more autonomous in terms of day-to-day management and control. However, there are restrictions on how much they can charge from their patients – that is, they are expected to continue to subsidize care users and are subject to revenue caps. The gap between their resources/revenues and costs is made up by government subsidies.

By allowing patients a free choice of providers, Singapore's system can be expected to promote patient satisfaction and quality care. However, as far as cost containment and cost-effectiveness are concerned, the picture is less clear. *Medisave* is likely to reduce the problem of moral hazard since the patients are effectively using up their own money and presumably likely, for that reason, to become more responsible, including using preventive care. This is further facilitated by the government of Singapore spending substantial amounts of resources on promoting low health risk behaviours, on free immunization services and the like. Costs are also likely to be curtailed by the "revenue caps" in public facilities since any increased provision of services would lead to enhanced revenues owing to co-payments. On the other hand, if people do not view the amounts in Medisave as their own money and have a short-term horizon, they might end up consuming much more of hospital based care, even for relatively minor problems. Moreover, with little by way of intermediation between doctors and patients, there is a real danger of supplier-induced demand causing a sharp increase in overall health spending. Also, the level of integration between lower levels of care and hospital-based care are low, suggesting another cost-enhancing inefficiency by duplication of tests and medical services. Finally, the existence of Medishield – the catastrophic insurance coverage – can create expenditure enhancing income effects since the desire to keep a large balance in the Medisave account is counteracted by the ease with which one can reach the deductible level for the Medishield policy to kick in. In terms of equity, the Medifund provides substantial safeguards to the poorest people. It is possible, however, that for low-income (but not "least income") individuals the existence of substantial co-payments may lead to a relatively large burden of health care spending.

The overall setting in Singapore seems to support the objectives of equity and quality of care. Indeed Singapore is known to attract patients from abroad to its facilities. However, its experience with costs in recent years is a little less impressive. At the moment it spends about 2.5 per cent of its GDP on health, which is quite low considering its achievements in terms of life expectancy at birth and the infant mortality rate – 76 years and 4 per 1,000 live births, respectively. However, there is evidence that its expenditures are increasing at a rate faster than in the period before Medisave accounts were introduced, in the 1980s (Harvard Team, The, 2000).

3.4. Lessons for India

The experiences of these countries hold three key lessons for India, which is plagued by poor quality of health care, potentially high costs of care and increased burden of health spending on the poor.

The first set of messages has to do with patient satisfaction and quality of care. It is quite clear that patient choice among providers and insurers is emerging as one of the single most valuable elements of health policy internationally. This is certainly the case for the private sector oriented United States, but also true of countries where the government has traditionally played an important role. The United Kingdom is the best example, but Netherlands, Germany, Israel and Canada all have provider choice as a key element of their public supported health systems. In some cases, people have choices over both insurers and providers and in others, only one.

A key issue is how to reconcile the need for choice among providers with cost-containment. The lesson here is the importance of various sorts of budgetary caps and supply side controls – as in Canada, the United Kingdom, Germany, the Netherlands and even Singapore, through its "revenue" caps on public hospitals. Indeed, countries that have focused on the demand side as a means to curtail costs have not done as well. The only demand side control that appears popular across countries has to do with co-payments for pharmaceuticals. A classic example is the Republic of Korea which has experienced rapid increases in its health spending, despite co-payment rates as high as 50 per cent (World Bank 1989; Yang 1996). In our sample of countries, Singapore has experienced rapid increases in its health spending, even though its aggregate share of GDP is still quite small.

A third important message has to do with the reconciliation of consumer choice with equity. Private provision and private health insurance are one extreme, with high levels of consumer choice but low levels of equity. The work by Wagstaff and Doorslaer and others suggests that at least in terms of financing, countries that fund their compulsory health care by general revenues do better than those with social insurance, who in turn do better than private insurance, with out-of-pocket payments being the least equitable. In general some sort of cross-subsidy from the rich to the poor appears desirable and it is important that the richer groups participate financially in the scheme, directly or indirectly (through tax revenues).

We did not include in this discussion any significant reference to issues of technical quality, about laws on consumer protection, about government regulations on supply of medical personnel, infrastructure and equipment, and the quality and prices of drugs. Indeed, it is the case that government policy in these areas would have quite direct impacts on some of our objectives. For instance, it is often contended that an increase in the supply of doctors, instead of leading to reduced prices, may sometimes actually increase the average cost of care, through an increased number of specialties and supplier induced demand (Harvard Team, The 2000). Thus countries often put a range of restrictions on the number of doctors, proportion of specialists, number of immigrant doctors, and so on. Similar restrictions may arise on the introduction of new drugs and technology. Quality and cost of care is also crucially dependent (although not necessarily in the same direction) on laws for consumer protection and requirements for continuing education. All the countries that we discussed above have various forms of regulatory structures that deal with these issues. India too, does have such structures, but there are substantial gaps as in the case of medical infrastructure regulation and poor enforcement, especially in issues of consumer protection.

Also not discussed above was the fact that health reform is typically a long-term process, requiring close monitoring of outcomes. Most of the countries discussed in the previous section have been tinkering with their health sector for years to fine-tune and refine the system. For instance, Singapore introduced the Medishield scheme in 1990 nearly six years after it first introduced the Medisave scheme and two years later, added the Medifund scheme. Similarly, the Netherlands, Germany and the United Kingdom introduced several refinements in its health system during the course of the 1990s.

In applying these ideas to India, policymakers are faced with a number of opportunities and challenges. For one, health care (but not health insurance) is primarily a state subject so any improvements in underlying regulations is a responsibility of the states and the not the federal government. Thus improvements in this area will require coordination among states.

Second, it may be useful to think of bringing together large funds such as the ESIS and parts of the health budgets of state governments, and use those to either buy private health insurance, or to negotiate contracts with private providers. This is one way in which patient choice among providers and quality can be enhanced. A potential problem is that with 75 per cent of the health spending already going to private sector, it may be difficult to imagine provider associations agreeing to anything like a fixed rate.

In a setting with limited budgets relative to health needs, however, there still remains the question about who will get to benefit from whatever subsidized scheme the government supports. It can be shown that substantial gains accrue to the poor if the government were to introduce some form of income/expenditure cut-off rules for beneficiaries (Mahal 2000b). But this faces the problem of sustained political support for schemes that undertake cross-subsidies from the richer groups to the poor. The question then as to where the cut-off would have to be to yield significantly large benefits to the poorer segments of the population becomes important.

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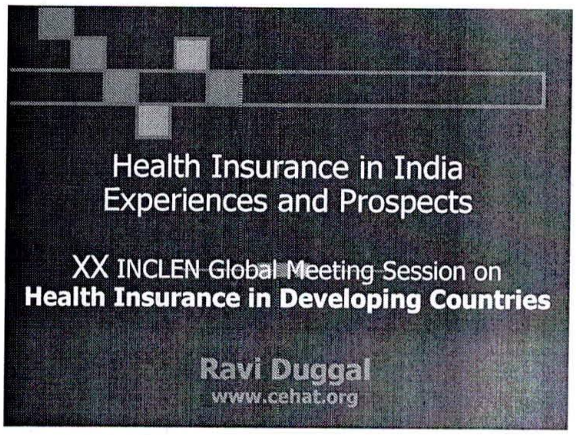

Health Insurance in India
Experiences and Prospects

XX INCLEN Global Meeting Session on
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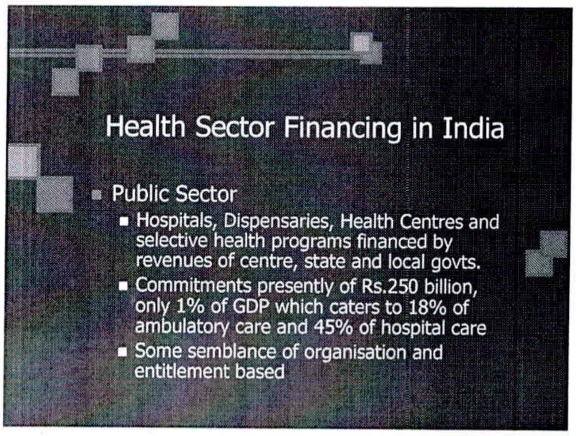
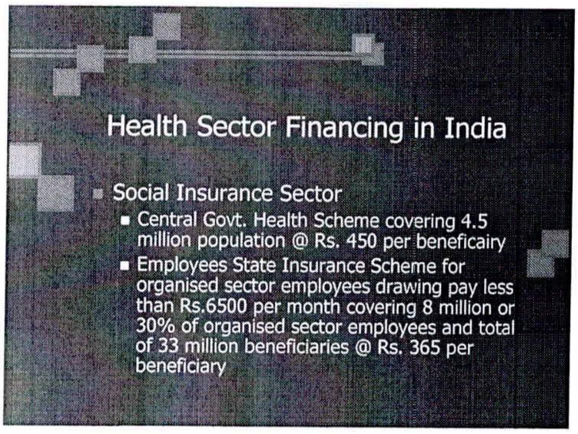


Health Sector Financing in India

- Public Sector
  - Hospitals, Dispensaries, Health Centres and selective health programs financed by revenues of centre, state and local govts.
  - Commitments presently of Rs.250 billion, only 1% of GDP which caters to 18% of ambulatory care and 45% of hospital care
  - Some semblance of organisation and entitlement based

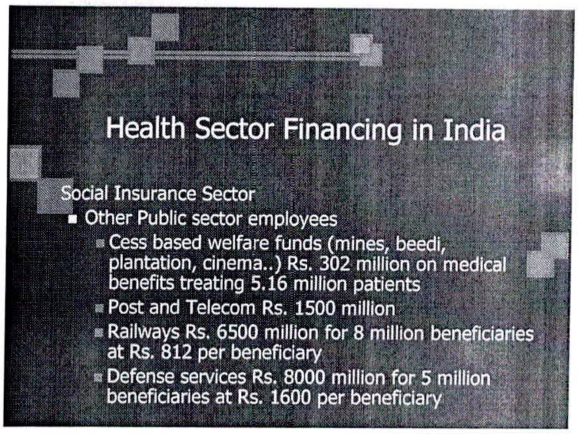
Health Sector Financing in India

- Private Sector
  - Hospitals, Clinics, diagnostic centres, financed largely through out-of-pocket fees for service basis
  - Valued at Rs.1250 billion or 5% of GDP which caters to 80% of ambulatory care and 55% of hospital care
  - Unregulated supply induced demand market based and mostly curative



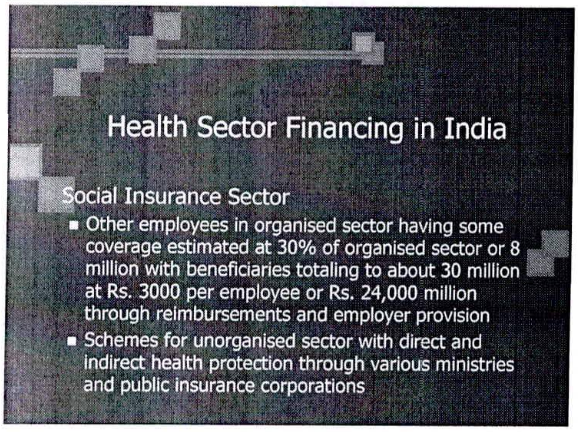
Health Sector Financing in India

- Social Insurance Sector
  - Central Govt. Health Scheme covering 4.5 million population @ Rs. 450 per beneficairy
  - Employees State Insurance Scheme for organised sector employees drawing pay less than Rs.6500 per month covering 8 million or 30% of organised sector employees and total of 33 million beneficiaries @ Rs. 365 per beneficiary



Health Sector Financing in India

Social Insurance Sector
- Other Public sector employees
  - Cess based welfare funds (mines, beedi, plantation, cinema..) Rs. 302 million on medical benefits treating 5.16 million patients
  - Post and Telecom Rs. 1500 million
  - Railways Rs. 6500 million for 8 million beneficiaries at Rs. 812 per beneficiary
  - Defense services Rs. 8000 million for 5 million beneficiaries at Rs. 1600 per beneficiary



Health Sector Financing in India

Social Insurance Sector
- Other employees in organised sector having some coverage estimated at 30% of organised sector or 8 million with beneficiaries totaling to about 30 million at Rs. 3000 per employee or Rs. 24,000 million through reimbursements and employer provision
- Schemes for unorganised sector with direct and indirect health protection through various ministries and public insurance corporations

Health Sector Financing in India

- Private Insurance Sector
  - Public sector insurance companies cover 10 million persons with a premium collection of Rs. 10,000 million
  - Private sector insurance companies have come in recently and they are estimated to cover about 1 million persons with premiums in range of Rs.1500 million
  - Community based health insurance and Health NGOs covering about 10 million persons

Summary Table of Financing

	Users in millions	Expenditure (Rs. Billions)
Public Sector	**300(opd) 16(ipd)**	**252 (17)**
Of which Social Insurance	55(opd) 2(ipd)	30 *(2)*
Private Sector	**700(opd) 20(ipd)**	**1250 (83)**
Of which social insurance	*30*	*24 (1.6)*
Private insurance	*11*	*11.5 (0.8)*
Out of Pocket	*659*	*1214.5 (80)*

Health Insurance Issues and Concerns

- Highest burden of out-of-pocket financing of health care in India
- Public investment and expenditures which have been low are seeking even lower levels of support
- Social insurance coverage is restricted to middle classes and also seems to be shrinking under the impact of new economics
- Private and community based insurance being pushed as options for India's future health financing strategy, respectively for the middle classes and the poor

Health Insurance Issues and Concerns

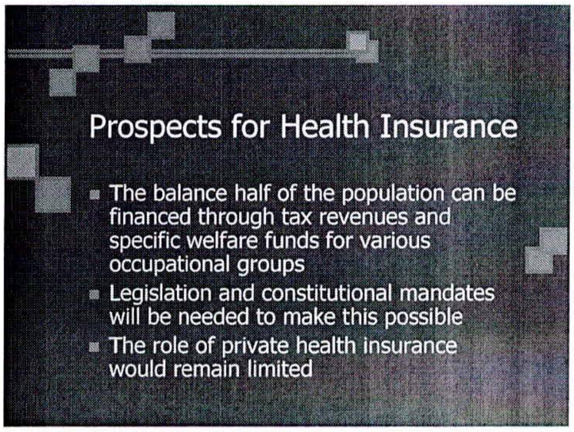
- The private health sector is the main provider of ambulatory care and also is accounting for an increasing share of the hospital sector
- The private health sector is unorganised, unregulated, lacks standards and protocols for care and completely lacks any ethics in practice
- Such an environment of healthcare provision is grossly unsuitable for insurance of any kind
- The little health insurance that exists in India has a definitive class character

Prospects for Health Insurance

- Public financing is the key to setting up an insurance based healthcare system
- The healthcare system needs to be organised in a systematic fashion with clearly defined flows, including referral systems
- Regulation, including price control and standardised protocols for care essential

Prospects for Health Insurance

- Efforts would be needed to greatly increase the coverage of social insurance for which it is estimated that 50% of the population has the potential to contribute and if ESIS kind of contributions can be netted then additional 2% of GDP can be added to the state health kitty



Prospects for Health Insurance

- The balance half of the population can be financed through tax revenues and specific welfare funds for various occupational groups
- Legislation and constitutional mandates will be needed to make this possible
- The role of private health insurance would remain limited