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Review of Experience of Social Health Insurance in Three Asian Countries: China, Thailand, and Vietnam

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Philippine Institute for Development Studies
Surian sa mga Pag-aaral Pangkaunlaran ng Pilipinas

Review of Experience of Social Health Insurance in Three Asian Countries: China, Thailand, and Vietnam

Rolando G. Talampas

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**Review of Experience
Of Social Health Insurance
In Three Asian Countries:
China, Thailand and Vietnam**

By

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For

PHILIPPINE INSTITUTE FOR DEVELOPMENT STUDIES
Makati City, Philippines
May 2014

Abstract

The study assesses the experience of three Asian countries: China, Thailand and Vietnam in the pursuit of universal health coverage (UHC) of their social health insurance (SHI) schemes. It seeks to analyze a set of domains including membership fees, services, benefits, equity, among others relative to the economic and political conditions of these countries as “push and pull” factors in achieving UHC.

This paper mainly utilizes empirical studies, assessment reports, international discussions and proceedings and individual country plans of integrating, widening and deepening health insurance coverage with the end goal of identifying comparative areas where the Philippines might be able to benchmark itself in its UHC quest. The study adopts the UHC cube of the WHO as the framework for the review.

It finally submits applicable recommendations that the Philippines may consider in advancing its plans towards universal health coverage.

Keywords: health, health insurance, social health insurance, universal health coverage

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I. Introduction

Social health insurance (SHI) schemes in various countries initiated by governments—and sometimes by private entities—are meant as “alternative to tax payments and out-of-pocket expenditures” at times of medical needs. Recently, SHIs have sought to achieve so-called universal health coverage (UHC, also UC for universal coverage). While advanced economies have achieved UHC, SHIs in developing countries are “typically characterized by large-scale exclusion,” observed a commentary.¹

In 2005, the World Health Assembly passed Resolution 58.33 defining “universal coverage” as

... access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO’s concepts of health for all and primary health care.²

The definition highlights the importance of health financing as a key component of the health system. Relative to this, financing is typically linked to question of out-of-pocket (OOP) expenses (especially of the poor and near-poor) and risk-pooling efforts to finance health insurance costs.³ Over and above financing issue, the World Health Organization (WHO) raises the question of the equity impact of social health insurance,⁴ one that implies that poor-inclusive UHC continues to be burdened by sustainability factors,⁵ and also one that seeks to equate UHC with “health for all”.⁶

In terms of its objectives or desired outcomes, according to the WHO, UHC seeks to promote “equity in access to health services,” quality health care services, and

¹Oxfam, 2013.

² WHO, 2005, “Sustainable health financing, universal coverage and social health insurance,” http://www.who.int/health_financing/documents/cov-wharesolution5833/en/

³See, e.g., Medicus Mundi International Network, “MMI discussion paper: Universal Health Coverage,” 27 May 2013, pp. 4-5.

⁴Gilson L, ed. (2012). *Health Policy and Systems Research: A Methodology Reader*. Alliance for Health Policy and Systems Research, World Health Organization, 2012, p. 44.

⁵WHO, “Financing for Universal Health Coverage,” <http://www.who.int/healthsystems/topics/financing/healthreport/en/index.html>

⁶ See a contrary view in Indranil Mukhopadhyay, “Universal Health Coverage: The New Face of Neoliberalism,” *Social Change*, 43:2 (2013), 177–190.

“financial-risk protection.”⁷ These are the “three broad dimensions” of UHC covering population inclusion, service expansion, and cost reduction. Varied experiences of countries seeking to achieve UHC have yielded different measures of success, but also rival claims of success or shortcomings. In much of the case studies, poor and vulnerable sectors are foremost in consideration because it is their ill health and the conditions that expose them—and consequently cause them to succumb—to diseases that impact not only on their productivity but also on their ability to rise from poverty.⁸

With universal interest in achieving UHC, efforts have been exerted to draw lessons from many SHI experiences. The WHO and the World Bank, in particular, have sought links between SHIs and health outcomes and financial risk protection, respectively. Both WHO and WB studies utilized data from existing studies, with the WHO study hewing close to the “cube” framework. The WHO studied the “transition” of a few countries to UHC by looking into “seven key design issues” that policies ought to address—“population coverage, the method of finance, the level of fragmentation, the composition of risk pools, the benefit package, provider payment mechanisms and administrative efficiency”.⁹ The study involved economically developed countries. As for low and middle-income countries, Acharya et al. used data from 34 studies in search for SHI enrolment-related outcomes and impacts and

found little evidence on the impact of social health insurances on changes in health status. There was some evidence that health insurance schemes increased healthcare utilization in terms of outpatient visits and hospitalization. Finally, there was weak evidence to show that health insurance reduced out-of-pocket health expenses; the effect for the poorest was weaker than for the near poor.¹⁰

Aside from health effects of SHIs, the WB commissioned a review of 2000-2011 studies on the impact of developing countries’ SHIs on “access to health care services, financial protection, and health status”. Indeed, the review concluded with some reservation, that access to health care improved, “UHC often has a positive effect on financial protection, and that, in some cases it seems to have a positive impact on health status.”¹¹ As for seven southeast Asian countries whose health financing schemes were reviewed by

⁷WHO, 2010, “Universal Health Coverage,”

http://www.who.int/healthsystems/universal_health_coverage/en/

⁸Cf. David Bloom and David Canning, “The Health and Poverty of Nations: From theory to practice,” *Journal of Human Development: A Multi-Disciplinary Journal for People-Centered Development*, 4:1 (2003), 47-71,

⁹ Guy Carrin and Chris James, “Reaching universal coverage via social health insurance: key design features in the transition period,” WHO, 2004.

¹⁰ Arnab Acharya, et al., “Impact of National-level or Social Health Insurance for the Poor and the Informal Sector: A Systematic Review for LMICs, p. v. By their own admission, the study had a number of limitations that made comparison across cases difficult, if not impossible.

¹¹Ursula Giedion, et al., *The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence*, Washington DC: World Bank, 2013, p. 99.

Tangcharoensathien and his collaborators, UHC attempts at expanding coverage have specific funding for particular groups who benefit differently under varied schemes.¹²

Health effects of SHI are hard to ascertain, claim Quimbo et al: “With non-experimental data, causality between health insurance and health is difficult to establish because of the complex behavioral responses from both the patient and health care provider....”¹³ Even with the inability to single out any factor behind a positive health, financial protection or access outcome, SHI progress toward UHC has been much endorsed, almost by every country that seeks to define its own policies and implementations based on actual conditions.¹⁴

Among the said countries often cited for making giant strides in their SHIs towards UHC are China, Thailand and Vietnam. China’s embrace of the new economic order and its own successes in that regard has exemplified almost 100 percent health insurance coverage in various forms in a relatively short period of time, but with lingering issues like OOP expenses¹⁵. Thailand was a front runner in SHI among developing countries, covering a huge majority on informal workers and poor who were uninsured under any scheme (see figure below).

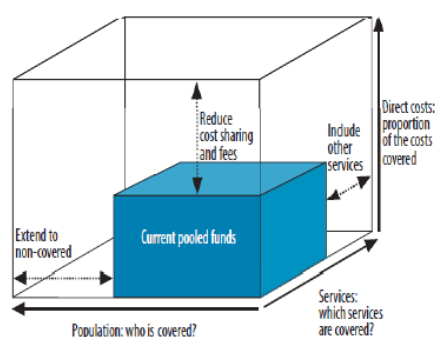
¹² Viroj Tangcharoensathien, et al.. “Health-financing reforms in southeast Asia: challenges in achieving universal coverage,” *Lancet* 2011; 377: 863–73

¹³ Stella A. Quimbo, et al, “Evidence of a Causal Link between Health Outcomes, Insurance Coverage and a Policy to Expand Access: Experimental Data from Children in the Philippines,” *Health Economics*, 20:5 (2011 May), p. 2

¹⁴ UHC was deemed the “silver bullet to health care needs” especially in poor countries but it simply shifted the question to one of financing instead of rebuilding the public health system that has fallen under the spell of the market. Amit Sengupta, “Universal Health Coverage: Beyond rhetoric,” Municipal Services Project – Occasional Paper No. 20, November 2013.
<http://www.alames.org/documentos/uhcmit.pdf>

¹⁵ See, e.g., Lufa Zhang and Nan Liu, “Health reform and out-of-pocket payments: lessons from China,” *Health Policy and Planning* 29:2 (2014): 217-226,

UHC cube: what has been achieved in Thai UHC?



- X axis:
 - 99% pop coverage by 3 schemes [UCS 75%, SHI 20%, CSMBS 5%]
- Y axis:
 - Free at point of services, very minimum OOP,
 - Low incidence of catastrophic health expenditure and health impoverishment
- Z axis:
 - Extensive and comprehensive benefit package, very small exclusion list,
 - Most high cost interventions were covered: dialysis, chemotherapy, major surgery, medicines (Essential drug list)

Source: Prakongsai, et al. (2013)

In 2012, Thailand gained prominence in the ASEAN+3 countries for its willingness to share its UHC lessons.¹⁶ The beginnings of health insurance in the Philippines and Vietnam were two years apart in the early 1990s and their differentiated devolved/decentralized health system settings would not only showcase attempts to make the poor the principal beneficiaries but also pose distinct challenges to the full realization of their own targets.¹⁷ The participation of the different stakeholders at the different levels of the Philippine and Vietnamese health systems would produce thought-provoking questions not only about SHIs but also their associations with key success indicators.

Thus, seeking to gain better understanding of how SHIs can achieve UHC, these three countries—China, Thailand and Vietnam—are good candidates for assessment relative to the WHO-prescribed “cube” framework.

Statement of the Problem

Given the existing practice of SHIs in China, Thailand and Vietnam, the various efforts at contributing to the assessment of each country’s progress towards UHC may yield

¹⁶ Simone Ghislandi, et al., “The impact of Universal Health Coverage on healthcare consumption and risky behaviours: evidence from Thailand,” 2013, p. 4.

http://www.iussp.org/sites/default/files/event_call_for_papers/GMP.pdf

¹⁷ Samuel S. Lieberman, “Health Decentralization in East Asia: Some Lessons from Indonesia, the Philippines and Vietnam,” U.P. School of Economics - Discussion Paper No. 0408, August 2004.

<http://www.econ.upd.edu.ph/dp/index.php/dp/article/view/27/109>. See also Viroj Tangcharoensathien, et al., “Universal Coverage and Its Impact on Reproductive Health Services in Thailand.” *Reproductive Health Matters*, Vol. 10, No. 20, pp. 59

different findings, conclusions and recommendations. As such, this review hopes to contribute to gathering relevant information of their SHIs by asking the state of their progress towards UHC and the factors contributing to or that are associated with said state. Thus, this review seeks to answer the following questions:

1. How have China, Thailand and Vietnam SHIs sought to achieve UHC?
2. What factors have affected the achievement of UHC in the Chinese, Thai, and Vietnamese SHIs?
3. What lessons can the Philippines learn from the Chinese, Thai and Vietnamese progress towards UHC?

Objectives of the Study

This study seeks to achieve the following objectives:

1. To describe the developments in population, service and financial risk protection of Chinese, Thai and Vietnamese SHIs
2. To determine the barriers to the achievement of UHC in Chinese, Thai and Vietnamese SHIs
3. To draw lessons from the Chinese, Thai, and Vietnamese SHIs that are relevant to the Philippine efforts to achieve UHC.

Significance of the Study

The study is important for the following reasons:

1. It shall be able to provide updated assessments of specific aspects/dimensions of the SHIs in China, Thailand and Vietnam.
2. It shall be able to determine consensus points on how to move SHIs towards UHC and to indicate their progress.
3. It shall be able to recommend some mechanisms to strengthen the monitoring and evaluation of Philippine SHI in achieving UHC.

Methodology

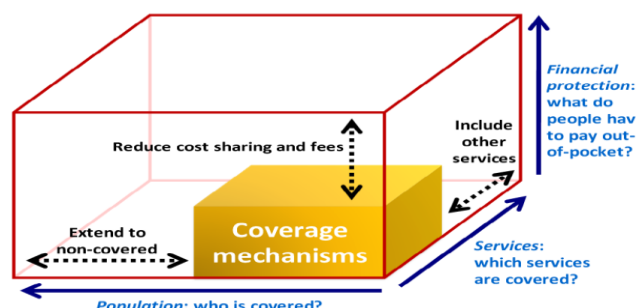
1. Conceptual Framework

This review adopts WHO's "UHC cube" (see figure below) as framework of the study. This "cube" emphasizes the importance of population, services and financial risk protection in assessing the achievements of China's, Thailand's and Vietnam's SHIs.

Using the three dimensions of the “cube,” the X-axis indicates how inclusive the insurance has become, the Y-axis measures how much people share in the cost of healthcare, and the Z-axis shows the services available to those in the scheme. These are the dimensions in the SHI direction to UHC. Thus framed, UHC is not impossible to achieve as suggested by Rabovskaja¹⁸.

Framework of the Review

Towards universal coverage



Source: World Health Report, 2010

One of the latest attempts to clarify UHC was given in a 2013 presentation by Dr Marie-Paule Kieny, Assistant Director General of WHO for Health Systems and Innovation.¹⁹

Axis 1 (Z): Coverage with needed health services

- Promotion, prevention, treatment, rehabilitation, palliative care
- Population-based and personal interventions
- Interventions at different levels of the system: community, primary, secondary, tertiary
- Quality as an overarching consideration

Axis 2 (Y): Financial risk protection indicators

- Incidence of catastrophic health expenditure due to out-of-pocket payments
- Incidence of impoverishment due to out-of-pocket payments

Axis 3 (X): Population and Equity

- UHC is fundamentally about equity – all people get what they need and all people pay only an affordable price
- Each of the indicators described earlier needs to be disaggregated by key socioeconomic factors: income, age, sex, rural/urban, etc.

¹⁸Viktoria Rabovskaja, “Universal Health Coverage - reflections from a development perspective,” Discussion Papers on Social Protection, 2012. <http://www.giz.de/fachexpertise/downloads/giz2012-social-protection-universal-health-coverage-reflexions-from-a-development-perspective.pdf>. Cf. Sherri Haas, et al., *Indicators for Measuring Universal Health Coverage: A Five-Country Analysis (DRAFT)*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc

¹⁹ Dr Marie-Paule Kieny, “Universal Health Coverage: What is it and how can it be measured?” 2013. http://www.who.int/healthinfo/UHC_PresentationWHA_2013.pdf

As much as possible, the presentation of findings of this review shall be in keeping with the axes clarifications in the box above.

2. Sources of Data

Data used in this study were drawn from the following sources, a substantial percentage of which are in the public domain.

- a. Government documents and reports
- b. Academic and policy studies on social health insurance
- c. Critiques, published statements, presentations/papers of SHI authorities, especially from established academic and public policy journals
- d. Studies of international agencies/organizations
- e. Key informants from concerned agencies

3. Analytical Tools

Cross-case synthesis (after Yin 2003 and Creswell 2007) shall be the main analytical process involved in drawing descriptions and comparisons of the Thai, Chinese and Vietnamese social health insurance programs. It shall include the following:

- a. Chronological reconstruction of key SHI developments in the three countries shall be made to situate the factors informing reforms, if any, in SHI programs.
- b. Detailed matrices of relevant items shall be constructed to sort the qualitative data culled for comparing across the three countries' SHI programs.
- c. Meta-analyses of the cases shall be used to abstract lessons that can be derived for purposes of policy recommendations.

II. Review of Literature

Quality healthcare for all commands a price paid for either by taxes collected by governments or by social health insurance (SHI) or by a combination of both (mixed type). SHI is compulsory membership to an organization and payment to a collective fund used to pay for health services.²⁰ In developed countries with well-established organizations (such as trade unions) and institutions (such health care industry), SHIs have reached near universal coverage as people appreciate their own medical requirements and the need to be protected financially via insurance. People in such places live longer and healthier lives. But in developing countries, especially where the majority live below the poverty line, ensuring that everyone is provided healthcare falls on the lap of government, donors, charitable institutions or community-based efforts. Sick people therein also simply turn to religion, self-medication or traditional healers, where available. They typically live shorter and miserable lives.

As health of the people has grown in importance relative to development, SHIs have been put in place chiefly by governments with clear health agendas and these are participated in by a host of public and private care providers. The limitations of SHIs in providing quality health care for the majority of the population in many countries have been addressed by governments' increasing role in health financing through subsidies and new tax measures, among others. Official development assistance too has provided for technical and financial requirements of global health issues such a malaria and HIV/AIDS. It has not been a simple case of establishing SHIs to celebrate inclusiveness in health matters. Everyone may possibly have an insurance coverage but their provisions, entitlements, etc. may differ across sectors, geographical locations, health providers, not to mention cost to the person covered by the insurance. Even if these were the same across countries, politics, demographics, history, economy, and cultural factors may intervene heavily in health outcomes.²¹ With SHIs, for sure, there will be changes in people's health and productivity, but how soon, to what extent, and what cost are also relevant questions that need to be answered. Acharya et al. advance a "theory of change due to health insurance"²² that identifies effects of health status, labor

²⁰ Guy Carrin and Chris James, "Social health insurance: Key factors affecting the transition towards universal coverage," *International Social Security Review*, Vol. 58, 1 (2005), p. 2. See also, Ole Doetinchem, et al., "Thinking of introducing social health insurance? Ten questions," WHO: World Health Report Background Paper, 26, (2010). http://www.who.int/healthsystems/topics/financing/healthreport/26_10Q.pdf. These 10 questions almost exclusively talk about financing.

²¹ For a rent-seeking SHI example, see Paul Gertler and Orville Solon, "Who Benefits From Social Health Insurance? Evidence from the Philippines," 2002. http://faculty.haas.berkeley.edu/gertler/working_papers/Gertler-Solon%20Philippines%20Hopsital%20Paper%203-1-02.pdf

²² Arnab Acharya, et al., "Impact of National-level or Social Health Insurance for the Poor and the Informal Sector: A Systematic Review for LMICs

productivity and out-of-pocket expenditure that, when aggregated, also shape the national scene.

When people in middle- and low-income countries²³ already have health insurance coverage, it could be reasonably expected that they would partake of the cost by paying mandated premiums, live healthy lives, and become more productive. (It would not be too much to expect too that their poverty figures fall over time.) The result could only be conditionally affirmed as other requirements such legal framework, administrative mechanisms, provider ethical behavior, cultural acceptability are present. Intuitively, middle income economies might be expected to make more progress toward UHC than low income ones.

China and Thailand and upper middle-income countries which share a good number of pre-UHC developments in their SHIs. Vietnam is closer to the Philippine case relative to income category and preparedness towards UHC. All three countries strive to reach high economic development levels aided by strong and vast human capital that is largely dependent of education and health improvements. Their modern histories have been beset by various crises that have hit the poor the most. To alleviate the conditions of poor, these countries have resorted to a combination of approaches that have more recently invested resources in health sector/system reform.

China and Vietnam represent the cases of socialist centrally-planned economies shifting to their own versions of market socialism with corresponding changes in healthcare systems. While Vietnam is a young independent reunited polity with a population still reeling from the ravages of war, China has a huge population of 1.3 billion with a huge number shifting to urban areas and now below replacement. Karen Eggleston²⁴ presents, among others, changes in demographic and epidemiological characteristics of China and the attempts of the managers of healthcare delivery and health insurance programs as China negotiates a change from centralized planning to market-based economy planning to centralize planning to market-based economy and as more people shift to urban areas.

Also dealing with China's social health insurance are Adrien Dumoulin-Smith,²⁵ Hsiao WC Liu X,²⁶ and Shanlian Hu.²⁷ Dumoulin-Smith singles out Dengist "gradualism"

²³Based on GNI pe capita, China and Thailand are upper-middle income economies ((\$4,086 to \$12,615), while the Philippines and Vietnam are lower-middle income economies (\$1,036 to \$4,085) , according to the latest World Bank categorization. <http://data.worldbank.org/about/country-classifications/country-and-lending-groups>

²⁴ "Healthcare for 1.3 Billion: An Overview of China's Health System".

²⁵ Adrien Dumoulin-Smith, "Social health insurance in China: An example of nascent social Security in China," n.d. inequality.cornell.edu/people/.../Dumoulin%20Smith_paper.pdf

²⁶Hsiao WC Liu X, "The cost escalation of social health insurance plans in China: Its implication for public polic," *Social Science and Medicine*, 41:8 (October 1995): 1095-101.

²⁷Shanlian Hu , "Universal coverage and health financing from China's perspective." <http://www.who.int/bulletin/volumes/86/11/08-060046/en/index.html>

as a factor in delaying broader benefit to poor people who need healthcare but cannot afford it. Hsia WC Liu follows up on the story of how Chinese social health insurance fared in the aftermath of the thoroughgoing reforms in the post-Mao period (1978 and beyond): “change in Chinese hospital financing and payment policy caused rapid adoption of high-tech medicine and abusive use of more expensive drugs which largely explained the annual increases in expenditures of 7.4 percent between 1985 to 1989. Chinese experience also shows that demand strategy (co-payment by patients) had very little effect to contain cost escalation.” Shanlian Lu foresees changes in the Chinese social health insurance: “Now that China has put health financing on the political agenda, health reform policies will begin to move towards universal coverage.”²⁸

The available executive summary of Qian²⁹ lists, among others, the peculiarities of the Chinese social health insurance: “First, social insurance schemes in China are managed by the local government. Second, the central government and lower level governments provide subsidies to some of these schemes according to the number of enrollees. Third, enrollment into many social health insurance schemes is voluntary.”

Ladinsky et al.³⁰ focus on Vietnam’s case in the light of *doi moi*, the World Bank-IMF’s “structural adjustment” and the policy of opening to the global market to provide insights in the factors sustaining the healthcare system and the issues to be addressed by Vietnam in the transition period more than a decade ago.³¹ Nghiem Tran Dung of Health Insurance Department of Vietnam’s Ministry of Health updates the insurance programs with a 2010 presentation in the aftermath of a 2008 legislated social health insurance. Gunag Than Long³² notes how the SHI “significantly contributed to the impressive progresses of the country’s health sector, but it also will face a variety of administrative and financial challenges posed by labor mobility, widening inequality, poverty severity, and expected aging population.”

Tangcharoensathien, et al.³³ describe the “health financing system prior to universal coverage, and the extent to which Thailand has achieved reproductive health objectives prior to this reform.” Thailand has had its population policy as early as 1970 which aimed to substantially cut fertility growth rate below replacement. Piya

²⁸ For the pre-2009 period of the Chinese social insurance, see Khatri JR and Shuiyuan X, “Health care financing in China prior to health reform 2009,” *Janaki Medical College Journal of Medical Sciences* Vol. 1:2(2013): 46-64

²⁹ Qian Jiwei, “Social Health Insurance in China: Getting the Incentive Right,” *EAI Background Brief* No. 759, October 2012.

³⁰ Judith Ladinsky, et al., “Changes in the Healthcare System of Vietnam in Response to the Emerging Market Economy” *Journal of the Public Health Policy*, Vol. 21, No. 1, pp. 82-98.

³¹ See also, M Segall, et al., “Economic transition should come with a health warning: the case of Vietnam,” *Journal of Epidemiological Community Health*, 2002;56:497–505,

³² “Social Health Insurance in Vietnam: Current Issues and Policy Recommendations,” Written for the International Labor Organization.

³³ V. Tangcharoensathien, et al, “Universal Coverage and its Impact on Reproductive Health Services in Thailand,” *Reproductive Health Matters*, Vol. 10, No. 20, pp. 59-69.

Hanvoravongchai and William C. Hsiao³⁴ present the evolution of universal coverage highlighting supply side of medical care that increased utilization and affordability, including some of the pressing challenges beyond 2008, notwithstanding the reported success of the “capitation” method.

³⁴Piya Hanvoravongchai and William C. Hsiao, “Thailand: Achieving Universal Coverage with Social Health Insurance,” In W. Hsiao and R.P. Shaw (Eds.) *Social Health Insurance for Developing Nations*, World Bank, 2007.

III. Presentation of Findings

Social Health Insurance- China, Thailand and Vietnam

China

A. Profile

China is the world's second biggest economy spurred by liberal trade arrangements with many countries, its own cheap labor from the world's largest population, and suspected piracy of intellectual property, among others. The Chinese Communist Party resolve to make China a "great power" has meant massive migration to urban areas and exclusive economic zones that feeds into its new industrial revolution. Thus, modern China has come to mean new technologies, extravagant lifestyles of the new elite, high literacy rates and substantial reduction in poverty in many, but not all, areas of the country. Crises though in world market and its financial institutions, not to mention allegations of wanton corruption among Party and government officials, seem unable for the meantime to fully stop China's rise, while Chinese attempts to acquire needed resources and territories have caused diplomatic problems with some countries, bordering on open conflict. Health and safety issues like the H1N1 virus, the melamine-contaminated milk, school building destruction during earthquakes, mining workplace incidents, environmental degradation and pollution, among others have caused many illnesses and deaths and they seem to recur in new forms over time.

No doubt China has been speeding up way past its decades of stagnation and humiliation such that remarkable changes and growth since the 50th anniversary of the founding of the people's republic have been unveiled with grandiose events such as the Beijing Olympics. And as China produces for and sells more and more to the world market, it has been sharing its income with the people through various programs, infrastructures, services, entitlements, and the like. The table below summarizes some health-related statistics that indicate progress in this important sphere.

Characteristics	China
Country characteristics in 2012*	
Population	1,350,695,000
GDP (US\$)	\$8.227 trillion
GDP per capita (US\$)	\$ 6,188
NHE as % of GDP	5.2%
Health expenditure per capita(US\$)	\$278
Infant mortality rate (per1,000 live births)	13
Out-of-pocket health expenditure (% of private expenditure on health) (2011)	78.8
Life expectancy (2011)	75
Percent of population 65 years old and above	9

Source: World Bank, 2013

B. SHI

In terms of SHI, developments in China's integration of pre-existing schemes towards universal coverage is chronologized in the box below.

CHINA

1998 – Implemented the Urban Employee-Basic Medical Insurance (UE-BMI)

2003 – Implemented the New Rural Cooperative Medical Scheme (NCMS)

2007 – Implemented the Urban Residents-Basic Medical Insurance (UR-BMI) among 79 pilot cities

2010 – The UR-BMI targeted all cities

2009 – Integration of the three existing social health insurance schemes (UE-BMI, NCMS, UR-BMI) that covered 87% of the population

2010 – 93% of the population had some health insurance coverage

2011 – 95% of the total population had some form of insurance coverage

2012 – Introduced a supplementary scheme to cover critical diseases of rural and unemployed rural folks

2013 – 99% coverage (800 million) of the rural population reportedly under the NCMS

1. Service Coverage

Service	China
Ambulatory services	Rural grassroots ambulatory services are provided by the private practitioners. ³⁵
Inpatient (IP)/ Outpatient (OP) services	UEBMI- covers OP and IP services NCMS - covers both OP and IP in about 70% of the NCMS counties; 30% IP only. URBMI – IP only. All schemes include reimbursed druglists. ³⁶
Choice of providers	Public and private providers can be chosen for ambulatory services ³⁷
Referral mechanism	“Upward” and “downward referrals for patients with certain types of diseases still need improvements for integration. ³⁸ Two-way referrals between primary care centers and hospitals also to be prepared ³⁹ ; More

³⁵Yuanli Liu, et al. “Health care in China: The role of non-government providers.” *Health Policy* 77 (2006), p. 214

³⁶Qingyue Meng and Shenglan Tang, p. 7

³⁷Yuanli Liu, et al. “Health care in China: The role of non-government providers.” *Health Policy* 77 (2006), p. 214

³⁸T. Ye et al, “Hospital availability in rural districts of China--a secondary data analysis on multiple utilisation of hospital services under the conditions of the Chinese medical health-care system,” *Gesundheitdesen*,;75:3 (March 2013),:160-5.

³⁹Chinese Center for Disease Control and Prevention, “China National Plan for NCD Prevention and Treatment (2012-2015), 7/25/2012, http://www.chinacdc.cn/en/ne/201207/t20120725_64430.html

	referrals from village health stations to township hospitals improve efficiency ⁴⁰
Cash benefits	60 RMB per year for those with severe disability, 30 RMB of which is financed by the central government ⁴¹
Physical check-up	NCMS partially covers general physical examination, blood pressure screening, and prenatal examination ⁴² ; Xiamen city enjoys a free general check up if they did not receive a reimbursement in the pervious year. ⁴³
Prevention, health promotion	NCMS covers preventive care; child health promotion included in government package ⁴⁴
Services not covered	Noncatastrophic care uncovered in NRCMS. ⁴⁵ Private health insurance supplements to cover services uncovered by BMI and the NCMS. ⁴⁶

2. Financial Risk Reduction

Premium per capita in the Chinese SHI schemes are: 1,400 RMB (UEBMI), 350 RMB(URBMI), and 100(NCMS).⁴⁷ Under UEBMI, employers shoulder 6-8 percent of employees salaries as employee premium for those below 45 years old and 8-10 percent for those above 45. Employees pay 2 percent of their salaries. Urban residents pay 8-120RMB a year to URBMI,⁴⁸ government subsidized rural residents' 150RMB premium in 2010.⁴⁹

About 10 years ago, OOP outstripped SHI contributions and other subsidies in funding the healthcare expense requirements of the people. After studying the many cases of impacts resulting from cost inflation as China's economy heated, Wagstaff et al.

⁴⁰Cited in Aurore Pelissier, "Health Insurance Reform and Efficiency of Township Hospitals in Rural China: an Analysis from Survey Data," n.d., p. 17.http://www.ces-asso.org/sites/default/files/PELISSIER_AUDIBERT_MATHONNAT_HUANG.pdf

⁴¹State Council Document No. 20, 2007, in Wanchuan Lin, et al, "The Urban Resident Basic Medical Insurance:A Landmark Reform Towards Universal Coverage In China," *Health Economics*. 18: (2009), p. S84

⁴²Wei Yang, "China's new cooperative medical scheme and equity in access to health care: evidence from a longitudinal household survey," *International Journal for Equity in Health* 2013, 12:20

⁴³Wanchuan Lin, et al, "The Urban Resident Basic Medical Insurance:A Landmark Reform Towards Universal CoverageIn China," *Health Economics*. 18: (2009), p. S89

⁴⁴QingyueMeng and Shenglan Tang, p. 16

⁴⁵Adam Wagstaff, et al.. *Reforming China's Rural Health System*, World Bank, 2009, p. 74. The authors deal with uncovered services at length and submit proposals for substantial reforms.

⁴⁶A. Bhattacharjya and P. Sapra, "Health Insurance in China and India: Emergence of Segmented Roles for Public and Private Financing," *Health Affairs* 27, no. 4 (2008): p. 1011

⁴⁷Cited in Meng Qingyue and Tang Shenglan, "Universal Coverage of Health Care in China: Challenges and Opportunities," World Health Report (2010) Background Paper, No 7, Table 1.
http://www.who.int/healthsystems/topics/financing/healthreport/7ChinaM_T.pdf

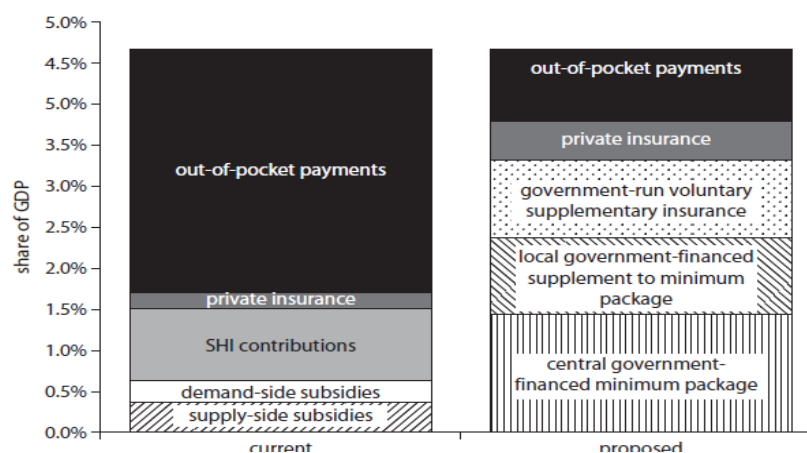
⁴⁸Chen et al. "New evidence on financing equity in China's health care reform - A case study on Gansu province, China," *BMC Health Services Research* 2012, p. 12. Until about 2007, government support for premium merely helped insurance enrolment but not significant IP cost coverage in the rural areas.

Shanlian Hu, "Reform of how health care is paid for in China: challenges and opportunities," *www.thelancet.com* Vol 372 November 22, 2008, p. 1847.

⁴⁹Cited in MengQingyue and Tang Shenglan.

proposed a new financing mix. Whether or not this proposal has been accepted is yet to be evaluated.

2004 and Proposed Financing Mixes



Source: Adam Wagstaff, 2009, p. 197

What is available is the matrix below constructed by Barber and Yao in 2010, showing increasing state share. In 2011 NCMS premium amounted to 230RMB, 80 percent of which is government subsidized.⁵⁰ Insurance premiums in general—together with hospital income and pharmacy sales—contributed around 3 percent of China's 2011 GDP, says a recent estimate.⁵¹

Characteristic	New Rural Cooperative Medical Scheme (NCMS) ³²	Urban Employee-Basic Medical Insurance (UE-BMI) ³³	Urban Residents-Basic Medical Insurance (UR-BMI)
Source of revenues	<p>100 RMB/year (2009)</p> <p>For western areas, the contribution is 40 RMB each from local and central government, and 20 from individuals. The central contribution to eastern provinces tends to be lower, compensated by higher provincial or municipal contributions.</p>	<p>8% of employee wages: "6+2": 6% payroll tax on employers (ranging from 4 to 1 % by municipality) and 2% employee contribution</p> <p>Medical savings accounts generally cover OP expenses, medicines (employer contribution + 30% of employee contribution)</p>	<p>Average 245 RMB for adults, 113 RMB for minors (pilots 2008). In 2008, the government contribution was at least 80 RMB /person, with a central level contribution to west and central areas of 40 RMB/ person. Provincial contributions vary. The poor and disabled receive an additional 60 RMB per year (50% from central).</p>

Source: Barber and Yao, 2010

⁵⁰Tang et al., "Controlling cost escalation of healthcare: making universal health coverage sustainable in China," *BMC Public Health* 2012, 12(Suppl 1):2/13.

⁵¹Dong Junyu, "Cited in Healthcare sector boosted by State Council guidance," *Global Times*, 15 October 2013. <http://www.globaltimes.cn/content/817977.shtml>

Karen Eggleston writes that China has expanded risk pooling through “wide but shallow coverage” that is gradually deepened over time to achieve universal coverage with a robust benefit package; this approach is sometimes called “equal access by 2012 and universal coverage by 2020.”⁵² She adds that household enrolment and voluntary health insurance at the county level manifested NCMS risk pooling such that by 2009, “94% of rural counties offered NCMS.” Municipal-level risk pooling was initiated as UEBMI in 1998.⁵³

Government subsidy to URBMI participants was required to more than 40-80 RMB per enrollee, rural participants in poor provinces upwards of 20 RMB per enrollee.⁵⁴ 200RMB was state subsidy for NCMS and non-UEBMI enrollees in 2011, enrollees paid 30–50 RMB. Complementary Medical Assistance for poor families was managed by the Civil Affairs Ministry.⁵⁵

Other government subsidies have mixed results: higher level hospitals received more causing an imbalance in resource allocation and service delivery and accessibility.

Expenses borne by Chinese patients have been steadily increasing over the years. In 1990, average IP expense in general hospitals of the health sector cost 473.3 RMB and 3,597.7RMB a decade later.⁵⁶ IP expense is covered up to 1436RMB under URBMI scheme or roughly 45 percent of IP cost.⁵⁷ The World Bank states that normal OP service fees cannot be made subject of claims. Under URBMI, normal OP service fees are not eligible for insurance claims.⁵⁸

Using latest available data, OOP expenses for both IP and OP services are recently reported by Zhao et al.:

For the most common health insurance program, the NCMS, the median out-of-pocket (OOP) cost of all inpatient visits in the past year is 2,400 yuan, the median ratio of annual cost to annual expenditures per capita is

⁵²“Health Care for 1.3 Billion:An Overview of China’s Health System,” 2012, p. 8

⁵³ibid. Relying on different risk pools, the three schemes have different IP and OP percentages of expense coverages.”Social Solidarity in BRIC countries,” National Health Insurance Policy Brief No. 23, 2010.

⁵⁴Wanchuan Lin, et al, “The Urban Resident Basic Medical Insurance:A Landmark Reform Towards Universal CoverageIn China,” *Health Economics*. 18: (2009), p. S84); See also, Karen Eggleston, “Health Care for 1.3 Billion: An Overview of China’s Health System,” 2012, p. 8

⁵⁵Winnie Chi-Man Yip, et al. “Early appraisal of China’s huge and complex health-care reforms,” *www.thelancet.com* Vol 379 March 3, 2012, p. 834. Cf: Qingyue Meng and Shenglan Tang, pp. 16-17.

⁵⁶*Chinese Health Statistics Year Book*, 2003, cited in Jian Wang and Amir Mahmood, “The analysis of determinants of individual’s provider choice in urban China,” http://www.cfses.com/06confchina/documents/Final_Papers/Paper_WangJian_Determinants_Of_Individual%27s_Provider_Choice.pdf. “For inpatient expenses, individual’s co-payment does not exceed 20%.”

⁵⁷State Council Evaluation Group for the URBMI Pilot Program, 2008, cited in Wanchuan Lin, et al, “The Urban Resident Basic Medical Insurance:A Landmark Reform Towards Universal Coverage in China,” *Health Economics*. 18: (2009), p. S85.

⁵⁸World Bank, 2010, p. 19

39.7%, and 39.0% of those making inpatient visits spent more than 50% of their annual household expenditure per capita. The median out-of-pocket **inpatient** costs for the two main urban schemes are similar (**2,400 and 3,000 yuan** for the Urban Employee and Urban Resident insurance programs), with median costs as a share of expenditures per capita being significantly lower than the rural scheme (22.2% and 29.7% for the Urban Employee and Urban Resident schemes). Across all schemes the share of individuals with inpatient visits whose out-of-pocket costs exceeded 50% of their expenditures per capita ranged from 15.0% to 39.0%, suggesting that hospital visits create a significant financial burden. Median out-of-pocket costs are somewhat less for outpatient visits, ranging from 100 to 170 yuan for all visits in the past month for the three main schemes. Among outpatients, median costs in the past month as a share of monthly expenditures per capita were 25.0% for NCMS and 11.2% and 22.3% for the Urban Employee and Urban Resident insurance programs.⁵⁹ (emphasis supplied)⁶⁰

Substantial reimbursement levels are targeted by 2015 for UEBMI, URBMI and NRCMS : 75% for inpatient care and above 50% for all outpatient care.⁶¹

Payment relationship in China has been schematically represented as follows:

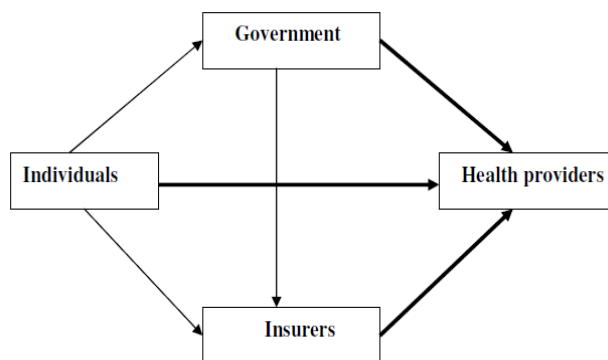
⁵⁹Yaohui Zhao, et al, "Challenges of Population Aging in China: Evidence from the National Baseline Survey of the China Health and Retirement Longitudinal Study (CHARLS), May 2013.

<http://online.wsj.com/public/resources/documents/charls0530.pdf>

⁶⁰Yaohui Zhao, "Challenges of Population Aging in China: Evidence from the National Baseline Survey of the China Health and Retirement Longitudinal Study (CHARLS)," 2013, <http://online.wsj.com/public/resources/documents/charls0530.pdf>. See also Hyacinthe Tchewonpi Kankeu, et al, "The financial burden from non-communicable diseases in low- and middle-income countries: a literature review, *Health Research Policy and Systems* 2013, 11:31, Table 2, page 6 of 12. <http://www.health-policy-systems.com/content/11/1/31>

⁶¹Xuezheng Qin and Gordon G. Liu, "Does Participating in Health Insurance Benefit the Migrant Workers in China? An Empirical Investigation," 2013. <http://www.lepp.zju.edu.cn/upload/2013-05/13053118586236.pdf>

Payment Relationships Between Parties



Source: Meng Qingyue, 2005

China has also been evolving a set of fee schedules for a variety of considerations:

For medical services, the national government provides principles for price setting. Provincial or prefecture governments set fee schedules for public hospitals. Before 1980, a lower-than-cost pricing policy was implemented in order to assure the affordability of health care users. Since early 1980s, prices of medical services were increased. During 1990s, the pricing policy featured lower prices for basic medical services and higher prices for high technologies, which was regarded as one of the causes for rapid expansion of advanced medical technologies. In 2000, the central government reformed the methods by increasing prices of professional services and by decreasing prices for high technologies. Up to middle 2003, most of the provincial governments had adjusted their fee schedules for about 4000 fee items.⁶²

The MOH, the National Development and Reform Commission (NDRC), and the State Administration of Traditional Chinese Medicine (SATCM) issued the *National Schedule of Medical Services* in 2001 with almost 4,000 procedures. Evaluated later, a 2007 edition was released with 207 new and 144 modified procedures. The third edition was released in May 2011 with the intention of becoming the “national standard of pricing in the near term.” Fee categories in these latest editions have been expanded from six to 11 “in order to reflect the efforts of medical personnel and technical risks in a reasonable way.”⁶³

“Episode-based payment” and “fee-for-service” payment have been advanced in the light of liberalization.⁶⁴ Thus hospitals and doctors have sought to make profit by

⁶²Meng Qingyue, “Review of Health Care Provider Payment Reforms in China,” 2005, p. 6.

⁶³Xiaoqing Lu Boynton, et al., *Key Issues in China's Health Care Reform: Payment system reform and health technology assessment*, Center for Strategic and International Studies, 2012, p. 7.

⁶⁴Ye Li, et al. “Factors affecting catastrophic health expenditure and impoverishment from medical expenses in China: policy implications of universal health insurance.” *Bulletin of the World Health Organization* 2012;90: pp, 668, 669.

adding technology-dependent procedures. “Case-mix payment” system has been the goal of introducing “clinical pathway system (*linchuang lujing*) intended for standardisation of healthcare service.”⁶⁵

Given continuing high OOP expenses, especially in the rural areas, three reforms were introduced in 2006-2009 period: the Suqian, Shemmu and Anhui reforms. Suqian district sold public hospitals to “finance public health centres and basic health insurance.” Shemmu, a rich district, “significantly increased health care service levels since 2009, to the extent that a sort of state-financed, free-of-charge health care system.” The poor Anhui province seeks to increase health services at local center, refer severe cases only to hospitals, conduct rehabilitation at home, and make essential medicine at roughly 50 percent of market price, all at government cost and insurance money.⁶⁶

Two writers claim, “NCMS co-payments are high and financial risk protection is thus limited.”⁶⁷ Ye Li says that, in general, high co-payments are meant to “control the financial risk carried by the insurer.”⁶⁸ The co-payments are pegged at 45%, 60% and 70% for MIUE, MIUR and NCMS enrollees, respectively, adds Li, “even though Chinese policy stipulates that the reimbursement rate for inpatients should be above 60%.” In 2009, the “URBMI Annual Cap on Co-payment for Inpatient is 50,-100,000 RMB; Outpatient (Regular Annual Cap) – 50-900RMB; Catastrophic – 80,-110,000RMB.”⁶⁹

In one county, the NCMS-covered expenses excluded:

- Drugs and expenses excluded under urban employees’ health insurance scheme.
- Expenses at uncontracted health facilities.
- Expenses due to alcoholism, suicide, accident, violence, injury, criminality, and occupational injury.
- Expenses for hospitalization after getting notice of discharge.⁷⁰

Mingsheng Chen, et al. arrived at the same conclusion as O’Donnell: “Out-of-pocket payments were progressive but not equitable. Public health insurance coverage has

⁶⁵Alex HE Jingwei, “China’s Ongoing Healthcare Reform: Reversing the Perverse Incentive Scheme, *East Asian Policy*, 2(3), 2010, p. 46.

⁶⁶Dongmei Liu and Barbara Darimont, “The health care system of the People’s Republic of China: Between privatization and public health care,” *International Social Security Review*, Vol. 66, 1/2013, pp. 107-107. British and German-modeled proposals are also competing reforms advanced by different research groups. Ibid., pp. 108-110.

⁶⁷Qingyue Meng and Shenglan Tang. Universal Coverage of Health Care in China: Challenges and Opportunities. *World Health Report* (2010) Background Paper, 7, p. 14.

⁶⁸Ye Li, et al. “Factors affecting catastrophic health expenditure and impoverishment from medical expenses in China: policy implications of universal health insurance.” *Bulletin of the World Health Organization*, 2012;90: p. 668

⁶⁹“China’s Health Care Reforms,” *Health International* No. 10. 2010, p. 57

⁷⁰Xiaoyun Sun, et al, “Health payment-induced poverty under China’s New Cooperative Medical Scheme in rural Shandong,” *Health Policy and Planning* 2010;25: 421

expanded but financing equity has decreased.”⁷¹ O’Donnell would hazard a hypothesis: “If aim (of subsidy) is to ensure poor get most of public health services, then (it is) failing.”⁷²

Poverty and catastrophic impact may derive from basically same source, but for purposes of delineation based on studies the following are being cited:

Medical expenses are said to have rendered 23.3 percent of the rural population impoverished. As to impoverishment, Xiaoyun Sun writes:

Our study found that for the households remaining below the NPL after reimbursement, their health payment-induced poverty gap before NCMS reimbursement was 1210.1 Yuan, which means these households’ annual per capita incomes were pushed far below the poverty line due to paying for health care. After reimbursement the average was reduced to 977.2 Yuan, but this is still too severe a burden for these rural households. Both indicators of health payment-induced poverty were reduced after households received NCMS reimbursements. However, the majority of health payment-impovertised households remained in health payment-induced poverty; the severity of their situation was simply alleviated slightly.⁷³

And concerning catastrophic impact, Ye Li’s statistical inquiry has identified some determinants of catastrophic health expenditure:

Households headed by a female, an unemployed person or a person having little education, and households having at least one member who was elderly, ill from tuberculosis or any chronic non-communicable illness, or hospitalized were more likely to experience catastrophic health expenditure. Households without insurance were at higher risk of catastrophic health expenditure compared with those covered by the MIUE and MIUR. Economic status was inversely associated with catastrophic health expenditure, that is, wealthier households were more protected against catastrophic health expenditure. Urban households were more likely to escape catastrophic health expenditure than rural

⁷¹“New evidence on financing equity in China’s health care reform - A case study on Gansu province, China.” *BMC Health Services Research* 2012, 12:466, pp. 1,8.

⁷² Owen O’Donnell, et al., “Analyzing Health Equity Using Household Survey Data,” The World Bank, Washington DC, 2008, www.worldbank.org/analyzingtheequity. PPT file

⁷³Xiaoyun Sun, et al. “Health payment-induced poverty under China’s New Cooperative Medical Scheme in rural Shandong, *Health Policy and Planning* 2010;25: p. 424

households. Having a large family and at least one young member appeared to be protective factors.⁷⁴

FFS is also to blame for “perverse incentives that exacerbate catastrophic health expenditure.”⁷⁵ Meanwhile, with NCMS reimbursements are reported to have reduced the intensity of catastrophic health expenditure in Datong county but not so in two other counties. Datong county folks were said to have other sources of reimbursements than NCMS.⁷⁶

3. Population Coverage

At the time of the SHI integration in 2009, more than 200 million were said to lack health insurance.⁷⁷ By 2011, 95% of the total Chinese had some kind of coverage. In 2013, China claims 99 percent (800 million) coverage of the rural population under the New Rural Cooperative Medical Scheme (NCMS). A decade ago, it was a mere 8 million, and eight years ago it was 179 million. In 2010, 93 percent of the entire Chinese population had some health insurance coverage, urban residents around 65 percent with many of them possibly circularly migrating. Closer to Hong Kong 43.1 percent of Shenzhen residents remained uninsured in mid-2013, according to a study.⁷⁸

In August 2012, a supplementary scheme to cover critical diseases of rural and unemployed rural folks was introduced. At no additional cost to the insured, the scheme hopes to pay for at least “50 percent of medical expenses over and above the reimbursement ceiling in the basic scheme.” Additionally, migrants may enjoy portability of their insurance coverage.⁷⁹

Economics (or income class) and geography inform Chinese utilization rate.

⁷⁴Ye Li, et al, “Factors affecting catastrophic health expenditure and impoverishment from medical expenses in China: policy implications of universal health insurance,” *Bulletin of the World Health Organization* 90 (2012): 666-667

⁷⁵Ibid, p. 665.

⁷⁶Luying Zhang, “How effectively can the New Cooperative Medical Scheme in China reduce catastrophic health expenditure among the poor and non-poor?” <http://ihea2009.abstractbook.org/presentation/799>

⁷⁷Veronica M. Valdez, “Today, more than 200 million Chinese lack health insurance: China's De-Socialized Medicine,” 11 June 2009.

http://www.foreignpolicy.com/articles/2009/06/10/chinas_de_socialized_medicine. “The new government spending will pay for basic health care, but hospital services will still be financed by the employment-based SHI scheme or by self-payment by the uninsured in urban areas and by the NCMS in rural areas. (p. 466) .Winnie Yip and William C. Hsiao, “The Chinese Health System At a Crossroads,” *Health Affairs*, 27, no.2 (2008):460-468.

⁷⁸“Nearly 1.3 billion Chinese now have health insurance, but poor are still neglected,” 19 July 2013. http://www.cmaj.ca/site/earlyreleases/19july13_Nearly_1_point_3_billion_Chinese_now_have_health_insurance_but_poor_are_still_neglected.xhtml

⁷⁹ISSA, 2012.

Rich rural residents utilize more healthcare than poor counterparts, given the same needs for healthcare. The exception is that poor rural residents utilized more outpatient service than the rich in 2008.... The inequity of inpatient utilization dramatically increased from 1993 to 2003 and decreased afterward. The magnitude of inequity remained large over fifteen years. ... Even though utilization of inpatient service became less inequitable in 2008, the gap between the concentration indices of inpatient and outpatient services is still distinguished.⁸⁰

Thus, utilization inequity persists with the poor-rich divide:

Even with the same need for inpatient services, richer individuals utilize more inpatient services than poorer individuals. Income is the principal determinant of this pro-rich inpatient utilization inequity- wealthier individuals are able to pay for more services and therefore use more services regardless of need. However, rising income and increased health insurance coverage have reduced the inequity in inpatient utilization in spite of increasing inpatient prices.

It has been hoped or wished though that growth and prosperity, especially in relation to income, may diminish or wipe out the inequity.⁸¹

Kakwani Index for China, 2002 and 2007, by Area

Year	2002		2007	
	Urban	Rural	Urban	Rural
General taxation	-0.0024	-0.0281	-0.0177	-0.0097
Public health insurance	0.0742	-0.0615	0.0661	-0.1436
Overall Kakwani Index	0.0431	0.0148	0.0351	-0.0226

Source of data: Mingsheng Chen, et al., 2012, p. 1

Thailand

A. Profile

Thai identity rests on the so-called “three pillars” formulated by King Rama VI. These are:

- the nation, including people, land, and language (*chat*)
- Buddhism, the religious dimension (*satsana*)

⁸⁰Zhongliang Zhou, et al, Assessing equity of healthcare utilization in rural China: results from nationally representative surveys from 1993 to 2008,” *International Journal for Equity in Health* 2013, 12: p. 43

⁸¹Zhongliang Zhou, “Measuring the equity of inpatient utilization in Chinese rural areas,” *BMC Health Services Research* 2011, p.11

- the King, or monarchy (*phramahakesat*)

Its economy is 60 percent export dependent even as its tourism is one of the most vibrant in the region. Recent disturbances chiefly in the Thai capital of Bangkok over the question of leadership, including the devastating “Asian tsunami” and the 1997 financial crisis have not dampened Thai performance. With these and the populist Thaksin Shinawatra, Thailand has pushed vigorously for inclusive health insurance, especially among the poor.

Characteristics	Thailand
Country characteristics in 2012*	
Population	66,785,001
GDP (US\$)	\$365.6 billion
GDP per capita (US\$)	\$5,480
NHE as % of GDP	4.1%
Health expenditure per capita(US\$)	\$202
Infant mortality rate (per1,000 live births)	11
Out-of-pocket health expenditure (% of private expenditure on health) (2011)	55.8
Life expectancy (2011)	74
Percent of population 65 years old and above	9

Source: World Bank, 2013

B. SHI

The key developments in the Thai SHI are chronologized in the box below:

Pre-1974 – Fee exemption system among poor people covered by the universal coverage scheme (UCS)
 1974 – Implementation of workmen’s compensation fund (WCF) among private formal sector employee
 1975 – Implementation of low income scheme (LIS) among poor people under the UCS
 1978 – Implementation of civil servants medical benefits scheme (CSMBS) among government employee
 1981 – Implementation of Type B fee exemption among poor people under the UCS
 1983 – Implementation of health card scheme (HCS) among near poor under the UCS
 1990 – Implementation of social security scheme (SSS) among private formal sector employee
 1994 – Implementation of medical welfare scheme (MWS) among poor people under the UCS
 1999 – Implementation of SIP in 6 provinces among poor people under the UCS
 2001 – The universal coverage policy pilot was tested in 6 provinces; CSMBS and SSS combined covered only 15 million people. The “30 Baht scheme” replaced the existing welfare scheme for indigent people and voluntary health insurance for those who are self-employed
 2002 – UCS implemented nationwide under National Health Security Act that mandated the National Health Security Office (NHSO) and the National Health Security Fund
 2006- UC scheme (30-Baht card) abolished as Thaksin was unseated in a late September coup
 2012- UC scheme reintroduced “for patients who receive prescriptions and are willing to pay”; Universal Health Insurance prepared by the Ministry of Health in 2012 and is integral to 2011-2015 Five-Year Health Sector Development Plan

Adam Wagstaff and Wanwiphang Manachotphong describe the two components of the Thai UC:

For the Transition State, there are two action plans. First is the expansion of the coverage with the Social Security Scheme. Second is the reform of the existing welfare scheme for indigent people and voluntary health insurance for self-employed people to the new compulsory scheme, “the 30 Baht scheme”. After the Universal Coverage Policy was totally introduced in April 2002, the social health protection can be divided in to three groups, schemes for public employees, schemes for private employees and scheme for the rest of Thai (informal sector).⁸²

The NHSO 10-year report (2001-2010) cites the following features of Thailand’s UCS:

- a tax-financed scheme free at the point of service (the initial co-payment of 30 baht or US\$ 0.7 per visit or admission was terminated in November 2006);
- a comprehensive benefits package with a primary care focus;
- a fixed annual budget with a cap on provider payments.⁸³

Historically, Hanvoravongchai and Hsiao claim that Thai sought to legislate, unsuccessfully at that, a social security bill in 1954.⁸⁴ Meanwhile, Wang and Pielemeier claim that Thailand was among a few countries that instituted so-called “community-based health insurance” (CBHI) meant as a kind of coping strategy for the rural population.⁸⁵

Sakunphanit⁸⁶ visualizes the historical development of the Thai health insurance system up until 2002, the actual UC year, for each sectoral coverage.

⁸² Ibid.

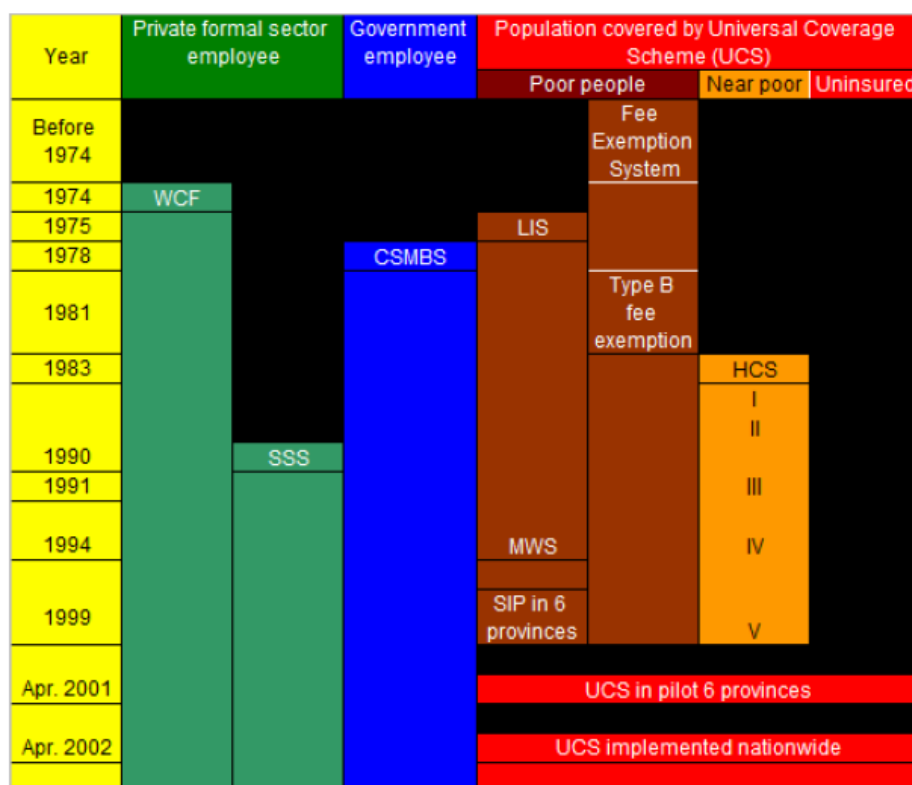
⁸³ Joanne McManus et al, *Thailand’s Universal Coverage Scheme: Achievements and Challenges, An independent assessment of the first 10 years (2001-2010)*, 2012, p. 23

⁸⁴ Piya Hanvoravongchai and William C. Hsiao, “Thailand: Achieving Universal Coverage with Social Health Insurance,” in William C. Hsiao and R. Paul Shaw, eds. *Social Health Insurance for Developing Nations*, World Bank, 2007, pp. 133-154.

⁸⁵ Ibid, p. 140. See also, Hong Wang and Nancy Pielemeier, “Community-Based Health Insurance: An Evolutionary Approach to Achieving Universal Coverage in Low-Income Countries,” *Journal of Life Sciences* 6 (2012), p. 322.

⁸⁶ Thaworn Sakunphanit, “Universal Health Care Coverage Through Pluralistic Approaches: Experience from Thailand,” ILO Subregional Office for East Asia, n.d., http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---secsoc/documents/publication/wcms_secsoc_6612.pdf

Chronological development of the health insurance system in Thailand



Source: Sakunphanit, n.d.

The different schemes have been described as to qualifications of beneficiaries⁸⁷, services that maybe availed, benefits⁸⁸ (e.g., cash for income loss), and modes of payment (importantly, who covers the cost⁸⁹).

1. Service Coverage

Item\Country	Thailand
Ambulatory services	UC beneficiaries have access to free ambulatory care at registered primary-care contractor networks, which is normally a district health system (DHS), consisting of sub-district health centres—(HC) and district

⁸⁷See, e.g., Cha-Aim Pachanee and Suwit Wibulpolprasert, "Incoherent policies on universal coverage of health insurance and promotion of international trade in health services in Thailand," *Health Policy and Planning*, 2006, 21 (4): 310-318.

⁸⁸Hanvoravongchai and. Hsiao, 2007.

⁸⁹See, e.g. Reisman, D A. "Payment for health in Thailand," *International Journal of Social Economics* 26. 5 (1999): 609-641.

	hospitals (DH), with a nominal payment, 30 Baht, equivalent to US\$ 0.7 per visit (with exemption for previous LIC holders ⁹⁰
Inpatient (IP)/ Outpatient (OP) services	Community hospitals supply IP services to amphur (district) CSMBS-IP services WCS- OP and IP services ⁹¹
Choice of providers	CSMBS- freer choice of health facilities with access to IP services at private hospitals. SSS- only to contracted hospital (public or private) WCS- provides freer access but with copayments if the total charge is higher than the set ceiling. HC- only to MOPH facilities with referral networks and has no copayment. ⁹²
Referral mechanism	Referral system for patients with STEMI was developed as a guideline for practice among health care team at network hospitals. Referral system was designed based on geographic distribution and proficiency level of network hospitals. ⁹³
Cash benefits	SSS provides cash benefits
Physical check-up	SSS does not cover annual check-ups, etc. ⁹⁴ CSMBS- yes to annual check-up ⁹⁵
Prevention, health promotion	Health promotion and disease prevention are directed to four different levels of government. ⁹⁶ UCS provides for preventive (e.g., immunizations, annual physical checkups, premarital counseling, antenatal care and family planning services, etc.). ⁹⁷
Services not covered	Private bed, special nurse, eye glasses. Services of private clinics or those secured bypassing the registered providers without referral procedures. ⁹⁸

⁹⁰Supon Limwattananon, et al., "Equity in financing healthcare: impact of universal access to healthcare in Thailand," EQUITAP Project: Working Paper # 16, 2005, p. 3;

<http://www.equitap.org/publications/docs/EquitapWP16.pdf>

⁹¹Reisman, D A, "Payment for health in Thailand," *International Journal of Social Economics* 26. 5 (1999): 609-641.

⁹²Sanguan Nitayarumphong, "Universal Coverage of Health Care: Challenges for the Developing Countries," in *Achieving Universal Coverage of Health Care*, p. 202

⁹³Apiradee Treerutkuarkul, ed. Achara Suksamran, et al, *Universal Health Coverage: Case Studies From Thailand*, HSRI, 2012, pp. 64-65

⁹⁴Reisman, 1999

⁹⁵Thaworn Sakunphanit, p. 13

⁹⁶Chris Bates and Peter Annear, "What Other Countries Can Learn from Thailand's Path to Universal Health Coverage," Issues Brief, Nr 5, December 2012, p. 2,
http://ni.unimelb.edu.au/__data/assets/pdf_file/0010/679519/IB_5.pdf

⁹⁷"Thailand: Universal Coverage Scheme," n.d. <http://jointlearningnetwork.org/content/universal-coverage-scheme>

⁹⁸Supon Limwattananon, et al., "Why has the Universal Coverage Scheme in Thailand achieved a pro-poor public subsidy for health care?," *BMC Public Health* 2012, 12(Suppl 1): 8

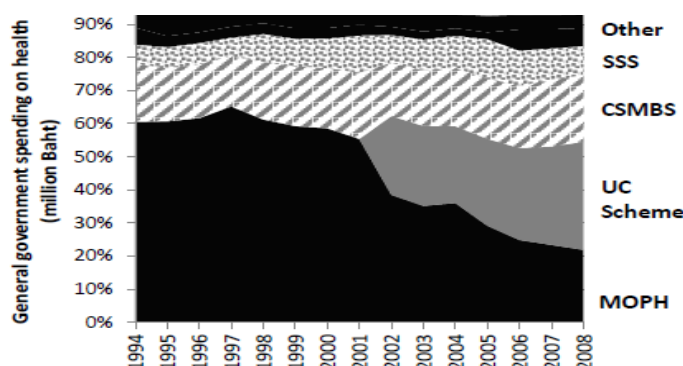
In 2003, Thailand had 34,863 private hospital beds (Bangkok, 15,227; Provinces, 19,636).⁹⁹ The following year, it had 1,278 hospitals (979 public, 299 private) with 133,245 beds. This means one bed per almost 2,000 persons. Then, public hospital beds outside Bangkok constituted roughly 80 percent of total beds. There are more private hospitals in Bangkok, in the big cities, and in the Central region than in most rural areas, say, northern Thailand.¹⁰⁰ By 2007, total beds counted 140,007. The 318 private hospitals had 30,564 and the 1,020 public hospitals 156,494.¹⁰¹

Outpatient care was accessed, based on a study, at about 3.01 times per person per year at an average expense of 1,572.33 Baht per time. For inpatient, it was 1.14 times/person/year and 3.89 days/time at 15,656.25 Baht/time. This was for 45 years old and above and elderly.¹⁰²

2. Financial Risk Protection

From a very big share of financing healthcare, MOH is now supplemented by UC, CSMBS and SSS contributions (figure below). Throughout the 1980s, health services were generally paid for from private sources. (See table below)

Changing Financing Mix in Thailand



Source: Thai National Health Accounts (2010)

Source: Magnus Lindelow, et al, "Government Spending and Central-Local Relations in Thailand's Health Sector," World Bank, August 2012, p. 20)

⁹⁹Chap 6: Health Service Systems in Thailand," p. 279

¹⁰⁰Pornthip Chompook, et al, *Thailand: Health System and Pandemic Preparedness: Rapid Situational Analysis Report*, 2009, p. 18.

¹⁰¹Health Resources Survey Report, Bureau of Policy and Strategy, Ministry of Public Health, 2007

¹⁰²Papar Kananurak, "An Economic Analysis Of Voluntary Health Insurance After Retirement," Ph.D. Economics Dissertation,. Natioal Institute of Development Administration (Thailand), 2013, p. 160.

Percent Source of Thai Health Financing, 1984, 1986, 1987

Sources of funding	1984	1986	1987
Public sources:	27.9	26.0	24.2
MOPH	17.4	15.3	14.1
Other ministries	6.9	6.5	6.0
Public employee medical benefits	3.6	4.2	4.1
Workmen's compensation fund	0.5	0.4	0.4
State enterprise employee medical benefits	0.8	0.9	0.8
Private insurance	0.8	0.7	0.7
Foreign aid	0.8	0.8	0.7
Private households	69.3	71.2	73.2
Total: Percent	100.0	100.0	100.0
Million Baht	53,032.9	62,099.9	67,771.3

Sources: Nittayaramphong and Tangcharoensathien, 1994 originally from Health Planning Division, MOPH; National Accounts; Workmen's Compensation Fund, Ministry of Labour and Social Welfare; The Controller-General's Department, Ministry of Finance; Financing Health Service and Medical Care in Thailand, 1987 report, MOPH.

Source: Supakankunti S., "Future Prospects of Voluntary Health Insurance in Thailand," 1997, p. 12

As Thaksin was unseated in a late September 2006 coup, the 30-Baht Scheme previously declared as the Thai version of UC scheme which was strongly pro-poor and pro-uninsured was beginning to be evaluated. The 30-Baht Scheme replaced the original 100-Baht plan promised during the campaign. The pre-existing Health Card Scheme (HCS) and the Health Welfare for the Poor and the Disadvantaged Scheme (HWPDS) were said to have given birth to the 30-Baht Card that improved utilization by the poor.¹⁰³ This UC scheme was abolished in September 2006 (and reintroduced in 2012 "for patients who receive prescriptions and are willing to pay"¹⁰⁴), perhaps the only initiative that went beyond the particularistic "card-giving," "hospital-building" and "hospital-upgrading" that ate much of increases in the pre-Thaksin Thai health budget and improved infant mortality figures in a relatively short period.¹⁰⁵

The 30-Baht premium collection was terminated due to technical feasibility issues and was instead replaced by a general tax to cover UCS premiums. Premiums for SHI for public and private sector employees remained as independent schemes and were fully covered by enrollees.¹⁰⁶

¹⁰³Viroj NaRanong and Anchana NaRanong, "Universal Health Care Coverage: Impacts of the 30-Baht Health-Care Scheme on the Poor in Thailand," *TDRI (Thailand Development Research Institute) Quarterly Review*, Vol. 21 No. 3 September 2006, pp. 3-10.

¹⁰⁴Chris Bates and Peter Annear, "Lessons learned from Thailand's universal health care scheme: Institutional and organisational arrangements," *Health Policy & Health Finance Knowledge Hub Issues Brief No. 11*, May 2013, p. 2. http://ni.unimelb.edu.au/_data/assets/pdf_file/0010/778726/IB_11.pdf

¹⁰⁵Allen Hicken, and Joel Sawat Selway, "Forcing the Genie Back in the Bottle: Sociological Change, Institutional Reform and Health Policy in Thailand," *Journal of East Asian Studies*, 12:1 (Jan-Apr 2012), pp. 67-68

¹⁰⁶Viroj Tangcharoensathien, "Promoting universal financial protection: how the Thai universal coverage scheme was designed to ensure equity," *Health Research Policy and Systems*, 11:25 (2013). For more on

NHSO fee schedule is provided for, among others:

1. Referred OP cases on reimbursement basis
2. Additional payment using NHSO fee schedule for medical instruments
3. Disease management initiatives and special services. (Leukemia, lymphoma, cleft lip & cleft palate, open heart surgery, haemophilia, cataract extraction, surgery in epilepsy patients, urgent treatment in stroke fast track, bone marrow transplantation in children and secondary prevention for Diabetes Mellitus.)
4. Rehabilitation services for the disabled-for payment of services, instruments, and prosthesis.¹⁰⁷

The prevailing CSMBS's FFS "leads to an uncontrollable cost escalation," says a senior health policy official. He adds:

Single fee schedule throughout the country with unified rule and mechanism is applied. Thailand needs to learn Japan's cost control experience both in terms of process of cost control, fee schedule development and its revision every two years and technical requirements in order to control the total cost, CSMBS's expenditure and apply the fee schedule systems to control cost of referral out-patient between hospitals of UC Scheme.¹⁰⁸

Capitation is the main mode of payment by government to contractors and their contracted service providers for OP services and prevention and health promotion (P&P). Under the UC scheme, it has risen from about 1,200 Baht in 2002 to about 1,900 Baht five years hence¹⁰⁹. IP services are paid by "global budget plus DRG (diagnosis-related groups) at provincial level." Global budget is planned to be operated at the national level. NHSO maintains and manages fee schedule for "outside registered provider of A&E. Although co-payment¹¹⁰ has not been provided for, CSMBS is reportedly introducing it for long private room stays and boarding. Belatedly, National

the UC Scheme, see Netnapis Suchonwanich, "Universal Coverage Experiences of Thailand," 2010. http://www.metaphilippines.org.ph/MeTA-Philippines-Downloads/UHCHandout-1-Sept-2010-%5BAnnex-13%5D%20Updated_Model_Thailand.pdf

¹⁰⁷NHSO Annual Report 2008, p. 14

¹⁰⁸Walaiporn Patcharanarumol, "The Case of Thailand," (International Health Policy Program (IHPP), Ministry of Public Health), <http://ihea2013.abstractsubmit.org/sessions/1628/>

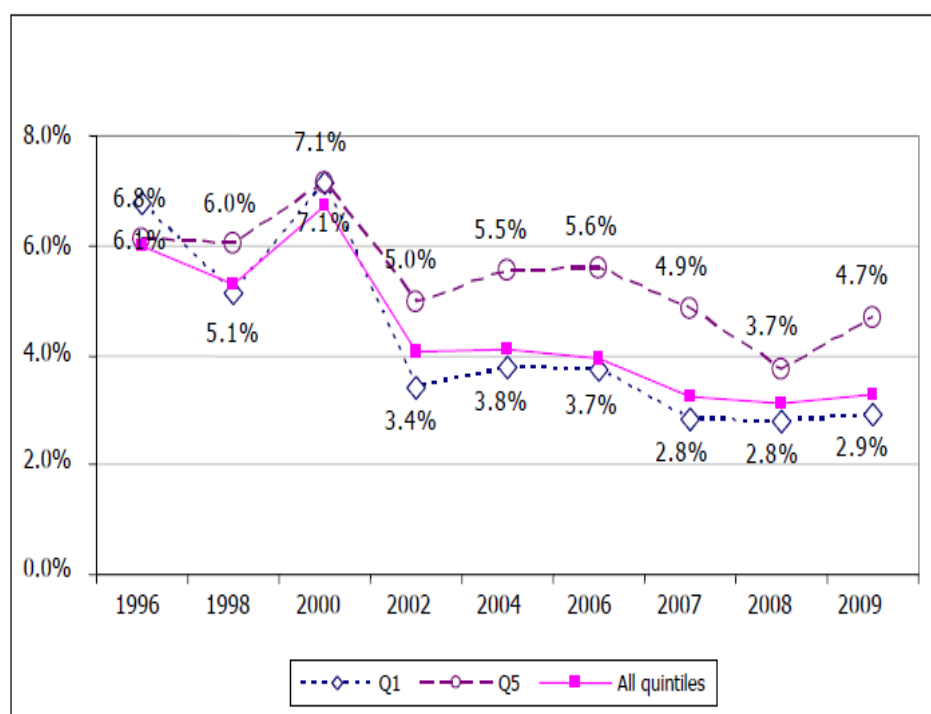
¹⁰⁹Samrit Srithamrongsawat, "Payment methods of health insurance system in Thailand," PPT, n.d., slide 22.

¹¹⁰High co-payments was meant to deter abuse of access to OP services and to reduce cost to the prevailing schemes. See Viroj Tangcharoensathien, et al., "Research Series of Thai Health Care Financing : Part 3: Co-Payment in Universal Coverage Scheme : A Policy Analysis," Vol. 15 No. 1 January - February 2006. <http://thailand.digitaljournals.org/index.php/JOHS/article/view/15234>; Thitiwan Sritharoen, Universal Health-Care Demands In RuralNorthern Thailand: Gender And Ethnicity," *Asia-Pacific Development Journal* Vol. 15, No. 1, June 2008, p. 71)

Economic and Social Development Board (NESDB) has proposed that the patients share cost of IP services in terms of co-payment under the UC (“30Baht”) scheme that covers about 48 million people, but in May 2013 activists have protested against co-payments for People Living with HIV/AIDS.¹¹¹

OOP cost impoverished Thais for covering IP services. The 30-Baht card of the Thaksin’s UC scheme pushed impoverishment incidence from 11.9% in 2000 to 2.6% in 2004. Subsequently less and less (except in 2009) poor Thais had experienced CHEs.¹¹²

Incidence of Catastrophic Health Expenditure, by Income Quintile, 1996-2009



Source: “Thailand’s UCS : Achievements and Challenges 2001-2010,” 2010

Reisman (1999) cites Kovindha’s 1997 study that concludes that, in Pattani, religion and educational attainment could not help predict utilization rate.¹¹³ With demographic

¹¹¹Apiradee Treerutkuarkul, ed. Achara Suksamran, et al, *Universal Health Coverage: Case Studies From Thailand*, HSRI, 2012, pp. 19; Sanguan Nitayarumphong, “Universal Coverage of Health Care: Challenges for the Developing Countries,” in *Achieving Universal Coverage of Health Care*, p. 208-209; “NHSO delays UC co-payment talks,” 18 May 2013, <http://www.bangkokpost.com/news/health/350631/nhso-delays-uc-co-payment-talks>

¹¹²JadejThammatach-aree, “Health systems, public health programs, and social determinants of health: Thailand,” October 2011, p. 22

¹¹³O. Kovindha, “The Social Security Health Insurance Model in Pattani, Thailand: Health Status and Patterns of Utilization,” PhD thesis, University of Calgary, 1997.

shift, elderly Thais use health services “2.3 times of general population.”¹¹⁴ In some respects, utilization rate is relied upon for negotiating contractors’/providers’ fees. For the UC and SHI OP utilization is important in determining capitation rate.¹¹⁵ The 2008 THE budget per capita rose to US\$171 due, among others, to increased utilization rates.

3. Population Coverage

Universal coverage was unveiled in Thailand in 2001 although it became operational only in the succeeding year. It was a “national strategic policy.” Latest estimate of Thai UHC coverage is 99 percent of the population.¹¹⁶

Before 2001, four schemes were available to the Thai population: the Medical Welfare Scheme (WHS-33 percent); the Health Card Scheme (HCS-12 percent); the Civil Servants Medical Benefits Scheme (CSMBS- 11 percent), and; the Social Security Scheme (SSS- 10 percent).¹¹⁷ However, in 2001, 75 percent of the population, or 43 million, were still uninsured. These schemes have been described, thus:

The Medical Welfare Scheme (WHS) provided tax-financed coverage to the poor and vulnerable groups, including the poor, the elderly, children below the age of 12, secondary school students, the disabled, war veterans, and monks. The Health Card Scheme (HCS) was a public voluntary insurance program for nonpoor households who were ineligible for the WHS. The Civil Servants Medical Benefits Scheme (CSMBS) was provided as a fringe benefit to current and retired civil servants and their dependents. The Social Security Scheme (SSS) aimed to cover employees of establishments with more than 10 workers, but not their dependents, and was – and still is – financed through a payroll tax (1.5 percent paid by the employer, 1.5 percent paid by the employee) and a subsidy (the government also pays 1.5 percent). Outlays per enrollee varied considerably across the schemes: the CSMBS recorded the highest at baht 2,106; the SSS recorded the second highest at baht 1,558; and the HC and MWS recorded much lower outlays per enrollee of just baht 534 and baht 363 respectively.¹¹⁸

¹¹⁴Thai working group on Observatory of Health Systems and Policy, “Thailand Health Financing Review 2010,” 2010, p. 39

¹¹⁵World Bank, “Health Equity and Financial Protection Report, World Bank, 2012, p Table 14, p. 30

¹¹⁶ Phusit Prakongsai and Suwit Wibulpolprasert, “Roles of governments in achieving universal health coverage:Lessons from Thailand,” Seminar on Toward the future we want: Health social protection for everyone

Utopicus: Spacio_US, Concepción Jerónima Madrid, Spain, 25 October 2012.

¹¹⁷“Should India Create a Single National Risk Pool? Some Lessons from Thailand, Mexico, and Colombia,” Results for Development Institute, April 2011, p. 6.

<http://r4d.org/sites/resultsfordevelopment.org/files/R4D%20PHFI%20Risk%20Pooling%20Technical%20Note%2011%20April%202011%20final.pdf>

¹¹⁸Ibid.

The CSMBS and SSS combined covered only 15 million people in 2001. The CSMBS was funded by general taxation and SSS by payroll tax. CSMBS members were free to choose providers who were paid on a FFS basis while SSS members “had to register and seek care at first-contact facilities. Those bypassing the system had to pay out of pocket.”¹¹⁹

The overall Thai Kakwani index in 2006 was 0.041¹²⁰. In 2008, the NHSO noted that:

many features of the UC promote equity in health. Empirical evidence shows that Concentration Index (CI) of general tax revenue in 2002 was 0.6996 which indicated *the rich contributed a larger share than the poor*. Recent study on benefit incidence analysis found that for ambulatory services, the government subsidy was pro-poor at district health system. The CI was - 0.3326 and - 0.2921 for health center and community hospital, respectively. It was slightly less progressive at general and regional hospital level (CI = -0.1496). For in-patient care, it was more progressive in favor of the poor at community hospital, the CI was - 0.3130 in 2001 and -0.2666 in 2004. It was less progressive in favor of the poor at general and regional hospital, the CI was -0.1104 in 2001 and - 0.1221 in 2004.¹²¹ (emphasis supplied)

Vietnam

A. Profile

The Vietnamese successively and successfully fought the French, American and Chinese forces from the 1950s. Vietnam’s rise from the ravages of war has been phenomenal and its *doi moi* policy seems to have fueled the people’s aspirations to

¹¹⁹Ibid.

¹²⁰Limwattananon, Vongmongkol et al., 2011, cited in JadejThammatach-aree, p. 21; Equity in care but not in financing is discussed in Siriwan Pitayangsarit, “The Introduction of the Universal Coverage of Health Care Policy in Thailand: Policy Responses,” University of London Ph.D. Thesis, 2004. Kakwani index is explained, thus: “The Kakwani index, another indicator for measuring the progressivity of health care payments, is defined as twice the area between the concentration curve of health payments and the Lorenz curve. The index can be calculated as, $\pi K = C - G$, where C is the health payment concentration index and G is the Gini coefficient of household income or expenditure. The value of the Kakwani index (πK) ranges from -2.0 to +1.0. A negative Kakwani index value indicates that health care payments are regressive, and the concentration curve lies inside the Lorenz curve. In contrast, a positive value indicates the progressive nature of health care payments, and its concentration curve lies outside the Lorenz curve.” Limwattananon S, “The equity impact of Universal Coverage: health care finance, catastrophic health expenditure, utilization and government subsidies in Thailand,” IHPP Thailand, 2011, p. 15. http://www.crehs.lshtm.ac.uk/thai_biafia_19jul.pdf

¹²¹NHSO Annual Report 2008, p. 25.

go beyond the limitations of resources and opportunities afforded by the regional and global environment. It has become net rice and coffee exporter with an expanding industrial sector, a devalued though stable currency, and huge FDI inflows. Its version of the 2012 “three pillar” economic reform hopes to address issues in public investment, banking and state enterprises. New technologies and infrastructure are steadily assisted by foreign donors and creditors. Below is a summary of some key figures of Vietnamese health-related facts at a glance:

Characteristics	Vietnam
<i>Country characteristics in 2012*</i>	
<i>Population</i>	88,775,500
<i>GDP (US\$)</i>	\$141.7 billion
<i>GDP per capita (US\$)</i>	\$1,596
<i>NHE as % of GDP</i>	6.8%
<i>Health expenditure per capita(US\$)</i>	\$95
<i>Infant mortality rate (per1,000 live births)</i>	17
<i>Out-of-pocket health expenditure (% of private expenditure on health) (2011)</i>	93.3
<i>Life expectancy (2011)</i>	75
<i>Percent of population 65 years old and above</i>	7

Source: World Bank, 2013

B. SHI

Vietnamese SHI experienced steadily increasing coverage, especially among the poor but continuing OOP expensed. Liberal policies under *doi moi* not only increased GDP but also a market for health services and pharmaceutical products with negative impacts.¹²² Increasing government spending covered more people who were poor and near poor but also those under 6 years old, elderly and students. Care utilization has steadily risen. The public sector still dominates the health scene with more human resources, hospitals, and beds, among others, than the private sector. It also covers all levels of health care provision down to the communes. User fees, capitation, co-payment, and subsidies have seen rising cost of health care but also improving health status.

¹²² Anna Marriott, “Vietnam’s healthcare system suffers on policy failure,” Oct 24th, 2011. <http://www.globalhealthcheck.org/?p=423>. Cf. Nguyen Thi Dan Thanh, “The Vietnamese social health insurance for the near-poor: A health capability approach,” Master thesis in Development Geography. University of Oslo. 2013. Shortly after implementing the insurance law, at least one assessment spoke negatively on the poor’s attitude toward enrolment. See “Health insurance fails to attract poor,” July 5, 2011. <http://vietnamnews.vn/print/213003/health-insurance-fails-to-attract-poor-.htm>. Corruption too has been expected to derail Vietnam’s SHI. See Taryn Vian, et al., “Confronting corruption in the health sector in Vietnam: Patterns and prospects,” *Public Administration and Development*, 32:1 (2012):49-63. Government’s medicine procurement system is also deemed problematic. See Tuan Anh Nguyen, “Medicine Prices and Pricing Policies in Vietnam,” Ph.D. Thesis University of New South Wales, April 2011.

VIETNAM

- 1986 – *Doi moi* policy called for acceleration in the sustainability of the Vietnamese health system
- 1990 – allowed market forces to come in and public health services paid for privately and public health manpower to practice privately
- 1992 – implemented Decree No. 299/HDBT which included employees and employers with more than 10 workers, civil servants, pensioners, socially aided people, staff of international representative organizations in Vietnam
- 1994 – Decree No. 95/1994/ND-CP, which entitled the poor to free medical treatment
- 1998 – Decree No 58/1998/ND-CP which included members of the congress and people's council, pre-school teachers, socially protected people, dependents of army officers and soldiers, and foreign students in Vietnam
- 1999 – Circular No.05/1999, which legalized provinces to use their budget to enrol at least 30% of the poor in their jurisdiction
- 2002 – Decision No. 139/2003/QĐ-TTg introduced the Health Care Fund for the Poor which provided free medical treatment for the poor in every province
- 2005 – Decree No. 63/2005/ND-CP which included children under 6 and near poor people
- 2006 – Enrolment, coverage and usage of health coverage started to pick up
- 2007 – Joint Circular No. 06/2007/TTLB-BYT-BTC, which included the voluntary participation in the health insurance scheme
- 2008 – Health Insurance Law passed by the National Assembly, which included farmers, those working in agriculture, forestry, fishery and salt producers
- 2009 – declared the implementation of the Law on Health Insurance by 2014

4. Service Coverage

Item\Country	Vietnam
Ambulatory services	SHI covers all ambulatory and hospital basic as well as advanced diagnostic curative health services and therapeutic services. Transportation costs in case of referral are covered for the poor, persons entitled to social assistance allowances and those in remote areas. ¹²³
Inpatient (IP)/ Outpatient (OP) services	SHI covers most OP and IP care received at government facilities ¹²⁴
Choice of providers	Patients may reimburse payments to noncontracted providers, local and abroad, subject to certain limits. ¹²⁵
Referral mechanism	Comment: "Capitation system ... weakens the district-level health system. The capitation system places district hospitals entirely at risk for the costs of referrals to the provincial level. Referral costs at secondary and tertiary hospitals for those registered at the district hospital are deducted from the capitation package of that district

¹²³Tran Van Tien, "Health Financing Review Of Viet Nam: With a Focus on Social Health Insurance," WHO, 2011, p. 24

¹²⁴Samuel S. Lieberman and Adam Wagstaff. *Health Financing And Delivery In Vietnam-Looking Forward*, World Bank, 2009, pp 64, 155-157 (n.8); See also Aparnaa Somanathan, 2013, p. 9

¹²⁵¹²⁵Samuel S. Lieberman and Adam Wagstaff, 2009

	<p>hospital. District hospitals therefore have few incentives to refer patients and carry out their gatekeeping functions effectively. Meanwhile, secondary and tertiary hospitals that are paid on a fee-for-service basis have little incentive to control costs, since the risk is borne by the district hospital.”</p> <p>Self-referrals cost patients graduated fees upwards of 30 percent of copayments.¹²⁶ This is meant to deter such practice.</p>
Cash benefits	(Transportation costs for people who are the poor and living in mountainous areas.)
Physical check-up	<p>Law on Examination and Treatment provides legal basis for expansion of related service.</p> <p>Pre-marital check-up, ante- and pre-natal screenings are not yet expanded.¹²⁷</p>
Prevention, health promotion	<p>Preventive care subsidies are capitation based.</p> <p>Provincial health bureaus manage the provincial hospitals and Centers for Preventive Medicine, responsible for disease surveillance activities at the provincial level.¹²⁸</p>
Services not covered	<p>Interventions covered by vertical programs such as HIV/AIDS prevention and treatment programs, drugs not on the MOH list, treatments not yet approved by MOH, various “luxury” interventions such as cosmetic surgery, dental care, treatment of self-inflicted injuries, and treatment for drug addiction.¹²⁹</p>

5. Financial Risk Protection

Starting on 1 January 2010, Vietnam has implemented a new schedule of premium rates for different categories of enrollees of insurance schemes. The schedule came with qualifications for government subsidies, some of them up to 100 percent, for select categories.

¹²⁶Aparnaa Somanathan, et al, *Integrating the Poor into Universal Health Coverage in Vietnam*, World Bank, 2013, pp. 7,10

¹²⁷Five-Year Health Sector Development Plan 2011-2015. Online at http://www.wpro.who.int/health_services/viet_nam_nationalhealthplan.pdf

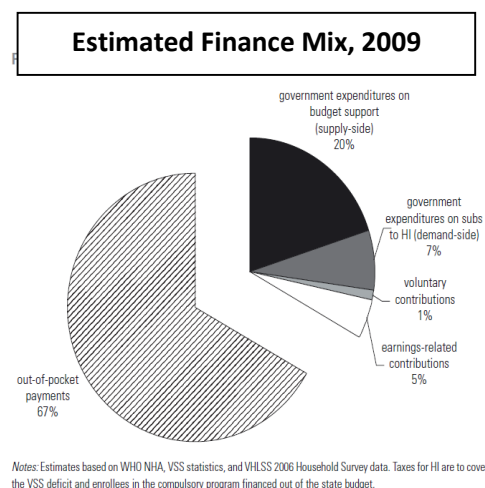
¹²⁸Aparnaa Somanathan, et al, 2013, pp. 6, 18

¹²⁹Samuel S. Lieberman and Adam Wagstaff. *Health Financing And Delivery In Vietnam-Looking Forward*, 2009. For the complete list, see Midori Matsushima and Hiroyuki Yamada, p. 15.

Health Insurance Premium Rate as of 1 January 2010

Category	Rate	Subsidies
<i>Compulsory groups</i>		
Formal sector workers, Officers	4.5% of monthly salary	No subsidies
Pensioners	4.5% of monthly pension	100% paid by the social security agency
People on working capacity loss allowance	4.5% of working capacity loss allowance	100% paid by the social security agency
Poor, Children under 6, Meritorious people, Near poor etc.	4.5% of the monthly minimum salary	100% subsidy by the government (Near poor receive at least 50% subsidies from the government)
The unemployed	4.5% of unemployment benefit	100% paid by the social security agency
Pupils and students	3% of the monthly minimum salary	30% subsidy by the government

The financing mix as estimated by Lieberman and Wagstaff in 2009 consists of large OOP of almost 70 percent, about 27 percent for government share to the command supply and demand sides, and the remainder contributions.



Source: Samuel S. Lieberman and Adam Wagstaff. *Health Financing And Delivery In Vietnam-Looking Forward*, World Bank, 2009, p. 88)

Only one risk pool has been established by combining compulsory and voluntary schemes. This allows for “cross-subsidies” across provinces. The VSS scheme for the poor is “not pooled nationally.” Nguyen and Afsar say that unspent provincial funds go back to the Provincial HCFP Boards. Additionally,

In the case of VSS overspending in a province, the deficit financing needs to be negotiated with the Provincial HCFP Board, which has access to funds from the donors who contribute to the fund. As HCFP scheme is not

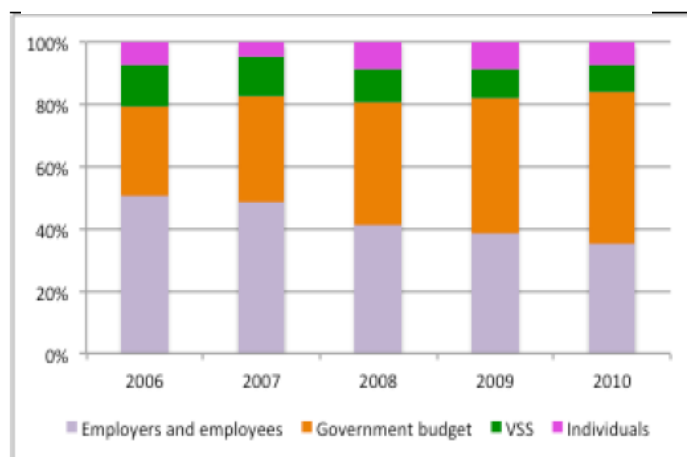
pooled nationally, VSS does not need to cover deficit of poor scheme in one province from the surplus of another, neither is there a mechanism to cross-subsidise HCFP members from surpluses of compulsory or voluntary schemes.¹³⁰

Beginning in 2006, government's direct budget subsidy to providers would cover "mainly essential public health and primary care, and certain parts of recurrent expenditures of tertiary care." Savings from this would be channeled and "premium subsidies of vulnerable population groups in order to enrol them in SHI."¹³¹ On 1 July 2009, a law said government would "compensate patient for their health care according to three categories:"

- 100% for children under 6, the Nation's deserving people, and police forces
- 95% for the retired, industrially disabled persons, the poor and ethnic minorities in difficulty
- 80% for the others, including employees¹³²

Reportedly, government share in social health insurance revenues has been on the upswing starting in 2006, from 29 percent in that year to about 50 percent.¹³³

Sources of SHI Revenues: Vietnam, 2006-2010



Source: Authors' calculations based on data from Vietnam Social Security (VSS 2012).

¹³⁰Thi Kim Phuong Nguyen and Afsar Akal, "Recent Advances in Social Health Insurance in Vietnam: A Comprehensive Review of Recent Health Insurance Regulations," WHO, 2003, p. 28

¹³¹Tran Van Tien, et al., "A Health Financing Review Of Viet Nam: With A Focus On Social Health Insurance," WHO: 2011, p. 11

¹³²David Albrecht, et al, *Urban Development in Vietnam: the Rise of Local Authorities*, Agence Française de Développement, 2010, p. 115; See also "Social Health Insurance in Vietnam: Financial Protection of the poor and OOP protection," http://api.ning.com/files/UbSgRBJXnchVKGeYFiCuZP61YxazPwCFXTteMYLvFTTrTcRVJy3v6eqqFbA272y8SLMQYLh5ihT2Rb*BH4Ym2jz2jdqHucvZ/Vietnam.pdf

¹³³Aparnaa Somanathan, et al. "Integrating the Poor into Universal Health Coverage in Vietnam," WHO, 2012, p. 4.

Source: Somanathan, 2013, p. 4

IP and OP expenses though have been contributing to catastrophic spending.¹³⁴ Until a few years back, IP and OP expenses have been draining precious little resources.¹³⁵ (See Table below) These are relatively less expensive care costs. But for smoking-related diseases like lung cancer, OOP expenses for IP services are surely catastrophic.¹³⁶

Studying one Vietnamese rural commune, Kim Thuy Nguyen concludes:

One inpatient treatment, or the accumulation of several outpatient treatments, constitutes a significant proportion of mean annual income per capita, even for the insured. Costs for 1 inpatient treatment is equivalent to 81% of mean annual income per capita for the uninsured and 37% for the insured who use insurance. Five outpatient treatments equal 26% of mean annual income per capita for the uninsured and 12% for the insured who use insurance. With one quarter of our sample population experiencing 5 to 10 outpatient treatments, it is not surprising that one half of health payments for Vietnamese households are for outpatient treatments.¹³⁷

Year	OOP for outpatient services		OOP for inpatient services	
	VND 000	US\$	VND 000	US\$
2002	16.1	1.05	28.1	1.83
2004	48.4	3.08	51.5	3.28
2006	57	3.55	50.4	3.14
2008	78.6	4.77	78.4	4.75
2010	97.1	5.13	96	5.07

Source: (?)

Vietnam has FFS, capitation and DRG payment schemes used by the existing SHIs.

FFS is regulated but the schedules vary as “service by relevant state agencies (take) into account the capacity of the hospital in terms of their techniques and ability of residents

¹³⁴Ibid., p. 46. Adam Wagstaff, “Benefit Incidence Analysis Are Government Health Expenditures More Pro-rich Than We Think?” World Bank, 2010, presents substantially differing IP and OP care expenses from his own survey and National Health Accounts data. Table 3, p. 22.

¹³⁵H. Van Minh et al, “Financial burden of household out-of-pocket health expenditure in Vietnam: Findings from the National Living Standard Survey 2002-2010,” *Social Science and Medicine*, 2012. For the financing breakdown of OOP, see Samuel S. Lieberman and Adam Wagstaff. *Health Financing and Delivery in Vietnam: Looking Forward*, World Bank, 2009, p. 58

¹³⁶Hana Ross, “The costs of smoking in Vietnam: the case of inpatient care,” *Tobacco Control* 2007;16:405–409.

¹³⁷Kim Thuy Nguyen, et al., “Impact of Health Insurance on Health Care Treatment and Cost in Vietnam: A Health Capability Approach to Financial Protection,” *American Journal of Public Health*, August 2012, Vol 102, No. 8, pp. 1459-1460.

to pay for the treatment.”¹³⁸ It is dominant for secondary care but is also used by tertiary hospitals and in “certain high-cost services that are excluded from capitation payment.”

Primary care and general district hospital care use capitation, as described below:

Capitation is paid by the health insurance fund every month per enrolled patient regardless of the number of treatments and treatment types. The calculation for the capitation is based on the expenditure of the previous year. Capitation rate is calculated separately for 6 membership groups, grouping not necessary related to age, gender and health risks; Capitation rate is calculated based on historical expenditure of the previous year specifically for each province and not based on actual health care need.¹³⁹

An example of schedule on capitation rates is shown below:

Capitation rate of Six SHI Membership Groups in Kien Gang Province, 2011

Member groups	Level of health risk within the group	Capitation rate (VND)
a) civil servants and formal sector workers	Rather low risk: young and healthy	534,258
b) pensioners, meritorious people, beneficiaries of social security/protection allowances, veterans	Rather higher health risks (older, sick, vulnerable people)	1,686,558
c) the poor and near poor	Relatively higher health risks	117,528
d) children under six years of age	Overall low health risks (young and healthy)	119,601
e) schoolchildren and students	Overall low health risks (young and healthy)	87,836
f) the remaining members (mainly voluntary members)	relatively high risk (due to adverse selection)	893,316

Source: Vietnam Social Security, 2011

Source: Cited in Tran Van Tien, et al. 2011, p. 29

¹³⁸Midori Matsushima and Hiroyuki Yamada, p. 18.

¹³⁹“Social Health Insurance in Vietnam: Financial Protection of the poor and OOP protection,” http://api.ning.com/files/UbSgRBJXnchVKGeYFiCu-ZP61YxazPwCFXTteMYLvFTTrCrvJy3v6eqqFbA272y8SLMQYLh5ihT2Rb*BH4Ym2jz2jdqHucvZ/Vietnam.pdf

The DRG is applied to patients with acute pneumonia for adults or children, appendix operation, and normal delivery.

Meanwhile, co-payments are only for non-students who have opted for voluntary enrolments. In the light of the shift from voluntary to mandatory SHI, all participants co-pay 20 percent. Exempted are the “poor, pensioners, recipients of social allowances and some other privileged groups who must pay 5% of their health insurance claim. Those insured from the army and the police and children under-six are totally exempt of co-payments.”¹⁴⁰

Co-payments are limited, thus:¹⁴¹

- Amount reimbursed capped to 40 times the minimum wage.
- 90 percent of the health care fund of the district hospital. The health care fund of the district hospital is 90 percent of the premium revenues collected from members registered at the district hospital; the remaining 10 percent goes into a reserve fund. For secondary and tertiary hospitals with fee-for-service remuneration, the cap is based on historical expenditures adjusted for inflation.⁵ In addition, there is a cap per episode on the maximum benefit that the SHI fund will cover, defined as 40 months of the minimum monthly salary (approximately US\$35 in 2010) for high-tech and high-cost services.
- Cap for inpatient expenditures = average expenditure per admission last year x 1.1 x number of admission per month. Cap for outpatient specialist care = average expenditure per outpatient visit last year x 1.1 x number of visits per month
- 40 times of month minimum salary as the maximum reimbursement for high-tech expensive health services, starting January 2010

Balance billing is reportedly widely prevalent and justified as in pursuit of:

“better quality” technical services, pharmaceuticals, and supplies that are not part of the official price list and package. Finally, informal payments

¹⁴⁰Paulette Castel, et al., “Health Insurance in Viet Nam towards universal coverage: The case of the workers of the informal sector,” Policy Research Study, UNDP Vietnam, November 2011, p. 5-6

¹⁴¹Aparnaa Somanathan, Integrating the Poor into Universal Health Coverage in Vietnam, World Bank, UNICO Studies Series No. 24 2013, p. 7; HI Law 2008 (1/7/2009, cited in Paulette Castel, et al., Health Insurance in Viet Nam towards universal coverage: The case of the workers of the informal sector,” Policy Research Study, UNDP Vietnam, November 2011, p. 3. Moving Towards Universal Coverage In Health Care: A Report From Vietnam, PPT; See also, “Social Health Insurance in Vietnam: Financial Protection of the poor and OOP protection,” http://api.ning.com/files/UbsgRBJXnchVKGeYFiCu-ZP61YxazPwCFXTteMYLvFTTrRVJy3v6eqqFbA272y8SLMQYLh5ihT2Rb*BH4Ym2jz2jdqHucvZ/Vietnam.pdf

to individual doctors and nurses are reported to be quite common at higher-level hospitals.¹⁴²

Vietnam showcases mixed signal of equity in financing. It has been claimed that pre-payment has worked in favor of the poor. Ekman writes:

(T)he way this programme is funded suggests that it is highly progressive as the poor contribute relatively less to the general taxation revenues of the government. With respect to the SHI programme, the flat rate payroll tax with which this programme is financed, with no contribution ceiling, suggests that this programme is largely proportional. However, the fact that many private companies do not contribute to its financing may indicate that the programme is regressive as the private sector tend to pay higher wages compared with the public sector.¹⁴³

Two sets of reckoning progressivity, namely a recent one for consumption, taxes and the SHI schemes and another for 1998 for hospital IP and OP health care (which are all in the negative Kakwani indices without the standard error). The previous voluntary insurance that has been made mandatory has not benefited the majority of its poor rural users, the majority of the Vietnamese!

Progressivity in Health Financing, Vietnam

	Consumption	Taxes	SHI	Voluntary Insurance	Out-of-pocket spending	Total payments
Lowest quintile	7.4	4.3	0.5	4.8	5.3	4.4
2	11.4	8.8	3.1	12.6	9.8	8.7
3	15.5	13.5	8.2	18.4	14.9	13.7
4	21.9	22.5	19.2	26.8	23.2	22.5
Highest quintile	43.8	50.9	69.0	37.5	46.8	50.8
NHA shares		26.6	12.7	1.6	54.8	95.7
Gini coefficient	0.360***					
Concentration index		0.428***	0.658***	0.343***	0.414***	0.426***
Kakwani index		0.068+	0.298***	-0.017	0.054***	0.066+

Source: Distribution of consumption, SHI contributions, voluntary insurance premiums, and out-of-pocket payments estimated by authors using ADePT and data from the 2006 VHLSS. Distribution of taxes by quintile were taken from Table 5.1 in World Bank (2007). The distribution of total payments was calculated as a weighted average of payments from the different sources using NHA shares as weights. The standard errors for the concentration indices for taxes and total payments were calculated using the grouped data method from the quintile shares for total payments. Standard errors for the Kakwani index for taxes and total payments were not computed because of use of grouped data.

Note: * Significant at 10%, ** Significant at 5%, *** Significant at 1%. + Standard error not computed.

Source: World Bank. 2012. *Health Equity and Financial Protection Report – Vietnam*. Washington, D.C.: World Bank, p. 29

¹⁴²Aparnaa Somanathan, et al, *Integrating the Poor into Universal Health Coverage in Vietnam*, World Bank, 2013, p. 13

¹⁴³Bjorn Ekman, 2008, p. 2

PROGRESSIVITY OF HEALTH SPENDING (SHARES) ⁴	Q1	Q2	Q3	Q4	Q5	CI/Gini	Kakwani	Share
2006 ⁴								
Consumption	7.4	11.4	15.5	21.9	43.8	0.360***		
Taxes	4.3	8.8	13.5	22.5	50.9	26.6	0.431	26.6%
SHI	0.5	3.1	8.2	19.2	69.0	0.658***	0.298***	12.7%
Voluntary Insurance	4.8	12.6	18.4	26.8	37.5	0.343***	-0.017	1.6%
Out-of-pocket spending	5.3	9.8	14.9	23.2	46.8	0.414***	0.054***	54.8%
Total payments	3.8	9.0	14.4	23.5	49.4	0.454***	0.094	95.7%

Source: World Bank. "Health equity and Financial Protection datasheet - Vietnam." Washington, D.C.: World Bank, 2012

Distribution of Public Health Care Subsidies in Vietnam, 1998

Cumulative shares	Equivalent household consumption	Hospital care		Commune health center	Polyclinic	Other public health services	Total subsidy	
		Out-patient	Inpatient				Scaled user fees	Reported user fees
Poorest 20% (standard error)	8.78% (0.0429)	10.21% (1.3456)	10.98% (1.3099)	22.65%* (1.886)	23.18%* (5.9155)	13.22% (2.9644)	12.29%* (1.1219)	14.81%* (1.5426)
Poorest 40%	21.38% (0.0880)	24.75% (2.1043)	29.44%* (2.1703)	47.83%* (2.4084)	33.48% (6.3918)	47.09%* (6.3806)	31.87%* (1.8559)	37.70%* (2.4110)
Poorest 60%	37.19% (0.1360)	45.50%* (3.0206)	50.12%* (2.5461)	77.86%* (1.9943)	59.88%* (6.8763)	59.00%* (6.0599)	53.11%* (2.1498)	60.43%* (2.5184)
Poorest 80%	58.17% (0.1793)	67.65%* (3.2196)	73.02%* (2.5157)	90.60%* (1.4456)	78.52%* (6.6011)	79.63%* (4.5689)	74.88%* (2.1076)	81.25%* (2.0504)
Test of dominance								
-against 45° line		-	-	+			-	-
-against Lorenz curve			+	+	+	+	+	+
Concentration								
Index ^a (robust standard error)	0.3229 (0.0083)	0.2160 (0.0450)	0.1444 (0.0378)	-0.1567 (0.0335)	0.0298 (0.1035)	0.0056 (0.0777)	0.1106 (0.0319)	0.0115 (0.0343)
Kakwani Index (robust standard error)		-0.1069 (0.0506)	-0.1785 (0.0427)	-0.4797 (0.0376)	-0.2932 (0.1031)	-0.3174 (0.0792)	-0.2124 (0.0365)	-0.3115 (0.0379)

Source: Owen O'Donnell, *Analyzing Health Equity Using Household Survey Data*, World Bank, 2008, p. 173.

But as Vietnam's economy touches the lives of the majority formal and informal sectors (wherever they may be found), it might be expected to reverse the trend that has been there since its transition to liberal set-up.

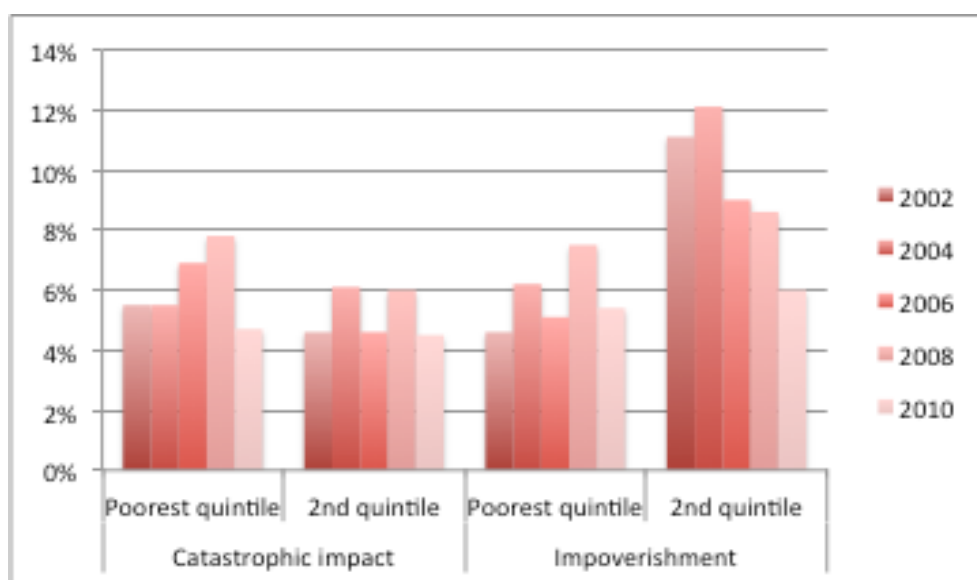
The Vietnamese seem to have a different story. Somkrota and Lagrada conclude that "(h)ouseholds that are likely to experience catastrophic health spending after UC

are those in highest income quintile; with elderly, chronically ill, or disabled family members; with hospitalization.”¹⁴⁴

In terms of number of households, OOP expenses remain the culprit.

In absolute terms, the numbers of households with catastrophic expenditure were 811,499 in 2002, 1,055,910 in 2004, 1,096,177 in 2006, 1,151,500 in 2008 and 862,661 in 2010. The same was true for impoverishment. The rates and numbers of households who were put into poverty were high until 2008 but declined in 2010. The rates and numbers of households who were pushed into poverty because of OOP were 3.4% or 590,446 households in 2002, 4.1% or 769,505 households in 2004, 3.1% or 667,863 households in 2006, 3.5% or 742,587 households in 2008, and 2.5% or 563,785 households in 2010.¹⁴⁵

Share of Poor Households Experiencing Catastrophic Impact and Impoverishment among the Poor



Source; Aparnaa Somanathan, 2013, p. 13

Some factors have been determined to be associated with catastrophic health expenditure in Vietnam: “use of either public facilities or private facilities is associated with a high financial burden”; households with senior or young members are associated

¹⁴⁴Terawit Somkotra and Leisel Lagrada, “Which households are at risk of catastrophic health spending: experience in Thailand after universal coverage,” *Health Affairs* 2009, cited in Kannika Damrongplasit, Thailand's Universal Coverage System and Preliminary Evaluation of its Success, 2009, http://iis-db.stanford.edu/evnts/5747/presentation_Kannika.pdf

¹⁴⁵H. Van Minh et al., “Financial burden of household out-of pocket health expenditure in Viet Nam: Findings from the National Living Standard Survey 2002-2010” *Social Science & Medicine* xxx (2012), p. 3

with a higher financial burden; size of households; household with members from several generations; is likely to have more resources; location of household (urban-rural).¹⁴⁶

In Vietnam, “group-specific” capitation rates impact on utilization rates. Capitation rates depend on previous periods costs. The pyramidal service delivery structure places widespread community health centers at the base that are underutilized, their users being poor rural folks. At this base quality of care is said to be inferior, adding to the preference for higher level care elsewhere up the pyramid. In the end, lower utilization maintains lower capitation, and consequently poor use.¹⁴⁷

6. Population Coverage

By early 2008, Bjorn Ekman et al. summarized the main schemes in place in Vietnam. Combined, these four schemes covered only 49 percent of the population, 18 percent of which are poor. Coverage in 2010 was estimated at 59.64 percent¹⁴⁸. It was in 2006 that enrolment, coverage and usage started to pick up—all desirable developments but increasing financial burden on the part of government. It was in this context that the 2008 insurance law was passed and made effective in 2009. Since then, schemes meant to implement UHC involve the mandatory and voluntary programs.¹⁴⁹ Nghiem Tran Dung (Health Insurance Dept.-MOH) cites 52.96 million, or 62 percent of population as of June 2010.¹⁵⁰ They include 14.96 million poor; 8.12 million under 6; 9.89 million students, and; 3.7 million under voluntary program. Four agencies plus the National Assembly are involved in the administration of the existing schemes:¹⁵¹

¹⁴⁶Ke Xu, “Health service utilization and the financial burden on households in Vietnam: the impact of social health insurance. Discussion Paper No. 6. WHO, July 2006, p. 10.

http://apps.who.int/iris/bitstream/10665/85632/1/EIP_HSF_DP.06.6_eng.pdf

¹⁴⁷Aparnaa Somanathan, 2013, p. 11; World Bank, “Health Equity and Financial Protection Report, World Bank, 2012, pp. 11-13)

¹⁴⁸Ibid, p. 7.

¹⁴⁹Midori Matsushima and Hiroyuki Yamada, p. 12 qualify this though: “Compulsory groups are required to pay the premiums every month. The voluntary enrollees can choose to pay every 6 months or annually. For the first time, the enrollees have to wait 30 days for the insurance to be valid for the basic treatment and 180 days for technologically advanced medical treatment. Once the insurance becomes valid, the continuous payment allows people to receive the benefit whenever they have medical treatment. However, when the insured fails to pay on the due date, he/she can only use the health insurance card 30 days after the date of payment, and has to wait 180 days to be able to use the insurance for technologically advanced medical treatment.”

¹⁵⁰ Nghiem Tran Dung, “Social Health Insurance in Viet Nam,” 2010.

http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-hanoi/documents/presentation/wcms_145792.pdf

¹⁵¹Ibid., p. 16

Summary of Vietnam health insurance system, 2007

Programme	Population coverage	Target group(s)	Financing	Reported impacts
Social health insurance (SHI)*	9%	Formally employed, retirees, disabled, meritorious people	3% payroll tax (2% employers and 1% employees)	<ul style="list-style-type: none"> – Increased utilization – Reduced out-of-pocket payments – Improved risk protection
Health care funds for the poor (HCFF)*	18%	The poor, ethnic minorities in mountainous areas, inhabitants in disadvantaged communities	General government revenues (75%) and Provincial resources (25%)	<ul style="list-style-type: none"> – Increased utilization – Reduced out-of-pocket payments – Reduced risk of catastrophic payments
Programme of free health care for children under 6 years of age	11%	All children under 6 years of age	General government revenues	No reported impacts
Voluntary health insurance (VHI)	11%	Self-employed, informal sector workers, dependents of CHI-members, students and school children	Private premium contributions based on ability to pay	<ul style="list-style-type: none"> – Increased utilization – Reduced out-of-pocket payments
Total	49%			

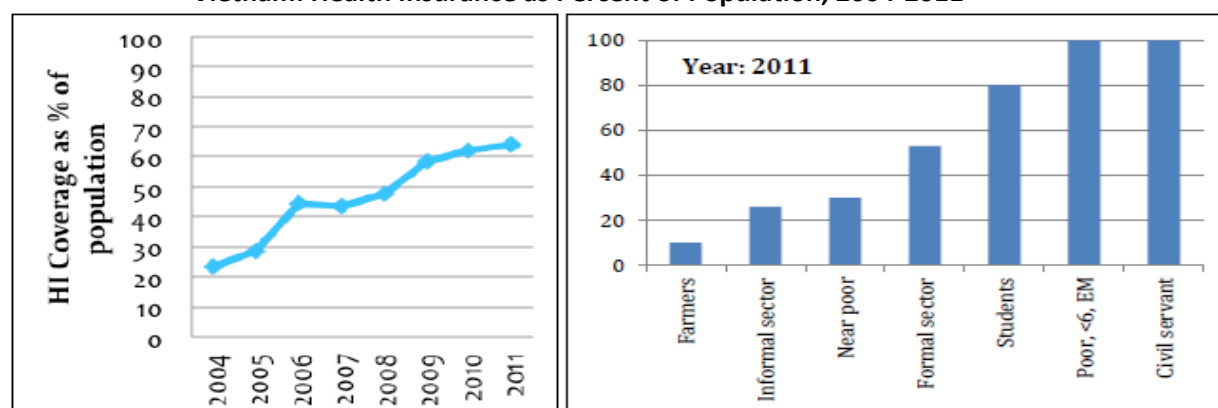
Source: Vietnam Social Security (VSS) 2007.

*Formally part of Compulsory Health Insurance (CHI).

Source: Ekman, 2008, p. 255.¹⁵²

As Vietnam indeed has improved in getting more people covered by existing schemes (as seen below), it has had to address with improvements in services in a number of areas as suggested in assessments, critiques and plans.

Vietnam: Health Insurance as Percent of Population, 2004-2011



Source: Ekman, 2008, p. 255.

As to the others who have yet to be covered or to benefit from any scheme, a writer reports:

36.7% of the “non-insured” indicated that they had no need for it. This finding is not surprising. As VSS and many studies both in and outside of

¹⁵²Bjorn Ekman, et al. “Health insurance reform in Vietnam: a review of recent developments and future challenges,” *Health Policy and Planning* 2008;23:252–263.

Vietnam have already observed, voluntary participation in health insurance faces serious problems of self-selection.¹⁵³

¹⁵³Paulette Castel, et al, "Health Insurance in Viet Nam towards universal coverage: The case of the workers of the informal sector," UNDP Vietnam, 2011, p. 15.

IV. Summary of Findings

Some of the key findings of this review are the following:

1. China, Thailand and Vietnam have had pre-existing SHI schemes¹⁵⁴ (of varying lengths of implementation, forms, scopes, and impacts) that are being integrated, expanded and deepened for UHC. UHC or more commonly UC in these countries is largely aimed at improving access of entire population, quality of service, and financial protection. Voluntary and private insurance schemes though exist side by side with SHIs. Some sections of the Chinese, Thai, and Viet populations have been sensitive to insurance enrolment on account of (lack of) information about SHI and, more commonly, cost entailed by their participation. Their service utilizations too typically differ as to income class while their actual entitlements are dependent on the scheme that they have enrolled into. Quality of health service, while generally improving, has been affected by geographical location of patients, technology and resource availability, fund counterparting (if any), income class, and payment scheme for IP and OP services, among others. Rapid commodification of health services and pharmaceuticals in Vietnam seems to have slowed down enrolment and utilization of even public health resources.
2. The Thai experience in populist attempts of the UC scheme has been helped by a bureaucratic efficiency that addresses the poor with generous state support. Elite democratic hang-ups in a free market setting overtake well-intentioned health initiatives and create conditions for default in significant ways that do not help much in realizing MDG health targets. Dominant party politics in Vietnam and China seek to be populist but also still fall short of shifting the burden of health as they negotiate the transition to liberal economic set-up.
3. New challenges have confronted the Thai, Vietnamese and Chinese health insurance systems as studies have indicated different outcomes of responses of the different SHIs. Lingering and worsening OOP expenses of the poor and near-poor, corruption, health manpower and health technology availability, and financial sustainability problems haunt all three SHIs in varying degrees and forms¹⁵⁵. Different proposals by a number of entities—local as well as foreign—have been made to address what ails the insurance implementations in these countries. These countries also have their short-, medium and long-term plans for their SHIs, and most of these are moderately keeping with their respective needs.

¹⁵⁴Amit Sengupta, "Universal Health Coverage: Beyond rhetoric," Municipal Services Project – Occasional Paper No. 20, November 2013, p. 16.

¹⁵⁵Curiously, more than half of injured Vietnamese prefer OOP to cover medical cost. See Nguyen Xuan Thanh, "The injury poverty trap in rural Vietnam: Causes, consequences and possible solutions." Ph.D. Thesis. Umeå University (Sweden). 2005.
<http://www.divaportal.org/smash/get/diva2:144046/FULLTEXT01.pdf>

4. The involvement of the different jurisdictional levels in actualizing the implementation of SHIs in these countries have had mixed results, not uncommonly working against the interest of the poor and near-poor, but also becoming the source of ideas for reform as in China. In Thailand, class and political divides have colored the UCS program such that it has had to be abolished and then re-established, leaving a period that jeopardized the poor's access to primary benefits.
5. Research has become an important component in understanding the extent of SHI success, shortcomings and failures. Thailand leads in having its own agencies, personnel and advocates who push through with identifying gaps and bottlenecks and with proposing measures to address them. China's health and insurance counterparts, especially in the academe, undertaking researches are aided by many foreign scholars deeply interested in the Chinese SHI. Question is how much research outputs have been used to correct mistakes and maximize gains.
6. One important area where research may inform SHI planning and interventions is with respect to the question of so-called "adverse selection" and "moral hazard". "Adverse selection" happens when more sicker people prefer more coverage and healthier ones opt out. "Moral hazard" occurs as people decide whether to insure or not on account of their estimate of cost and resulting financial implication. Thailand has shown the way by covering almost all people and providing services that benefit all.¹⁵⁶ And by clearly providing for the type of payment (FFS, capitation, DRG, OOP) for type of service (IP/OP), it has secured the lot of the patient and tamed provider misbehavior. In cases, like in Vietnam, where services are contingent owing to limited health manpower resource, chiefly in the rural areas, people suffer catastrophically, if not are impoverished. The political and actuarial assumptions of SHIs, to be sure, have to be tested time and time again to protect whatever gains SHIs claim have gained.

¹⁵⁶Phusit Prakongsai, et al., "Public Health Insurance and Financial Risk Protection: Lessons from Thailand," *CREHS Policy Brief*. 2010. In countries like Rwanda, it has been suggested that an "income-dependent progressive premium" policy be implemented. See Pia Schneider, "Review article : Why should the poor insure? Theories of decision-making in the context of health insurance," *Health Policy and Planning* 19(6), *Health Policy And Planning*; 19:6 (2004), 349–355

V. Some Lessons for Philippine Social Health Insurance

Characteristics	Philippines
Population	96,706,764
GDP (US\$) (2012)	\$250,182,008,487
GDP per capita (US\$)	\$2,587
National Health Expenditure as % of GDP	4.1
Health expenditure per capita(US\$)	\$97
Infant mortality rate (per1,000 live births)	24
Out-of-pocket health expenditure (% of private expenditure on health) (2011)	83.9
Life expectancy (2011)	68
Percent of population 65 years old and above	4

Source: World Bank, 2013

Like the three countries under study, a number of issues have been raised relative to achieving UHC in the Philippines via the state agency called Philhealth. Established in 1995 as the National Health Insurance (and amended by RA 10606-“Act Amending the National Health Insurance Act of 1995”) in June 2013, and subsequently implemented to reach more via indigent sponsorship, extension to OFWs, among others, subsidies to particular sectors covered under the expanded anti-poverty programs, the P110-billion-asset-owning Philhealth is now one of the country’s biggest state corporations described as a “financial intermediary” that has been criticized as it “operates like a traditional private insurance company whose primary concern is solvency.”¹⁵⁷ Philhealth has been accused of “double counting” of its membership and inability to contribute to the mandated total health expenditure of government that could substantially reduce OOP and cover more poor people.¹⁵⁸ Likewise, it has allegedly helped increase enriching hospitals and clinics, if not doctors, even as more poor people draw from and exhaust their resources to pay for hospital bills. Earlier, a case of fraudulent claims was exposed in media.¹⁵⁹ Worse, groups accused the present government of “abandoning”¹⁶⁰ the

¹⁵⁷Gertler and Solon 2002, cited in Hsia and Shaw. p. 34

¹⁵⁸ Ramon Pedro P. Paterno, “The Future of Universal Health Coverage: A Philippine Perspective,” *Global Health Governance*, Volume VI, NO. 2 (SUMMER 2013). <http://ghgj.org>

¹⁵⁹ Some even allege fraudulent claims. See Edwin G. Espejo, “Bogus claims haunt Philhealth,” May 31 2011. <http://www.mindanews.com/special-reports/2011/05/31/bogus-claims-haunt-philhealth/>. No less than former Philhealth president Dr. Eduardo Banzon described the common practices associated with such claims. Eduardo Banzon, “Preventing fraud, abuse and adverse selection.” *BusinessMirror*. 7 August 2012. <http://www.businessmirror.com.ph/index.php/en/news/opinion/6651-preventing-fraud-abuse-and-adverse-selection>. An anonymous Philhealth official describes the “point-of-care” program where health provider (hospital) enrolls poor uninsured as the “worst form of adverse selection.” This is akin to what Banzon describes as “patient recruitment.”

¹⁶⁰John Rizle L. Saligumba “Costly health insurance fees,” February 20, 2012 <http://davaotoday.com/main/2012/02/20/costly-health-insurance-fees/>

people. Elsewhere, doubts are cast as to possible misuse or abuse of Philhealth multi-million capitation fund in the hands of local government units.¹⁶¹

In the light of the studies and proposals have been made to assess the value of Philhealth.¹⁶² Kraft et al.¹⁶³, for example, subjected Philhealth's ability to help in times of "shock". In 2010, a group headed by the late former Secretary of Health Alberto Romualdez presented a situationer on health that covered some concerns relating to Philhealth.¹⁶⁴ And in early October 2013, "stocktaking exercise" was conducted with financing in focus. In this regard, the exercise concluded: "Purchasing functions determine UHC outcomes, provider payment determines efficiency and cost containment." Finally, the exercise, as Romualdez had said before in 2008 and in 2010, involves politics, or a commitment of government to reserve resources for UHC.

A number of experiences and issues in UC and SHI implementations in China, Thailand and Vietnam resonate in the Philippine case:

1. Coverage and fees

With the 2013 amendments to the national insurance law, about 6.1 million have gained entitlement to Philhealth coverage. Belatedly Sen. Ralph Recto has filed Senate Bill No. 712 (Republic Act 9994, or the Expanded Senior Citizens Act of 2010) to include "indigent" senior citizens.¹⁶⁵ With Philhealth covering about 81 percent of Filipinos, the proposal may increase the count substantially. However, the president of the Philippine Medical Association Leo Olarte quotes the 2008 National Demographic Health Survey to claim that in 2008, only "38 percent of respondents were aware of at least one household member enrolled in PhilHealth."¹⁶⁶ So-called "information asymmetry" among target beneficiaries pervades the current state of SHI.

¹⁶¹ Edwin Espejo, "Philhealth's capitation fund: yet another source of abuse?" 27 May 2011. <http://archives.newsbreak-knowledge.ph/2011/05/27/philhealth%E2%80%99s-capitation-fund-yet-another-source-of-abuse/>

¹⁶² "Universal Coverage: can we guarantee health for all?" 2011. <http://www.universalhealthcare.ph/2011/08/universal-coverage-can-we-guarantee-health-for-all/#more-50>

¹⁶³ Aleli Kraft, "Securing Consumption When Ill or Injured: Does Social Health Insurance in the Philippines Help?" HEFPA Working Paper No. 10. http://www.bmg.eur.nl/fileadmin/ASSETS/bmg/english/HEFPA/Publications/Working_Papers/HEFPA_WP_10.pdf

¹⁶⁴ The entire issue of *Acta Medica Philippina*, vol 44, No. , October-December 2010, is devoted to UHC and Philhealth. The Universal Health Care Study Group headed by Romualdez, as commissioned by then UP President Emerlinda Roman, submitted a draft Executive Order to Malacanang for signature.

¹⁶⁵ Ernie Reyes, "Mandatory PhilHealth coverage for all 6.1 million senior citizens pushed in Senate," October 6, 2013. <http://www.interaksyon.com/article/72161/mandatory-philhealth-coverage-for-all-6-1-million-senior-citizens-pushed-in-senate>.

¹⁶⁶ Philip C. Tubeza, "PhilHealth firm on claim: 81% of Filipinos covered," July 25, 2013. <http://business.inquirer.net/134533/philhealth-firm-on-claim-81-of-filipinos-covered>

The concern with releasing figures such as these relates to moves by concerned agencies to enrol individuals, as in Thailand and in Vietnam, without or with little real access to effective and affordable health care. While Philhealth president Alex Padilla relies on actual headcount, surveys fail to come close to the health insurance agency claim. Claims about number of persons enrolled have a lot to do with government funds, hundred-billion-peso “sin taxes”¹⁶⁷ and the like included, being appropriated for premiums and healthcare supply costs.

The burden of proof in sustaining coverage figures lies with the tally between hospital records and the Philhealth databases. The complete real-time connectivity of health information systems of Philhealth-accredited providers may still be too far off, but surely, the variance between claims must be respectably low, even with allowance for the lag and standard errors.

Fee schedules are well circulated in urban centers, but there is hardly any accounting of rural folk knowledge, especially in the geographically isolated and disadvantaged areas where possibly 10 percent of the people reside. It also remains to be established if accredited providers keep to prescribed rates for procedures, or if bills are for services actually rendered.¹⁶⁸

2. Service Coverage Rates

Philhealth covered rates are online. They are what are typically reflected in hospital bills that are paid for as Philhealth deductions or reimbursements if already paid for. One nice thing about billing is the absence of referral fees, as in Vietnam, from one medical facility to another. For a good number of cases though, private patients with serious illnesses get to pay fees to doctors and the like over and above Philhealth entitlements. Informal balance billing, now claimed to have been abolished, has in fact impoverished those at the poverty line even with their own coping mechanisms.

3. Impoverishment and Catastrophic Health Spending

¹⁶⁷ Reportedly sin tax collections will hit about PhP55 billion by 2013. Enrique Ona, “Universal Health in the Philippines: Gains and Challenges,” 2013. PPT/PDF file.

http://csis.org/files/attachments/131112_EnriqueOna_PublicHealthinthePhilippines.pdf

¹⁶⁸ Edwin G. Espejo, “How to cure Philhealth’s woes?” 1 June 2011

<http://www.mindanews.com/special-reports/2011/06/01/how-to-cure-philhealth%E2%80%99s-woes-by-edwin-espejo/>

An MA Economics thesis has concluded that catastrophic health expenditures have made 14 percent of total households become impoverished.¹⁶⁹ More importantly, and more recently, it has been said that Philhealth reimbursements have been “ineffective as financial safety nets for indigent in-patients.” The bigger picture, based on 2009 survey data, is that indirect taxes have been regressive relative health finance.

Progressivity of health care financing in the Philippines, FIES 2009

Per capita expenditure and health financing source	average per capita health finance	Gini and CI	Kakwani Index
Per capita expenditure, gross	37,058.9	0.4337	
Direct Tax	753.0	0.8160	0.3823
Indirect Tax	4,447.1	0.4337	-0.0000
Out of Pocket	1,057.9	0.6218	0.1882

Source: “Out of Pocket and Catastrophic Health Expenditures,” “Stocktaking exercise” PPT, October 2013.

4. Informal Sector

A large informal sector counting the underemployed or those engaged in the informal economy requires imaginative administrative ability to enrol, to collect, to provide health care for and to monitor. They may share similar characteristics with China’s large migrant population shifting residences and that has already gained portable health insurance. Philhealth provides for non-poor informal sector and group enrolment for cooperative and microfinance organizations (for which the programs dubbed POGI and Kasapi allegedly flopped) but this is certainly less problematic as with the really poor members who have been pushed by crises to be parts of the informal sector.

5. OFWs

Former Sen. Manny Villar calls the OWP and its announced plan to increase by 166 percent the annual premium a “costly duplication,”¹⁷⁰ the UC expansion goal notwithstanding. This increase comes with 50 percent of the increase as employer’s share. As in many fee payments, it is prevalent practice of recruiters

¹⁶⁹Ronaldo D. Ico, “Catastrophic Health Care, Poverty and Impoverishment in the Philippines,” MA Economics Thesis, UP Diliman, 2007.

http://phileconsoc.files.wordpress.com/2013/03/ico_catastrophichealthcarepoverty.pdf

¹⁷⁰Manny Villar, “Health Care for Overseas Filipinos,” *Manila Bulletin*, January 31, 2012.

and placement agencies, acting in behalf of their foreign principals, to pass onto the OFWs fees otherwise that should otherwise be borne by foreign employer/agent/broker. It may appear that the costly increase and duplication will simply saddle the OFW with additional cost.

The transfer of funds from OWWA to Philhealth to inaugurate this health insurance was contested by groups who saw that the former president intended coverage expansion (and Philhealth card-giving/premium payment) for political ends. It would be next to impossible to depoliticize Philhealth-related moves, regardless of UC intent, as different health needs would simply overtake the grandiose plans to lick persistent morbidity and mortality causes.

6. Human resources for health

Vietnamese health personnel move to where capitation budgets are better. Filipino counterparts seek lucrative private practice in urban areas, or work abroad. State-subsidized medical education has yet to actualize really big returns to public health, but here Philhealth may give its share. Creative programs incentivize decisions against exodus maybe crafted to be effective approaches to addressing health needs of elderly, disabled, and other people with special needs. And with increasing incidence of emergencies, especially in remote areas, a standing pool of health manpower with special training for disasters able to train vulnerable populations and actual victims would greatly minimize casualty rates and speed up needed interventions.

7. Utilization rate

The poor, males and non-paying use less Philhealth benefits than the rich who could afford other costs.¹⁷¹ They are less informed and are located where there are less health facilities. These are structural constraints, and not just behavioral qualities. Philhealth relies on network of providers that maybe less concerned with access as their goal.

In view of the foregoing, this study recommends the following:

1. For Philhealth research to mine the experiences of similarly situated SHI and UC programs for relevant stocktaking that can be applied to the Philippines. Likewise, subject the normative manner by which said programs are framed, assessed or evaluated. While, for example, no balance billing (NBB) policy has been sought to be strengthened for DSWD-identified indigents, “sponsored”

¹⁷¹ Emerito Jose A. Faraon, et. al., “Significant Predictors of Underutilization of Inpatient Benefits among PhilHealth Members in Selected Barangays in Manila,” *Acta Medica Philippina*, Vol. 47 No. 3, 2013, pp. 69-73.

patients,¹⁷² and *kasambahays* (helpers, under the law)¹⁷³, and though this may have indeed improved financial risk protection of these select target beneficiaries, the fact remains that IP expenses do still prove catastrophic for a great many. The effectiveness of the mechanisms deployed by the relevant Philhealth circular could be constrained by geographical, technical, structural, even cultural factors. Philhealth must be able to monitor the outcomes of its policy pronouncements and the effectiveness of the attendant mechanisms put in place in pursuit thereof, or even to simply gauge if intended beneficiaries know how to use Philhealth access.¹⁷⁴ A 2013 study has already suggested that Philhealth use NSO to unravel issues on coverage and utilization¹⁷⁵, notwithstanding the fact that NSO surveys are once in five years. With its own resources, Philhealth can maximize the use of its units to do this on its own.

2. For the Department of Health and its attached agencies and devolved units to actively engage LGUs, other devolved/decentralized agencies, special administrative units, and other stakeholders in identifying health requirements of the poor that should be addressed at applicable and workable scale. The DOH, having reclassified existing hospitals in the country, must ensure that earlier skepticism¹⁷⁶ as to its effect on medical cost and patient access is unfounded. Furthermore, it should result in better access and utilization rates than previous, especially in the remote areas where the majority of the affected smaller hospitals are found. Hospitals downgraded into “infirmaries” both by DOH and Philhealth caused tremors among hospital owners, with Philhealth insisting that only quality care is paid and assuring that patients may still use infirmary services. Philhealth card holders reportedly could no longer go to Abra

¹⁷² Before the NBB circular, Lavado found that indigent enrolment has been “rather sporadic,” dependent on national executive wishes, and constrained by local government willingness and ability for co-financing. Rouselle F. Lavado, “Is PhilHealth’s Sponsored Program reaching the poorest of the poor?” Policy Brief No. 2, 2010. http://www.unicef.org/philippines/brief02_fnl.pdf

¹⁷³ Philhealth Circular 0003, series of 2014. http://www.philhealth.gov.ph/circulars/2014/circ03_2014.pdf

¹⁷⁴ Bacareza, Philhealth regional vice president for Eastern Visayas, reported that SWS surveys (2009, 2011) indicate that 11 percent are not satisfied with Philhealth services, and that 65 percent of these did not even know how to use Philhealth. Walter R. Bacareza, “Social Protection: PhilHealth’s Policy on Partial Subsidy Scheme for Microenterprises and Inputs from the Ground in PhilHealth Region VIII,” n.d. (2012?) http://www.pcw.gov.ph/sites/default/files/documents/efiles/webmaster/gwp_rf_mnl_philhealth_policy_partial_subsidy_scheme.pdf.

¹⁷⁵ Maria Elizabeth Angeline D. Puyat, “Factors Influencing PhilHealth Coverage and In-patient Benefit Utilization of Filipino Children Under Five,” Discussion Paper Series No. 2013-37, PIDS, 2013. <http://dirp4.pids.gov.ph/ris/dps/pidsdps1337.pdf>

¹⁷⁶ Cai Ordinario, “Hospital reclassification to burden poor?” 12 November 2012.

<http://www.rappler.com/nation/15392-hospital-reclassification-to-burden-poor>. Hospital owners also opposed the DOH order. See, PHA and PHApi, “Joint Position Paper On the DOH Administrative Order Re:Re-classification of Hospitals, 28 July 2012. <http://www.pha.ph/downloads/PHA-PHApi-toDOH-New%20Classification.pdf>

Provincial Hospital after its downgrade by DOH, unconfirmed report says.¹⁷⁷ In this regard, Philhealth and DOH must ascertain via extensive studies how many beneficiaries are actually affected by the reclassification of hospitals.

3. For health service providers to fully comply with their contractual agreements with the Philhealth and their moral responsibility to the people who in turn have the civic duty to give active feedback on the SHI scheme elements/domains that they have personally come to know. While entire health system is not about to curtail doctors' wishes to earn what they think they deserve, the Philhealth system itself should not lend itself as an instrument for their enrichment. What Philhealth can do is actively engage health professionals for the benefit of those who truly need quality care the most. This is easier said than done, but it could be done as the state re-assumes its central role in ensuring health for all as is the case in the three Asian countries in this study. As service purchaser, Philhealth must be able to account for its own demand and seek to educate Philhealth members how to be involved.
4. As Vietnam and Thailand's programs have shown that percentage increases in THE reduce poverty incidence over time, targeted investments in health (and education) should be studied and prepared for roll-out. Poor localities' situations may lead to health improvement with governance effectivity. Philhealth has more money now than before and it is mandated to use this money for health investments. Again, Philhealth should take a central role in local development by placing health, among others, on top of urgent governance agendas. But it can only do this under difficult conditions in a good number of areas where local powers care less about the poor and the like. Therewith, Philhealth can only help indigents, etc. with being more productive for their own sake and less dependent on local elites.
5. Low income communities maybe helped to devise means of alternative payment schemes that can help promote coverage and utilization. This way, the poor are not excluded or stigmatized on account of being needy. Or, other agencies and health NGOs may support access to healthcare services. They may be incentivized for this. Reportedly, increasing Philhealth membership (not to mention budgetary allocations for the 40 million "poorest" Filipinos) will cause improvements in medical personnel care availability due to faster reimbursements.¹⁷⁸

¹⁷⁷ "Breaking News: DOH ordered Abra Provincial Hospital downgraded to level 1 classification," 18 February 2014. <http://news.abrenian.com/2014/02/18/breaking-news-doh-ordered-abra-provincial-hospital-downgraded-to-level-1-classification/comment-page-1/>

¹⁷⁸ "PhilHealth now covers 40M poorest, DOH says," 11 February 2014. <http://www.ptvnews.ph/bottom-news-life2/11-11-nation-submenu/28670-philhealth-now-covers-40m-poorest-doh-says>

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