

Private Health Insurance in Low- and Middle-Income Countries

Scope, Limitations, and Policy Responses

by

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Abstract

This paper aims at analyzing characteristics of private health insurance (PHI) in low- and middle-income countries and evaluating its significance for national health systems. It yields three major results: First, PHI involving pre-payment and risk sharing currently only plays a marginal role in the developing world. Coverage rates are generally below 10 % of the population while private risk sharing programs only have wider significance in a small number of countries (e.g., South Africa, Uruguay, and Lebanon). Secondly, in many countries the importance of PHI to finance health care is on a rise. Various factors contribute to this development: growing dissatisfaction with public health care, liberalization of markets and increased international trade in the insurance industry, and overall economic growth allowing higher and more diversified consumer demand. This last aspect in particular is expected to put pressure on the supply side of the system to increase choices and improve the quality of health care coverage. Third, the development of PHI presents both opportunities and threats to the health care system of developing countries. If PHI is carefully managed and adapted to local needs and preferences, it can be a valuable tool to complement existing health care financing options. In particular non-profit group-based insurance schemes could become an important pillar of the health care financing system, especially for individuals who would otherwise be left outside of a country's health insurance system. However, PHI could also undermine the objective of universal coverage. Opening up markets for private health insurance without an appropriate regulatory framework might lead to rising inequalities in the access to health care: it may lead to cost escalation, a deterioration of public services, a reduction of the provision of preventive health care and a widening of the rich-poor divide in a country's medical system. Given these risks, the crucial challenge for policy makers is to develop a regulatory framework that is adapted to a country's institutional capacities and that, at the same time, sets the rules and standards in which PHI can efficiently operate and develop.

Table of Contents

1.	Introduction.....	1
2.	Typology of Health Care Financing	4
2.1	Systems of Health Care Financing.....	4
2.1.1	Social Insurance	5
2.1.2	Tax-based Financing.....	6
2.1.3	Out of Pocket Spending	6
2.1.4	Private Health Insurance	7
2.2	Private Health Insurance in Low- and Middle-Income Countries	8
3.	Evidence of PHI in Low- and Middle-Income Countries	10
3.1	Insurance Market and Private Health Insurance in Latin-America	11
3.1.1	General Overview	11
3.1.2	PHI in Latin America	12
3.1.3	Market Indicators and Evidence of Market Failure	13
3.1.4	Regulation and Regulatory Concerns of the PHI Sector in Latin America.....	16
3.1.5	Trends of PHI in Latin America.....	17
3.2	Insurance Market and Private Health Insurance in Asia.....	18
3.2.1	General Overview	18
3.2.2	PHI in Asia.....	19
3.2.3	Market Indicators and Evidence of Market Failure	20
3.2.4	Regulation and Regulatory Concerns of PHI in Asia	24
3.2.5	Trends of PHI in Asia	25
3.3	Insurance Market and Private Health Insurance in Africa	26
3.3.1	General Overview	26
3.3.2	PHI in Africa.....	27
3.3.3	Market Indicators and Evidence of Market Failure	28
3.3.4	Regulation and Regulatory Concerns of PHI and especially MHI in Africa.....	31
3.3.5	Trends of PHI in Africa	32
3.4	Insurance Market and Private Health Insurance in Eastern Europe	34
3.4.1	General Overview	34
3.4.2	PHI in Eastern Europe	34
3.4.3	Market Indicators and Evidence of Market Failure	34
3.4.4	Regulation and Regulatory Concerns of PHI in Eastern Europe.....	36
3.4.5	Trends of PHI in Eastern Europe	37
3.5	Insurance Markets and Private Health Insurance in the Middle East.....	39
3.5.1	Global Overview.....	39

3.5.2	PHI in the Middle East.....	39
3.5.3	Market Indicators and Evidence of Market Failure	39
3.5.4	Regulation and Regulatory Concerns of PHI in the Middle East.....	42
3.5.5	Trends of PHI in the Middle East	43
4.	Lessons Learned: How to best integrate PHI into a health system?.....	44
4.1	Structure of the Schemes – Comprehensive vs. Supplementary Coverage	46
4.2	Price Setting Mechanisms – Profit vs. Non-Profit Schemes	48
4.3	Premium Collection – Individual vs. Group Coverage.....	50
4.4	Trade and PHI – International vs. Domestic Provider	51
5.	Outlook.....	52
	Annex 1: WHO Data on Health Care Expenditure Between 1997 and 2001	60
	Annex 2: Country Groups According to 2005 World Bank Classification.....	63
	Annex 3: PHI Spending in Various Country Groups	65
	Annex 4: Non-Life and Life-Insurance Around the World.....	66

List of Figures

Fig. 1:	Private Health Insurance in WHO Countries	3
Fig. 2:	Systems of Health Care Financing.....	5
Fig. 3:	Relative Importance of Commercial Insurance Markets in 2000	11
Fig. 4:	Total Health Expenditure and Expenditure on PHI in Latin America.....	18
Fig. 5:	Total Health Expenditure and Expenditure on PHI in Asia	26
Fig. 6:	Expenditure for Health Care Through Financial Intermediaries in Eastern and Southern Africa (1997-1998)	29
Fig. 7:	Total Health Expenditure and Expenditure on PHI in Africa.....	33
Fig. 8:	Total Health Expenditure and Expenditure on PHI in Eastern Europe.....	38
Fig. 9:	Total Health Expenditure and Expenditure on PHI in the Middle East.....	44

List of Tables

Tab. 1:	OOP Spending in WHO Countries	7
Tab. 2:	Typology of PHI in Low- and Middle-Income Countries	9
Tab. 3:	Private Health Insurance in Latin American Countries.....	13
Tab. 4:	Private Health Insurance in Asian Countries	20
Tab. 5:	Private Health Insurance in African Countries	27
Tab. 6:	Types and Characteristics of Health Insurance in Western and Central Africa.....	30
Tab. 7:	Target Groups* of MHI in Western and Central African Countries.....	30
Tab. 8:	Private Health Insurance in Eastern European Countries	34
Tab. 9:	Private Health Insurance in Middle Eastern Countries.....	39

List of Boxes

Box 1.	Prepaid Medicine Programs in Latin America.....	14
Box 2.	Managed Care in Latin America.....	15
Box 3.	<i>Medisave</i> Program in Singapore	19
Box 4.	Private Health Insurance in South Africa.....	28
Box 5.	Mutual Health Insurance in African Countries.....	30

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
GNI	Gross National Income
GDP	Gross Domestic Product
GNP	Gross National Product
HMO	Health Maintenance Organization
ILO	International Labor Organization
ISAPRE	Private Health Insurance Schemes in Chile
MHI	Mutual Health Insurance
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHA	National Health Account
OECD	Organization for Economic Cooperation and Development
OOP	Out of Pocket Expenditure
ORT	Organization for Educational Resources and Technological Training
PHI	Private Health Insurance
SARS	Severe Acute Respiratory Syndrome
THE	Total Health Expenditure
USD	U.S. Dollar
VHI	Voluntary Health Insurance
WHO	World Health Organization
WTO	World Trade Organization

List of Abbreviations

comp.	compare
e.g.	for example
et al.	et altera
i.e.	that is; in other words
int.	international
pop.	population

1. Introduction

Health care financing continues to be a key challenge in many low- and middle-income countries. Despite various efforts to improve the health situation in the developing world, many emerging economies are still far from achieving “universal health coverage”¹. Worldwide, 1.3 billion people do not have access to effective and affordable health care, including drugs, surgeries, and other medical interventions (Preker et al., 2002: 22). As documented by the World Health Organization (WHO, 2000: 7), low- and middle-income countries merely account for 18 % of world income and 11 % of global health spending, yet bear 93 % of the world’s disease burden. Obviously, poor health drastically impedes the social and economic development of a country: beyond directly affecting people’s well-being (reduced life expectancy, high infant mortality, spread of infectious diseases etc.) poor health also lowers the productivity of labor and menaces the entire economy (WHO, 2001). Estimates for Botswana suggest, for example, that the economy will be between 33 % and 40 % smaller by 2010 due to the influence of AIDS (HSRC, 2003).

To a large extent, health problems of low- and middle-income countries stem from financial and institutional deficiencies. According to estimates of the Commission on Macroeconomics and Health (WHO, 2001), around USD 34 per year are needed to cover all essential interventions of an individual. On average, this amount is only reached by about 15 % of all low-income countries²; merely looking at private expenditure on health this number even drops to a little over 6 %. The situation is equally worrisome as regards public provision of health care. Universal health coverage would require public spending of around 12 % of GNP in low-income countries to meet the international development goals (Gupta et al, 2001: 19). Such spending is far from being realized; i.e., only one low-income country (East Timor) has public spending exceeding 5 % of GNP. In order to achieve greater health coverage, it thus seems indispensable to pool resources by bundling available funds and spreading the risk of illness and health care financing.

Low- and middle-income countries rarely have the financial means and institutional capacity to offer state-based social health insurance to their citizens. A large percentage of health spending consequently comes directly out of patient’s pockets. According to WHO (2003) data, out of pocket payments (OOP) account for 1/3 of total health care spending in 2/3 of all low-income countries. Catastrophic health costs (i.e., payments exceeding 40 % of a household’s capacity to pay) occur in many countries and drastically increase the risk of impoverishment; especially considering the impact of

¹ According to Nitayarumphong and Mills (1998: 3), “universal coverage is defined as a situation where the whole population of a country has access to good quality services (core health services) according to needs and preferences, regardless of income level, social status or residency”.

² Not adjusting for purchasing power parity.

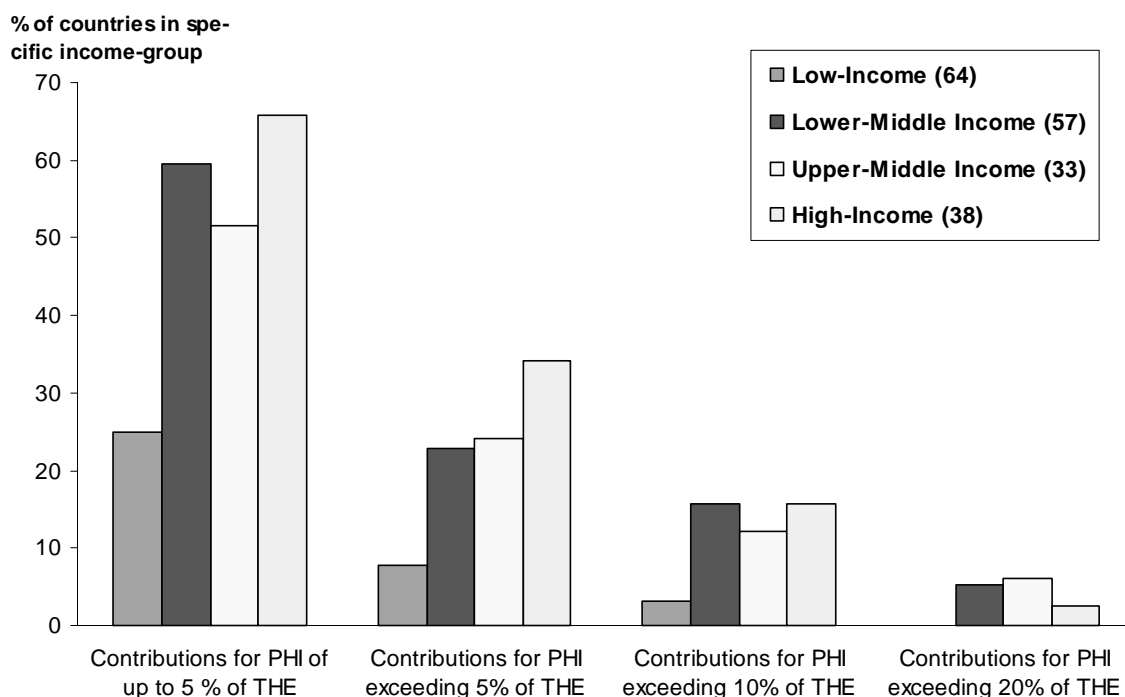
indirect costs of health expenditure, i.e., loss of productive capital associated with illness (Xu et al., 2003). In view of these perils, a main focus of the current debate on health reform consequently emphasizes the need “to move away from excessive reliance on out-of-pocket payment as a source of health financing” (Bennett/Gilson, 2001: 1).

Given the limitations of a public health care system, private health insurance (PHI)³ offers a potential alternative to insure against the cost of illness. As indicated by the WHO (2000), private schemes can serve as “a preparatory process of consolidating small pools into larger ones” to eventually achieve universal coverage. Such development would indeed correspond to the experience of many industrialized countries, where universal social insurance emerged out of private risk-sharing programs (e.g., Germany and Sweden, comp. Sekhri/Savedoff, 2005: 129). As indicated in Fig. 1, the relative importance of health care financing through private risk-sharing entities is very similar across the world. With the exception of low-income countries, PHI exists in nearly the same share of middle- and high-income countries. Similar observations apply for an increasing relative importance of private health insurance; the share of countries in which contributions exceed 5, 10, and 20 percent of total health care spending are equally alike. At the same time, Fig. 1 also highlights that very few countries cover large parts of their health care expenses through PHI; i.e., only six countries have contributions for PHI exceeding 20 % of total health expenditure. The contribution of private risk-sharing programs toward universal health coverage is thus still very limited.

Yet, this picture may gradually change as insurance markets in developing countries are on a rise. Measured as premium volume, the insurance industry in low- and middle-income countries grew more than twice as fast as in industrialized economies during the past ten years (10.4 % as compared to 3.4 % in the life-insurance sector and 7.3 % as compared to 2.6 % in the non-life-insurance sector respectively). This development has been particularly strong in Asia and Eastern Europe where the industry expanded by 10.5 % and 13 % between 1998 and 2003 (Swiss Re-Insurance Company, 2004a: 15). Even though growth rates have recently dropped below their long-term average, analysts still see a great development potential for the insurance industry in low- and especially middle-income countries. The overall development may even be more dynamic than indicated in these figures. Available data often only capture the revenue of commercial providers and consequently miss other forms of insurance contracts that may be particularly important in the developing world (i.e., non-profit or community-based programs). Being a sub-sector of the insurance industry, PHI can be expected to benefit from the industry’s general growth trend.

³ In this study, PHI denotes all risk-sharing arrangements that are based on a private contract between the insurance entity and the insured individual which cover health care costs.

Fig. 1: Private Health Insurance in WHO Countries



Note: Existence of PHI and volume of contributions are measured as share of private spending on prepaid risk-sharing programs relative to total health expenditure (THE). Absolute number in each income group is given in parentheses. Source: Own Calculations. Data: WHO (2003).

It is nevertheless essential to note that low- and middle-income countries compose a very heterogeneous group. Particularly striking is the large disparity of expenditure for insurance premiums among individual countries, reaching from per capita values of USD 1064 in Barbados to USD 3 in Bangladesh. Similarly, insurance penetration (premium income relative to Gross Domestic Product, GDP) varies from 0.5 % in Saudi Arabia to 15.9 % in South Africa, which indeed is the highest penetration rate in the world (Swiss Re-Insurance Company, 2004).

Although PHI is becoming increasingly important to finance health care in low- and middle-income countries (Sekhri/Savedoff, 2005), little is known about its impact on health care coverage. In this paper, we analyze characteristics of private health insurance in the developing world and evaluate its significance for national health systems. The scope of our analysis therefore goes beyond other research in the field as previous studies either focused on specific types of PHI (e.g., community-based programs: Preker/Carrin, 2004; Microinsurance: Dror/Jacquier, 1999) or restricted the analysis to countries where the insurance industry is already well established (e.g., Latin America: Barrientos/Lloyd-Sherlock, 2003; Iriart et al., 2001; South-East Asia: WHO, 2004). Our paper tries to fill this gap, giving a systematic and comprehensive overview of market performance of PHI and discussing regulatory aspects as a response to possible incidences of market failure.

The structure of the paper is as follows. We develop a typology of private health insurance and identify distinct features of PHI in low- and middle-income countries. Using National Health Accounts (NHA) as well as country case studies we then give an overview of the health insurance industry in different regions of the world and develop an inventory of existing schemes. This part will equally consider trends of PHI development, cover issues of market performance, and present areas of market failure. Especially this last aspect will be important to derive policy implications and discuss prospects of PHI in the developing world. A final chapter concludes.

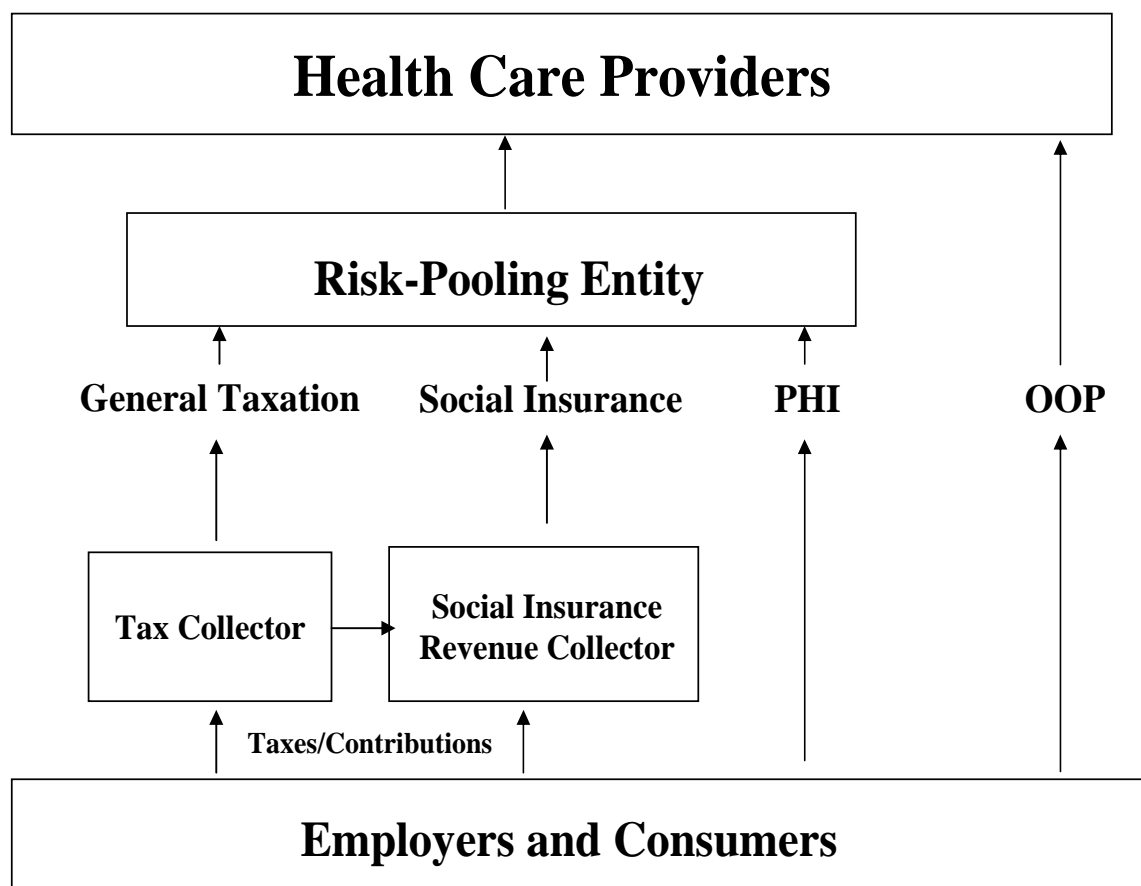
2. Typology of Health Care Financing

2.1 Systems of Health Care Financing

Health care can generally be financed in four different ways: (i) social insurance, which is based on tax-like contributions and managed or regulated by the state, (ii) a health system, which is completely financed from tax revenues and other government resources, (iii) private direct payments (out of pocket), and (iv) private health insurance (Mehrotra/Delamonica, 2005). The World Health Organization (WHO, 2004) identifies internal donations as a fifth dimension of health care financing, which will not be considered in our analysis. These groups are not mutually exclusive; in fact, all health systems depict a mixture of various elements. Similarly, the distinction between private and social insurance is not as clear-cut as indicated in our typology; i.e., most health insurance systems are somewhere in-between the extreme ends of either category (Jost, 2001). Fig. 2 gives an overview of the main systems of health care financing and the corresponding flow of financial resources.

Although our paper mainly focuses on PHI, other forms of health care financing are nevertheless important for our analysis; i.e., private health insurance may be a tool to eventually achieve universal public insurance. Similarly, PHI-based health systems often contain cost sharing (e.g., user fees, co-payments, or deductibles) in order to restrain household demand and consumption of health care. Finally, out of pocket spending may become the starting point of an insurance-based system if resources are redirected for prepayments. Several studies derive a willingness and ability to pay for health insurance based on the large OOP spending on health in low- and middle-income countries. As argued in several studies, even the poor may be willing to pay for health insurance (Asfaw, 2003; Amoako et al, 2002; Asenso-Okyere et al., 1997).

Fig. 2: Systems of Health Care Financing



Source: adapted from Skehri/Savedoff (2005: 128).

2.1.1 Social Insurance

Social insurance is generally compulsory, although people sometimes have the choice between various insurance packages or whether or not to take additional coverage. Only few countries (e.g., Hong Kong, Mexico⁴) offer public health insurance that is voluntary. Due to this mandated membership, social insurance can spread individual health risks in a large risk-pool. This has certain advantages over other forms of health financing. Specifically, premiums can be based on income rather than individual health risks (i.e., higher equity), participation is usually non-discriminatory, and the financial base large and stable. If schemes are well managed and local circumstances allow an easy premium collection, social health insurance can also reduce administrative costs. However, critics claim that social insurance schemes rarely work efficiently, that is, due to a lack of public

⁴ In Mexico, a voluntary, publicly financed insurance scheme has recently started to operate. This so called "seguro popular" aims at individuals who are currently without social security coverage (about 50% of the population). This initiative is intended to establish universal coverage by 2010.

oversight they neither contain health costs nor prevent premium escalation. Especially when social insurance separates health financing and provision, health care providers can pass cost increases on to consumers (Svedoff, 2004). Furthermore, social insurance often leaves large parts of the population uncovered as premium collection is typically limited to formal sector employment. These aspects may be particularly pronounced in low- and middle-income countries with relatively weak institutional capacities and large informal sectors. As documented in Carrin et al. (2001), social health insurance also demands a high degree of consensus among the population. This may be missing in developing countries which are often torn by internal conflicts and social cleavages.

2.1.2 Tax-based Financing

Although some countries (e.g., Taiwan) refer to their tax funded programs as national insurance, health care directly financed by the state is technically not considered insurance⁵. Funds are raised through general taxation or other government revenues while benefits are usually granted to every citizen (*Beveridge model*). Health services covered can be broad and comprehensive (e.g., the U.K. and other OECD countries with tax-funded health systems, but also rich oil-producing countries like Saudi Arabia), but are often limited to basic treatment or emergency care. This is especially true for low- and middle-income countries where the ability to raise taxes is relatively weak. Frequently, the state does not only pay for health care, but also supplies services through public facilities and state employees. This high demand for public oversight and management is rarely free of efficiency loss. Even developed countries like the U.K. have long waiting lines for certain types of medical treatment like non-urgent hospital care. In addition, tax-financed health systems often show low responsiveness to patients' particular needs, which may reduce the quality of care (Mahal, 2002: 440).

2.1.3 Out of Pocket Spending

Out-of-pocket spending constitutes a large and very important source of health care financing in developing countries. Payments are not made beforehand but when care is needed. This can have catastrophic outcomes, especially for low-income families: (i) people may not be able to pay for needed care and thus risk a grave deterioration of their health condition, (ii) people may be reluctant to pay for needed care and thus fail to get therapy when it is still effective, or (iii) people may pay for needed care by using a large portion of their resources and thus risk impoverishment. Despite these perils that are extremely critical for the health situation but also the overall economic performance in low- and middle-income countries, OOP is particularly important in the developing world. Some low

⁵ This distinction is somewhat subtle: as taxes are not specifically collected to pay for health insurance, this form of health care financing does not involve prepayment (i.e., a specific health financing tax – comparable to the taxation of gasoline, tobacco, or liquor – would fall in the insurance category).

income countries meet more than 2/3 of their total health care spending through OOP; such high value is not reached by any other country-group. Furthermore, in 2/3 of all low-income countries does OOP account for more than 1/3 of total health care spending compared to only 13 % of high-income countries (comp. Tab. 1).

Tab. 1: OOP Spending in WHO Countries

	Low-Income Countries		Lower-Middle-Income Countries		Upper-Middle-Income Countries		High-Income Countries		Total	
	n	%	n	%	n	%	n	%	n	%
Total	64	100	57	100	33	100	38	100	192	100
OOP < 33 % of THE	22	34.4	30	52.6	19	57.6	33	86.8	94	49.0
OOP > 33 % of THE	42	65.6	27	47.4	14	42.4	5	13.2	98	51.0
OOP > 50 % of THE	21	32.8	9	15.8	4	12.1	2	5.3	36	18.8
OOP > 66 % of THE	8	12.5	0	0.0	0	0.0	0	0.0	8	4.2

*Note: Existence and volume of OOP spending are measured as percentage of total health care expenditure.
Source: Own calculation. Data: WHO (2003).*

2.1.4 Private Health Insurance

Unlike Social Insurance, PHI is usually (but not always) voluntary⁶, which may leave the risk-pool relatively small. This has certain consequences that may be problematic from a policy maker's point of view. In risk-rated schemes, premiums are primarily based on individual health risks and not on a person's income. In community- or group-rated schemes, on the other hand, the relatively small pool will make cross-subsidization between different risk-groups more difficult than in social insurance schemes (issue of equity). Furthermore, providers of PHI have an incentive to be selective concerning whom to insure. Beyond raising premiums for bad-risk individuals providers can simply refuse to insure high-risk/high-treatment patients (issue of discrimination). This cream-skimming is difficult to prevent. Sometimes, public regulation may even deteriorate market outcomes; i.e., in the case of community-rated schemes, general enrollment obligations for insurance providers will mainly attract bad-risk individuals. This will lead to premiums escalation, which further discourages good-risks from joining the scheme (adverse selection). Health risks are not shared in a large risk-pool, but are spread among few individuals or across time. Without efficient management PHI may thus run the risk of going bankrupt. On the positive side, PHI will offer personalized insurance packages⁷ and competitive premiums to its clientele, particularly to good-risk individuals. Due to small company sizes and reduced bureaucratic processes, PHI can also work more efficiently than social

⁶ Switzerland, for example, has a mandatory health insurance system that is based on private providers.

⁷ Jack (2000: 27) reports that the 35 private health insurance companies in Chile offered close to 9,000 distinct insurance policies in 1995, "reflecting a near continuum of vertical differentiation".

insurance schemes, although insurers may face higher administrative costs due to product development as well as advertising and distribution activities. Alternative ways of premium collection may furthermore expand coverage beyond formal sector employment. Especially the non-profit PHI sector offers room for innovation to include individuals who would otherwise be left outside insurance-based programs. As van Ginneken (1999: 29) argues, there is a “need for experimentation” in order to establish ways of extending health care coverage to the excluded majority in developing countries.

2.2 Private Health Insurance in Low- and Middle-Income Countries

Private health insurance in low- and middle-income countries has multiple facets. We define PHI in the sense that financial resources are channeled directly to the risk-pooling institution with no or relatively little involvement of the state. Specifically, our study allows for public subsidies to a private provider of health insurance. Similarly, we also consider “private social insurance schemes” (WHO, 2003) as PHI, although such programs may be managed by a public entity. The main distinction between social and private health insurance consequently stems from the type of contract between the risk-pooling entity and the insured individual or group. Whereas social insurance relies on tax-like contributions, PHI rests upon a private contract between the insurance company and its clientele that sets the level of an insurance premium in exchange for a given benefit coverage. As participation in these schemes is rarely mandatory, PHI is often referred to as voluntary health insurance (VHI). In our analysis, we will nevertheless stick to the PHI-notation.

According to the Organization for Economic Cooperation and Development (OECD, 2004), health financing through insurance involves both prepayment and risk pooling. Following this general classification, there are nevertheless several possibilities how expenditure for health care can be financed through private prepaid contributions. The spectrum of PHI in developing countries ranges from large commercial providers to small non-profit schemes, which can either be run by a private entity (including health care providers), a Non-Governmental Organization (NGO) or the community. Furthermore, insurances may offer individual contracts or cover particular groups of people, which is often the case with employer-based schemes that rarely extend beyond the formal labor market. In our analysis, we finally consider prepaid medicine programs, although their degree of risk pooling is very limited. These schemes also offer insurance-like services, especially when the insurance industry is relatively small or not well developed.

Due to the diversity of existing schemes and the non-exclusivity of particular features it is impossible to derive a strict typology of private risk-sharing arrangements. A classification of schemes may nevertheless consider the type of supplier, the level of compulsion, the extent and type of risk pooling, as well as the form of insurance contract. Furthermore, PHI schemes may be distinguished by

the degree of coverage, the type of the insurance business (profit vs. non-profit), and whether or not they employ some sort of cost-sharing (i.e., co-payments, deductibles, and coinsurance). Tab. 2 gives an overview of various dimensions of PHI.

Tab. 2: Typology of Private Health Insurance in Low- and Middle-Income Countries

Dimension			
Type of Supplier	<i>Public</i>	<i>Parastatal</i>	<i>Private</i>
Level of Compulsion	<i>Mandatory</i>	<i>Mandatory, but choice between packages</i>	<i>Voluntary</i>
Extend of Risk Pooling	<i>Large Pool</i>	<i>Small Pool</i>	<i>None</i>
Type of Risk Pooling Arrangement	<i>Community-Rated Premiums</i>	<i>Group-Specific Premiums</i>	<i>Individual-Specific Premiums</i>
Form of Insurance Contract	<i>Community</i>	<i>Group</i>	<i>Individual</i>
Degree of Coverage	<i>Comprehensive</i>	<i>Supplementary</i>	<i>Complementary</i>
Type of Cost Sharing	<i>Co-payments</i>	<i>Deductibles</i>	<i>Co-insurance</i>
Type of Insurance Business	<i>Profit</i>	<i>Non-Profit</i>	<i>Charity</i>

Source: Own Compilation.

In many OECD countries⁸, PHI is offered by for-profit providers. Such private commercial health insurance has the least significance in low- and middle-income countries. As in Cambodia, commercial PHI in the developing world is usually “restricted to a relatively small population, the so-called better-off, employees of large enterprises and big NGOs” (GTZ, 2003: 13). Such observations are confirmed for basically all low- and middle-income countries that in some way or the other rely on PHI in their health care financing. Private commercial health insurance offers both comprehensive and supplementary coverage, where the latter predominantly covers superior treatment or additional services. Generally, people with private coverage are free to consult the health provider of their choice and get reimbursed according to the specific insurance package they have selected.

The narrow focus of private commercial health insurance on high income percentiles is a direct result of their specific design, which yields high premiums relative to the disposable income of the majority of the population. Since commercial providers are primarily interested in maximizing profits, they are highly selective in whom to insure. Bad-risk patients with frequent and/or high cost treatment are not only a menace to the revenue generating objective of private insurers, but also jeopardize the survival of the firm – especially since the risk pool of PHI is typically very small so that individual risks cannot be counterbalanced. High-cost patients are often excluded from the schemes, or premiums have to rise in order to compensate for the financial risks they impose. The

⁸ In some OECD countries, on the other hand, private health insurance is primarily offered by non-profit funds; i.e., Australia and France.

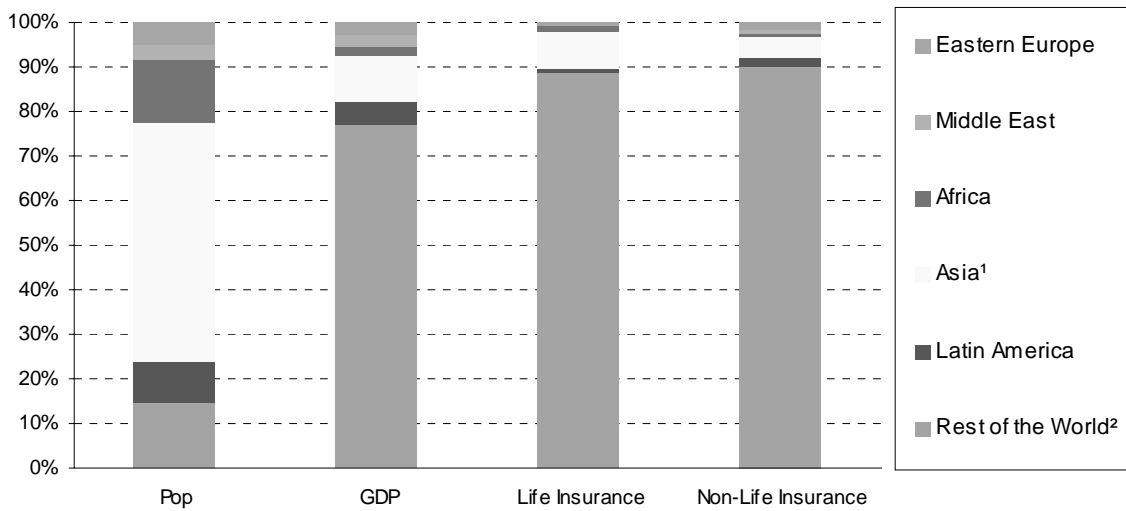
outreach of commercial providers is additionally reduced by a lack of information on both the insurer and the consumer side. Potential buyers of PHI are often not aware of the possibility to insure against health risks through private providers; in some cases, they may not even be familiar with the concept of health insurance (Bennett et al, 1998: 19; Asfaw/Jütting, 2002: 6). On the other hand, a lack of reliable data on the health situation in low- and middle-income countries makes it difficult for providers of PHI to offer customized schemes at an affordable price; e.g., the U.S. Department of Commerce (2000) estimates that a foreign provider of insurance services needs on average three to five years before breaking even. This time span is essential to accumulate all “relevant information about the targeted subsectors of a country’s health care system, investment requirements, and cultural attitudes towards health care that will have a bearing on success” (ib.: 43-6).

3. Evidence of PHI in Low- and Middle-Income Countries

This section will give an overview of private prepaid health programs in different regions of the world. Specifically, we will analyze the private health insurance market in Latin-America, Asia, Africa, Eastern Europe, and the Middle East. Besides illustrating various indicators of market performance, this section will also consider areas of market failure, discuss corresponding policy responses, and give an outlook of PHI development.

Measured as insurance premium income, private risk-sharing markets in low- and middle-income countries are still relatively insignificant. This appraisal is particularly true for private commercial health insurance. Naturally, the role of PHI heavily depends on the government’s involvement in this line of business (Swiss Re-Insurance Company, 2004: 10). Despite severe shortcomings of other forms of health financing, private health and accident insurance has not yet become a major factor of the health care system in the developing world. In 1995, insurance penetration only amounted to 0.1 %, 0.2 %, and 0.4 % in Asia, Latin America, and Eastern Europe respectively (Swiss Re-Insurance Company, 1998: 7). Obviously, these data need to be treated with care as premium income from small scale insurance schemes often times does not get recorded. Fig. 3 gives a global overview of life and non-life insurance as regards population size and gross domestic product (GDP).

Fig. 3: Relative Importance of Commercial Insurance Markets* in 2000



* measured as share of global insurance premium income.
 1: Asia excluding Japan; 2: Rest of the World predominantly covering OECD countries.
 Source: Own calculations; data: Swiss Re-Insurance Company (2004).

As illustrated in Fig. 3, both life and non-life insurance are still relatively undeveloped in low- and middle-income countries. Collectively, all five regions that will be considered in our analysis merely account for 10 % of global insurance premium income. This share is particularly low considering the fact that low- and middle-income countries account for more than 85 % of the world’s population. Furthermore, it does not necessarily reflect these countries’ economic potential as their share of global GDP amounts to around 23 %. The following section will give a detailed overview of the insurance and particularly health insurance industry in Latin America, Asia, Africa, Eastern Europe, and the Middle East.

3.1 Insurance Market and Private Health Insurance in Latin-America

3.1.1 General Overview

In 2000, the private insurance market in Latin America accounted for 1.6 % of global insurance premium income (USD 39 billion). Of this, approximately 18 % is attributable to health and personal accident/workmen’s compensation insurance. The insurance industry is particularly developed in Argentina, Brazil, Chile, Colombia, Mexico, and Venezuela who account for 92 % of Latin America’s total insurance premium income. The volume of insurance premiums has significantly increased in the past couple of years, especially after regulatory changes and liberalization efforts in the 1990s, which introduced foreign insurers to the national markets. In certain countries, international suppliers cover up to 70 % of the insurance market, e.g., Chile, Argentina, and Mexico (Swiss Re-

Insurance Company, 2004a: 12). Penetration by multinational corporations has also started to increase in Brazil and Ecuador (Iriart et al., 2001).

The high inflow of capital and the increased presence of foreign insurance providers in the 1990s have not been met by an equally growing demand for these products. Despite an increase of insurance based transactions of around 5 % there remains a mismatch of supply and demand. This may have a simple explanation: On the one hand, market liberalization in Latin America and the subsequent inflow of foreign providers occurred very rapidly and in a profound fashion: i.e., regulations dropped, new licenses were granted, and restrictions on foreign investments fell. On the other hand, consumer preferences usually tend to change at a more incremental pace, especially so when per capita income does not increase sufficiently to support a change in consumption (Salazar, 1999).

The growth of the insurance industry is mainly due to the development of life-insurance. Even though Latin America experienced high growth rates in health and personal accident insurance between 1995 and 2000, the overall non-life insurance sector only grew proportionately to GDP. Furthermore, the comparatively strong growth rate of 6 % in 2001 was mainly driven by higher premiums and rising international prices in property insurance rather than a general expansion of the business (Swiss Re-Insurance Company, 2002: 3f).

3.1.2 PHI in Latin America

Despite the relative insignificance of private health insurance premiums, PHI does play a significant role in some Latin American countries. It is particularly important in Uruguay, where over 60 % of the population is covered through PHI. Similar to a public insurance system, coverage through private entities is mandatory; those who cannot afford the premiums (i.e., elderly and poor people) are covered through publicly funded programs (Sekhri/Savedoff, 2005: 131). PHI is either offered through prepaid care associations, membership-based professional cooperatives, or non-profit health services (PAHO, 1999: 6). Although the state merely exercises some legal and technical control, the autonomy of private health insurance providers in Uruguay is limited; i.e., the state sets a price ceiling on monthly premiums. High coverage is also reached in Colombia where half of the population is estimated to have private health insurance (U.S. Department of Commerce, 2000: 43-7).

Particularly noteworthy is the significant increase of formal coverage in Colombia following health sector reforms in the early 1990s, especially amongst lower income groups (Jack, 2000: 14). Compared to 1993, insurance coverage had more than doubled in 1997 with 57.2 % of the population being formally insured. Due to tax benefits this increase had been proportionally largest amongst the lowest income percentiles. It has also been argued that the insurance system in Colombia was more focused than elsewhere in Latin America while standard insurance packages for high and low

income groups allowed some redistribution between the rich and the poor (Jack, 2000: 30). After a general deterioration of the country's economy, total spending on health care has nevertheless dropped significantly in Colombia between 1997 and 2001 (WHO, 2003).

Measured in terms of total expenditure on health care, PHI is also important in Chile and Brazil, largely due to insufficiencies of publicly financed insurance schemes. About one quarter of the population is covered through private health insurance in each respective country (U.S. Department of Commerce, 2000: 43-7). Although not yet reflected in relative expenditure on private health insurance, PHI has recently also gained significance in Mexico where the industry is experiencing "vigorous growth" (Swiss Re-Insurance Company, 2002: 35). Still at a comparatively low level, spending on prepaid plans in Mexico increased by more than 80 % between 1997 and 2001 (WHO, 2003). The Mexican National Commission of Insurances and Guarantees estimates PHI coverage at around 3 percent. Tab. 3 gives an overview of all Latin American countries where spending on PHI has been recorded.

Tab. 3: Private Health Insurance in Latin American Countries (2001)

Country	Importance of PHI*	Country	Importance of PHI*
Argentina	14.5	Honduras	3.5
Barbados	7.9	Jamaica	13.0
Bolivia	2.6	Mexico	2.7
Brazil	21.0	Nicaragua	2.1
Chile	22.6	Panama	5.8
Colombia	11.9	Paraguay	17.5
Costa Rica	0.5	Peru	7.2
Dominican Republic	0.3	Suriname	0.3
Ecuador	4.7	Trinidad and Tobago	4.0
El Salvador	2.6	Uruguay	37.4
Guatemala	2.7	Venezuela	1.7

* expenditure on private prepaid plans as % of total expenditure on health: not including countries without PHI or where data was not available.

Source: Own Calculations. Data: WHO (2003).

3.1.3 Market Indicators and Evidence of Market Failure

Social insurance provided the primary model of health insurance in Latin America before the insurance market opened for private providers (Mesa-Lago, 1991). When PHI started in the 1990s (Chile 1981), most social security programs in the region had low coverage, coped with high administrative costs, suffered from inefficiency, corruption, and escalating costs, and faced fiscal imbalances. The entry of private and especially international insurers led to an increased and often times predatory competition, which was characterized by hostile takeovers of local insurers as well as a number of

mergers and acquisitions. Multilateral lending agencies and the World Bank in particular strongly supported the privatization of public services and the entry of foreign corporations. Specifically, countries that failed to implement market structures in the health sector (structural adjustment programs) were threatened with cutoffs or drastic reductions of loans, import credits, and food aid (Stocker et al., 1999).

However, this development has not yet materialized in more competitive products such as lower premiums. Even though market concentration has recently decreased as some small start-up companies have entered the market, the industry remains non-competitive and the level of premiums high. Consequently, private health insurance predominantly addresses to the highest income percentile; low income groups remained in the existing social insurance schemes or are left without any insurance at all. Such inequities have been reported for Argentina, Chile, and Colombia (Barrientos and Lloyd-Sherlock, 2003), Brazil (Jack, 2000: 26), and Peru (Cruz-Saco, 2002: 17). In some cases, the introduction of PHI even pushed people out of other forms of prepaid programs (e.g., prepaid medicine schemes) and arguably deteriorated health care coverage (comp. Box 1).

Box 1. Prepaid Medicine Programs in Latin America

In countries where the insurance market is not well developed, prepaid medicine programs offer an alternative option to secure against medical risks. Technically, these plans are not an insurance as beneficiaries do not buy policies with the objective to protect themselves from unexpected expenses. Rather, individuals purchase the right to reduced rates for medical services that they will most likely use in the future. Such programs predominantly focus on the provision of high quality simple curative and preventive care. People who know that they will need medical services can join the program with the exception of individuals who exhibit severe health conditions. For an annual entry fee people can choose between various packages that offer different degrees of coverage. The annual fee depends on the person's age, medical history, as well as the package chosen.

Prepaid medicine programs have been particularly relevant in some Latin America countries (e.g., Argentina, Bolivia, Chile, and Colombia), where such schemes were basically the only way to privately insure against health risks before PHI was introduced. Similar to commercial health insurance, prepaid medicine programs mostly cover people from the upper-middle and high income class. As a consequence, they rarely extend beyond formally employed workers in urban areas.

After the introduction of private health insurance, the importance of prepaid programs has clearly decreased. Especially in Argentina, membership declined significantly during 1997 and 2001, also as a consequence of economic crisis that put former beneficiaries out of regular employment. Today, membership is therefore limited even further to the high income groups of the Argentinean society. In Bolivia, the decline of membership has not been as significant, partly because the public insurance system could not offer sound alternatives. In 1995, prepaid medicine programs still had a larger market share than private health insurance. The overall importance of prepaid risk schemes has nevertheless been very weak; i.e., only 0.86 % of total resources for health care got channeled through health insurance companies compared to 1.62 %, which were paid for prepaid medical institutions (PHR, 1998).

Frequently, PHI is faced with both the inherent problems of health insurance markets and “the administrative weakness and political conflicts present in the health sector in Latin America” (Barrientos and Lloyd-Sherlock, 2003: 189). Previous experience raises concerns whether the introduction of private schemes will provide a solution for the apparent problems of health care financing in Latin

America. In many countries basically all relevant indicators of a successful health insurance system have not improved or even deteriorated from the time private schemes were introduced. According to Barrientos and Lloyd-Sherlock (2003), private insurance has neither contained health care costs nor promoted equity, nor has it absorbed all risk-groups in an un-discriminatory fashion (cream skinning). As noted by the International Labor Organization (ILO), there exists a large discrepancy between coverage in urban and rural areas. For the early 1990s, the ILO made out vast disparities between the best and the worst served areas in Argentina, Mexico, and Panama (ILO, 2000). Small non-profit schemes may arguably better adapt to local circumstance and cover a higher percentage of people than imported types of insurance that are largely based on the U.S. health maintenance system (Iriart et al., 2001: 1243). Box 2 discusses managed care in more detail, which has become a characteristic feature of the Latin American health care market.

Box 2. Managed Care in Latin America

In the course of liberalizing and privatizing health care, many Latin American countries have adopted private health insurance schemes that are based on the principles of managed care. In this respect, the private insurance market in Latin America is primarily influenced by U.S. type Health Maintenance Organizations (HMOs). HMOs are private prepaid health programs in which members pay monthly premiums to receive maintenance care (i.e., doctors' visits, hospital stays, emergency care). Care is often provided through the organization's own group practice and/or contracted health care providers, which limits consumer choice (exceptions may exist for emergency care). Similarly, it is usually not possible to consult a specialist before seeing a pre-selected primary care doctor who serves as a gatekeeper to all health needs. Other types of managed care include Preferred Providers Organizations (PPOs) that have recently gained importance in the United States.

Managed care can be a way to control and limit health care spending. To some extent, such appraisal may apply to the United States, where managed care is dominating the health care industry with a projected share of about 93 % of patients by 2005 (U.S. Department of Commerce, 2000). Due to their combined packages of health insurance and care HMOs can exert more influence on service delivery than regular insurance providers. Techniques utilized by managed care organization (HMOs, PPOs, and other types) to control costs include a combination of preadmission certification, utilization management, and clinical guidelines. In theory, this should remedy the inherent information problem between insurer and health care entity (principal agent problem) and at the same time limit an overuse of health services (moral hazard). Although their impact on health care provision has not yet led to significant quality improvements (OECD, 2004a), managed care may have helped to stabilize and contain the rate of growth in medical costs; from 5.5 % in 1995 to 4.9 % in 1996 and 1997, and 4.8 % in 1998 (U.S. Department of Commerce, 2000; Phelps, 1997). Recently, double digit growth in health premiums has nevertheless resumed in the United States.

It is nevertheless doubtful whether HMOs will contribute to improving health care delivery and/or containing health care costs in Latin America. After the North American market is close to being saturated corporations seek new investment opportunities abroad, which may be given by the growing upper middle class in Latin America. In fact, Stocker et al. (1999: 1132) point out that the primary motives for foreign HMOs to enter the Latin American market have been financial rewards. Other goals that have traditionally been valued by some HMOs in the United States (e.g., preventive care or quality control) only have minor relevance. Mandatory co-payments have created barriers of access to care and deteriorated health care provision for vulnerable groups. Furthermore, "managed care organizations in Latin America have attracted healthier patients, whereas sicker patients gravitate to the public sector" (ib.: 1133).

3.1.4 Regulation and Regulatory Concerns of the PHI Sector in Latin America

Problems connected to the introduction of PHI have occurred in many countries. Due to insufficient regulatory arrangements and a lack of public oversight a large part of the wealthy population in Chile has opted out of the social insurance system, making public health care *de facto* an insurer of last resort (Barrientos, 2000). The Chilean government only gradually responded to these regulatory demands and established an official agency (the *Superintendencia de ISAPRE*) to supervise the private insurance scheme ten years after the initial reform. Jack (2000) argues that the highly fragmented insurance market – in 1995, the existing 35 private insurance companies in Chile offered close to 9,000 distinct insurance programs – could also have caused superfluous insurance for high income percentiles. Although the quality of coverage rises with the level of premiums paid or income earned respectively (in Chile, premiums are a percentage of income), this increase may only be marginal for the very rich. Furthermore, the stop-loss clause of many PHI contracts allows insurance companies to limit the extent of coverage in case of catastrophic health care costs. As health risks usually increase during a person's lifetime old people are significantly underrepresented in private schemes; only 6.9 % of the people older than 65 years are members of an ISAPRE compared to 26.7 % in the 25-54 age-group (Jack, 2000: 28).

Despite a learning-process in Argentina and Colombia, even there the regulatory framework has not yet been completely established. In Argentina, the *Superintendencia de Servicios de Salud* started to operate in 1997 and initially only supervised the public schemes. Naturally, this situation was very beneficial for private health insurers as it did not impose any regulatory requirements on them and at the same time weakened the monopolistic power of public providers. Similarly, the largest of the *Entidades de Promoción de Salud* in Colombia (competitively operating health insurance schemes) only started to participate in the risk-adjustment mechanisms in 1999. As reported by Jack (2000: 26), “regulation of the private insurance market was virtually non-existent until 1998” in Brazil – harming not only the performance of the private insurance industry in terms of equity and efficiency, but also causing a poor reputation of private prepaid group organizations.

Even with an institutional framework in place regulation is a critical issue as the implementation of adequate legislation is costly; i.e., regulation induced transaction costs are estimated to account for 30 % of the total premium revenue in Chile (Kumaranayake, 1998: 16). This may be one reason that the costs of administering insurance are estimated to be ten times higher for PHI as compared to social insurance (Mahal, 2002: 434). Apart from efficiency aspects, the Chilean experience with private health insurance also offers evidence for apparent cream skimming on the side of the insurers. Baeza (1998: 18) reports that the older population of Chile is strongly underrepresented in PHI schemes. Although the share of people over 60 years accounts for 9.5 % of the Chilean population, only 3.2 % of all people with private insurance belonged to this age group.

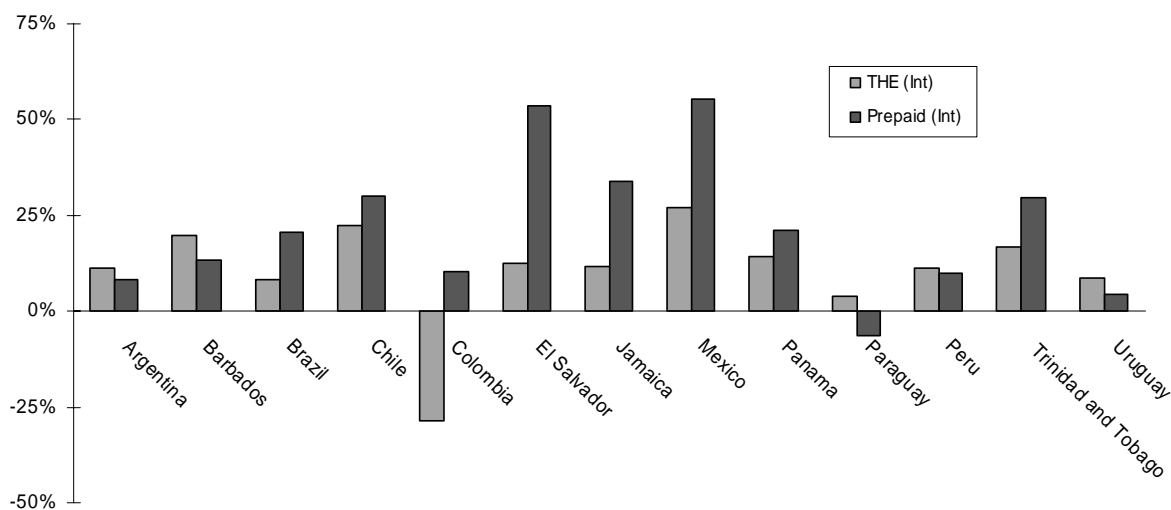
3.1.5 Trends of PHI in Latin America

It is difficult to derive a clear trend for PHI in Latin America. After the insurance industry flourished in the 1990s (Cruz-Saco, 2002), recent data from the WHO indicate a slowdown of activity. Although expenditure for prepaid programs continued to increase between 1997 and 2001 in countries where PHI plays a significant role in health care financing (except Paraguay), this increase may mostly be due to the general development of health care spending. Measured in international dollars (U.S. Dollars adjusted for purchasing power parity), the increase of private prepaid expenditure is smaller than the increase of total expenditure for health care in Argentina, Barbados, and Uruguay. Similarly, expenditure for prepaid programs decreased in Paraguay despite the fact that total health expenditure increased over the same period of time.

Nevertheless, the relative importance of PHI as regards total health care spending increased in a number of countries, including Brazil, Chile, Colombia⁹, Jamaica, Mexico, and Panama. This picture is confirmed looking at the development of PHI with respect to total health expenditure. Although the increase of PHI spending seems to be driven by the overall development of health care spending, PHI often grows faster than total health care spending. Yet, this correlation does not apply to all countries as the relative importance of PHI declined in Argentina, Paraguay, and Peru. Furthermore, there does not seem to be any correlation between economic development and the level of prepaid health spending as some countries show increasing levels of prepaid spending although their GDP declined and vice versa. Fig. 4 gives an overview of the development of total health expenditure and private spending on prepaid programs between 1997 and 2001.

⁹ The sharp decrease of total health care spending in Colombia between 1997 and 2001 (-28.4 %) may possibly be due to a general "deterioration of [... the country's] economic, social, and political situation, aggravated by armed conflict, which has contributed to the most acute crisis in Colombian history" (UNFPA, 2003: 230).

Fig. 4: Total Health Expenditure and Expenditure on Prepaid Plans in Latin America



Note: Total Health Expenditure and Expenditure on Prepaid Plans measured as Int. Dollars (percentage change between 1997 and 2001). Only countries with spending on private health insurance exceeding 10 Int. Dollars in 2001. Source: Own Calculations. Data: WHO (2003).

3.2 Insurance Market and Private Health Insurance in Asia

3.2.1 General Overview

Considering Asia's large population, the private insurance market is relatively insignificant. Particularly in Central Asia, the private insurance industry is barely developed. Excluding Japan, the most important insurance markets are found in South Korea, Taiwan, Hong Kong, Singapore, and Malaysia where insurance penetration reaches 5-7 %. The insurance industry is also gaining importance in Thailand, Indonesia, Vietnam, China, and India. Especially the last two are expected to offer significant growth potentials in the near future. In 2003, premium income amounted to USD 207 billion (141 billion life and 66 billion non-life business respectively), which is just a little over 7 % of the world's total premium income. More than 90 % of the total premium income was traded in South and East Asian countries.

The positive correlation between insurance premium income and GDP growth seems particularly pronounced for Asian countries. In the non-life insurance sector, growth rates have recently regained momentum after the 1998 economic crisis had significantly slowed down the development of the insurance industry. The Severe Acute Respiratory Syndrome (SARS) epidemic of 2003 and its negative consequences on the Asian economy temporarily added another kink to the generally steep growth path of Asian insurance markets. In the long run, SARS may even have a positive impact on the non-life insurance sector as it may increase awareness of the need to prepare for unex-

pected health hazards. On average, the non-life insurance industry grew by 6.9 % across markets in 2002 (Swiss Re-Insurance Company, 2003: 6).

The presence of foreign insurers is still relatively small. Only 39 % of all non-life insurance companies are foreign owned. The market share of foreign insurers is particularly strong in Singapore, Indonesia, Malaysia, and the Philippines. In the rest of the continent (including Japan), their market share is clearly below 20 %. This difference is even more pronounced as regards the relative non-life insurance premium income of foreign insurers. Despite a recent growth of 5.3 % between 1997 and 2001, foreign insurers only account for 10 % of premium income in Asia (4 % if Japan is excluded).

3.2.2 PHI in Asia

Like the whole non-life insurance sector, PHI is only gradually evolving in Asia. Private health and accident insurance clearly play a secondary role in health care financing. In many countries, PHI has not yet entered the health care market. This may partly be due to the role of the state in Asian health financing systems, which generally offers (and often times requires) public health insurance. Additionally, some countries use medical savings accounts as a form of prepaid health insurance; Box 3 will discuss further issues of the *Medisave* program in Singapore.

Box 3. *Medisave* Program in Singapore

The *Medisave* program is one of the three pillars of Singapore's health care system. As this program essentially only spreads an individual's health risks over time, *Medisave* will unlikely cover true catastrophic health costs in case of severe illness; it is therefore accompanied by an inter-personal risk-pooling entity called *Medishield*. Singapore provides health care for the very poor through its third financing pillar *Medifund*

Medisave is compulsory for all employees and self-employed who have to pay 6-8 % of their payroll tax to the Central Provident Fund. Contributions are borne by employers and employees who pay equal shares; they are tax deductible and earn interest. Expenses for hospitalization and surgery can be withdrawn from an account for an individual and his/her family. Patients are free to choose between public or private providers while public services require a co-payment whose rate depends on the class of care (Mahal, 2002: 451).

Among Asian middle-income countries only Hong Kong and India do not have obligatory public health insurance. However, this does not necessarily promote the development of PHI; e.g., Hong Kong predominantly relies on tax-paid health care and highly subsidizes public hospitals. Lately, the government's role in providing medical insurance is similarly declining in China (Swiss Re-Insurance Company, 2003: 24). Given the region's high rate out of pocket spending, PHI could become an important source of health care financing if resources for direct payments can be channeled to prepaid schemes. Tab. 4 gives an overview of Asian countries for which spending on PHI has been documented.

Tab. 4: Private Health Insurance in Asian Countries (2001)

Country	Importance of PHI*	Country	Importance of PHI*
China	0.3	Papua New Guinea	1.0
Hong Kong**	1.6	Philippines	10.9
India**	< 1	Sri Lanka	0.6
Indonesia	6.1	Thailand	4.1
Malaysia	3.3	Vietnam	3.0

* expenditure on private prepaid plans as % of total expenditure on health: not including countries without PHI or where data was not available (e.g., India).

** data for Hong Kong are extracted from *Special Report on Estimates of Domestic Health Expenditures*, Harvard Report 1999. Data for India are estimated in WHO (2004: 40).

Source: Own Calculation. Data: WHO (2003).

Even in the Philippines, where spending on PHI is relatively significant, most of the population is covered through public health insurance. Specifically, the parastatal Philippines Health Insurance Cooperation extends to both formal and informal employees and covers around 75 % of the Philippine population (WHO 2004: 35). Evidently, this situation does not leave much room for PHI development. According to the Institute for Public Health Management, only 2 % of total health expenditure in the Philippines is channeled to private commercial providers. The remaining 9 % can be attributed to spending on micro- and community insurance. According to WHO (2003) data, expenditure for private risk-sharing programs also constitutes a large share of total health care spending in South Korea (9.6 % in 2001). However, as a high income country South Korea will not be considered in our analysis. The same applies to Hong Kong.

Although small in volume relative to its large population size, India is estimated to have the largest market for private health insurance covering 33 million people or 3.3% of its population (Sekhri/Savedoff, 2005: 130). These estimates are nevertheless based on 1997 (coverage) and 2001 (PHI spending) data. They consequently do not take into account the dynamic development of private insurance markets which has occurred in recent years. After progressively privatizing its health sector, the relevance of PHI in India is expected to rise significantly in the future. The National Council of Applied Economic Research estimates that the country has a 300 million strong middle class population, which obviously would be a promising market for PHI.

3.2.3 Market Indicators and Evidence of Market Failure

Private health insurance is mostly a new phenomenon in Asia. In order to improve health care coverage, some countries have recently started to shift resources to private risk-sharing programs. This development largely occurred as a response to increased health costs that overburdened existing social security mechanisms; e.g., as one option to deal with the new challenges, the Vietnamese government proposes to expand private commercial and community-based health insurance (ADB, 2002). Despite large informal sectors, insurance brokers (e.g., Gras Savoye, comp. U.S. Vietnam

Trade Council, 2003) see significant development potentials of PHI in Vietnam. Other dynamic insurance markets are predicted for China and India (Swiss Re-Insurance Company, 2004a). The following part presents preliminary experiences from the promotion of PHI in Indonesia and Thailand; it also discusses initial evidence or projected domains of market failure in both countries. Furthermore, this section considers opportunities and challenges of private health insurance in India and China.

Indonesia

Health insurance is currently being re-organized in Indonesia. According to the WHO (2004: 101ff), the issue of health care financing has stagnated over the past two decades, leaving large parts of the population uninsured and without equitable access to health care. Census data from 1992 and 2001 (*Susenas Socioeconomic Surveys*) reveal that hospital care has hardly been accessible for the bottom 60 % of the population.

Existing inequities have multiple sources: e.g., a separate insurance scheme for public employees, the possibility of large companies to opt out of the social security scheme, and a lack of private non-profit health insurance. Under current legislation, all private health insurance operating as managed care must be commercial in order to obtain a license; such U.S.-type HMOs currently only cover 500,000 people. The for-profit nature of managed care is very different from the U.S. American experience as 96 % of all HMOs had initially been non-profit in the United States. After legislative reforms in 1992, general and life insurance companies sell PHI as riders or separate lines of business; the market is also open to foreign insurers. Such programs generally address to large firms that can afford the high premiums. With 64 insurance companies in 2001, the WHO nevertheless estimates the market for traditional health insurance promising. Recent data indicate that premium income of traditional health insurance is five and coverage eight times higher than in the HMO sector.

A 1970s initiative to implement micro and community health care in Indonesia was stopped after the Social Safety Net program was introduced in the late 1990s. At that time, coverage was very low (< 2 % of the population, comp. Thabrany et al., 2001) and access to inpatient care among fund members not significantly different from non-members. However, members utilized health centers more often than the uninsured. The difficulties of micro and community schemes in Indonesia stem from multiple sources. First of all, households spend a very low percentage of their household income on health (between 2-4 %) while most of their resources are exhausted from buying food. Second, health care is highly subsidized for the poor who could often get treatment for less than what they had to spend for insurance contributions. Finally, the WHO (2004: 135) argues that it was unwise to base contributions for the community schemes on consensus among the (mostly low income) households. This resulted in very low premiums while higher income households should actually

have had contributed more to the health funds. In this respect, community involvement may also have had undesired effects.

Thailand

In Thailand, the private insurance industry has a long history that dates back to 1929; nevertheless, the first private health insurance company did not start operating before 1978 (WHO, 2004: 177ff). Coverage from voluntary PHI has decreased between 1991 and 1999 from 3.1 % to 1.4 % and mostly extends to better-off individuals (reimbursement model). At the same time, contributions to private prepaid programs have gained importance in total health expenditure (+ 11.7 % between 1997 and 2001; comp. WHO, 2003), largely due to the introduction of a health card insurance program (Supakankunti, 2000; Nitayarumphong/Pannarunothai, 1998). Since its initiation as a pilot in 1991, this government promoted voluntary risk-sharing scheme has attracted 28.2 % of the Thai population (WHO, 2004: 179). Apart from the fact that half of the insurance premiums are paid from public subsidies, the large expansion of the health card program may also be due to an extensive TV and radio advertising campaign. As argued by the WHO, the card program could therefore pave the way to universal coverage. So far, the initiative is not self-sustainable (i.e., despite the subsidies, costs per person exceed the revenues) and may potentially run the risk of attracting too many bad risk patients. Since high individual health risks are not reflected in the premiums, such situation could undermine the base of the program. Before being eligible for services individuals now have to qualify for 30 instead of 15 days.

India

The private health insurance industry in India is still very young and insignificant. However, PHI is expected to grow in the near future, especially after legislative reforms have recently introduced the "last phase in the move towards the privatisation of the insurance sector" (Mahal, 2002: 412). It is certainly still too early to discuss market indicators of the private health insurance industry and present possible evidence of market failure. Nevertheless, an analysis of the current regulatory framework allows some projections about the future performance of PHI in terms of cost and quality of care as well as its influence on equity related issues. Mahal (2002: 436) argues that the introduction of PHI will not have cost-increasing effects in the Indian health sector. Similarly, it would equally be unlikely that PHI will deteriorate the quality of health care, which is not to say that it would necessarily lead to improvements either. According to Mahal's analysis, the regulatory framework in India is already sufficiently established or existing gaps could be filled with appropriate legislation to enforce quality and costs standards.

Given the relatively weak legislation on consumer protection and especially the poor enforcement mechanisms in India, Mahal nevertheless believes that the expansion of PHI could have an equity-worsening effect. This could even be amplified if, as Mahal expects, the insurance market remained

small for a certain period of time. The establishment of a well-functioning PHI sub-sector typically requires several years of refining and fine-tuning the system. Such equity concerns are shared by the WHO (2004: 97ff). According to their analysis the private sector currently “continues to operate in an almost unhindered manner”. In order to gradually advance toward universal coverage (which is still a long way given the fact that currently only 10 % of the population have some sort of health insurance), policy makers would thus have to implement adequate licensing and regulatory requirements. As PHI will primarily target the middle and upper class population of India, the state would also need to find new and innovative ways to provide health care coverage for the poor.

China

Following massive reforms in 1998 (urban areas) and 2002 (rural areas), the Chinese health care system is currently being reorganized after coverage rates had dropped significantly in the 1980s and 1990s (i.e., 64 % of the Chinese population in rural and 15 % in urban areas did not have health or accident insurance at the end of the 1990s; comp. Swiss Re-Insurance Company, 1998: 21). Particularly challenging are escalating health care costs that have increased tremendously after trade liberalization and open-market policies in the 1980s. In the process of reform, “China has carried out some of the most interesting experiments with new forms of health insurance financing” (van Ginneken, 1999: 18).

With the breakdown of collective economic structures the once “successful” (WHO, 2004: 60) health care system, which – at its peak in the 1970s – covered up to 98 % of villages is still adapting to new market structures. Although the government has started to encourage people to privately insure against health risks, PHI does not yet play a major role in China. According to NHA data, only 3.6 % of private spending on health care was channeled to PHI in 2000 (WHO, 2004: 33)¹⁰. Challenges for the private health insurance industry originate from large informal sectors in rural areas and information deficits on person’s current health status that make an actuarial calculation and pricing of insurance products difficult. Even though some progress has been achieved in recent years, a large part of the Chinese population still remains without health care coverage.

As reported in Bloom/Shenglan (1999), the recent move toward private risk-sharing arrangements is based upon the belief that people would more readily pay voluntary contributions than accept a tax increase. However, given the low significance of health insurance today the government’s aim to achieve universal coverage by 2010 seems overly ambitious; even if this involves establishing new and innovative forms of health care financing. As one initiative, community-based health insurance schemes (CHI) are intended to increase coverage in rural areas and revitalize old commune structures. As argued by the WHO (2004: 60), the Chinese government should not only promote the de-

¹⁰ According to WHO data (2003), only 0.3 % of total health expenditure was channelled to PHI in 2000.

velopment of such schemes, but first and foremost try to integrate CHI into the national health insurance framework.

3.2.4 Regulation and Regulatory Concerns of PHI in Asia

Regulatory requirements for PHI in Asia vary across countries. Depending on the development stage of the industry, policies should aim at establishing, consolidating, or regulating the insurance sector. Specifically, policies to open the market for foreign insurers may be a good option for China and India in order to import know-how and institutional capacity. In countries where the insurance industry has existed for some time measures may be more appropriate that increase coverage among the population. One prominent example would be Thailand's effort to induce higher participation in private plans through its publicly subsidized health card program.

Still, there are also some common features of insurance markets in Asian countries. Despite some regional variation PHI is overall a new phenomenon in Asia. All countries therefore face a trade-off between promoting a new industry with supportive policies on the one hand while similarly ensuring ample regulation and consumer protection on the other. As noted by Sekhri et al (2004), measures to increase competition among insurers may encourage innovation, efficiency, and responsiveness of private schemes; at the same time, such policies may also "lead to higher administrative costs, small risk pools that are not economically viable and aggressive pricing practices that can create market instability and insolvency" (ib.: 4). Regulation strategies must therefore find a balanced mix between support and sufficient regulation. Experiences from Latin America may serve as a negative example of how open-market policies can induce too much competition that does not necessarily materialize in better products.

Given the large low-income and mostly informal sector in many Asian countries, regulative requirements will surely have to cope with equity issues at some point of the industry's development. It is very doubtful if the private commercial insurance industry will extend to marginalized individuals without accompanying public regulation. Low-income individuals and high-cost patients are rarely covered through private entities; in fact, "no country [...] uses voluntary private insurance to cover the poor or the elderly" (Sekhri et al., 2004: 8). Regulation could simply mandate coverage of marginalized individuals or influence the composition of the insured through financial incentives. Specifically, coverage of high-risk and/or low-income patients could be subsidized with public funds or low-risk individuals could be encouraged to join private schemes by granting tax-benefits. Such policies would increase the risk pool of PHI, which would ideally allow some cross-subsidization among the insured. However, whether or not public subsidize do indeed provide a cost-effective way to improve health care coverage depends on a case-to-case analysis.

For low-income countries and societies with a high poverty rate, privately run micro-insurance schemes arguably seem to be the most promising option to expand coverage to otherwise excluded individuals through private insurance. The ILO (2000) reports the implementation of such schemes in Bangladesh, India, and the Philippines; in Bangladesh, community-based schemes are even the largest health insurance program of the country (Desmet et al., 1999). Community programs also exist in China, India, Nepal, and Thailand (WHO, 2004). Pilot programs were recently started in Lao People's Democratic Republic and Vietnam (WHO, 2004a). Micro-insurance often operates on a non- or low-profit basis and is highly subsidized by either the national government or international donors.

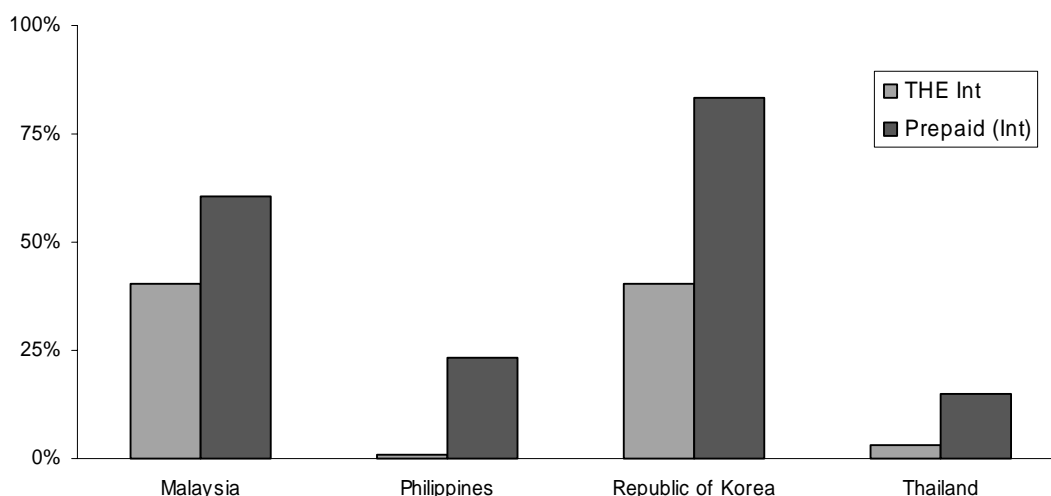
3.2.5 Trends of PHI in Asia

Development potentials of the private health insurance industry in Asia are subject to a multitude of factors including the general economic development of the region as well as the role of international investors. Most importantly, though, the development of PHI depends upon the future involvement of the state in financing or providing health care. Currently, many of the social health insurance programs are limited to people with formal sector employment. Additionally, insurance coverage is low in small and medium sized firms as insurance requirements often only apply to companies with a certain number of workers. Growth potentials for PHI therefore predominantly exist in the informal sector (often in rural areas), for unemployed as well as self-employed persons, and for high income individuals who may purchase additional coverage. In many countries, these groups make up a large part of the population.

Although small in volume, the private insurance industry in South-East Asia is on a rise. Measured in international dollars, spending on PHI augmented in all nine countries with available WHO data. Predominantly, spending increased in the range of 50 to 70 %. Prepaid programs evidently gain importance as a source of health care spending; their relative share of total health care spending increased in all countries analyzed. This development seems primarily to be driven by the overall economic performance. Except for Papua New Guinea, Indonesia, and the Philippines economic growth¹¹ and spending on PHI move in the same direction. Similarly, the significant but as regards other growth rates in the region relatively weak development of private health insurance in the Philippines (+ 23.2 %) and Thailand (+ 14.7 %) may be due to comparatively low economic growth rates (2.43 % and -0.64 % respectively). Fig. 5 illustrates growth rates of private prepaid spending exceeding 5 international dollars with respect to the development of total health care spending.

¹¹ Data on economic growth is taken from Penn World Tables 6.1; average growth rates between 1997 and 2000 are compared with the respective development of spending on prepaid health insurance.

Fig. 5: Total Health Expenditure and Expenditure on Prepaid Plans in Asia



Note: Total Health Expenditure and Expenditure on Prepaid Plans measured as Int. Dollars (percentage change between 1997 and 2001; Malaysia: 1998-2001). Only countries with spending on private health insurance exceeding 5 Int. Dollars in 2001.

Source: WHO (2003)

Apart from economic performance, the future development of PHI in Asia crucially depends upon the role of international investors. To a large part, the optimistic outlook for the development potential of the insurance industry in China and India rests upon the recent liberalization efforts of these countries. In India, the Insurance Regulatory and Development Authority Bill from 1999 opened up the insurance market for foreign investors who can now hold up to 26 % equity (WHO: 2004). The number of foreign insurance companies and investors has equally increased in China who opened up markets as part of its drive toward WTO membership. As of March 2004, the Swiss Re-Insurance Company (2004: 30) lists 12 large foreign investors that have already entered the Chinese non-life insurance market. Such figures should nevertheless belie that this development occurs on a very small scale. As Poonam Khetrphal Singh (2002) points out, PHI in India is still in its infancy and many of the problems connected to the introduction of private risk-sharing programs (primarily equity related) have not yet been answered satisfactorily.

3.3 Insurance Market and Private Health Insurance in Africa

3.3.1 General Overview

In 2003, the insurance industry in Africa accounted for just over 1 % of global premium income (USD 31 billion). This figure is particularly remarkable as 82 % of total insurance premium income can be attributed to South Africa. Other important insurance markets exist in Morocco (4 %), Egypt

(1.8 %), Zimbabwe (1.5 %), Tunisia (1.5 %), and Nigeria (1.3 %). Most of the total insurance premium income stems from life-insurance business (USD 22 billion = 71 %) while the non-life insurance sector only plays a minor role.

3.3.2 PHI in Africa

Similar to the whole insurance industry, private commercial health insurance is hardly developed in Africa. Nevertheless, private prepaid schemes are a significant source of total health financing in a couple of countries. Once again, the health insurance market is well established in South Africa, where 42.3 % of all expenditure on health care gets channeled through a private health insurance intermediary. Relative to total health expenditure, PHI also plays a significant role in Namibia and Zimbabwe. However, the high share of PHI spending is not reflected in equally significant coverage rates; i.e., only 8% of the population in Zimbabwe are estimated to have private health insurance (Campbell et al., 2000: 2) whereas PHI expenditure accounts for 19 % of total health care spending.

In absolute figures, private spending on prepaid programs is furthermore significant in Botswana, Morocco, and Tunisia. In each of these six countries, average PHI spending between 1997 and 2001 exceeded 20 international dollars and was growing over time. Tab. 5 gives an overview of all African countries where PHI spending has been recorded.

Tab. 5: Private Health Insurance in African Countries (2001)

Country	Importance of PHI*	Country	Importance of PHI*
Algeria	1.3	Mozambique	0.2
Botswana	6.9	Namibia	23.2
Cape Verde	0.1	Niger	1.8
Côte d'Ivoire	8.7	Rwanda	0.1
Egypt	0.3	Senegal	3.5
Kenya	7.5	South Africa	42.3
Madagascar	5.1	Tanzania	2.3
Malawi	1.0	Tunisia	5.4
Mali	11.5	Uganda	0.2
Morocco	13.8	Zimbabwe	19.0

* measured as expenditure on private prepaid plans as % of total expenditure on health: not including countries without PHI or where data was not available.
Source: Own Calculations. Data: WHO (2003).

Private health insurance in African countries predominantly occurs on a low membership, contributions, and coverage scale. The increasing emergence of community-based health insurance during the past couple of years has been particularly strong in the Sub-Saharan Africa region (Jütting, 2004). Micro-insurance schemes were recently implemented in Benin, Burkina Faso, Cameroon,

Côte d'Ivoire, Ghana, Guinea, Mali, Nigeria, Senegal, Tanzania, Togo, Tunisia and Uganda (ILO, 2000). Due to the non- or low-profit nature of these schemes, premiums are relatively moderate; this may explain the low level of expenditure on private prepaid programs in African countries. With the exception of South Africa, Namibia, and Botswana the average annual insurance premium between 1997 and 2001 did not exceed USD 10 on a per capita basis. During the same period, average spending on private prepaid health insurance across all 19 countries with available data amounted to USD 9.49 while South Africa clearly stands out with a level of USD 114.94 (comp. Box. 4).

Box 4. Private Health Insurance in South Africa

South Africa's strong and significant private health insurance industry clearly is an exception to the continent's general health financing systems. South Africa's system mostly resembles the structure found in the United States as health care is primarily financed through employer-based private insurance.

Despite the relatively well developed private insurance market, only foreigners or people from the high- and middle-income percentiles have private health insurance. Ernst & Young (2003) estimate PHI coverage to reach 18 % among the total South African population. The government provides basic health care services to the poor and is committed to achieve universal coverage.

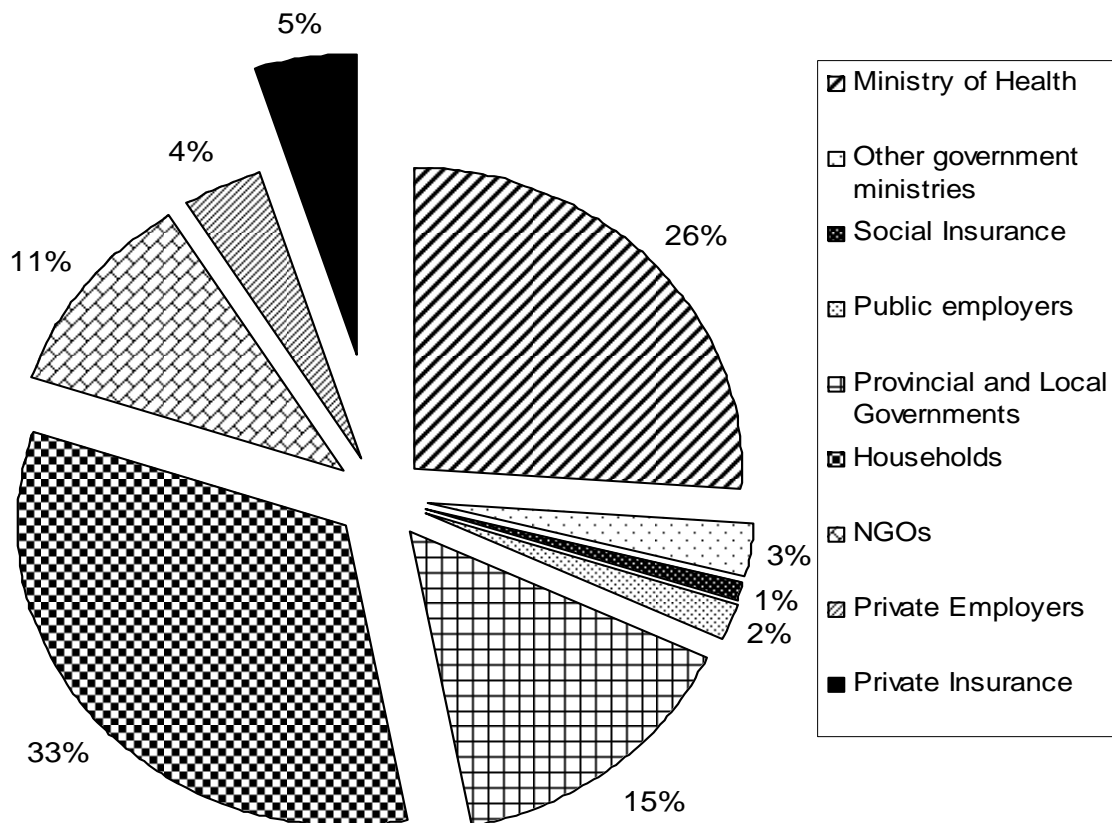
Information on small and regional-specific schemes often does not enter official data on health care expenditure. Only few countries have steadily recorded and collected data on their health systems. A comparison of available National Health Accounts from the WHO database reveals that households bear the largest burden of health costs in African countries. Specifically, one third of total health expenditure is out of pocket. Other important sources include the Ministry of Health (MoH), Provincial and Local Governments, and NGOs. Private health insurance only plays a minor role, especially bearing in mind that the average value of 5 % of total health expenditure primarily originates from the large PHI sector in South Africa. Fig. 6 gives an overview of health financing in nine Eastern and Southern African countries.

3.3.3 Market Indicators and Evidence of Market Failure

Among the African countries, only South Africa has a strong regulatory environment, which builds upon a long tradition of the private insurance industry. Nevertheless, even there private coverage is almost exclusively limited to high income percentiles. 80 % of all people with PHI are estimated to belong to the two highest income quintiles while only 2 % of the lowest income quintile has private health insurance (Sekhri/Savedoff, 2005: 130). Similar observations can be made for Namibia and Zimbabwe where the relatively high spending on PHI primarily stems from formal sector employees. In almost all African countries, international donors remain a very important part of the health care system, especially in the Sub-Saharan region where countries often obtain more than 25 % of total resources through these channels. Again, this number is notably greater for some countries (e.g.,

Mozambique with donor contributions accounting for 52 % of total health expenditure) while others may not receive any international funding.

Fig. 6: Expenditure for Health Care Through Financial Intermediaries in Eastern and Southern Africa (1997-1998)*



* countries included: Ethiopia, Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda, Zambia.
 Source: National Health Accounts of respective countries. Data: WHO (1999).

Private commercial health insurance will hardly be able to extend coverage to a large percentage of the African population. Due to institutional weaknesses and a lack of public resources, private spending will nevertheless constitute an important source of health care financing in Africa. It can be expected that PHI involvement will primarily occur on a non- or low-profit basis organized by local communities, private associations, or national and international NGOs. Box 5 discusses further insights into community-based Mutual Health Insurance (MHI) which will potentially play a prominent role in future health care financing in African countries.

Box 5. Mutual Health Insurance in African Countries

Mutual Health Insurance (MHI) is based on "local initiatives of rather small size ... with voluntary membership" (Wiesmann/Jütting, 2000: 195). Programs have either been initiated by health care providers (e.g., hospitals), Non-Governmental-Organizations, or local associations (Atim, 1998; Criel, 1998). Schemes are generally limited to a specific region or community and thus only reach a small number of people. Moreover, insurance packages are not comprehensive, but only offer supplementary coverage for certain medical treatments.

Despite these limitations, MHI is a promising approach to extend health care coverage to otherwise excluded individuals. Specifically, MHI has the potential to integrate a large part of the rural population in Africa which would otherwise be left with no or very little health care coverage. Although the scope of each individual scheme is very restricted, coverage could still extend to many individuals depending on the number of MHIs available. A recent survey of health insurance systems in 11 francophone West and Central African countries (La Concertation, 2004) reveals that 324 MHIs are currently offering their services; this is almost 90 % of the total number of the 366 registered insurance programs that are considered operational. MHI density is very different across countries, reaching from approximately eight schemes per one Million people in Senegal to just over 0.5 schemes per one Million people in Chad. Apart from Senegal, MHIs are also relatively numerous relative to population size in Benin and Guinea.

Mutual health insurance generally operates on a non- or low-profit basis. Besides offering moderate premiums to their clients, MHI has certain advantages over other forms of prepaid risk-sharing programs. Due to their small size and close ties to the local community, mutual health insurance schemes can better adapt to the specific needs of their clientele. Furthermore, MHIs are often partly or entirely managed by the local community, which again increases the programs adaptability to each particular environment.

Although health coverage through mutual schemes will typically remain relatively low, recent empirical findings (e.g., Jütting, 2005) suggest that MHI can under certain conditions indeed increase accessibility to health care and improve financial protection of the household. In this respect, MHI can serve as an important tool to reduce periodic expense shocks that would otherwise be induced by unanticipated OOP. Studies (e.g., Wiesmann/Jütting, 2000) indicate that, in order to serve the health needs of the poor, MHIs should primarily try to keep participation high by adjusting insurance premiums and benefits to the specific needs of individuals. The specific design of community-based health insurance depends on a case-by-case analysis.

Tab. 6: Target Groups* of MHI in Western and Central African Countries

Target Group of HMI	# of MHI	Relative to Total #	Cumulative
< 1,000	52	14.2 %	14.2 %
1,000-3,000	43	11.7 %	26.0 %
3,000-5,000	32	8.7 %	34.7 %
5,000-10,000	61	16.7 %	51.4 %
10,000-30,000	74	20.2 %	71.6 %
30,000-50,000	17	4.6 %	76.2 %
50,000-100,000	20	5.5 %	81.7 %
>100,000	31	8.5 %	90.2 %
Unknown	36	9.8 %	100.0 %
Total	366	100.0 %	

* according to a micro-survey of African insurance providers (own perception of target group)
Source: La Concertation (2004: 23).

Tab. 7: Types and Characteristics of Health Insurance in Western and Central Africa

Country	Pop. (Mio.)	# of PHI	# of MHI relative to # of PHI	Estimated # of Beneficiaries	Beneficiaries relative to Population	Only local outreach (rural or urban)	Regional and/or national outreach
Benin	7.5	43	93.0 %	43,387	0.58 %	72.1 %	27.9 %
Burkina Faso	13.6	36	77.8 %	14,580	0.11 %	88.9 %	11.1 %
Cameroon	16.1	22	68.2 %	10,098	0.06 %	59.1 %	40.9 %
Chad	9.5	7	85.7 %	2,072	0.02 %	57.1 %	42.9 %
Côte d'Ivoire	17.4	36	88.9 %	858,348	4.93 %	75.0 %	25.0 %
Guinea	9.3	55	100.0 %	96,635	1.04 %	98.1 %	1.9 %
Mali	12.0	56	69.6 %	499,856	4.17 %	62.5 %	37.5 %
Mauritania	3.0	3	100.0 %	13,056	0.44 %	100.0 %	0.0 %
Niger	11.4	12	91.7 %	84,372	0.74 %	16.7 %	83.3 %
Senegal	10.9	87	100.0 %	294,060	2.70 %	74.7 %	25.3 %
Togo	5.6	9	88.9 %	22,500	0.40 %	88.9 %	11.1 %
Total/Average	116.1	366	88.5 %	1,938,964	1.67 %	74.8 %	25.2 %

Source: La Concertation (2004).

Very few schemes in African countries operate on a regional or even national level. About 75 % of all health insurance programs in Central and Western Africa are either restricted exclusively to a rural or urban environment. The relatively small risk-pool of PHI in African countries is emphasized in Tab. 6. More than 70 % of all insurance schemes in Western and Central African countries describe their target group to be smaller than 30,000 people. Considering that, on average, an insurance scheme will probably reach 1/3 of its target group, only few schemes will consequently extend to more than 10,000 individuals. Tab. 7 gives an overview of types and characteristics of PHI in Western and Central Africa.

3.3.4 Regulation and Regulatory Concerns of PHI and especially MHI in Africa

Considering the low development stage of commercial PHI in African countries (except South Africa), there is no base to discuss regulatory issues of the private commercial health insurance industry. Public policies primarily involve the area of mutual health insurance schemes, which may be a small, but possibly important first step to eventually reach universal coverage. Specifically, policies could initiate and promote new *mutuelles* or improve the performance of existing programs. This last part may involve policies that support the growth and professionalization of regionally bounded schemes, which then will be capable of attracting and administering a larger percentage of the African population.

As argued by the research group on the development of mutual schemes in Africa (La Concertation, 2004: 79), one advantage of MHI could also be problematic for its future development. While their

small size ensures mutual schemes sufficient flexibility to adapt to local conditions, it also deprives them of financial stability and consolidation. 9 out of 10 schemes have less than 1000 constituents; 8 out of 10 cover less than 1000 people while half of them even cover less than 650 individuals, making *mutuelles* a true micro-insurance scheme. Although preferable from an organizational and participatory point of view this situation will hardly be sustainable in the future. The study therefore recommends more cooperation and possibly partnerships between existing schemes as well as the targeting of more constituents in the development of new programs. Only the expansion of the financial base would ensure growth and long-term stability of mutual schemes in Africa. The UMA-SIDA health insurance schemes in Tanzania (Mutual Society for Health Care in the Informal Sector) gives an illustrative example of this process as it resulted from the regrouping of five associations of the informal sector (Kiwara, 1999: 131). Public policies could support this process of consolidation which essentially needs to be based on a collective effort of the communities operating the schemes.

For the same reason, MHIs need to start operating in a more professional fashion. Currently, MHIs are very limited in both the services they offer and the number of people they cover. They can neither rely on a large risk-pool nor do they dispose of security mechanisms like guarantees or re-assurance funds. Professionalization would also include a gradual move from very low insurance premiums to contributions that allow both financial stability and a true insurance-based health care coverage. Today, most of the schemes only cover small risks and fundamentally rely on co-payments; expenses for specialists or hospital treatment are rarely included. This situation is particularly regrettable, as the true problem of health care financing often occurs as a result of catastrophic costs for major treatment. Public policies could accompany this process of professionalization by requiring adequate financial standards and security mechanisms.

As for the international donor community, the study on mutual schemes in Africa (La Concertation, 2004: 76) identifies a negative relationship between the number and functionality of *mutuelles* and the foreign aid received in a particular country. Specifically, the more schemes are operational in a country the less likely this country seems to attract financial resources from abroad. Although financial independence should be the long-term goal of the health care systems in Africa, the current status of MHI is in no way close to reaching universal coverage. In this respect, cutting foreign aid as a response to the initiation of new insurance schemes may give wrong incentives to renounce from such initiatives.

3.3.5 Trends of PHI in Africa

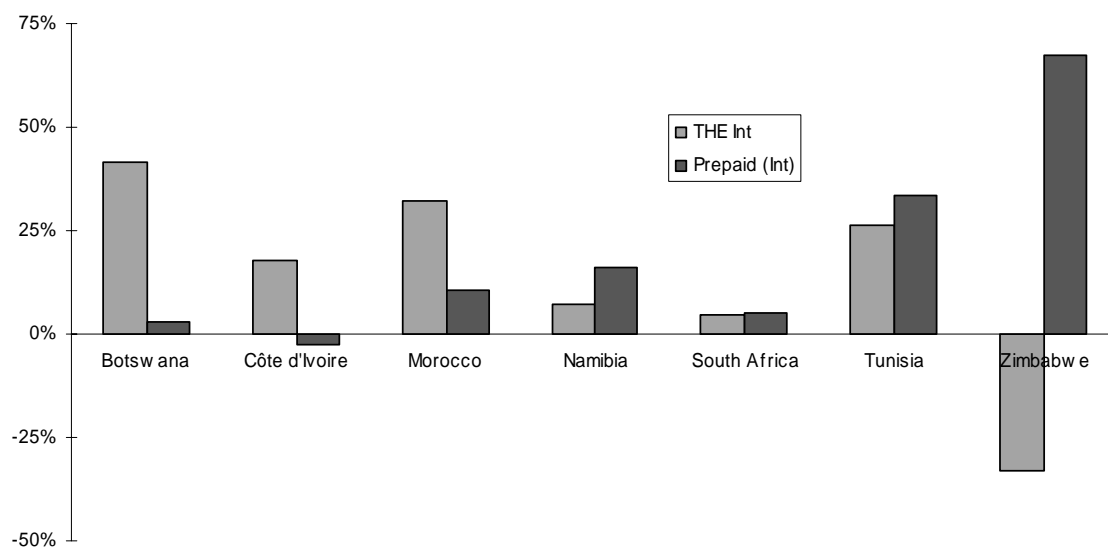
For most African countries, private health insurance is a new phenomenon. Except for some rare cases, health insurance predominantly occurs on a community-based level. Many of the schemes

that exist today have been initiated during the past 15 years while only a few programs build on a long tradition of community involvement in health care financing (e.g., in Senegal and the Republic of Congo, comp. Tine, 2000; Criel, 1998).

Given the institutional weaknesses in many African countries and the restricted financial resources of the local population, PHI will mainly evolve in the non-profit, community-based insurance segment. Already, almost nine out of ten schemes in Central and West Africa are so called *mutuelles*. Adding to the existing 366 schemes (mutual and others), another 142 are currently being implemented while 77 are planned for the near future. The regional focus of MHI lies on Senegal, Guinea, Burkina Faso, and Togo.

Due to the low volume of insurance premiums of mutual health insurance, this generally positive trend of PHI is not as visible in terms of private spending on prepaid programs. On average, PHI expenditure relative to total health care spending increased by 11.5 % across all 20 countries with available data between 1997 and 2001. This trend is, however, partly driven by significant growth rates in Cape Verde (+131 %) and Zimbabwe (+158 %). Fig. 7 illustrates the development of private prepaid spending and total health expenditure between 1997 and 2001.

Fig. 7: Total Health Expenditure and Expenditure on Prepaid Plans in Africa



Note: Total Health Expenditure and Expenditure on Prepaid Plans measured as Int. Dollars (percentage change between 1997 and 2001). Only countries with spending on private health insurance exceeding 10 Int. Dollars in 2001. Source: WHO (2003).

Due to the limited capacity and restricted outreach of mutual schemes, the development of MHI is obviously not an end in itself. But it can serve as a building block for the future development of

health insurance in Africa and thus be a first step in a country's endeavor towards universal coverage.

3.4 Insurance Market and Private Health Insurance in Eastern Europe

3.4.1 General Overview

Despite high growth rates in recent years, the insurance industry in Eastern Europe remains small. In 2003, total insurance premium income amounted to USD 41.6 billion, which is about 1.5 % of global insurance income. Roughly one third of total premium income can be attributed to life insurance business (USD 13.6 billion) while the remaining USD 28 billion stem from non-life insurance contracts (Swiss Re-Insurance Company, 2004).

3.4.2 PHI in Eastern Europe

Private health insurance in Eastern Europe is still in its infancy. In many countries, private insurers only recently entered the market as part of the general reform process toward market based systems. Measured as total insurance premium volume, the health and accident insurance industry is most significant in Russia, Slovenia, Poland, the Czech Republic, and Croatia (Swiss Re-Insurance Company, 1998: 6). Except for Slovenia, which, as a high income country, will not be considered in our analysis, PHI does not play a significant role for health care financing in Eastern Europe. Tab. 8 gives an overview of countries where expenditure for private prepaid programs has been reported.

Tab. 8: Private Health Insurance in Eastern European Countries (2001)

Country	Importance of PHI*	Country	Importance of PHI*
Albania	12.0	Latvia	0.1
Azerbaijan	0.8	Moldova	1.1
Belarus	0.1	Poland	2.1
Estonia	1.1	Romania	1.6
Georgia	0.2	Russian Federation	1.4
Hungary	0.3		

* measured as expenditure on private prepaid plans as % of total expenditure on health: not including countries without PHI or where data was not available.

Source: Own Calculations. Data: WHO (2003).

3.4.3 Market Indicators and Evidence of Market Failure

Despite previous reform efforts and government driven PHI pilot programs (e.g., in Estonia, Hungary, and Moldova; comp. respective EOHCS reports), private health insurance bears very low sig-

nificance in Eastern Europe. Merely Albania covers a larger portion of its total health care spending through private prepaid schemes. In all other countries, spending on PHI is negligible as compared to total health expenditure while insurance coverage through private providers is even less significant. However, even in Albania the importance of private risk-sharing programs is very limited.

Albania

Albania opened the market for private health insurance in 1994; however, as of 1999 there was only one insurance company that had entered the market, offering private insurance services mostly to Albanians traveling abroad (Albania, 1999). Up until today, the private insurance industry has not yet consolidated: during 1997 and 2001, spending on PHI relative to total health expenditure even decreased by 8.7 %. Moreover, the country's social health insurance scheme (Health Insurance Institute) is on its way to becoming the primary purchaser of health care service. In 1997, it already covered 70 % of the Albanian population (Albania, 2002). Furthermore, figures for Albania might be deceiving as the importance of PHI occurs on a very low scale; in 2001, total spending on health care merely accounted for 3.7 % of GDP which is relatively little compared to other countries in the region (WHO, 2003). On average, spending on private prepaid programs did not exceed 5 international dollars between 1997 and 2001.

Other Countries

The relative insignificance of PHI in Eastern Europe has multiple reasons. As documented in Dixon et al. (2004), many countries experienced problems with private health insurance. In Kazakhstan, most insurance companies went out of business shortly after the market opened up for PHI in the 1990s. The authors identify a lack of public regulation as well as missing oversight of the companies' solvency as the main explanation for this failure. A lack of regulation may also be the reasons that the many insurance companies in Russia have not yet been able to snatch a larger market share. Only 1.4 % of total health expenditure was channeled through private prepaid schemes in 2001; between 1997 and 2001, this level had even decreased by almost 25 %. In other countries, privatization has not yet been accomplished thoroughly (e.g., government joint stock companies sell private health insurance in Uzbekistan) or is limited to certain sectors of the health insurance market (e.g., Slovenia where the private insurance business only covers co-payments under the public health insurance regime).

Apart from regulatory deficiencies, the lack of non- or low-profit insurance companies that could attract a larger share of the population may certainly contribute to the relative insignificance of PHI in Eastern Europe. Except for Hungary, all countries with available data primarily rely on private commercial health insurance. In 1993, Hungary established the legal framework for the establishment of non-profit PHI, primarily based on the model of the French *mutualité*. Even though few voluntary non-profit funds have entered the insurance market so far, public subsidies gradually seem to pro-

mote the development of mutual health insurance. As reported by the European Observatory on Health Systems and Policies (Hungary, 2004: 46), “the government subsidizes the purchase of health insurance from mutual funds with a 30 % tax rebate up to a certain limit”. Between 1998 and 2001, the share of PHI relative to total health care spending increased from 0 to 0.3 %, which corresponds to a development of PHI spending from 0.3 to 3 international dollars (WHO, 2003).

Evidence of market exclusion of the poor is manifold. In Azerbaijan, private voluntary health insurance covers approximately 15,000 people, which is less than 0.1 % of the total population. Insurance premiums vary from USD 600 for hospital treatment in insurance owned facilities to up to USD 17,000 for eventual medical evacuation to Russia or Turkey, depending on the specific insurance package (Azerbaijan, 2004). Considering that the average per capita income in Azerbaijan amounts to around USD 700, it is obvious why PHI does not cover a larger part of the population. In fact, insurance companies do not seem to believe “that there is a viable market among the general population” (ib.: 24). Such observations are confirmed for Belarus (Belarus, 1997), Estonia (Estonia, 2000), Georgia (Georgia, 2002), the pro-profit market in Hungary (Hungary, 2004), and the Russian Federation (Russia, 2003). In Romania, PHI is offered by large firms for their employees (primarily multi national organizations operating in Romania) or it is used by Romanian residents traveling abroad as such services are not covered through compulsory social insurance (Romania, 2000).

3.4.4 Regulation and Regulatory Concerns of PHI in Eastern Europe

Since its first appearance in the 1990s, PHI has not been able to become a major pillar of the health care financing system in Eastern Europe. As document for many countries, private risk sharing programs are either restricted to a very small and exclusive part of the population; or the schemes are only rudimentarily developed while coverage is limited to very basic services.

The experience from Eastern Europe clearly underlines that a successful implementation of PHI demands more political and regulatory will than merely opening markets for private providers. Beyond financial constraints of the state that could foster the development of private insurance markets, it is, of course, a political decision whether or not PHI should gain a more prominent role in Eastern Europe. The determination to actively support the development of PHI varies largely across countries. Whereas the Ministry of Health in Belarus is “broadly in favor of the extension of voluntary [that is private, DD] health insurance” (Belarus, 1997: 42), Estonia has renounced of all attempts to increase the share of PHI. Sometimes, there is even a conflict between public and private financing mechanisms; e.g., Hungary does not allow private risk sharing programs to offer the same products that are covered under the public insurance regime. Equally deterring are policies that do not allow a subsidization of public health care coverage through private risk-sharing arrangements;

e.g., buyers of PHI are not rewarded any tax benefits in Moldova even though they may not use tax-paid public health care services (Moldova, 2002: 25).

Given the relatively low income level of large parts of the Eastern European population, the range of private risk sharing programs should not be limited to the pro-profit sector. Legislation that prevents the development of non- or low-profit schemes would impede a wider outreach of PHI among the population of Eastern Europe. In this respect, Hungary's efforts to establish complementary insurance schemes on a non-profit basis deserve special attention. Once again, it nevertheless remains uncertain whether Hungary's decision to subsidize the purchase of voluntary funds is the most cost effective intervention. Countries could also consider allowing innovative ways to sell and promote private health insurance; e.g., in Georgia, companies sell PHI as packages with other, more prominent and currently more profitable, insurance products (Georgia, 2002).

Once again, public policies to initiate and support the development of PHI need to be counterbalanced with accompanying measures aiming at more equitable and less discriminatory access to health care coverage. Preliminary experiences from Latvia indicate that the gradually expanding private health insurance market could lead to a "two-tier system of health care provision in terms of access and quality of care" (Latvia, 2001: 37). Also, the state should ensure that individuals are sufficiently informed about the pros and cons of private health insurance as well as the need to privately insure against health care costs in cases where the state cannot offer sufficient coverage. The move toward market structures and the reorganization of public services and responsibilities has often evoked confusion and uncertainty among the population. As a result of the reform process, many people may currently no longer be aware of the extent of public health care provision and coverage. Again, experiences from Latvia suggest that private insurers may have used the confusion in people's minds for their own benefit. Such situation would be extremely harmful for the future development of PHI. Not only would it lead to market inefficiencies and a higher level of segregation as providers could realize a larger producer surplus and further block access to PHI for low-income individuals. More importantly, it could undermine the still fragile trust in private suppliers that is only gradually developing after the region's shift towards market structures and which is crucial for the success and sustainability of the reforms.

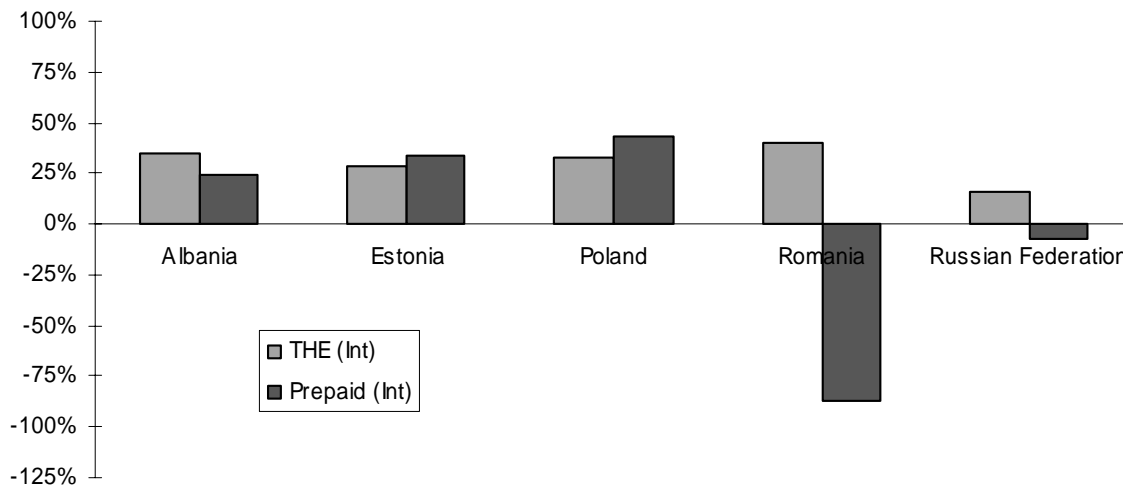
3.4.5 Trends of PHI in Eastern Europe

To some extent, the situation in Eastern Europe is comparable to Asian countries. The future development of PHI depends above all on a political decision as to what role private risk-sharing arrangements should play in the health care systems of Eastern Europe. If the state continues to provide health care (as before the market reforms) or offers efficient social insurance, PHI will hardly extend beyond people from upper income percentiles who are willing and able to pay the high pre-

miums. Thus far, private schemes are mostly a supplement to obligatory public health insurance, covering extra services and superior treatment. Many countries have not yet reached a clear political decision as to the extent and domain that should be covered by PHI. Naturally, such uncertainties hamper the development of the private insurance industry. In some cases (e.g., Estonia), the development has even reversed as pilot projects did not have the desired effect on the local health care system. After Estonia unsuccessfully tried to promote private insurance for complementary services there has no longer been any “policy attempt to increase the share of private insurance” (Estonia, 2000: 18).

Another aspect that will influence the development of the Eastern European health insurance industry is the general economic performance in each country. Especially due to the pro-profit nature of most insurance schemes in Eastern Europe, PHI primarily addresses to high income percentiles or foreign employees in each respective country. Depending on the general economic development, more people may be able to afford private insurance premiums or high inflows of foreign employees could drive market demand; e.g., such rationale applies to Azerbaijan where the insurance industry is expected to grow depending on whether the oil economy will continue to grow. This would increase the share of wealthy individuals in the local population, but would similarly increase the demand from expatriates of the oil industry (Azerbaijan, 2004). As indicated in Fig. 8, spending on prepaid programs rather decreased as regards total health care spending.

Fig. 8: Total Health Expenditure and Expenditure on Prepaid Plans in Eastern Europe



Note: Total Health Expenditure and Expenditure on Prepaid Plans measured as Int. Dollars (percentage change between 1997 and 2001, Estonia: 1999-2001). Only countries with spending on private health insurance exceeding 5 Int. Dollars in 2001.

Source: WHO (2003).

3.5 Insurance Markets and Private Health Insurance in the Middle East

3.5.1 Global Overview

The most important insurance markets in the Middle East are found in Turkey, Iran, the United Arab Emirates, Saudi Arabia, Lebanon, and Kuwait. In 2003, total insurance premium income amounted to about USD 8 billion of which approximately 80 % were spent for non-life insurance schemes (USD 6.5 billion); the remaining USD 1.5 billion can be attributed to the life insurance sector. According to these figures, the insurance industry of Middle Eastern countries merely accounts for about 0.5 % of global insurance premium income.

3.5.2 PHI in the Middle East

Private expenditure is an important financial source of health care systems in the Middle East. Nonetheless, PHI is a relatively new phenomenon in most of the countries in the region. Private funds are predominantly used for out of pocket expenditure (e.g., Yemen, where in 2001 58.4 % of total health expenditure was OOP) while only Lebanon and Saudi Arabia have a sizeable private health insurance industry. Although still at very low expenditure levels, PHI is also gaining importance in Turkey. The figures for Turkmenistan, on the other hand, are ambiguous. According to WHO data, 7 % of total health expenditure was channeled to PHI in 2001 (as contributions to social insurance that were considered as private social insurance). Conversely, the European Observatory on Health Care Systems (Turkmenistan, 2000) reports that private health insurance was not allowed in the country. Instead, the state would offer public voluntary medical insurance, which covered a large part of the population (approximately 90 % in 1999). Tab. 9 gives an overview of Middle Eastern countries where spending on private insurance has been recorded.

Tab. 9: Private Health Insurance in Middle Eastern Countries (2001)

Country	Importance of PHI*	Country	Importance of PHI*
Iran	1.5	Saudi Arabia	9.3
Jordan	3.9	Turkey	0.3
Lebanon	11.9	Turkmenistan	7.0

* measured as expenditure on private pre-paid plans as % of total expenditure on health: not including countries without PHI or where data was not available.

Source: Own Calculations. Data: WHO (2003).

3.5.3 Market Indicators and Evidence of Market Failure

Since the number of countries with PHI in the Middle East is very small, aspects of the private health insurance market will be discussed for each country individually. Based on these observa-

tions, the subsequent part will discuss some regulatory issues of PHI and derive development trends of the private health insurance industry for the whole region.

Turkey

In 1996, the WHO considered PHI to be the fastest growing insurance market in Turkey while coverage was still very low at that time. Subscribers to private schemes usually obtained higher quality service in addition to their public coverage. In fact, private insurers are the only means through which people can obtain supplementary voluntary health insurance in Turkey. Ernst & Young (2003) reports that, in the mid-1990s, about 30 institutions offered PHI, approximately covering 500,000 people. Considering the fact that this number had only amounted to 15,000 individuals in 1990, the private insurance industry had experienced significant growth in the first half of the 1990s. Although dissatisfaction about the quality and accessibility of public facilities have further raised the popularity of PHI, private risk-sharing programs still do not constitute a major factor in the country's health financing system. According to recent estimates (Turkey, 2002; Colombo/Tapay, 2004), coverage through private providers remains below 2 % of the total population while approximately 650,000 people are currently insured. According to the European Observatory on Health Care Systems (Turkey, 2002), coverage was highest amongst employees of banks, insurance companies, chambers of commerce, and computer companies.

Saudi Arabia

The high share of PHI expenditure relative to total health expenditure in Saudi Arabia predominantly stems from foreign workers (5-6 million) who now need to have mandatory private health insurance. Before the reform in 2003, expatriates in Saudi Arabia had been entitled to use public facilities that are not only open to Saudi citizens. Other forces driving the development of the private health insurance industry is a rising population, a quick growth of the private sector, the quick pace of industrialization, and high per capita medical expenditure (U.S.-Saudi-Arabia Business Council, 2004). This trend materializes in increased PHI spending while total health expenditure declined over the past couple of years. All these factors contribute to the ongoing readjustment of the country's health care system. Due to limited public resources, policy makers in Saudi Arabia are currently searching for alternative ways to finance health care. The five stage program that introduced PHI for expatriates will eventually also allow coverage of Saudi nationals (Sekhri et al., 2004: 8).

Lebanon

Another dynamic insurance market is reported for Lebanon, where private health insurance is already well established, largely due to insufficiencies of public health care institutions. Lebanon has a highly fragmented health care system, in which more than 70 % of total health care spending originates from private sources. Of this, a remarkable 16.5 % is used for private risk-sharing programs (WHO, 2003). Lebanon has a relatively large non-life insurance market with per capita

spending amounting to USD 84.70 in 2003 (Swiss Re-Insurance Company, 2004). According to these figures, the country's insurance density is much higher than its Gross National Income (GNI) would suggest. On a global scale, insurance density puts the country in 48th position while the World Bank GNI index only sees Lebanon in 81st position with per capita income of USD 4,040 in 2003. In 1998, approximately 70 private companies offered comprehensive and supplementary insurance programs that covered an estimated 8 % and 4.6 % of the total population respectively (NHA Lebanon, 2000). These companies varied in size and premium income while insurance volumes ranged from below USD 1 million to USD 5-50 million. Due to the size of the insurance market, which also includes non-profit providers and mutual insurance funds, supply is very competitive. Nevertheless, there exists anecdotal evidence that high risk/high cost patients are prevented from joining private schemes. The Ministry of Health may consequently be burdened with an extraordinarily large share of bad-risk patients (ib.: 6). The government is also the insurer of last resort for all individuals without any health care coverage.

Jordan

In Jordan, approximately 240,000 individuals (5 % of the population) are reported to have private health care coverage. Adding to this, another 152,200 people receive coverage through employer-based self-insurance (data: NHA Jordan, 2000). Compared to other forms of health care coverage, the number of privately insured is relatively insignificant; i.e., 81 % of Jordan's population is reported to have any form of health insurance. Furthermore, private health insurance programs do not offer a real alternative to social schemes. Of the 20 companies that are licensed to sell health insurance only one offers full coverage. Considering that, in 1997, such packages cost an annual premium of USD 866 (about 56 % of Jordan's average per capita income that year), full coverage through PHI is only affordable to a very small portion of the population (figures from NHA Jordan, 2000 and the 1998 economic report of Jordan's Central Bank). Coverage through PHI may equally be bounded by the small volume of group insurance that is sold in the country. Large companies, which would be the primary channels through which to distribute group insurance schemes, apparently prefer to rely on self-insurance programs. The number of uninsured people is estimated to be around 30 % of Jordan's population while about 20 % of the ones insured are reported to have multiple coverage.

Iran

Low coverage rates are also problematic in Iran. Although official statistics (e.g., Medical Service Insurance Organization, Social Security Organization) claim that 90 % of the Iranian population has health insurance, the number of uninsured is estimated to range around 30 %. This situation may be explained by considerable overlap between certain insurance categories (i.e., people have multiple coverage), which raises concerns about the efficiency of the specific insurance organizations (NHA Iran, 1998). Private funds are the most important source of health care financing in Iran. In

1998, household contributed 53 % of total health expenditure through OOP while 5.5 % were channeled through different insurance organizations. Apart from specialized insurance companies, PHI is also offered through banks that insure their employees (including dependents) and through the radio and TV network. Contributions to specialized insurance companies are shared among firms and employees while insurance packages exclusively cover inpatient services in private hospitals. The services covered through bank insurance schemes, on the other hand, include physician services, pharmaceuticals, dental and laboratory services, as well as expenses for radiology and imaging. Given the large extent to which people are willing and able to co-pay for medical treatment at private hospitals (on average, 65 % of all medical bills were paid by patients) PHI may be able to increase its popularity and mobilize further resources by offering more comprehensive packages.

3.5.4 Regulation and Regulatory Concerns of PHI in the Middle East

Regulatory requirements and policy recommendations depend on the specific stage of PHI development of each country. Whereas private health insurance companies in Jordan still operate under a general insurance law that lacks regulatory efficiency (NHA Jordan, 2000), other countries have a reasonably well developed and regulated insurance industry; i.e., 17 of all 70 insurance industries use re-insurance mechanisms to prevent financial imbalances (NHA Lebanon, 2000). On the other hand, even fairly developed countries like Turkey do not have legislation on proper risk-sharing or risk-adjustment mechanisms (Colombo/Tapay, 2004: 43).

A common feature of insurance markets in Middle Eastern countries seems to be a lack of policy co-ordination and institutional responsibility. Experience from Jordan suggests that there is little co-ordination between the Ministry of Industry and Trade, which is responsible for PHI regulation and control, and the Ministry of Health. In Lebanon, each separate branch of the insurance industry is associated with a distinct supervising ministry. Evidently, such shared responsibilities make public oversight very difficult. Strategic planning and policy co-ordination is equally constrained in Turkey as the whole health care sector is highly fragmented. Under such circumstances, it will be very difficult to formulate a national strategy for the future development of PHI.

Due to insufficient public oversight the industry may produce inefficiencies like multiple coverage as reported for Jordan and Iran. Better coordination mechanisms between respective ministries may arguably decrease uncertainty and improve market outcomes. Similar objectives can be attained by clearly defining areas in which PHI may support, complement, or substitute other forms of health care coverage. Particularly important is a clear distinction between private and public responsibilities in order to prevent unnecessary overlap between the two.

Without efficient regulatory instruments, it will be difficult to prevent market failures like cream skimming, cost and premium escalation, as well as fraud, which are basically confirmed for all countries in the Middle East that partly rely on PHI. Equity targets will equally be put into jeopardy if the state does not accomplish sound administrative and regulatory capacities. In Lebanon, the lack of an effective supply side control is seen to have contributed to the recent cost and premium escalation in the health care sector. As argued by the NHA report, moral hazard behavior may have led to over-supply of health care coverage and provision, which may partly explain the highly uneven distribution of health care costs. Whereas low income individuals spend on average 20 % of their household income on health care, this share merely accounts for 8 % of household resources in the highest income group. In order to respond to these challenges, a flat-rate system was tested for same day surgical procedures in 1998. Given the relative success of this program, similar instruments may be implemented for other medical treatments to contain health care costs.

Insufficient public oversight and especially inappropriate incentive structures may also cause inefficiencies in the allocation of resources. Specifically, reimbursement policies in Lebanon may have channeled too many resources into the development and prescription of high-tech curative treatment. Primary and/or preventive care, on the other hand, have been neglected by health financing institutions including PHI. Apart from contributing to the general escalation of health care costs, the focus of curative care may also not correspond to the health care needs of Lebanon.

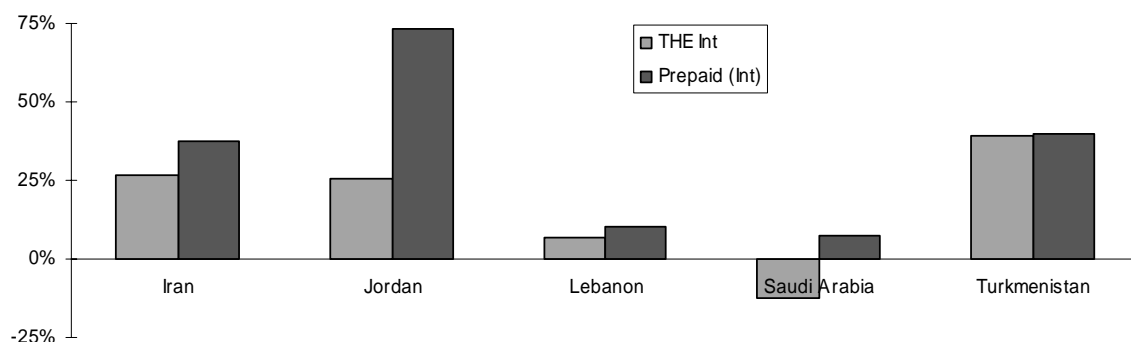
3.5.5 Trends of PHI in the Middle East

The development of the private health insurance industry in the Middle East depends on various factors. In systems that primarily rely on public provision of health care, limited fiscal resources will probably intensify the exploration of alternative ways of health care financing, including PHI. In this respect, the introduction of mandatory health insurance for expatriate workers in Saudi Arabia can be regarded as an initial step towards more private involvement in the health care system. Similarly, higher demand for health care and demand for higher quality treatment may become driving forces for the development of private health insurance in the Middle East. The case of Turkey clearly illustrates that the market responds to a growing demand of private health insurance if the government provides an adequate institutional and regulatory environment for this development. The significant increase of both, insurance companies offering and people having PHI up until 1998 primarily stemmed from higher demand for supplementary coverage. In fact, the initial increase of PHI had a self-reinforcing effect as it stimulated the growth of the private health care sector, which, in turn, made private health insurance more popular. Expenses to private health facilities are not covered under the public insurance plan.

However, the case of Turkey also illustrates that the market does not function perfectly as a substantial increase of premiums has recently slowed down the development of PHI. According to the Turkish Ministry of Finance (as cited in Turkey, 2002: 53), coverage in PHI has leveled off at around 600,000 since 1998. Between 1994 and 2002, the average annual premium per person increased from USD 200 to USD 800. Due to limited control over the costs of health care the private health insurance industry is faced with both fraud and adverse selection as more and more young and healthy individuals opt out of PHI. Increasing premiums and decreasing coverage progressively leave private insurers with older and less healthy people.

Apart from Turkey, Saudi Arabia, and Lebanon Sekhri et al. (2004) also identify Bahrain, Morocco, and Tunisia as countries with high development potential in the private health care industry. Driving forces include the need to cope with a large foreign workforce as well as increased demand for health services instigated by higher income levels. Fig. 9 illustrates that private prepaid contributions have increased relatively more than total health expenditure. This obviously supports the notion of a generally dynamic insurance market in the Middle East. Equally noteworthy is the rapid development of PHI in Jordan in the 1990s as the number of privately insured individuals multiplied by more than six between 1989 and 1997. As mentioned above, limited insurance packages may however restrain the future development of the industry.

Fig. 9: Total Health Expenditure and Expenditure on Prepaid Plans in the Middle East



Note: Total Health Expenditure and Expenditure on Prepaid Plans measured as Int. Dollars (percentage change between 1997 and 2001). Only countries with spending on private health insurance exceeding 5 Int. Dollars in 2001. Source: Own Calculation. Data: WHO (2003).

4. Lessons Learned: How to best integrate PHI into a health system?

PHI is gradually gaining importance in low- and middle-income countries, but still starting from a very low level. The previous discussion from different countries and continents has shown that private risk-sharing markets rarely function perfectly. Especially the large inequalities in access and

coverage of care are worrisome from a development point of view. Market failures can occur at various stages of the exchange process and can involve the supply as well as the demand side. Furthermore, failures have different dimensions including total exclusion or discrimination of individual patients, financial imbalances of suppliers, premium escalation, and a lack of competition. In principle, private health care markets in low- and middle-income countries are consequently faced with the basic dichotomy of efficiency (e.g., adverse selection and premium escalation) and equity (e.g., cream skinning). Specifically, in order to offer competitive prices insurers will discriminate against high-risk patients or try to reduce administrative costs by predominantly focusing on formal sector employees where premium collection is relatively inexpensive. At the same time, moral hazard behavior may induce cost escalation (i.e., more insurance offered or more services required than needed) or adverse selection may push low-risk patients out of private schemes.

How to respond to these market failures or inefficiencies is ultimately a political question. Its answer will in part depend on individuals' preferences on how to weigh efficiency and equity as well as the general needs and circumstances in each country. It is nevertheless unlikely that an insurance system can completely renounce of control mechanisms to supervise the performance of PHI. The need for regulation is not only fueled by potentially negative outcomes of the private insurance industry; regulation may be equally important as the introduction of PHI will also affect other forms of health care financing. Specifically, PHI may only leave bad-risk patients for public coverage or it may indirectly affect public provision of health care by raising health care costs. Policy makers should thus take into consideration the whole impact of allowing private risk-sharing arrangements into the market. The state needs to be able to respond to the manifold challenges that will arise when PHI is introduced into a health care system. Furthermore, it should ensure transparency of the system and be clear about public and private responsibilities. This will not only be important for potential consumers of PHI as it allows them to adjust their health expenditure. It also enables providers of PHI to offer adequate insurance packages that take account of the specific needs of their clientele.

An efficient regulatory framework is especially important in low- and middle-income countries as private risk-sharing arrangements may be the only form of health insurance available. At the same time, efficient regulation is often also very difficult to achieve as these countries rarely have sufficient experience and expertise in dealing with insurance markets. Furthermore, they often lack institutional capacity to establish and maintain a regulatory framework. Building institutional capacity is not restricted to setting up a government agency to monitor the insurance sector. Effective supervision has multiple layers and involves many different tasks, various public entities, and qualified specialists. Institutional capacity will extend from insurance legislation and licensing requirements to monitoring strategies and corrective control mechanisms. In a recent contribution to the debate on regulatory requirements of PHI in low- and middle-income countries, Sekhri et al. (2004) propose

five key questions that need to be answered by policy makers who want to establish a regulatory regime:

- (1) Who can sell insurance?
- (2) Who should be covered?
- (3) What should be covered?
- (4) How can prices be set?
- (5) How should providers be paid?

Due to the issue's complexity as well as the large array of possible risk-sharing arrangements and corresponding market-failure/policy-response patterns we will only focus on selected key issues of PHI in low- and middle-income countries. In particular, we consider the question of who and what should be covered through private risk-sharing programs by discussing the desired structure of the schemes. Furthermore, we explore price setting mechanisms by comparing pros and cons of commercial vs. non-profit schemes. We also analyze aspects of premium collection and discuss advantages of group programs as regards individual contracts. Finally, we present advantages and disadvantages of opening insurance markets for international providers. Obviously, such analysis is bounded by a high level of aggregation and generalization. Nevertheless, we believe that our discussion offers some important lessons that have already been learned in dealing with private health insurance in low- and middle-income countries.

4.1 Structure of the Schemes – Comprehensive vs. Supplementary Coverage

Health insurance can be classified according to the extent of coverage it offers, particularly as regards other forms of health care financing. In general, PHI may have a substitutive, complementary, or supplementary role in a country's health care system. As a substitute to other forms of health care financing, PHI offers comprehensive coverage in place of another entity or financial source. Complementary and supplementary coverage, on the other hand, closes gaps of other forms of health care financing; the former providing cover for services excluded or not fully covered otherwise, the latter to provide cover for faster access, better quality, and higher consumer choice (Thomson/Mossialos, 2004). In our analysis, we combine the last two health insurance types and distinguish supplementary from comprehensive coverage.

In many low- and middle-income countries private health insurance is the only available form of risk-pooling. More often than in developed countries, private schemes therefore offer comprehensive coverage. Nevertheless, there are only few low- and middle-income countries where private comprehensive health insurance covers a larger percentage of people (e.g., Lebanon, where 8 % of the population were reported to have comprehensive coverage from private commercial providers in

1998, comp. NHA Lebanon, 2000). Typically, comprehensive coverage is only affordable to the highest income groups or foreigners.

Supplementary insurance can in principle be a valuable tool to extend coverage to otherwise excluded individuals. Experiences from Ghana illustrate that supplementary private insurance may well be suited for low income groups when the respective schemes are adjusted to local conditions (Okello/Feeley, 2004). In Ghana, the poor were persuaded by information campaigns to only purchase relatively cheap premiums covering inpatient health care. Hospital services are rarely needed, yet pose a severe risk of impoverishment when they occur. Such rationale obviously faces a trade-off with other health risks. Specifically, supplementary coverage for only high costs/low frequency events may not be the best option when local conditions demand large scale preventive care (e.g., immunization). Furthermore, the limited coverage of mutual health insurance is seen to impede the long-run development of community-based programs in Africa (La Concertation, 2004: 79). Only if schemes are able to expand their services will they offer a true alternative towards other forms of health financing – and thus an attractive product. MHIs therefore face a dichotomy between attractiveness and affordability. Although low cost/low coverage programs may facilitate the initiation of a scheme, MHIs eventually need to develop beyond this stage if they want to attract larger parts of the population and contribute to attaining universal coverage.

Supplementary insurance is often also designed to cover additional or superior treatment, which obviously restricts its outreach to a relatively small group of people who are willing and able to pay for such services. In this respect, the role of PHI in low- and middle-income countries is comparable to the present situation in the developed world. Even though in OECD countries it is equally difficult to generalize the role of PHI, a basic pattern seems to indicate that private health insurance generally does not function as a substitute for other forms of prepaid health care financing. Only in a few countries and for certain individuals does PHI provide the primary form of insurance and consequently covers a more comprehensive range of services. More important, still, is PHI's role in providing cover for "ancillary and supplementary services" as this coverage of "small risks" can be observed for almost all OECD countries (Colombo/Tapay, 2004: 16). With the notable exception of the United States, PHI neither accounts for a high share of total health expenditure nor does it offer primary cover to larger parts of the OECD population. In European countries, for example, PHI primarily covers services that are excluded or not fully covered by the state: e.g., Croatia, Denmark, France, and Slovenia (Thomson/Mossialos, 2004).

From a development point of view, such narrow focus of PHI on high income individuals could only be justified if other health financing intermediaries (notably social health insurance or tax-paid health care) are compensated for the opting out of good-risk patients. In theory, this could be achieved through financial transfers between public and private suppliers or a clear separation of

either domain of health care coverage. Given the current institutional and regulatory capacity of many low- and middle-income countries, PHI that offers insurance to high income individuals seems to jeopardize rather than support the goal of universal coverage. Private health insurance in the developing world is often either too expensive or the schemes are ill adjusted to local circumstances in order to extend to a larger share of the population. At least, such assessment seems valid for private commercial schemes. As commercial providers of PHI primarily try to increase profit, their range of adaptability to the needs of the poor is relatively small (Dror/Jacquier, 1999). When discussing PHI in the context of low- and middle-income countries, it is therefore equally important to carefully distinguish between profit and non-profit schemes.

4.2 Price Setting Mechanisms – Profit vs. Non-Profit Schemes

In general, health insurance through private commercial providers is restricted to upper income groups who can afford the high premiums (Musgrove et al., 2002). Low family income is commonly associated with an increased rate of illness and disease, which seriously impedes any efforts to induce insurance companies to offer PHI in poor communities (Sbarbaro, 2000: 5). As documented for many countries, commercial schemes therefore rarely extend beyond formally employed workers in urban areas. Obviously, such limited outreach of PHI is problematic from a development point of view.

The literature offers many examples and possible explanations for the narrow focus of PHI in low- and middle-income countries. In Thailand, insufficient public oversight is seen to have raised PHI premiums beyond levels that are affordable for informal workers (Supakankunti, 2000). For the case of Sub-Saharan Africa, Bennett et al. (1998: 54) find the revenue generating potential of health insurance providers very limited. In order to reach people outside formal sector employment, the authors therefore propose to focus on non-profit or highly subsidized schemes serving as a supplement to publicly funded health programs. Similar conclusions are reached by the International Labor Organization that makes out significant discrepancies between private health coverage in urban and rural areas in Latin America (ILO, 2000).

Generally speaking, Dror and Jacquier (1999) argue that a mismatch between supply and demand for PHI in low- and middle-income countries excludes large parts of the population. Specifically, insufficient financial means and a large geographic spread keep the supply side from efficiently interacting with a potential demand for PHI. In order to ensure broader health coverage, the authors propose micro-insurance programs, which essentially are “voluntary group self-help schemes for social insurance” (Dror/Jacquier, 1999: 6)

A key advantage of such programs is their capability to harmonize accumulated reserves with community-specific risk- and benefit-priorities. Since commercial providers modify benefit packages

primarily to increase profit, they are less flexible to respond to particular needs and preferences, which make them less attractive to low-income groups. The World Labour Report 2000 reports the existence of micro-insurance schemes in Bangladesh, Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Guinea, India, Lebanon, Mali, Morocco, Nigeria, the Philippines, Senegal, Tanzania, Togo, Tunisia, Uganda, and several countries in Latin America (ILO, 2000).

Given the narrow outreach of commercial PHI it therefore seems advisable that policy makers and especially the international donor community ensure ample regulation of private profit providers or concentrate efforts on the development of non-profit schemes. Non-profit programs have a wide array of possible structures; they include schemes that are operated by NGOs, communities, voluntary associations, hospitals, large firms or even financial intermediaries like private banks.

The role of NGOs in administering private non-profit health insurance is manifold. Ron (1999) reports NGO involvement as an intermediary between health providers and a community health insurance scheme in Guatemala (the *Association por Salud de Barillas*). NGOs often also run and manage insurance programs; i.e., community schemes were set up by the *Organisation for Educational Resources and Technological Training* (ORT) in the Philippines and other developing countries. All ORT schemes try to be self-sustainable while at the same time offering affordable premiums to the target population. NGO involvement in community schemes is also reported for India (Gumber, 2001), Lesotho (DeRoeck/Levin, 1998), and Cambodia (GTZ, 2003). According to Cambodia study, NGOs are a "leading force in health insurance provision for the informal sector" (ib.: 29).

Small insurance schemes are occasionally also offered by health care providers including hospitals and local medical centers. Such programs have the advantage of bringing insurance closer to the target population, even though evidence from Zaire seems to indicate that they, too, fail to integrate the very poor into their coverage (Jütting, 2004; Criel et al., 1999); a perception that is confirmed for the hospital-based Lacor Health Plan in Uganda (Okello/Feeley, 2004). Yet, analyzing a hospital-based scheme in Ghana, the same study also reveals that the poor can be encouraged to join risk-sharing programs through information campaigns, marketing efforts, and insurance packages that are appropriate for the specific needs of low-income groups.

In some cases, even profit-maximizing behavior leads to the development of low- or non-profit health insurance schemes, as is indicated by the Grameen Bank health insurance program in Bangladesh. The WHO (2004) reports that around 140,000 people were reported to be covered under this scheme, which was initiated in order to reduce defaults of the bank's micro-credit loan program by improving the clients' health status (Desmet et al, 1999). Similarly, large companies in Jordan often offer health insurance to their employees, not necessarily as an additional source of income, but in order to protect the health condition of their workforce. At the end of the 1990s, almost

100,000 people were reported to have coverage directly through their employer (NHA Jordan, 2000).

4.3 Premium Collection – Individual vs. Group Coverage

Private health insurance can offer both individual and group coverage whereby the latter primarily occurs through employer- or community-based schemes. Group affiliation has traditionally been the basis on which small private risk-sharing schemes developed in many OECD countries, which later became the basis for universal coverage; e.g., in 19th century Europe, health insurance was often provided through labor unions, guilds, or employer associations (Sekhri/Savedoff, 2005). As they usually charge the same premiums for all members of a particular group, that is, regardless of age, income, or health status, they lack the customization of an individual scheme. Specifically, insurance packages are not as tailor-made as individual schemes as they do not take into account all relevant characteristics of their clientele. Especially for good-risk patients with small health needs premiums will probably be less attractive than in an individual PHI, because group insurance will always involve some sort of cross-subsidization of bad-risk patients. Group insurance could thus be accompanied by mandated participation for all members of a particular firm, association, or community. Low-risk individuals could furthermore be encouraged to join group insurance schemes through information and advertising campaigns. In small groups or on community level peer-pressure could also increase participation in the schemes.

Moreover, group insurance schemes may greatly reduce administrative costs that ideally could be used for a general reduction of premiums or better coverage respectively. Premium collection is enormously simplified if contributions do not vary across individuals. First, the insurance company does not need to calculate premiums for each individual separately by considering age, previous and current health status, as well as income and occupation to derive a personalized risk-structure. Second, premiums can easily be collected through the employer of a firm, the chairman of an association, or the head of a community etc. Group insurance schemes can also help to reduce adverse selection and they reinforce the bargaining position of insurance companies' vis-à-vis health care suppliers. In this way, group insurance may contain health care costs and improve a country's health care coverage.

Most importantly, though, group insurance may often be the only feasible alternative to implement an insurance-based health care system in low- and middle-income countries. Due to information gaps on either side of the market exchange process suppliers will often not be able to offer customized insurance packages while buyers may not have sufficient oversight to establish a clear price-benefit structure. Primarily implementing group insurance schemes and focusing efforts on the development of better and more efficient ways to collect insurance premiums can thus be an initial

step to promote the development of PHI. At a later stage, experiences and information from the performance of group insurance can be used to derive more personalized insurance products.

4.4 Trade and PHI – International vs. Domestic Provider

With the introduction of PHI into national health care systems, low- and middle-income countries are becoming international markets for foreign private health insurance. This development has multiple sources that primarily stem from the ongoing process of globalization. Most importantly, bilateral trade agreements, and the expansion of free-trade to the area of services have expanded opportunities for international exchange in PHI. Furthermore, multinational firms operating abroad increasingly demand a healthy work force and either promote the local insurance and health care industry or import respective facilities from the outside.

This development can generally be acclaimed since low- and middle-income countries can import know-how and institutional capacity through increased international exchange. International providers of PHI can contribute to the establishment of a functioning insurance market in low- and middle-income countries and possibly activate local providers to start operating in this line of business. They will increase competition in the insurance market that ideally will lead to better services and the development of adequate insurance packages. In the long-run, international providers can thus help lay the foundation of a functioning insurance system and contribute to the necessary base of information and experience of a national health care system.

Such positive effects through international providers of PHI are, of course, dependent upon their careful integration into local markets. Apart from general rules and regulations in the insurance market, adequate legislation has to ensure that international providers neither exploit a given market nor prevent the development of national providers. Undoubtedly, large international co-operations can contribute to the development of a functioning insurance market by offering expertise and institutional capacity from previous experience. On the other hand, each health care system requires that insurance products are carefully adjusted to local needs and conditions. There is some indication that international providers have not always been successful in providing this flexibility.

It has been emphasized that foreign insurance, which were imported to Latin American countries, may not have been well adapted to local circumstances. Specifically, the gradual implementation of U.S. type HMOs arguably reflects ideological beliefs on the inevitability of managed care rather than actual needs of health systems in Latin America (Iriart et al., 2001, Stocker et al., 1999).

5. Outlook

Private risk-sharing programs are gradually gaining importance in health care systems of low- and middle-income countries. Wisely managed and carefully adapted to local needs and circumstance, they can be an important tool to eventually reach the “ultimate objective” (Carrin et al., 2001: 131) of universal coverage. As documented above, prospects of the introduction of PHI are promising in a number of countries, particularly in the sector’s non- or low-profit segment. We believe that mainly five crucial factors justify our optimistic outlook: (i) many countries have difficulties with traditional ways of health care financing and look for alternative ways to achieve universal coverage; (ii) economic growth leads to higher income and diversified consumer demand in the health care sector that might not be met by public facilities; (iii) public entities frequently lack people’s trust and confidence – as PHI is generally associated with private health care providers it often enjoys wider popularity; (iv) globalization and economic opening-up will lead to more trade in the health care sector, which will boost the development of PHI in low- and middle-income countries; (v) PHI does not require a strong service infrastructure (Sbarbaro, 2000: 3) and may thus develop despite a country’s institutional weaknesses.

Nevertheless, the introduction of PHI is not an end in itself and demands a careful consideration of its impact on a country’s health care system. It will neither cure all shortcomings of the previous system nor remain free of (possibly negative) consequences on existing structures. Private risk-sharing programs are an alternative way to finance health care; as such, they expand a country’s options to cover health care costs and/or lay the foundation for further development towards universal coverage. In this regard, it is particularly important that a country have a clear concept as to what role PHI should play in the existing health care system or how it should develop to better serve future health care needs.

As documented above, the immediate effects of allowing PHI to enter a national health care system may occasionally prove disappointing. Potential inequities and discrimination caused by the emergence of PHI are of particular concern and may undermine the objective of universal coverage. First, PHI would have a direct affect on the extent of access to health care as not everybody will be able to afford its services. Case studies indicate that access to the commercial PHI sector in particular will often be limited to high income individuals. Second, PHI could deteriorate the quality of public health care by increasing health care costs, taking qualified health care personnel away from public institutions, and leaving only bad risk patients to public facilities. In this way, the introduction of PHI may have a detrimental effect even on people who have remained within existing structures. From a development point of view, a sufficient regulatory framework is therefore fundamental to prevent the gulf between the privileged und underprivileged within a country from widening.

In low- and middle-income countries that are prone to epidemics and infectious diseases it is equally important to consider the overall effects of PHI on a country's health indicators. Private risk-sharing programs arguably represent "a threat to the control of, and care for, [the] WHO's ten basic community diseases" (Sbarbaro, 2000: 14). Shifting resources from public to private entities may consequently pose additional risks if people are deprived of sufficient preventive health care such as vaccination and immunization (Khaleghian, 2004; Scott-Herridge, 2002). The state must either continue to provide such services or persuade people through information campaigns to include preventive measures in their private health care coverage. As argued by Sbarbaro (2000, 12), the introduction of PHI may even detract from development potentials as "public health services have the greater effect on a community's economic development". Sustainable economic development could consequently prove more difficult to attain the more a country relies on private insurance.

Despite these risks, the potential of introducing PHI into a country's health care system should not be disregarded. Private risk-sharing arrangements may well contribute to improving health care coverage in low- and middle-income countries if the role of PHI is clearly defined and the impact of its introduction on a country's health care system carefully considered. Schemes need to be adapted to local circumstances and regulation needs to be in place to correct for possible unintended consequences. The existence of PHI consequently does not discharge the state of responsibilities. On the contrary, it leaves an active role for governments to ensure the optimal performance of insurance markets and the entire health financing system. As illustrated by the case of Brazil, public regulation is not only vital to correct for market failures of PHI (e.g., cream-skimming, social exclusion, premium escalation). It can equally serve the insurance industry itself by establishing reputation and creating trust among the population (Jack, 2000: 26). PHI is certainly not the only alternative and ultimate solution to address alarming health care challenges in the developing world. But it is an option that warrants – and already receives – growing consideration by policy makers around the globe. Thus, the question is not if this tool will be used in the future, but whether it is applied to the best of its potential to serve the needs of a country's health care system.

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Annex 1: WHO Data on Health Care Expenditure Between 1997 and 2001

Country	Class	Prepaid (USD)		Prepaid (Int)		Prepaid/THE		THE (USD)		THE (Int)		THE/GDP	
		Level	Change	Level	Change	Level (%)	Change	Level	Change	Level	Change	Level (%)	Change
Latin America													
Argentina	U-M	\$98.55	-0.84%	\$157.39	8.43%	14.45	-2.32%	\$682.00	1.72%	\$1,089.60	11.30%	8.74	16.62%
Barbados	U-M	\$44.98	15.09%	\$67.52	13.22%	8.02	-6.43%	\$562.20	22.06%	\$843.60	19.89%	6.12	9.87%
Bolivia	L-M	\$1.37	-5.50%	\$3.14	10.68%	2.69	-7.89%	\$51.00	2.76%	\$117.00	19.00%	5.08	12.31%
Brazil	L-M	\$56.02	-29.48%	\$107.46	20.44%	19.56	11.96%	\$288.60	-41.68%	\$548.60	8.43%	7.56	2.84%
Chile	U-M	\$73.28	-10.53%	\$150.61	29.94%	21.48	8.23%	\$342.00	-19.15%	\$700.20	22.42%	6.82	6.04%
Colombia	L-M	\$13.54	-22.69%	\$39.37	10.17%	10.16	44.89%	\$138.20	-58.28%	\$394.20	-28.73%	6.18	-28.39%
Costa Rica	U-M	\$1.42	-4.22%	\$2.67	-2.23%	0.54	-25.05%	\$266.20	22.26%	\$502.60	24.07%	6.8	7.52%
Dominican Republic	L-M	\$0.30	337.89%	\$0.71	346.79%	0.23	296.56%	\$128.80	34.20%	\$307.40	31.39%	5.92	5.43%
Ecuador	L-M	\$2.82	44.36%	\$6.39	42.42%	4.03	30.16%	\$70.20	5.57%	\$158.40	10.38%	4.22	4.66%
El Salvador	L-M	\$5.38	54.71%	\$11.52	53.81%	3.27	42.06%	\$164.80	13.27%	\$353.40	12.70%	8.06	-1.20%
Guatemala	L-M	\$2.01	47.15%	\$4.62	54.71%	2.60	15.30%	\$77.00	32.02%	\$176.40	37.55%	4.48	24.74%
Honduras	L-M	\$1.77	35.40%	\$4.86	19.82%	3.53	-0.08%	\$50.20	36.04%	\$137.60	20.42%	5.74	12.51%
Jamaica	L-M	\$22.24	30.13%	\$28.68	33.83%	12.51	23.28%	\$177.80	8.31%	\$229.00	11.82%	6.42	5.16%
Mexico	U-M	\$6.90	81.18%	\$11.22	55.37%	2.33	26.33%	\$289.80	50.35%	\$476.00	27.26%	5.72	10.62%
Nicaragua	L	\$0.51	479.51%	\$1.35	492.39%	0.95	368.94%	\$49.60	31.87%	\$129.00	34.32%	6.58	25.71%
Panama	U-M	\$13.88	17.74%	\$24.02	20.92%	5.57	6.29%	\$249.00	11.31%	\$430.60	14.34%	7.4	-5.19%
Paraguay	L-M	\$20.61	-45.69%	\$55.86	-6.54%	17.37	-12.85%	\$117.60	-36.34%	\$321.20	4.06%	7.74	5.54%
Peru	L-M	\$7.50	-10.69%	\$16.57	10.08%	7.44	-1.84%	\$100.80	-8.68%	\$222.60	11.31%	4.66	6.99%
Suriname	L-M	\$0.87	-97.97%	\$1.98	-85.40%	0.50	-90.00%	\$168.80	8.43%	\$396.40	7.43%	9.7	-0.83%
Trinidad & Tobago	U-M	\$8.95	47.87%	\$13.66	29.70%	3.71	14.54%	\$239.40	33.44%	\$367.40	16.88%	4.34	-10.35%
Uruguay	U-M	\$247.00	-12.85%	\$360.20	4.18%	37.53	-4.13%	\$657.80	-8.80%	\$960.80	8.60%	10.54	8.77%
Venezuela, RB	U-M	\$4.87	27.04%	\$6.66	2.71%	1.93	-10.22%	\$255.60	40.67%	\$346.80	14.12%	5.66	10.76%
n=22	Avg.	\$28.85	44.4%	\$48.93	53.0%	8.20	33.1%	\$233.06	8.24%	\$418.58	15.4%	6.57	5.91%

Asia													
China	L-M	\$0.11	64.55%	\$0.48	79.17%	0.27	21.57%	\$40.60	41.59%	\$178.00	54.00%	5.06	18.29%
Indonesia	L-M	\$0.98	76.98%	\$4.39	74.96%	5.61	83.90%	\$18.00	-5.50%	\$78.40	-4.21%	2.52	0.90%
Malaysia	U-M	\$3.67	59.57%	\$8.68	60.59%	3.03	17.78%	\$121.80	16.05%	\$274.60	40.16%	3.2	32.08%
Papua New Guinea	L	\$0.19	183.03%	\$1.00	291.99%	0.72	224.74%	\$28.00	-27.51%	\$132.20	32.10%	3.98	33.98%
Philippines	L-M	\$3.33	-2.45%	\$16.19	23.22%	9.72	22.47%	\$34.40	-25.58%	\$166.60	0.70%	3.46	-8.58%
Republic of Korea	HI	\$39.49	59.06%	\$62.89	83.20%	7.92	37.94%	\$493.00	16.61%	\$777.60	40.27%	5.52	18.86%
Sri Lanka	L-M	\$0.16	23.09%	\$0.58	42.88%	0.52	11.32%	\$29.60	11.27%	\$109.60	30.75%	3.46	12.05%
Thailand	L-M	\$3.03	-16.93%	\$9.55	14.73%	3.95	11.67%	\$77.00	-28.56%	\$241.80	3.14%	3.72	0.35%
Vietnam	L	\$0.53	49.52%	\$3.29	55.16%	2.70	29.42%	\$18.80	29.17%	\$115.00	39.98%	4.9	15.56%
n=9	Avg.	\$5.72	55.16%	\$11.90	80.65%	3.83	51.20%	\$95.69	3.06%	\$230.42	26.32%	3.98	13.72%
Africa													
Algeria	L-M	\$0.78	36.56%	\$1.75	44.92%	1.23	9.73%	\$63.20	26.12%	\$142.60	34.12%	3.7	19.33%
Botswana	U-M	\$14.69	-23.40%	\$25.57	3.01%	8.66	-34.12%	\$170.80	12.60%	\$300.80	41.48%	5.96	15.58%
Cape Verde	L-M	\$0.02	159.57%	\$0.04	178.31%	0.04	131.09%	\$41.60	23.27%	\$107.20	46.89%	3.28	21.31%
Côte d'Ivoire	L	\$4.50	-32.29%	\$11.21	-2.48%	9.49	-19.01%	\$47.20	-13.08%	\$118.60	17.67%	6.26	0.08%
Egypt	L-M	\$0.14	-3.64%	\$0.37	21.08%	0.28	-2.14%	\$49.00	-1.08%	\$134.40	24.31%	3.88	0.07%
Kenya	L	\$1.91	29.93%	\$7.41	37.40%	6.44	37.57%	\$29.80	2.45%	\$115.00	4.79%	8.16	-1.17%
Madagascar	L	\$0.26	30.95%	\$0.97	10.19%	4.67	-2.98%	\$5.80	60.71%	\$21.20	32.79%	2.28	21.93%
Malawi	L	\$0.15	-29.44%	\$0.42	16.09%	1.02	21.06%	\$15.00	-41.19%	\$41.00	-4.70%	8.38	-10.57%
Mali	L	\$1.00	64.30%	\$2.66	76.31%	9.59	53.37%	\$10.40	10.91%	\$27.40	21.75%	4.3	3.74%
Morocco	L-M	\$8.54	-7.22%	\$25.83	10.39%	15.56	-19.56%	\$55.00	13.38%	\$167.20	32.14%	4.58	17.65%
Mozambique	L	\$0.02	-24.32%	\$0.07	15.85%	0.19	-31.23%	\$11.00	10.76%	\$36.60	51.51%	5.3	17.55%
Namibia	L-M	\$27.74	-15.18%	\$70.15	16.13%	21.92	8.81%	\$126.80	-24.76%	\$319.60	7.05%	6.86	-2.84%
Niger	L	\$0.11	-11.24%	\$0.39	-5.54%	1.81	-9.54%	\$6.20	2.38%	\$21.60	4.98%	3.44	9.31%
Rwanda	L	\$0.02	-47.65%	\$0.06	-1.52%	0.14	-13.56%	\$13.80	-35.44%	\$41.20	12.33%	5.32	10.03%
Senegal	L	\$0.90	-24.33%	\$2.15	4.55%	3.81	-12.31%	\$23.60	-12.33%	\$56.60	17.85%	4.82	-5.78%
South Africa	L-M	\$114.94	-32.49%	\$272.13	5.08%	43.43	0.48%	\$264.80	-32.93%	\$626.80	4.86%	8.76	-4.47%
Tanzania	L	\$0.27	1.30%	\$0.59	4.12%	2.41	-7.86%	\$11.00	19.09%	\$23.60	22.22%	4.32	7.37%
Tunisia	L-M	\$7.25	9.21%	\$21.91	33.38%	5.46	7.40%	\$132.80	2.27%	\$401.00	26.20%	6.32	0.08%
Uganda	L	\$0.03	-33.17%	\$0.11	8.18%	0.28	-46.14%	\$12.40	18.94%	\$42.00	65.78%	4.7	47.01%
Zimbabwe	L	\$6.74	61.39%	\$27.99	67.51%	14.88	158.00%	\$49.40	-24.14%	\$202.40	-32.93%	8.44	-30.67%
n=20	Avg.	\$9.50	5.44%	\$23.59	27.15%	7.56	11.45%	\$56.98	0.90%	\$147.34	21.55%	5.45	6.78%

Eastern Europe

Albania	L-M	\$5.18	50.16%	\$16.54	23.98%	13.13	-8.68%	\$39.80	59.22%	\$127.00	35.11%	3.66	-1.72%
Azerbaijan	L-M	\$0.02	n/a	\$0.07	n/a	0.15	n/a	\$11.40	2.80%	\$46.80	9.98%	1.96	-29.38%
Belarus	L-M	\$0.01	n/a	\$0.09	n/a	0.02	n/a	\$67.20	-13.95%	\$413.80	22.01%	5.72	-8.00%
Estonia	U-M	\$2.16	21.74%	\$5.21	33.28%	0.94	30.39%	\$230.67	-7.21%	\$553.67	2.54%	5.88	1.41%
Georgia	L-M	\$0.04	21.62%	\$0.18	51.55%	0.23	23.18%	\$18.00	29.31%	\$79.80	52.68%	2.96	28.81%
Hungary	U-M	\$0.44	328.16%	\$1.14	355.48%	0.13	310.59%	\$318.80	11.96%	\$782.60	30.21%	6.84	-2.86%
Latvia	U-M	\$0.06	n/a	\$0.15	n/a	0.03	n/a	\$183.80	30.50%	\$438.20	29.29%	6.64	-5.64%
Moldova	L	\$0.04	n/a	\$0.21	n/a	0.21	n/a	\$22.80	-51.59%	\$113.00	-36.67%	6.22	-43.45%
Poland	U-M	\$5.71	36.67%	\$12.37	43.38%	2.24	7.33%	\$255.00	26.46%	\$552.60	33.02%	6.12	0.51%
Romania	L-M	\$3.96	-72.54%	\$14.83	-86.72%	3.84	-117.00%	\$107.40	52.32%	\$408.20	39.90%	6.3	30.57%
Russian Federation	L-M	\$1.82	-37.36%	\$6.44	-7.33%	1.60	-22.22%	\$112.00	-14.69%	\$404.80	16.11%	5.54	-6.86%
n=11	Avg.	\$1.77	49.78%	\$5.20	59.09%	2.05	31.94%	124.26	11.38%	\$356.41	21.29%	5.26	-3.33%

Middle East

Iran	L-M	\$3.56	104.66%	\$5.45	37.52%	1.47	10.52%	\$244.80	97.19%	\$372.40	26.90%	6.22	6.93%
Jordan	L-M	\$4.37	71.31%	\$10.84	73.57%	2.98	44.41%	\$144.80	24.11%	\$358.40	25.33%	8.72	15.19%
Lebanon	U-M	\$66.22	-0.08%	\$82.85	10.36%	11.74	3.35%	\$564.00	-3.74%	\$705.80	6.95%	12.22	3.62%
Saudi Arabia	U-M	\$31.95	9.11%	\$52.19	7.21%	8.48	22.12%	\$378.20	-12.10%	\$619.80	-12.75%	4.8	-13.03%
Turkey	L-M	\$0.13	753.36%	\$0.32	1000.69%	0.11	1055.94%	\$133.60	-7.18%	\$293.80	8.75%	4.78	18.41%
Turkmenistan	L-M	\$2.84	81.59%	\$14.79	39.95%	6.99	0.63%	\$40.60	80.67%	\$211.60	39.19%	4.56	-11.12%
n=6	Avg.	\$18.18	170.0%	\$27.74	194.9%	5.29	189.5%	\$251.00	29.8%	\$427.0	15.7%	6.88	3.33%

N=68

Data for < 3 years

Only 1999-2001

Only 1998-2001

Source: World Health Report 2003, Statistical Annex, Geneva: WHO.

Annex 2: Country Groups According to 2005 World Bank Classification

Low Income (USD 765 or less)

Afghanistan	Guinea-Bissau	Pakistan
Angola	Haiti	Papua New Guinea
Bangladesh	India	Rwanda
Benin	Kenya	Sao Tome and Principe
Bhutan	Korea, Dem Rep.	Senegal
Burkina Faso	Kyrgyz Republic	Sierra Leone
Burundi	Lao PDR	Solomon Islands
Cambodia	Lesotho	Somalia
Cameroon	Liberia	Sudan
Central African Republic	Madagascar	Tajikistan
Chad	Malawi	Tanzania
Comoros	Mali	Timor-Leste
Congo, Dem. Rep	Mauritania	Togo
Congo, Rep.	Moldova	Uganda
Cote d'Ivoire	Mongolia	Uzbekistan
Equatorial Guinea	Mozambique	Vietnam
Eritrea	Myanmar	Yemen, Rep.
Ethiopia	Nepal	Zambia
Gambia, The	Nicaragua	Zimbabwe
Ghana	Niger	
Guinea	Nigeria	

Lower-Middle Income (USD 766 – USD 3,035)

Albania	Georgia	Philippines
Algeria	Guatemala	Romania
Armenia	Guyana	Russian Federation
Azerbaijan	Honduras	Samoa
Belarus	Indonesia	Serbia and Montenegro
Bolivia	Iran, Islamic Rep.	South Africa
Bosnia and Herzegovina	Iraq	Sri Lanka
Brazil	Jamaica	Suriname
Bulgaria	Jordan	Swaziland
Cape Verde	Kazakhstan	Syrian Arab Republic
China	Kiribati	Thailand
Colombia	Macedonia, FYR	Tonga
Cuba	Maldives	Tunisia
Djibouti	Marshall Islands	Turkey
Dominican Republic	Micronesia, Fed. Sts.	Turkmenistan
Ecuador	Morocco	Ukraine
Egypt, Arab Rep.	Namibia	Vanuatu
El Salvador	Paraguay	West Bank and Gaza
Fiji	Peru	

Upper-Middle Income (USD 3,036 – USD 9,385)

American Samoa	Grenada	Panama
Antigua and Barbuda	Hungary	Poland
Argentina	Latvia	Saudi Arabia
Barbados	Lebanon	Seychelles
Belize	Libya	Slovak Republic
Botswana	Lithuania	St. Kitts and Nevis
Chile	Malaysia	St. Lucia
Costa Rica	Mauritius	St. Vincent & the Grenadines
Croatia	Mayetta	Trinidad and Tobago
Czech Republic	Mexico	Uruguay
Dominica	Northern Mariana Islands	Venezuela, RB
Estonia	Oman	
Gabon	Palau	

High Income (USD 9,386 or more)

Andorra	Germany	Netherlands
Aruba	Greece	Netherlands Antilles
Australia	Greenland	New Caledonia
Austria	Guam	New Zealand
Bahamas, The	Hong Kong, China	Norway
Bahrain	Iceland	Portugal
Belgium	Ireland	Puerto Rico
Bermuda	Isle of Man	Qatar
Brunei	Israel	San Marino
Canada	Italy	Singapore
Cayman Islands	Japan	Slovenia
Channel Islands	Korea, Rep.	Spain
Cyprus	Kuwait	Sweden
Denmark	Liechtenstein	Switzerland
Faeroe Islands	Luxembourg	United Arab Emirates
Finland	Macao, China	United Kingdom
France	Malta	United States
French Polynesia	Monaco	Virgin Islands (U.S.)

Annex 3: PHI Spending in Various Country Groups

	Low-Income Countries		Lower-Middle-Income Countries		Upper-Middle-Income Countries		High-Income Countries		All Countries	
	n	%	n	%	n	%	n	%	n	%
Total	64	100	57	100	33	100	38	100	192	100
Contributions for PHI of up to 5 %	16	25.0	34	59.6	17	51.5	25	65.8	92	47.9
Contributions for PHI exceeding 5 % of THE	5	7.8	13	22.8	8	24.2	13	34.2	39	20.3
Contributions for PHI exceeding 10 % of THE	2	3.1	9	15.8	4	12.1	6	15.8	21	10.9
Contributions for PHI exceeding 20 % of THE	0	0.0	3	5.2	2	6.1	1	2.6	6	3.1

Low-Income Countries where Contributions to Private Health Insurance exceed:

- 1) 10 % of Total Health Care Spending: Mali, Zimbabwe
- 2) 5 % of Total Health Care Spending: 1) + Côte d'Ivoire, Kenya, Madagascar
- 3) 0 % of Total Health Care Spending: 2) + Malawi, Moldova, Mozambique, Nicaragua, Niger, Papua New Guinea, Rwanda, Senegal, Tanzania, Uganda, Vietnam

Lower-Middle-Income Countries where Contributions to Private Health Insurance exceed:

- 1) 20 % of Total Health Care Spending: Brazil, Namibia, South Africa
- 2) 10 % of Total Health Care Spending: 1) + Albania, Colombia, Jamaica, Morocco, Paraguay, Philippines
- 3) 5 % of Total Health Care Spending: 2) + Indonesia, Peru, Tunisia, Turkmenistan

Upper-Middle-Income Countries where Contributions to Private Health Insurance exceed:

- 1) 20 % of Total Health Care Spending: Chile, Uruguay
- 2) 10 % of Total Health Care Spending: 1) + Argentina, Lebanon
- 3) 5 % of Total Health Care Spending: 2) + Barbados, Botswana, Panama, Saudi Arabia

Annex 4: Non-Life and Life-Insurance Around the World (measured as premium income)

Eastern Europe	Population	GDP	Non-Life	Life
Russia	143.5	433	9220	4868
Poland	38.6	207	3946	2312
Czech Republic	10.2	83	2290	1424
Hungary	9.9	82	1473	981
Slovakia	5.4	34	676	465
Croatia	4.4	28	704	201
Romania	22.2	55	608	187
Lithuania	3.5	18	196	70
Bulgaria	7.9	20	343	43
Serbia and Monte-negro	10.7	19	420	15
Ukraine	48.4	48	1699	14
Slovenia	2	28	1095	344
Latvia	2.3	10	200	9
Others				
Total	309	1065	22870	10933

Africa	Population	GDP	Non-Life	Life
South Africa	43.5	160	4670	20728
Morocco	30.1	45	927	361
Zimbabwe	13	12	205	277
Egypt	67.5	83	386	179
Mauritius	1.2	5	95	146
Kenya	31.9	14	304	107
Nigeria	139	55	345	77
Tunisia	9.9	25	416	40
Algeria	31.9	63	384	15
Others	483.4	295	1053	254
Total	851.4	757	8785	22184

Middle East	Population	GDP	Non-Life	Life
Israel	6.6	105	3840	3052
Saudi Arabia	22.8	199	902	39
Kuwait	2.2	35	240	80
Iran	66.7	128	1368	116
Oman	2.6	21	221	36
Turkey	67.9	239	2672	570
Jordan	5.3	10	192	28
United Arab. Emirates	3.1	86	744	226
Lebanon	4.5	18	381	139
Total	181.7	841	10560	4286

Asia*	Population	GDP	Non-Life	Life
Taiwan	22.6	287	8662	23739
Hong Kong	6.8	159	2377	10117
Singapore	4.3	91	3337	5561
Malaysia	24.7	105	2154	3455
Thailand	62	143	1711	3222
China	1290.8	1410	14468	32442
India	1056.3	601	3712	13590
Indonesia	214.5	208	1733	1373
Philippines	81.4	80	489	702
Vietnam	81.5	38	218	331
Sri Lanka	19.2	18	137	102
Pakistan	148.5	70	269	165
South Korea	48.1	621	17760	41998
Bangladesh	138.1	52	102	194
Total	3198.8	3883	57129	136991

Rest of the World	Population	GDP	Non-Life	Life
USA	290.2	10988	574579	480919
Canada	31.6	867	36303	22841
Germany	82.3	2418	94073	76738
U.K.	59.2	1797	91891	154842
France	59.6	1759	58244	105436
Italy	57.5	1476	40066	71694
Spain	41	843	26972	20042
NL	16.2	515	24895	25371
SZ	7.2	320	16047	24713
Belgium	10.3	304	12810	21004
Sweden	8.9	302	6742	14297
Austria	8.1	255	8410	6586
Norway	4.6	216	5501	6031
Denmark	5.4	211	5793	10944
Greece	10.7	207	2040	1628
Finland	5.2	175	3058	11065
Ireland	3.9	163	8291	9037
Portugal	10	148	4688	6122
Luxembourg	0.4	25	1102	7130
Cyprus	0.8	13	295	295
Iceland	0.3	11	314	31
Malta	0.4	5	117	118
Japan	127	4429	97530	381335
Australia	19.8	506	18044	22341
New Zealand	3.9	76	3671	1059
Total	865	28029	1141476	1481619

Latin America	Population	GDP	Non-Life	Life
Brazil	176.3	492	8259	6306
Mexico	102.5	608	6690	4230
Chile	15.7	83	1225	2171
Argentina	38.3	130	2365	928
Colombia	44.3	78	1449	548
Peru	27.2	61	507	366
Trinidad and Tobago	1.3	10	162	348
Bahamas	0.3	5	183	223
Jamaica	2.6	7	236	173
Panama	0.3	11	261	127
El Salvador	6.6	15	246	104
Barbados	0.3	3	189	99
Venezuela	25.5	75	2093	65
Uruguay	3.4	11	185	52
Guatemala	12.3	24	222	48
Ecuador	13.3	27	412	46
Dominican Republic	8.8	16	368	33
Costa Rica	4	17	290	28
Others	52	39	459	175
Total	535	1712	25801	16070

Note: Population in millions; GDP in billions USD; Non-Life and Life-insurance Business measured as premium volume in millions of USD.

Source: Own Calculations. Data: Swiss Re-Insurance Company (2004)

	Total	Rest of the World	Latin America	Asia ¹	Africa	Middle East	Eastern Europe	Total
Population	5940	14.6%	9.0%	53.8%	14.3%	3.1%	5.2%	100%
GDP	36287	77.2%	4.7%	10.7%	2.1%	2.3%	2.9%	100%
Life Insurance	1672083	88.6%	1.0%	8.2%	1.3%	0.3%	0.7%	100%
Non-Life Insurance	1266621	90.1%	2.0%	4.5%	0.7%	0.8%	1.8%	100%

Source: Own Calculations; Data: Swiss Re-Insurance Company (2004).