Different Countries, Different Needs: The Role of Private Health Insurance in Developing Countries

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Abstract This article discusses the role of private health insurance (PHI) in developing countries. Three broad regional clusters are identified that share similar characteristics and policy challenges for the effective integration of private insurance into national health care systems: (1) Latin America and Eastern Europe, where there are already developed insurance industries facing important market and policy failures; (2) the Middle East/North Africa region and East Asia, where there is a projected strong growth of PHI that needs to be accompanied by efficient regulation; and finally, (3) South Asia and Sub-Saharan Africa, where PHI will only play a marginal role in the foreseeable future while the scaling up of small-scale, nonprofit insurance schemes appears to be of critical importance. Overall, this survey shows that the role of private insurance varies depending on the economic, social, and institutional settings in a country or region. Private health insurance schemes can be valuable tools to complement existing health-financing options only if they are carefully managed and adapted to local needs and preferences.

Sustainable instruments for health financing are urgently needed to reduce the high amount of out-of-pocket payments and the incidence of catastrophic health shocks in the developing world (World Health Organization [WHO] 2006). Several factors have recently stimulated the development of private insurance mechanisms as a means to finance health care in low- and middle-income countries. These factors include difficulties with traditional ways of health care financing, diversified consumer demand in the course of economic development, and intensified trade in the health-services sector, which has introduced foreign insurance providers to developing countries.

Journal of Health Politics, Policy and Law, Vol. 32, No. 3, June 2007
DOI 10.1215/03616878-2007-012

Despite numerous efforts to establish functioning health care systems, most people in developing countries must still rely on direct payments to finance their health care needs. In some regions, these out-of-pocket payments can account for up to 80 percent of total health expenditure. Private prepaid programs, such as community-based health insurance schemes, are often the only possible way for poor people to participate in risk-pooling programs. Evidence so far suggests that private schemes can improve access to health care and offer financial protection even to marginalized groups (Jütting 2005). Despite the growing importance of private health insurance (PHI), however, surprisingly little is known about its role in national health systems in the developing world (Sekhri and Savedoff 2005).

The literature reveals controversy concerning the pros and cons of shifting from public to private insurance in developing countries (Preker, Scheffler, and Basset 2006). Critics of private insurance argue that it will divert scarce resources away from the poor, escalate health costs, and allow cream skimming and adverse selection. According to this view, private health insurance largely neglects the *social* aspect of health protection.[1] In contrast, proponents of PHI claim that private insurance can bridge financing gaps by offering consumers value for money and helping them avoid waiting lines, low-quality care, and under-the-table payments—problems often observed when households can use public health facilities for free or participate in mandatory social insurance schemes (Zweifel 2005).

Although neither camp is short of anecdotal evidence to substantiate its position, we argue that both sides fail to take into account the current development and diversity of health-financing options. The essentially categorical discussion often neglects regional differences based on people's values, a country's institutional capacity, and previous patterns of economic development. We consequently believe that the debate on the pros and cons of private health insurance is inadequate and misleading. The question of whether private insurance is a vice or a virtue for health systems is largely context specific and cannot be answered in general terms. Different countries have different needs.

1. A joint conference of the World Health Organization (WHO), the International Labour Organization (ILO), and the German Agency for Technical Cooperation (Gesellschaft für Technische Zusammenarbeit, or GTZ) on Social Health Insurance in Developing Countries (www.shi-conference.de/) recently proclaimed that "the extension of social protection in health is the key strategy to reduce financial barriers to access health care and moving towards universal coverage" (GTZ 2006).

The analysis presented in this article is a modest attempt to provide fact-based evidence on the advantages and disadvantages of PHI in the developing world. Our regional approach aims to identify clusters of countries that share common structural characteristics and face similar policy challenges that obstruct the integration of PHI into a country's health system. The scope of our analysis goes beyond previous studies, which have either focused on specific types of PHI (e.g., community-based programs: Preker and Carrin 2004; Ekman 2004; microinsurance: Dror and Jacquier 1999) or restricted the analysis to countries where the insurance industry is already well established (e.g., Latin America: Barrientos and Lloyd-Sherlock 2003; Iriart, Merhy, and Waitzkin 2001; Southeast Asia: WHO 2004). To our knowledge, this broader discussion of PHI in developing countries is the first of its kind and will hopefully motivate further research in the field.

The second section of our article discusses the data and methodology used for our analysis, and the third section gives an overview of the relevance of PHI in different regions of the world. This part equally considers trends of PHI development, describes characteristics of insurance schemes, and considers instances of market failure. Based on these findings, the fourth section identifies clusters of countries with similar patterns and challenges of integrating PHI into their health systems.

Data and Methodology

Private health insurance in the developing world has multiple facets. For the purpose of this analysis, PHI is defined by the channeling of financial resources directly to the risk-pooling institution with no, or relatively little, involvement of the state. The main distinction between social and private health insurance is the type of contract between the risk-pooling entity and the insured individual or group. Whereas social insurance relies on tax-like contributions to the state, PHI rests on a private contract between the insurance company and its clientele in which the level of insurance premiums for a given benefit coverage is set (figure 1).

According to the Organisation for Economic Co-operation and Development (OECD 2004), health financing through insurance involves both prepayment and risk pooling. Following this general classification, there are nevertheless several possibilities to finance health care through private prepaid contributions. The spectrum of PHI in developing countries ranges from large commercial to small nonprofit schemes, which can be run by private entities, nongovernmental organizations (NGOs), or com-

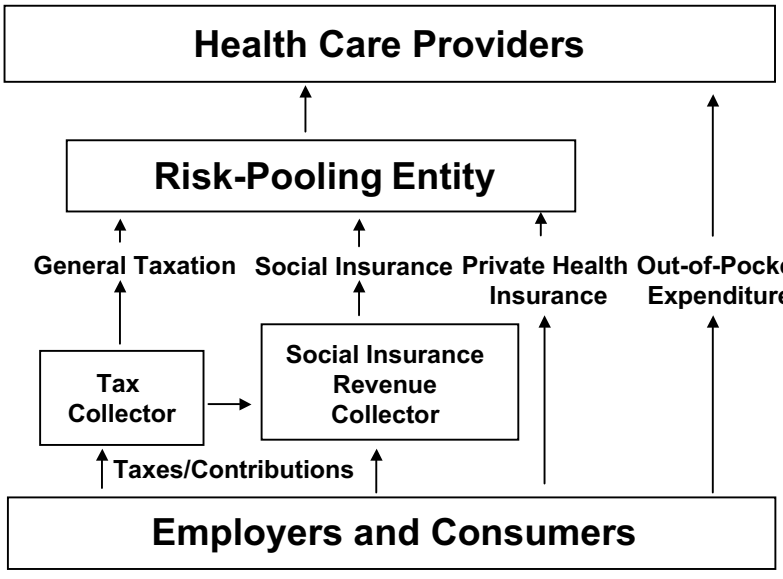

Figure 1 Systems of Health Care Financing

Source: Adapted from Normand and Busse (2000)

munities. The schemes might offer individual contracts or cover particular groups of people (e.g., employer-based schemes that rarely extend beyond the formal labor market).

Despite recent efforts of the World Health Organization (WHO) and other international entities to collect information on the quantity of financial resources used for health, data on health financing remain scarce, especially in the context of low- and middle-income countries. In order to overcome this problem, we employ various sources for our review including WHO's National Health Accounts (NHA) and country case studies as well as reports from actuarial firms and reinsurance companies (table 1). Some of our findings should nevertheless be treated with caution because of the unavailability of reliable time-series data.

Our analysis consists of three steps (figure 2). First, the relevance of PHI in low- and middle-income countries is assessed on the basis of the share of spending on such insurance relative to total health expenditure (THE) as recorded by WHO statistics. Our analysis incorporates 154 of the 192 WHO member countries; of these, 73 recorded spending on private prepaid programs in 2002 (WHO 2005: 192). Countries with relatively high spending on PHI are the focus of the second step of the analysis, which employs regional overviews, country case studies, and in-depth analyses of

Table 1 Main Data Sources and Evaluation

Data Source	Information Contained	Quality Assessment
WHO: National Health Accounts	Information on spending for private risk-sharing programs	Quality varies largely and depends on the country that collects the information
WHO: World Health Report	Data on health care systems and financing	Comprehensive compilation with no specific focus on health financing
European Observatory on Health Systems and Policies	Thorough analysis of health care systems in Europe and parts of Central Asia, including descriptions of health-financing mechanisms, types of insurance schemes, coverage rates, etc.	Quality varies depending on the specific country being analyzed; generally reliable and detailed information
La Concertation	Information on health insurance systems in West Africa with a particular focus on community-based financing	Reliable source, but very limited in scope; might miss many new schemes as development is very dynamic
Swiss Reinsurance Company (*Sigma* publications)	Data and analyses on insurance markets around the world	Reliable source, but health is not a main focus; primarily concerns for-profit, commercial insurance
International Labour Organization Strategies and Tools against Social Exclusion and Poverty (STEP) program	Data mostly concerning community-based programs and the development of social insurance	High-quality country case studies with a focused view on certain aspects of health insurance
Partnerships for Health Reform (PHR; now Partners for Health Reform *plus*)	Information with a focus on community-based health financing and decentralization in Africa, Asia/Near East, Eurasia, Latin America, and the Caribbean	Reliable source, but there is potential bias toward private mechanisms with U.S. Agency for International Development (USAID) involvement
World Bank (Health, Nutrition, and Population)	Issue-specific information covering various aspects of health care financing and a comprehensive list of countries	Reliable information for specific issues in health financing, but there is no systematic collection of country data

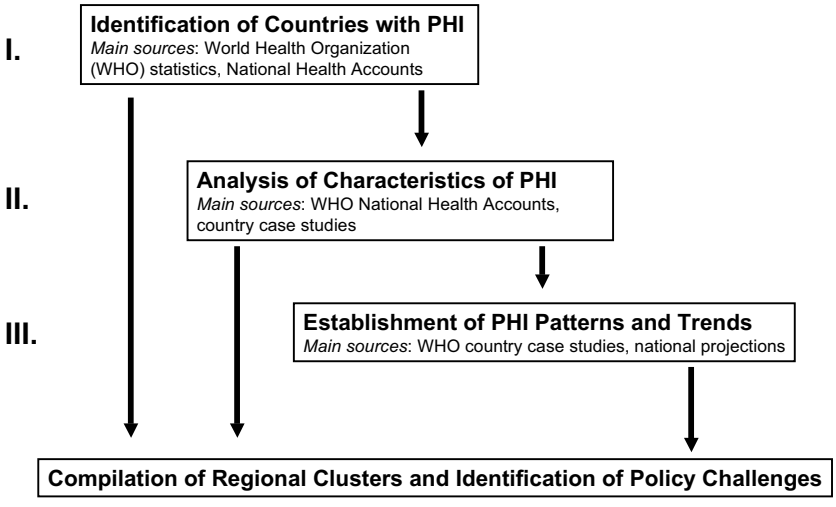

Figure 2 Analytical Framework

specific risk-sharing programs.[2] This portion of the analysis presents the dominant structure of schemes as well as price-setting mechanisms and methods of premium collection. The third step of the analysis establishes common patterns and trends of PHI development on the basis of countries' economic development and institutional capacity. This information is used to identify clusters of countries facing similar policy challenges in integrating private health insurance into their national health systems.

Empirical Evidence of Private Health Insurance in Low- and Middle-Income Countries

Private risk-sharing markets are comparatively small in low- and middle-income countries. Collectively, the six regions considered in this analysis account for a mere 10 percent of global insurance premium income (figure 3). This small share is particularly striking considering that these regions host more than 85 percent of the world's population and account for some

2. Although we do not apply a strict rule in determing when contributions can be considered high, we generally consider it to be when spending is near or exceeds 5 percent of total health expenditure.

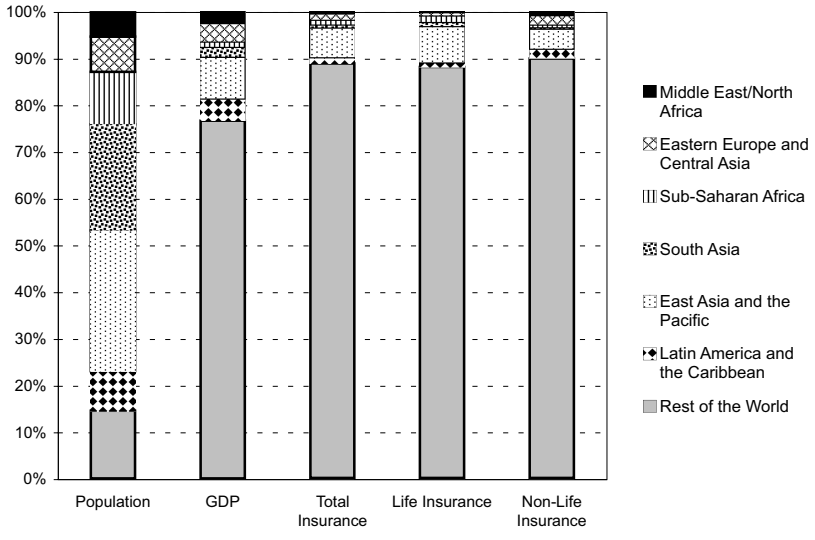

Figure 3 Relative Importance of Private Insurance Markets in 2003

Source: Authors' calculations based on data from Swiss Reinsurance Company (2004b)

Notes: Relative importance is measured as the share of global insurance premium income; East Asia and the Pacific excludes Japan; rest of world primarily covers Organisation for Economic Co-operation and Development countries.

23 percent of global gross domestic product (GDP) (Swiss Reinsurance Company 2004b).

This picture may nevertheless change, as insurance markets in developing countries are on the rise. Measured in terms of 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 percent as compared to 3.4 percent in the life insurance sector and 7.3 percent as compared to 2.6 percent in the non–life insurance sector respectively).[3] This development has been particularly strong in Asia and Eastern Europe, where the industry expanded by 10.5 percent and 13 per-

3. In accordance with conventions of the European Union (EU) and the Organisation for Economic Co-operation and Development (OECD), health and accident insurance are considered to belong to the non–life insurance segment, although some countries or insurance companies may employ a divergent classification (Swiss Reinsurance Company 2004a: 28).

cent, respectively, between 1998 and 2003 (Swiss Reinsurance Company 2004c: 15). Even though growth rates have recently dropped below their long-term average, analysts still see significant development potential for the insurance industry.

In view of the increasing importance of private insurance mechanisms, it seems vital to identify the different institutional and economic settings that can make PHI a useful contribution to the objectives a society has agreed upon. The following section singles out important determinants that need to be taken into account when discussing the various health-financing options and necessary reforms in developing countries.

Private Health Insurance in Latin America and the Caribbean

Latin America has experienced tremendous growth in the private insurance industry. The volume of insurance premiums has increased considerably, especially after regulatory changes and liberalization efforts in the 1990s brought private health insurance to many Latin American countries. Even in comparison to OECD countries, spending on private prepaid plans accounts for a high percentage of total health expenditure (table 2).

Importance of Private Health Insurance in Latin America and the Caribbean. The private health insurance industry in Latin America and the Caribbean has benefited from overall development of the insurance market. In 2002, spending on PHI was recorded for a remarkable twenty-two countries, and PHI expenditure amounted to more than 5 percent of total health spending in ten countries (table 3). The industry is particularly strong in Uruguay, where over 60 percent of the population is covered through private schemes (Sekhri and Savedoff 2005: 131). High coverage is also reported for Colombia, where half of the population is estimated to have private health insurance (Francis 2000: 43–47). Measured in terms of total expenditure on health care, PHI is even more important in Chile — where the military government imposed a U.S.-style insurance market and disassembled the existing public system in 1981 — 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 country (Höfter 2006; Francis 2000). Similar observations apply to Argentina and Jamaica, where PHI spending accounts for

Table 2 Health Care Financing in Latin America and the Caribbean

	Total Health Expenditure (THE) in USD (per capita)	Private Expenditure on Health in USD (per capita)	Out-of-Pocket Expenditure on Health as a Percentage of THE (per capita)	Spending on Private Prepaid Plans as a Percentage of THE (per capita)
Latin America and the Caribbean (LAC)	247.13	107.98	36.0	8.5
Organisation for Economic Co-operation and Development (OECD)	1,937.43	536.95	19.9	5.3

Source: Authors' calculations based on World Health Organization (2005). Values are averages for the region.

Note: OECD data (the average of all thirty OECD countries) are used to illustrate the relative importance of private health insurance (PHI) in LAC.

Table 3 Relative Importance of Private Health Insurance (PHI) in Latin America and the Caribbean

Country	Importance of PHI	Country	Importance of PHI
Argentina	15.5	Honduras	3.6
Barbados	7.2	Jamaica	13.8
Bolivia	3.8	Mexico	3.0
Brazil	19.4	Nicaragua	2.0
Chile	28.2	Panama	5.2
Colombia	5.4	Paraguay	7.1
Costa Rica	0.3	Peru	8.6
Dominican Republic	0.3	Suriname	0.2
Ecuador	1.5	Trinidad and Tobago	4.7
El Salvador	3.4	Uruguay	53.3
Guatemala	2.7	Venezuela	2.2

Source: Authors' calculations based on World Health Organization (2005).

Note: This table reflects PHI expenditure as a percentage of total health expenditure (THE) in 2002, not including countries without PHI or for which data were not available.

around 15 percent of total health expenditure. Although not yet reflected in coverage rates, which are estimated at 3 percent of the population, PHI has also gained significance in Mexico, where the industry is experiencing "vigorous growth" (Swiss Reinsurance Company 2002: 35).

Characteristics of Private Health Insurance in Latin America and the Caribbean. Many Latin American countries have adopted PHI schemes that are based on the principles of managed care. In this respect, the private insurance market 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., medical check-ups, hospital stays, emergency care). Consumer choice is limited because health services are often provided through the organization's own group practice, contracted health care providers, or both. Moreover, HMOs usually do not allow members to consult a specialist before seeing a preselected primary care doctor who serves as a gatekeeper to health care.

Although managed care can be an effective way to control health care spending (e.g., there is some evidence for this in the United States; Francis 2000; Phelps 1997), the capacity of HMOs to contain cost escalation in Latin America is doubtful. With the North American market nearing saturation, foreign investors have primarily targeted the growing upper-middle class in Latin America to maximize profits. In fact, Stocker, Waitzkin, and Iriart (1999: 1132) point out that the main motives for HMOs to enter the Latin American market is financial reward. Other goals (e.g., preventive care or quality control) that have traditionally been valued by some HMOs in the United States have received minor attention. Mandatory co-payments have further deteriorated the situation for vulnerable groups (ibid.: 1133).

Prospects of Private Health Insurance Development in Latin America and the Caribbean. Multilateral lending agencies strongly supported entry of private, particularly international, insurers into Latin America and the Caribbean. The result was increased and often predatory competition, which was characterized by hostile takeovers of local insurers as well as by a number of mergers and acquisitions. This development has not as yet materialized in more competitive products such as lower premiums. Although market concentration recently decreased as some small start-up companies entered the market, the industry remains noncompetitive

and the level of premiums high. Consequently, private health insurance predominantly addresses upper-income populations. Poor families must remain in the existing social insurance schemes or go without insurance. 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).

Private health insurance often faces 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 failures raise concerns about the capacity of private schemes to solve problems of health care financing in Latin America. In many countries, virtually all relevant indicators of a successful health insurance system have not improved or have even deteriorated from the time private schemes were introduced. Private health insurance has neither contained health costs nor promoted equity nor has it reduced vast disparities between coverage in urban and rural areas (International Labour Organization [ILO] 2000).

Many countries have reported problems with the implementation of PHI. In Chile, a large part of the wealthy population has opted out of the social insurance system, making public health care de facto an insurer of last resort (Barrientos 2000). Chile's highly fragmented insurance market is characterized by superfluous coverage (Jack 2000), while a stop-loss clause has allowed insurance companies to limit the extent of coverage in case of catastrophic health care costs.[4] Cream skimming is a common phenomenon in which private providers primarily target good-risk individuals: for example, only 6.9 percent of people older than sixty-five years are members of a private scheme (*Institución privada de salud provisional* [ISAPRE]) compared to 26.7 percent in the twenty-five to fifty-four age group (Jack 2000: 28; Baeza 1998: 18). Severe difficulties have also been reported for Argentina, Colombia, and Brazil, where the regulatory framework could not prevent the rise of inequalities and inefficiencies, either because such a framework was not in place when PHI was introduced into the market or because it was ill adapted to local situations. Moreover, implementation of adequate legislation is costly; for example, regulation-induced transaction costs are estimated to account for 30 percent of the total premium revenue in Chile (Kumaranayake 1998: 16).

4. In 1995, thirty-five private insurance companies offered close to nine thousand distinct insurance programs in Chile.

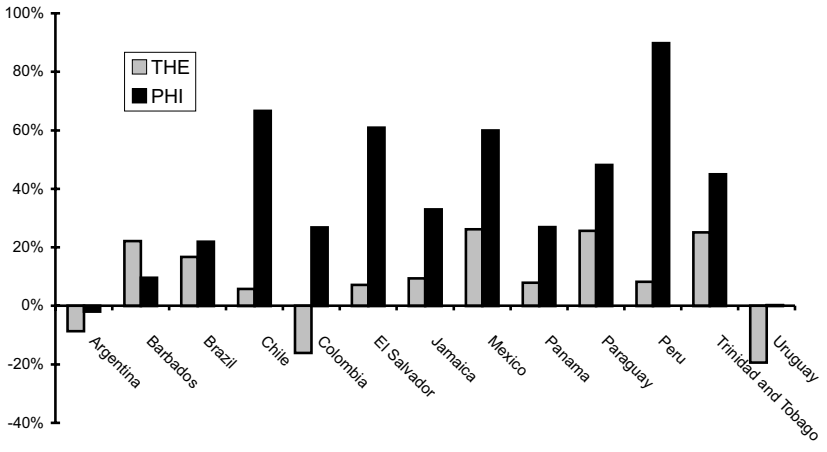

Figure 4 Total Health Expenditure (THE) and Private Health Insurance (PHI) Spending in Latin America and the Caribbean

Source: Authors' calculations based on World Health Organization (2005)

Note: Data reflect percentage change between 1998 and 2002. Only countries in which PHI spending exceeded $10 in 2002 are included.

Although PHI expenditure continues to increase in most Latin American countries (figure 4), identifying a development trend is difficult. Sustained expansion of the health insurance industry is primarily due to escalating health care costs in the private sector, and the consequent increase of PHI premiums. After the insurance industry flourished in the 1990s (Cruz-Saco 2002), recent studies mainly indicate a slowdown of its growth.

Private Health Insurance in the Middle East and North Africa

Private expenditure is an important source of health care financing in the Middle East and North Africa (table 4). Nonetheless, PHI is a relatively new phenomenon in most of the region's countries. Private funds are predominantly used for out-of-pocket spending; only Morocco, Lebanon, and Saudi Arabia have a sizeable private health insurance industry. Furthermore, a large share of private health expenditure is used for prepaid programs in Oman and Saudi Arabia.

Table 4 Health Care Financing in the Middle East and North Africa

	Total Health Expenditure (THE) in USD (per capita)	Private Expenditure on Health in USD (per capita)	Out-of-Pocket Expenditure on Health as a Percentage of THE (per capita)	Spending on Private Prepaid Plans as a Percentage of THE (per capita)
Middle East and North Africa (MENA)	351.84	118.30	37.7	4.4
Organisation for Economic Co-operation and Development (OECD)	1,937.43	536.95	19.9	5.3

Source: Authors' calculations based on World Health Organization (2005). Values are averages for the region.

Note: OECD data (the average of all thirty OECD countries) are used to illustrate the relative importance of private health insurance (PHI) in MENA.

Importance of Private Health Insurance in the Middle East and North Africa. Nine countries in the Middle East and North Africa have recorded spending on PHI; five of these countries channel more than 5 percent of their total health expenditure through private prepaid programs (table 5). Of all countries in the region, PHI covers the largest share of the population in Morocco, where public insurance does not exist (around 15 percent or 4.5 million people). Half a million people (12.6 percent of the population) are reported to have coverage in Lebanon. In other countries, PHI is restricted mainly to foreigners (5 to 6 million expatriate workers in Saudi Arabia) or

Table 5 Relative Importance of Private Health Insurance (PHI) in the Middle East and North Africa

Country	Importance of PHI	Country	Importance of PHI
Algeria	1.2	Morocco	15.5
Egypt	0.4	Oman	8.9
Iran	1.5	Saudi Arabia	9.2
Jordan	3.8	Tunisia	7.8
Lebanon	12.2		

Source: Authors' calculations based on World Health Organization (2005).

Note: This table reflects PHI expenditure as a percentage of total health expenditure (THE) in 2002, not including countries without PHI or for which data were not available.

high-income individuals (around 250,000 in Tunisia and Jordan, which corresponds to 2.5 percent and 5 percent of each country's population).

Characteristics of Private Health Insurance in the Middle East and North Africa. Some countries in the region have a surprisingly diversified health insurance market. Apart from public sources, various private providers, including private non- and for-profit companies, mutual benefit societies, and mutual funds for private and public sector companies, offer health care coverage; for example, in Lebanon, a country with less than 5 million inhabitants, seventy insurance firms provide PHI (Ammar et al. 2000). Furthermore, insurers offer both comprehensive and supplementary coverage; participation in these schemes predominantly depends on the extent of available public insurance.

Insurance markets in the region often lack policy harmonization and institutional accountability. In Jordan, coordination between the Ministry of Industry and Trade, which is responsible for PHI regulation, and the Ministry of Health is lacking (Halawani et al. 2000). Similar observations apply to Lebanon, where each branch of the insurance industry is associated with a distinct supervising ministry. Evidently, these shared responsibilities impede public oversight, which could lead to market inefficiencies such as overlapping health care coverage (which is reported for Jordan and Iran). Better coordination mechanisms between respective ministries could decrease citizens' uncertainty about crucial coverage and thereby 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 health care financing.

Prospects of Private Health Insurance Development in the Middle East and North Africa. Private health insurance schemes reportedly exclude high-cost/low-income individuals in Jordan, Lebanon, Morocco, and Tunisia. These schemes are mostly concentrated in urban areas and often do not extend to the rural population. Some countries have recently begun to promote PHI development, either through liberalization of insurance services or extension of existing schemes to a wider population. Saudi Arabia, for example, requires expatriate workers to have private insurance coverage. However, the main drivers of PHI development in the Middle East and North Africa are growing and more diversified consumer demand, overall economic growth, and increasing health care costs that the state can no longer finance (figure 5).

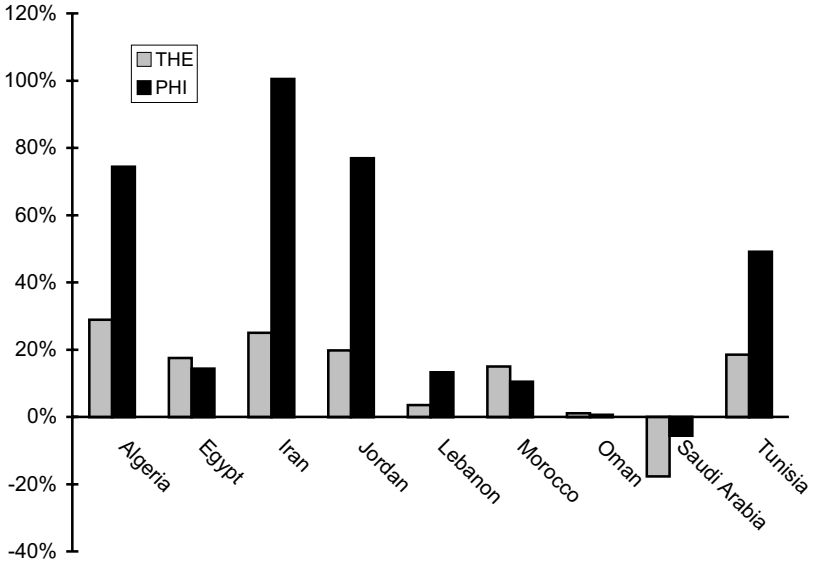

Figure 5 Total Health Expenditure (THE) and Private Health Insurance (PHI) Spending in the Middle East and North Africa

Source: Authors' calculations based on World Health Organization (2005)

Note: Data reflect percentage change between 1998 and 2002.

Cream skimming, cost and premium escalation, and fraud (which are all widespread in the region) will be difficult to prevent without efficient regulatory instruments. Similarly, equity targets will be in jeopardy if the state does not act in sound administrative and regulatory capacities. In Lebanon, lack of effective supply-side controls contributed to cost and premium escalation in the health care sector, which is characterized by severe inequities in the distribution of health care costs: for example, low-income individuals spend, on average, 20 percent of their household income on health care, while this share accounts for merely 8 percent of household resources in the highest income group (Ammar et al. 2000).

Insufficient public oversight and, in particular, inappropriate incentive structures cause inefficiencies in the allocation of resources. Reimbursement policies in Lebanon, for example, have channeled too many resources into the development and prescription of high-tech curative treatments. Primary and preventive care, on the other hand, has been neglected by health-financing institutions, including PHI. Apart from contributing

to the general escalation of health care costs, the focus on curative care may also fail to meet the health care needs of the local population, which might require preventive measures such as vaccination and immunization. Private health insurance schemes also appear to be maladapted to local requirements in Morocco. If private health insurance were to become a major pillar of the country's health-financing system, schemes would need to take into account the specific situation of the poor. The current design of PHI schemes, which primarily cover minor health care risks, does not provide sufficient protection against impoverishment, because catastrophic health care costs could still arise in the event of major medical treatments.

Private Health Insurance in Eastern Europe and Central Asia

Despite a relatively developed non–life insurance market (per capita spending of $52.60 [all monetary amounts in this article are expressed in U.S. dollars], which is the highest rate of all regions analyzed in this study), private health insurance is still in its infancy in Eastern Europe and Central Asia (table 6). In many countries of the region, PHI entered the market as part of the general transition to market-based economic systems. This development was often supported by health sector reforms and government-driven PHI pilot programs that attempted to establish PHI as a pillar of health care financing (e.g., in Estonia, Hungary, and Moldova).

Importance of Private Health Insurance in Eastern Europe and Central Asia. Except for Slovenia, which falls into the high-income category and will not be considered in our analysis, PHI has so far failed to become a major channel of health care financing in Eastern Europe and Central Asia. Although PHI expenditure has increased in many countries, a substantial expansion of private health insurance has not occurred. Average per capita spending on PHI in all eleven countries with available data amounted to merely $7.16 in 2002, which is less than 1 percent of THE in most countries of the region (WHO 2005: 192). Only the Russian Federation (6.5 percent), Turkey (4.1 percent), and Romania (1.9 percent) surpass the 1 percent threshold (table 7), but even in these countries, the extent of PHI remains limited; for example, only 650,000 people (1 percent of the population) are estimated to have private coverage in Turkey (Colombo and Tapay 2004; Savas, Karahan, and Saka 2002).

Table 6 Health Care Financing in Eastern Europe and Central Asia

	Total Health Expenditure (THE) in USD (per capita)	Private Expenditure on Health in USD (per capita)	Out-of-Pocket Expenditure on Health as a Percentage of THE (per capita)	Spending on Private Prepaid Plans as a Percentage of THE (per capita)
Eastern Europe and Central Asia (ECA)	180.79	50.72	37.1	1.4
Organisation for Economic Co-operation and Development (OECD)	1,937.43	536.95	19.9	5.3

Source: Authors' calculations based on World Health Organization (2005). Values are averages for the region.

Note: OECD data (the average of all thirty OECD countries) are used to illustrate the relative importance of private health insurance (PHI) in ECA.

Table 7 Relative Importance of Private Health Insurance (PHI) in Eastern Europe and Central Asia

Country	Importance of PHI	Country	Importance of PHI
Belarus	0.1	Lithuania	0.1
Bulgaria	0.4	Romania	1.9
Estonia	1.0	Russian Federation	6.5
Georgia	0.9	Turkey	4.1
Hungary	0.4	Ukraine	0.7
Latvia	0.4		

Source: Authors' calculations based on World Health Organization (2005).

Note: This table reflects PHI expenditure as a percentage of total health expenditure (THE) in 2002, not including countries without PHI or for which data were not available.

Characteristics of Private Health Insurance in Eastern Europe and Central Asia. In Eastern Europe and Central Asia, PHI schemes cater to a niche market of high-income individuals who seek additional or superior coverage to supplement existing public schemes. As in Romania, PHI is frequently offered by large multinational employers or is used by residents traveling abroad because out-of-country health care services are not covered by compulsory social insurance (Vladescu, Radulescu, and Olsavsky

2000). Except in Hungary, private health insurance is predominantly for profit and is generally unaffordable for a large share of the population.

Market exclusion of the poor is manifold. In Azerbaijan, private voluntary health insurance covers approximately 15,000 people, which is less than 0.1 percent of the country's population. Annual insurance premiums vary from $600, for hospital treatment in insurance-owned facilities, to $17,000, depending on the insurance package (Holley, Akhundov, and Nolte 2004). Considering that the average per capita income in Azerbaijan amounts to around $700 per annum, it is apparent why PHI is limited to relatively few individuals. In fact, insurance companies do not appear to believe "that there is a viable market among the general population" (ibid.: 24). This observation holds for Belarus (Karnitski 1997), Estonia (Jesse and Schaefer 2000), Georgia (Gamkrelidze et al. 2002), and the for-profit market in Hungary (Gaál 2004).

Prospects of Private Health Insurance Development in Eastern Europe and Central Asia. In an environment of overall escalating health care costs, contributions to private prepaid schemes have increased tremendously in a number of countries in Eastern Europe and Central Asia (figure 6). Various factors have nevertheless prevented PHI from becoming an important source of health care financing.

As documented in Dixon, Lagenbrunner, and Mossialos (2004), many countries experienced severe difficulties when markets were opened for private health insurance; for example, in Kazakhstan, most insurance companies went out of business shortly after their market entry. These failures owed mainly to lack of public regulation and to lack of oversight of the companies' solvency. In other countries, privatization has not been thoroughly accomplished (e.g., government joint stock companies sell private health insurance in Uzbekistan) or is limited to certain sectors of the health insurance market (i.e., private insurance only covers co-payments under the public health insurance regime). Albania opened the market for private health insurance in 1994 but failed to attract suppliers of PHI. As of 1999, only one insurance company had entered the market, offering private insurance services mostly to people traveling abroad (Nuri and Healy 1999). The private insurance industry has still not consolidated, while the country's social health insurance scheme is on its way to becoming the primary purchaser of health care services (Nuri 2002).

Apart from regulatory deficiencies, the lack of non- or low-profit insurance companies may also have contributed to the limited prevalence of PHI in Eastern Europe and Central Asia. Hungary appears to be the only

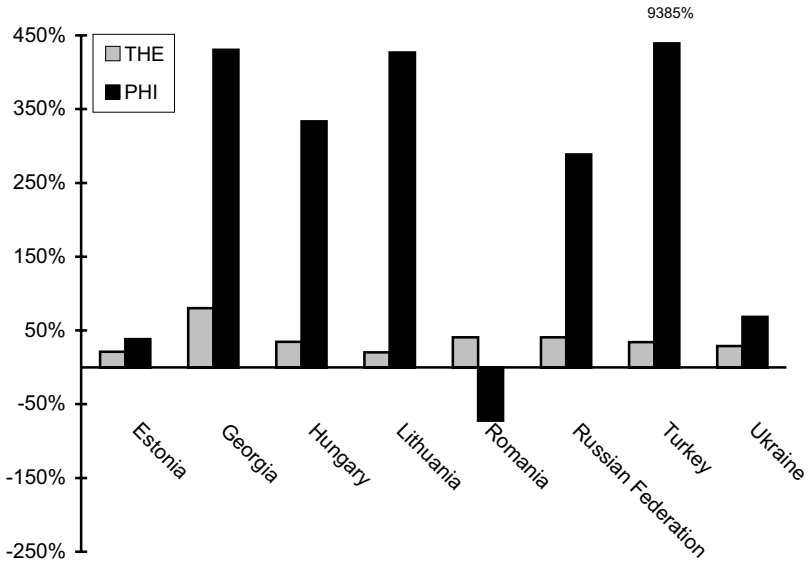

Figure 6 Total Health Expenditure (THE) and Private Health Insurance (PHI) Spending in Eastern Europe and Central Asia

Source: Authors' calculations based on World Health Organization (2005)

Note: Data reflect percentage change between 1998 and 2002 (Estonia between 1999 and 2002).

country in the region to have succeeded in promoting the development of PHI through a mix of institutional reforms and public subsidies. In 1993, it created the legal framework for the establishment of nonprofit private health insurance, which is primarily based on the model of the French *mutualité*.

Another dynamic market may develop in Turkey, which witnessed an increase of coverage from 15,000 to 650,000 people between 1990 and 2002. During this period, subscribers to private schemes were primarily acquiring higher-quality service to supplement their public coverage. The significant increase of insurance companies offering and people acquiring PHI was mostly due to the country's economic development, which allowed diversified consumer demand. High premiums, however, have recently reduced the growth of PHI as the average annual premium per person increased from $200 to $800 between 1994 and 2002.

Whether PHI will gain a more prominent role in Eastern Europe and

Table 8 Health Care Financing in Sub-Saharan Africa

	Total Health Expenditure (THE) in USD (per capita)	Private Expenditure on Health in USD (per capita)	Out-of-Pocket Expenditure on Health as a Percentage of THE (per capita)	Spending on Private Prepaid Plans as a Percentage of THE (per capita)
Sub-Saharan Africa (SSA)	49.14	21.29	39.9	3.5
Organisation for Economic Co-operation and Development (OECD)	1,937.43	536.95	19.9	5.3

Source: Authors' calculations based on World Health Organization (2005). Values are averages for the region.

Note: OECD data (the average of all thirty OECD countries) are used to illustrate the relative importance of private health insurance (PHI) in SSA.

Central Asia is above all a political decision. Support of PHI development varies greatly across countries. Whereas the Ministry of Health in Belarus is "broadly in favor of the extension of voluntary [i.e., private] health insurance" (Karnitski 1997: 42), Estonia has renounced all policy attempts "to increase the share of private insurance" (Jesse and Schaefer 2000: 18).

Private Health Insurance in Sub-Saharan Africa

Private health insurance, like other forms of insurance, is not widespread in Sub-Saharan Africa. Except for South Africa, where private insurance is a major pillar of the health care system, PHI is a niche product or takes the form of small community-based schemes that offer limited coverage and financial protection (table 8).

Importance of Private Health Insurance in Sub-Saharan Africa

PHI spending is recorded for twenty countries and is 5 percent or more of total health expenditure in seven of these countries (table 9). The health insurance market is particularly well established in South Africa, where 46.2 percent of all expenditure on health care was channeled through PHI in 2002 (WHO 2005: 192). (Because South Africa is an exceptional case, it is not included in the qualitative analysis; the interested reader should

Table 9 Relative Importance of Private Health Insurance (PHI) in Sub-Saharan Africa

Country	Importance of PHI	Country	Importance of PHI
Benin	5.0	Niger	2.7
Botswana	7.6	Nigeria	5.0
Cape Verde	0.0	Rwanda	0.1
Chad	0.2	Senegal	1.9
Côte d'Ivoire	4.2	South Africa	46.2
Ethiopia	0.2	Swaziland	8.1
Kenya	3.9	Tanzania	2.0
Madagascar	5.0	Togo	2.1
Malawi	1.0	Uganda	0.1
Mozambique	0.2	Zimbabwe	18.8
Namibia	22.4		

Source: Authors' calculations based on World Health Organization (2005).
Note: This table reflects PHI expenditure as a percentage of total health expenditure (THE) in 2002, not including countries without PHI or for which data were not available.

refer to Söderlund and Hansl 2000). Measured in financial flows, PHI also plays a significant role in Namibia and Zimbabwe (the latter being the only low-income country in which PHI spending exceeds 10 percent of THE). Because private for-profit health insurance is almost exclusively reserved for high-income individuals, the large share of PHI spending is not reflected in equally significant coverage rates; for example, only 8 percent of the population in Zimbabwe is estimated to have private health insurance (Campbell et al. 2000: 2) although PHI expenditure accounts for almost 19 percent of the country's total health expenditure.

Innovative approaches have gradually begun to increase the importance of PHI in other African countries and among other income groups. The increasing emergence of community-based health insurance, which usually operates on a nonprofit basis, has been particularly strong in Sub-Saharan Africa (Jütting 2004). New schemes have been implemented in Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Guinea, Mali, Nigeria, Senegal, Tanzania, Togo, and Uganda (ILO 2000).

Characteristics of Private Health Insurance in Sub-Saharan Africa. In the foreseeable future, private for-profit insurance will not become a significant pillar of the health care system of African countries. Community-based health insurance promises far greater development potential. Such

schemes are established through "local initiatives of rather small size . . . with voluntary membership" (Wiesmann and Jütting 2000: 195). They can be initiated by health care providers (e.g., hospitals), NGOs, or local associations (Atim 1998; Criel 1998) and are generally limited to a specific region or community. The schemes consequently only reach a small number of beneficiaries. Moreover, insurance packages are not comprehensive but typically offer supplementary coverage for certain medical treatments.

A survey of health insurance systems in eleven francophone West and Central African countries (Concertation 2004) identified 324 community-based health insurance schemes; this corresponds to almost 90 percent of all 366 registered insurance programs that are considered operational in these countries. In addition to offering moderate premiums, community-based health insurance schemes can often better adapt to the specific needs of their clientele. Although health coverage through such schemes will typically remain low, recent empirical findings (e.g., Jütting 2005) suggest that these schemes can increase households' access to health care and reduce periodic expense shocks that would otherwise be induced by unanticipated out-of-pocket spending (Ekman 2004).

Prospects of Private Health Insurance Development in Sub-Saharan Africa. One feature of community-based health insurance schemes could prove problematic for the future development of such schemes not only in Africa but around the world (Baeza, Montenegro, and Núñez 2002): the smallness of the schemes, which ensures sufficient flexibility to adapt to local conditions, also deprives them of financial stability (Concertation 2004: 79). In West African countries, eight out of ten schemes cover fewer than 1,000 people; one-half of them cover fewer than 650 individuals. Small size, although preferable from organizational and participatory perspectives, will not provide the necessary financial basis to be sustainable in the future. Greater cooperation and possible partnerships among existing programs, as well as the targeting of more constituents in the development of new schemes, therefore seem advisable. The Mutual Society for Health Care in the Informal Sector (Umoja wa Matibabu Sekta Isiyo Rasmi Dar es Salaam, or UMASIDA) health insurance schemes in Tanzania give an illustrative example of how this cooperation could be accomplished, because the society resulted from the regrouping of five associations of the informal sector (Kiwara 1999: 131). Public policies could support consolidation of programs through the collective effort of the communities running the schemes.

In order to achieve long-term stability, community-based health insur-

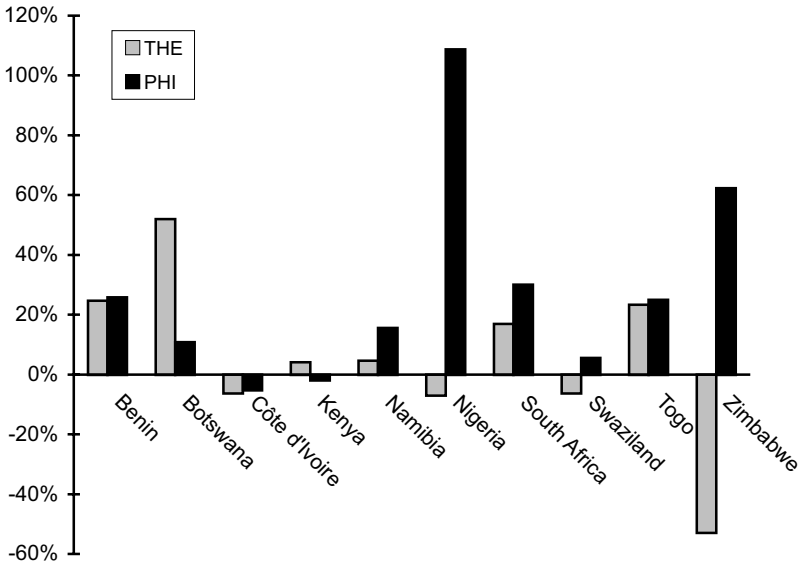

Figure 7 Total Health Expenditure (THE) and Private Health Insurance (PHI) Spending in Sub-Saharan Africa

Source: Authors' calculations based on World Health Organization (2005)

Note: Data reflect percentage change between 1998 and 2002. Only countries in which PHI spending exceeded $1 in 2002 are included.

ance schemes should operate on a more professional basis by increasing risk pools and disposing of security mechanisms such as guarantees and reinsurance funds. Moreover, they should gradually move from low premiums to contributions that allow both financial stability and true insurance-based health care coverage. The current low coverage offered by community-based health insurance is particularly unsatisfactory because it does not protect individuals from catastrophic health expenditure.

Considering the institutional weakness of many Sub-Saharan African countries and the limited financial resources of the African people (46.5 percent of the population live on less than $1 a day), PHI will mainly evolve in the nonprofit, community-based insurance segment. In francophone countries, 142 new schemes are currently being implemented, and 77 are planned for the near future (Concertation 2004). Due to the low contribution level of community-based schemes, this dynamic development will not be accompanied by a significant increase of PHI spending (figure 7). The implementation of schemes that only offer limited cover-

Table 10 Health Care Financing in East Asia and the Pacific

	Total Health Expenditure (THE) in USD (per capita)	Private Expenditure on Health in USD (per capita)	Out-of-Pocket Expenditure on Health as a Percentage of THE (per capita)	Spending on Private Prepaid Plans as a Percentage of THE (per capita)
East Asia and the Pacific (EAP)	162.74	56.93	32.1	1.0
Organisation for Economic Co-operation and Development (OECD)	1,937.43	536.95	19.9	5.3

Source: Authors' calculations based on World Health Organization (2005). Values are averages for the region.

Note: OECD data (the average of all thirty OECD countries) are used to illustrate the relative importance of private health insurance (PHI) in EAP.

age is obviously not an end in itself, but it can serve as a building block for the future development of more efficient forms of health insurance in Sub-Saharan Africa.

Private Health Insurance in East Asia and the Pacific

Considering the region's large population and economic potential, private health insurance is surprisingly small in East Asia and the Pacific (table 10). Economic growth, escalating health care costs, and recent pandemics such as the Severe Acute Respiratory Syndrome (SARS) have nevertheless intensified the quest for new health-financing options and increased demand for private health insurance.

Importance of Private Health Insurance in East Asia and the Pacific. Private health insurance clearly plays a secondary role in health care financing in East Asia and the Pacific. In 2002, spending on private prepaid programs was recorded for seven countries but surpassed 5 percent of total health expenditure in only one—the Philippines (table 11). Given the region's high rate of out-of-pocket spending, PHI could nevertheless become an important source of future health care financing if resources

Table 11 Relative Importance of Private Health Insurance (PHI) in East Asia and the Pacific

Country	Importance of PHI	Country	Importance of PHI
China	0.3	Philippines	10.9
Indonesia	3.3	Thailand	4.3
Malaysia	3.3	Vietnam	3.0
Papua New Guinea	1.1		

Source: Authors' calculations based on World Health Organization (2005).
Note: This table reflects PHI expenditure as a percentage of total health expenditure (THE) in 2002, not including countries without PHI or for which data were not available.

for direct payments can be channeled to prepaid schemes. Furthermore, high levels of household savings might help to underpin the growth of the insurance market (Swiss Reinsurance Company 2004c: 7).

Characteristics of Private Health Insurance in East Asia and the Pacific. With the exception of Thailand, where the government-sponsored Health Card Program has already attracted 28.2 percent of the Thai population (WHO 2004: 179), PHI schemes only cater to niche markets in East Asia and the Pacific. The schemes run the gamut of arrangements from private, for-profit HMOs to nonprofit, community-based health insurance programs (WHO 2004). Depending on the efficiency and outreach of mandatory social schemes, private programs offer both comprehensive and supplementary coverage. In some countries (e.g., China and Vietnam), rural areas, which are often insufficiently serviced by public insurance, have witnessed the emergence of community-based health insurance schemes similar to those found in Sub-Saharan Africa. Urban areas are typically served by private for-profit schemes that provide additional coverage to high-income individuals.

Prospects of Private Health Insurance Development in East Asia and the Pacific. Private health insurance has already begun to realize some of its growth potential in East Asia and the Pacific (figure 8). As a response to increasing health costs that overburdened existing social security systems, many countries are developing private risk-sharing programs. Thailand's Health Card Program offers an illustrative example of how such government initiatives can be supported by subsidized premiums and an exten-

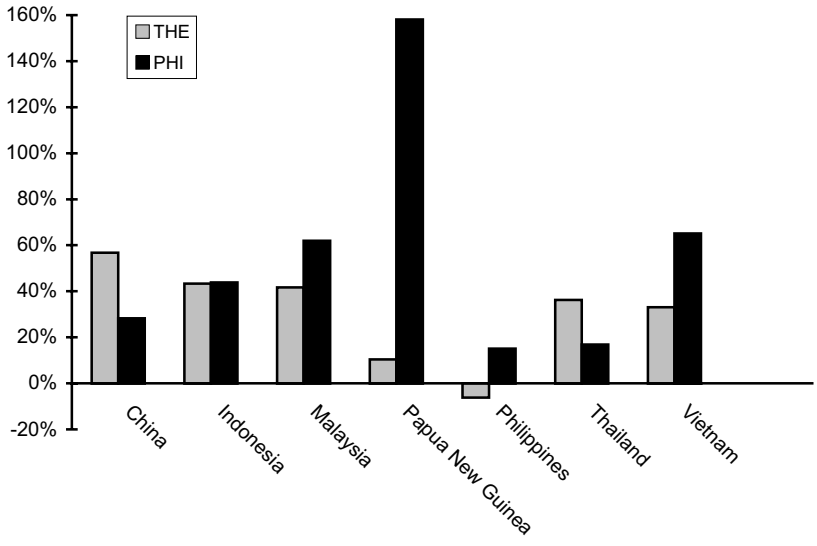

Figure 8 Total Health Expenditure (THE) and Private Health Insurance (PHI) Spending in East Asia and the Pacific

Source: Authors' calculations based on World Health Organization (2005)

Note: Data reflect percentage change between 1998 and 2002.

sive publicity campaign. Similarly, Vietnam has begun to investigate new policy tools to finance health care, including user fees, health insurance, and health care funds. Adams (2005) argues that the scope for PHI provision in Vietnam is increasing. In Indonesia, where social insurance does not cover large segments of the population, the government is considering various forms of private health insurance, including managed care and community schemes. However, the contribution of PHI to universal coverage is still limited, as the number of people insured and services covered remain small (WHO 2004).

Following regulatory reforms in 1998 (urban areas) and 2002 (rural areas), China is expected to become a dynamic market for insurance providers (Swiss Reinsurance Company 2004c). The Chinese health care system is being restructured in the wake of significant decreases in coverage rates of social insurance in the 1980s and 1990s, by the end of which 64

percent of the rural population and 15 percent of the urban population had no health or accident insurance (Swiss Reinsurance Company 1998: 21). Health care costs increased tremendously after implementation of 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). At the same time, the government is decreasing its provision of medical insurance to make room for an increased private provision (Swiss Reinsurance Company 2003: 24).

In the process of developing a market for private health insurance, East Asian countries face a trade-off between promoting a new industry with supportive policies and ensuring ample regulation and consumer protection. Sekhri, Savedoff, and Tripathi (2004: 4) note that measures to increase competition among insurers may encourage innovation, efficiency, and responsiveness of private schemes but 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."

Private Health Insurance in South Asia

Of the regions analyzed here, South Asia represents the smallest and least significant health insurance market (table 12). Although the region is home to 22.7 percent of the world's population and contributes 2.1 percent of the world's GDP, its share of the world's total insurance premium income was a mere 0.6 percent in 2003 (Swiss Reinsurance Company 2004b).

Importance of Private Health Insurance in South Asia. World Health Organization data indicate spending on private health insurance in only three of the region's countries: Bangladesh, India, and Sri Lanka (table 13). Even in these countries, per capita PHI spending is negligible (between $0.01 and $0.17 in 2002).[5] Other countries had no PHI spending at the time the data were collected in 2002, or the spending was not recorded in national statistics.

5. Coverage rates can nevertheless be quite elevated, as is indicated by the Grameen Bank health insurance program in Bangladesh. The WHO (2004) reports that around 140,000 people are covered under this scheme, which was initiated in order to reduce defaults of the bank's microcredit loan program (Desmet, Chowdhury, and Islam 1999).

Table 12 Health Care Financing in South Asia

	Total Health Expenditure (THE) in USD (per capita)	Private Expenditure on Health in USD (per capita)	Out-of-Pocket Expenditure on Health as a Percentage of THE (per capita)	Spending on Private Prepaid Plans as a Percentage of THE (per capita)
South Asia (SA)	30.50	11.21	48.8	0.2
Organisation for Economic Co-operation and Development (OECD)	1,937.43	536.95	19.9	5.3

Source: Authors' calculations based on World Health Organization (2005). Values are averages for the region.

Note: OECD data (the average of all thirty OECD countries) are used to illustrate the relative importance of private health insurance (PHI) in SA.

Table 13 Relative Importance of Private Health Insurance (PHI) in South Asia

Country	Importance of PHI	Country	Importance of PHI
Bangladesh	0.1	Sri Lanka	0.5
India	0.6		

Source: Authors' calculations based on World Health Organization (2005).

Note: This table reflects PHI expenditure as a percentage of total health expenditure (THE) in 2002, not including countries without PHI or for which data were not available.

The insurance industry in South Asia was largely marginalized during a period of nationalization in the twentieth century. It has now begun to regain some of its vitality as countries reopen their markets for private insurance companies. However, "poverty, lack of awareness and perhaps strong belief in fatalism" (Pereira 2005) still prevent development of private insurance markets. India, with a relatively developed economy and a strong middle-class population (roughly 300 million people), offers the most promising environment for PHI development. Not surprisingly, India already has the largest market for private health insurance in South Asia. Private health insurance schemes cover 33 million people or 3.3 percent of the Indian population (Sekhri and Savedoff 2005: 130).

Characteristics of Private Health Insurance in South Asia. Among South Asian countries, India is an interesting example to use to study private health insurance for a number of reasons. India not only dominates the region in terms of population size and economic potential, it also offers a wide selection of various health-financing options, including innovative forms of private health insurance. In fact, the country is clearly moving away from a state-financed health care system; public expenditure on health as a percentage of GDP decreased from 1.3 percent in 1990 to 0.9 percent in 2004. This process involved exploration of different forms of health insurance, including private for-profit, community- and employer-based schemes as well as mandatory public insurance. After passage of the Insurance Regulatory Development Authority Bill in 1999, foreign and domestic providers' entry into the market further sparked PHI development.

Public insurance schemes have only recently started to emerge and serve a small segment of the Indian population. Consequently, the market leaves considerable room for alternative programs, including PHI, to evolve. Private schemes already cater to various health insurance needs, regions, and income groups. Large for-profit insurance companies and employer-based schemes primarily cover upper-middle- and high-income groups in urban centers and people working in the formal sector. Community-based schemes and insurance offered by NGOs, on the other hand, typically target poorer populations living in rural areas. As in Sub-Saharan Africa, these schemes reach the population by adapting the services they offer and the premiums they charge to the economic capacities of the local population. In the long run, such programs could become an important foundation on which to construct more comprehensive health insurance. Even some of the larger insurance companies target poor population groups (e.g., Jan Arogya Bima insured approximately 7.2 million in 2001). However, such schemes generally employ risk-rated (e.g., age-based) premiums and preexisting disease clauses that allow exclusion of high-risk individuals (WHO 2004).

Prospects of Private Health Insurance Development in South Asia. With the exception of India, it is unlikely that private health insurance will play an important role in South Asian health systems in the near future. Without further reforms and political determination to establish a sizeable PHI market — and in the absence of economic development and a considerable reduction of poverty — private health insurance will remain a niche product for a relatively few privileged individuals. As in Sub-

Saharan Africa, small community-based schemes and insurance offered through NGOs and other nonprofit organizations will have the greatest development potential.

Due to the lack of time-series data for South Asian countries, no patterns for PHI spending can be derived. Although such spending increased in Bangladesh, India, and Sri Lanka between 1998 and 2002, it did so at less than $1 per capita, making inferences difficult to draw.

Regional Challenges to Integrate Private Health Insurance into a National Health System

The previous discussion revealed important differences in the development of PHI around the world. In the following section, we identify regional clusters that share similar characteristics and policy challenges for an effective integration of private insurance into a country's health care system. These patterns are based on (1) the role PHI has played in the past, (2) the problems that these regions have experienced in implementing private health insurance schemes, and (3) the expected importance of PHI to these regions in the near future. Our cluster approach clearly leads away from any general assessment of the pros and cons of PHI for developing countries. Rather, it helps us to distill the underlying determinants that can guide policy makers to decide if and how PHI should be integrated into the overall health strategy of a country. We propose and subsequently discuss the following three regional clusters:

- Countries in which PHI grew significantly after liberalization of markets; these countries need to better integrate private health insurance into the health system (Latin America and the Caribbean [LAC]) or establish alternative insurance mechanisms (Eastern Europe and Central Asia [ECA])
- Countries in which the socioeconomic environment will likely foster nascent PHI development (East Asia and the Pacific [EAP]; the Middle East and North Africa [MENA])
- Countries in which PHI will probably remain a niche product in the foreseeable future but in which innovative approaches may induce development of private health insurance mechanisms (Sub-Saharan Africa [SSA] and South Asia [SA])

Reducing Market and Policy Failures: Latin America and the Caribbean, Eastern Europe and Central Asia

The track record of private health insurance in most of LAC and ECA is disappointing. Many countries have realized that extending the market to private insurance does not cure every problem of the health care system: health care costs have not decreased, quality of care mostly has not improved, and the percentage of the population that is covered has not increased. Also, many countries have experienced deteriorations in the health sector, especially as regards equitable access to financial protection, while most problems have originated from a regulatory framework insufficient to effectively integrate PHI into the existing structures.

Chile, where private ISAPRE schemes first entered the market in 1981, only gradually responded to regulatory demands and established a supervising agency ten years after the initial reforms. Similar delays could be observed in Argentina, Colombia, and Brazil. In the latter case, "regulation of the private insurance market was virtually nonexistent until 1998" (Jack 2000: 26). Not surprisingly, such a situation negatively reflected not only on the efficiency of the system but also on the reputation of PHI.

In ECA, countries have learned that implementation of PHI goes beyond opening markets for private providers. Many governments have failed to provide proper risk-sharing and risk-adjustment mechanisms, undertake strategic planning, and communicate the pros and cons of private insurance to the public. Insufficient policy coordination has left the health sector highly fragmented. The radical move toward market structures has confused the population about the need and ways to obtain PHI for treatments not otherwise covered.

Although ECA and LAC have had similar experiences with the introduction of PHI, their responses have differed significantly. While most Latin American countries are determined to maintain PHI, countries in ECA are predominantly shifting back to other forms of health financing — most notably, social health insurance. The challenge in LAC will be to improve the integration of PHI into the health care system, which will not be an easy task given the early shortcomings that have weakened trust in private insurance. The challenge in ECA will be to explore alternative solutions to organize health care spending and to use experience with private insurance to structure other forms of health financing.

Controlled Growth through Efficient Regulation: East Asia and the Pacific, the Middle East and North Africa

Private health insurance can be expected to grow in EAP and MENA, largely because of the importance of private spending on health and recent economic development. Both regions are in a good position to influence the future growth of PHI, although private health insurance has already become an important industry in some countries, especially in MENA. If countries understand the lesson from the experiences of ECA and LAC, they will modify regulatory frameworks to allow effective integration of private health insurance into existing structures. China, Indonesia, Saudi Arabia, and other countries view the establishment of private health insurance as a way to release pressure from overburdened health-financing systems. These countries must find a balance between promoting a new industry with supportive policies and ensuring ample regulation and consumer protection.

Strategies to develop PHI markets vary significantly between the two regions. Whereas the state has traditionally had an active role in providing social insurance in East Asia, countries in MENA have relied on public health care (e.g., Yemen, Saudi Arabia) or had no health insurance mechanisms (e.g., Morocco). In this respect, development of a functioning PHI system will probably be less challenging in East Asia, because governments can rely on existing know-how in dealing with insurance systems.

As illustrated by Thailand's Health Card Program, governments are already taking an active stance in promoting the development of a private insurance system. Similar projects could also succeed in other countries of the region while close cooperation between the public and the private sector (e.g., public-private partnerships) might prove particularly beneficial.

In MENA, PHI has sometimes developed in an institutional vacuum. Lack of policy harmonization, low institutional accountability, and insufficient coordination between respective ministries have obstructed public oversight, which may explain some of the problems experienced with private health insurance. Making up for these shortcomings should nevertheless be possible in this region, given the early stage of PHI development.

Small-Scale Programs a Start for the Better: Sub-Saharan Africa and South Asia

In many SSA and SA countries, private health insurance is the only available form of risk pooling. Despite various efforts to build up functioning health systems over the past decades, most people still have to pay their health care out-of-pocket. India, where roughly 80 percent of total health expenditure is directly borne by patients, can be cited as a prominent example. Although schemes generally only cover selected health risks, private health insurance implies an important improvement to the status quo of having no protection at all.

Experiences show that private insurance can be well suited for low-income groups when the respective schemes are adjusted to local conditions. In Ghana, for example, the poor were persuaded by information campaigns to only purchase relatively cheap premiums covering in-patient health care (Okello and Feeley 2004). Hospital services are rarely needed, yet pose a severe risk of impoverishment when they occur. In other circumstances, coverage of high-cost, low-frequency events may not be the best option as conditions demand large-scale preventive care (e.g., immunization and vaccination campaigns). In order to better harmonize accumulated reserves with community-specific risk and benefit priorities, Dror and Jacquier (1999) propose microinsurance programs. Such programs can have various forms, including schemes operated by NGOs, communities, voluntary associations, hospitals, firms, or even private financial institutions (as demonstrated by the Grameen Bank in Bangladesh).

The role of NGOs in administering private nonprofit health insurance is manifold, occasionally making them a "leading force in health insurance provision for the informal sector" (German Agency for Technical Cooperation [Gesellschaft für Technische Zusammenarbeit, or GTZ] 2003: 29). Nongovernmental organizations can facilitate the functioning of schemes or manage insurance programs entirely. Small insurance schemes are 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 chronic poor into their coverage (Jütting 2004; Criel, Van der Stuyft, and Van Lergerghe 1999), a perception that is confirmed for the hospital-based Lacor Health Plan in Uganda (Okello and Feeley 2004).

Small-scale insurance programs need to balance the limited financial capacities with the health needs of their prospective clients. Due to their

limited coverage and risk protection, they are merely a starting point for the development of more efficient insurance mechanisms. In the long run, private health insurance schemes will have to expand their services and provide a wider range of coverage in order to become a true alternative to other forms of health financing. Private health insurance thus faces the challenge of offering an attractive product and maintaining affordable premiums. Although low-cost, low-coverage programs may facilitate the initiation of a scheme, schemes eventually need to develop beyond this stage if they want to attract larger parts of the population.

Conclusion and Outlook

Currently, private health insurance plays only a marginal role in health care systems of low- and middle-income countries, but it is gradually gaining importance. This review argues that any categorical discussion of the pros and cons of private insurance for developing countries is an artificial and misguided debate. Based on the findings presented in this article, we believe it is imperative to identify and make use of determinants that help policy makers decide if PHI should play a role in the overall health care financing strategy of a country, and if so, to what degree. Factors that may be considered include (1) a country's economic development, (2) its institutional capacity to set up an efficient regulatory system, (3) the degree to which a society is willing to accept inequality of health care coverage, (4) the predominant types of illness in the country, and (5) the past performance of existing insurance mechanisms.

Future research should explore these issues in more detail — ideally on a case-by-case basis. This approach would also increase available data, which, to date, are very limited and only allow an incomplete assessment of the role of PHI in developing countries. Private health insurance is certainly not the only alternative or the ultimate solution to address alarming health care challenges in the developing world. However, 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 will be applied to the best of its potential to serve the needs of a country's health care system.

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