

WHOdoc

3el. lea. u. l. e. r. e. a. n
Insurance, Health
social security

2944



WORLD HEALTH ORGANIZATION

SHS/TLH/86.2

ORGANISATION MONDIALE DE LA SANTE

ORIGINAL: ENGLISH

HEALTH SYSTEM FINANCING BY SOCIAL SECURITY

Milton I. Roemer, M.D.
Emeritus Professor of Public Health
University of California, Los Angeles, CA, USA
Consultant



CONTENTS

	<u>Page</u>
Historical Background	1
Health Insurance Extension to Developing Countries	2
Patterns of Health Care Delivery	4
The ILO/WHO Joint Committee - 1970	6
Health Insurance Developments Since 1970	8
Appraisal of Health Systems Financing by Social Security	10
Trends	14
References	16

Historical Background

Since medieval times, groups of people have pooled their resources, in order to protect themselves against certain types of adversity, such as old age, disability and sickness. In European cities, guilds would build up funds from periodic contributions of their members, and money would be taken from the fund to help a member faced with a problem, such as serious illness. Later in the late 18th and early 19th centuries, when independent artisans were replaced by wage-earners in factories, the same insurance idea was adopted by groups of workers in a particular industry or a certain locality; the organizations were called sickness funds or mutual benefit societies.

By the late 19th century, there were thousands of small sickness funds in Europe. In order to improve his image as a "friend of workers" and to oppose the rising socialist movement, Chancellor Bismarck led the enactment in Germany of a law requiring that all workers, with wages less than a certain amount, must have the protection of a sickness fund. This was in 1883 and marks the birth of the social security movement.⁽¹⁾ The same idea was soon adopted by Austria and Hungary, then later by Great Britain (1911) and the Scandinavian countries. When France enacted similar legislations in 1928, virtually all the industrialized countries of Europe had developed programmes of social security (or social insurance) for health services and usually certain other benefits as well.

The exact population coverage and health service entitlements differed widely among countries. The original German law, for example, assured payment of the doctor on a fee basis, with no charge to the worker or dependant. The Scandinavian legislation (in reaction to the notion that some people "abused" the insurance with excessive calls on the doctor) required that the patient pay a share of the fee (about 20 per cent.). The British law changed the fee-for-service pattern, and paid general practitioners by capitation (a monthly sum for each person choosing the specified doctor). The French law required the patient to pay the doctor directly and then seek reimbursement later from the insurance fund (typically, 80 per cent. of the fee paid) later.

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted or quoted without the agreement of the World Health Organization. Authors alone are responsible for views expressed in signed articles.

Ce document ne constitue pas une publication. Il ne doit faire l'objet d'aucun compte rendu ou résumé ni d'aucune citation sans l'autorisation de l'Organisation mondiale de la Santé. Les opinions exprimées dans les articles signés n'engagent que leurs auteurs.

The trend in all countries, nevertheless, was toward broadening of both population coverage and range of services over the years. The income level, below which insurance for health care was mandatory, was gradually elevated. Still by the end of World War I, none of the European countries had evolved to the point of covering their entire population with entitlement to medical care. It took the Russian Revolution in 1919 to lead in the 1920s to a policy decision by the government of the Soviet Union to establish general health service as a right of every resident. For the first two decades of the new socialist nation, social security was extended to cover all workers and their families in the cities, but the rural population was covered by a separate system financed by general revenues. Only in 1937 were the two sub-systems unified into a "national health service", covering everyone for comprehensive health services.⁽²⁾

The first country with a market economy and without a revolution to achieve 100 per cent. population coverage for a broad range of health services was New Zealand in 1939.⁽³⁾ This is relatively a small country, largely dependent on sheep-herding and agriculture. The land holdings were in relatively small plots and a strong humanitarian tradition developed. Women were granted the right to vote, for example, in 1908 - much before other countries. After World War II, Norway and Sweden extended their coverage to 100 per cent. under social security, and Great Britain launched its National Health Services covering everyone in 1948. These extensions of coverage to the total population gradually led to financial support from general revenues and discontinuance of reliance on social security as a source of funds. It is noteworthy however, that this shift to support from conventional taxation (usually considered more "progressive") has never occurred without many years of prior experience with social insurance.

Perhaps the only feature of social security for health service that is found in all countries is the derivation of money from contributions of both workers and employers. For one form of benefit - compensation for work-connected injuries or diseases - contributions (premiums) are paid only by the employers, on the ground that such injuries should be regarded as a cost of production. ("Experience-rating" of premiums - i.e. raising them if accident rates are high and vice-versa - also encourages measures to promote workplace safety.) The employer contribution was specified in the first German legislation, and it has been incorporated in all subsequent social security laws. The exact percentages of wages or payrolls levied on employers and workers have differed over time and among countries. It is also customary to "tax" not the full wage, but up to a certain ceiling - e.g. on the first 1 000 francs per month. Sometimes there is also a contribution to the insurance fund from the government, in recognition that the insurance pays for certain services formerly financed by government - such as the care of tuberculosis or service to indigent persons making no insurance contribution.

As a short-cut in terminology, social security supporting health services has come to be called "statutory health insurance". If the insurance is not required by law, it is usually described as "voluntary health insurance". Reference to either type of insurance protection for health service may use simply "health insurance". This concerns insurance for general health services, not solely to compensate for work-connected injuries or diseases. Extension of health insurance outside of Europe and to the developing countries requires special consideration.

Health Insurance Extension to Developing Countries

The first extension of health insurance outside Europe was to Japan in 1922. Japan was already quite industrialized by then, and the initial law applied only to industrial workers and their families. Agricultural workers, the self-employed, and certain others were not covered until after World War II.

In 1944, Chile became the first developing country to adopt statutory health insurance for part of its population. A moderate amount of industrial development and mining was occurring in this Latin American country, and a political party, representing workers, had taken shape. The initial law applied only to this wage-earning population, not to their dependants, nor to agricultural workers or the self-employed. There were certain commercial workers, enrolled in voluntary health insurance schemes, not affected by the 1924 law. Perhaps 10 or 15 per cent. of the Chilean population were covered by

this first law. Chile was alone in the developing world, as a country with statutory health insurance, for a decade. But in 1930 the entire world sank into a massive economic depression, and the costs of medical care became a widespread problem.⁽⁴⁾

In 1934, Brazil set up its first "institute" for statutory health insurance, applying only to commercial workers; two years later a similar institute for industrial workers was established. In 1935 Ecuador passed a national statutory health insurance law and in 1936, Peru. In all these countries, including Chile, the patterns of delivery of health services under insurance financing was different from the European model; doctors, instead of being paid by fees for services in their private offices, were put on salary and employed in polyclinics established by the social security organization. These patterns will be discussed below.⁽⁵⁾

With the onset of World War II in Europe, several other Latin American countries joined the "social security club", providing medical care for a relatively well-employed workforce in a robust wartime economy. Venezuela adopted legislation in 1940, Costa Rica and Panama in 1941, Mexico in 1942, and Paraguay in 1943. After the war, Colombia and Guatemala started programmes in 1946, the Dominican Republic in 1949, Bolivia and El Salvador in 1949, Honduras in 1954, and Haiti in 1967. It may be noted that among the 20 sovereign Latin American countries (not counting the small Caribbean island states) at the time, only Argentina was missing from the social security camp. In that relatively prosperous country, voluntary health insurance, through hundreds of sickness funds organized around labour groups as "obras sociales", covered the majority of the workers and their families. (More will be said about Argentina later.) In the Caribbean islands, statutory health insurance was established in Bermuda in 1970, Trinidad-Tobago in 1971, and Antigua-Barbados in 1978.

After World War II (when 12 of the 20 Latin American republics had already established schemes), social security made its debut in Asia. In 1948, India established under law the Employees' State Insurance Corporation, covering employees (and dependants) in private industrial and commercial establishments with 20 or more workers and earning less than 1 000 rupees per month. In 1949 Iran enacted social security legislation, and in 1950 Turkey (straddling Asia and Europe). In 1951, under its new socialist Government the People's Republic of China established statutory health insurance for its industrial workers in factories and mines. Burma took similar action in 1954, Indonesia in 1957, and Pakistan in 1965. Asian countries encompassing social security in more recent years include Taiwan in 1968, the Philippines in 1969, Iraq in 1971, and South Korea in 1976.⁽⁶⁾

The last of the developing continents to adopt statutory health insurance programmes was Africa - first in North Africa, where Algeria took action in 1949. Other North African countries enacted social security in the following decades - Libya in 1957, Tunisia in 1960, and Egypt in 1975. Another country of the WHO Eastern Mediterranean Region (though not in North Africa) that adopted statutory health insurance was Lebanon in 1963. In sub-Saharan Africa, the first action in social security for health care was taken by Guinea in 1952, with coverage of employed persons and their dependents. In 1963, Mauritania passed a law quite similar to statutory health insurance, under its Labour Code. Senegal took health insurance action in 1975. In 1966, Kenya established an unusual statutory health insurance programme, in its limitation to higher income (not lower income) employees and its provision of financing only for hospitalization.

Other countries like some island states enacted social security for health care after World War II - Cyprus in 1956 and the Seychelles in 1979. Just off the West Coast of Africa, the islands comprising Cape Verde enacted statutory health insurance in 1976.

Altogether, the developing countries with statutory health insurance legislation, starting in Chile in 1924 and going up to 1979, are as follows:

<u>Area</u>	<u>Countries</u>	<u>Year Enacted</u>
Latin America	19	1924-1967
Caribbean	3	1970-1978
Asia	11	1948-1976
North Africa and Mediterranean	5	1949-1963
Sub-Sahara Africa	4	1952-1975
Island States	3	1956-1979
Total	45	1924-1979

Thus of the 85 countries in the world that have established social security programmes that include, among their benefits, the financing or direct provision of health services, 45 or more than half are developing countries. The patterns by which health services are delivered in these countries are, on the whole, quite different from those in the older national programmes of Western Europe.

Patterns of Health Care Delivery

When statutory health insurance was enacted in Europe, the pattern by which medical care was provided was essentially a replica of the pattern that previously prevailed in the private medical market. Thus, patients who could afford it went to private doctors, pharmacies, and local hospitals (public or private), and the insurance fund paid the bills (or the greater part of them). In most European countries, administration was by hundreds of small local sickness insurance funds, not by a single national body. Health care financing, furthermore, was typically only one of several social insurance benefits, the others being old age pensions, work-injury compensation, wage compensation during disability and for maternity leave, and sometimes compensation for unemployment.⁽⁷⁾

In the developing countries, the patterns of health care delivery are, by and large, quite different, and the administrative arrangements are also different. In the Latin American countries, where statutory health insurance in developing countries was first applied, the private medical market was not so strong. While many doctors were in private practice, they were quite happy to receive an assured salary, full-time or part-time, as against an uncertain receipt of medical fees. From the viewpoint of the insurance fund, payment of doctors, like other personnel, by salary was much more economical and less subject to abuse. From the outset, in Chile in 1924, therefore, doctors were engaged on salary - usually for two or three hours a day - and stationed in organized polyclinics. The insured workers, furthermore, were quite accustomed to obtaining medical care in clinics, especially when each facility was served by various specialists.

In the pioneer Chilean programme, ambulatory care was provided in polyclinics built and run by the social security body itself. Hospital care, however, was provided in the hospitals of "beneficencia" societies or the ministry of health, to which the social security organization made payments. This was the initial arrangement also in Brazil's programme, started in 1934, and Ecuador's which started in 1935. But when Peru enacted statutory health insurance in 1936, it found the condition of its general hospitals of all sponsorships to be extremely poor. The social security authorities argued, on behalf of the workers, that these public or charity hospitals were inadequate for people who were "paying their own way" for services; they deserved something better. The Peruvian social security programme, therefore, set out to build a much more modern and well equipped hospital exclusively for insured workers. Borrowing capital funds from its own old age pension fund, it began constructing in Lima (the national capital) a new facility, which opened its doors as the "Hospital Obrero" in 1940. Soon several other Workers' Hospitals were built throughout Peru, and a new pattern was established.

From 1940 on, every social security programme in Latin America providing medical care, except Chile, built both polyclinics (for ambulatory care) and hospitals specifically to serve its own beneficiaries. In Peru, in fact, a second social security programme for white-collar employees (rather than manual workers) was started in 1948, with still other newly constructed facilities; the hospitals were particularly attractive, even luxurious. The Mexican social security programme starting in 1942, soon developed a reputation for architecturally impressive health facilities.⁽⁸⁾

Another special feature was innovated by Peru, in launching the health insurance programme for white-collar employees in 1948. These higher-salaried people were accustomed to consulting private physicians, and many doctors were accustomed to have the employees as their private patients. In order to accommodate the wishes (and political pressures) from both sides, the programme allowed employees to have a choice of two patterns of medical care. They could use the regular and rather elegant facilities of the organized sub-system or they could consult a private doctor and/or hospital and have the fee paid by the social security programme - but with substantial co-payment (33 per cent. or more) by the patient. This dual choice arrangement was then also adopted by several other Latin American programmes.

When statutory health insurance spread to Asia and other continents after World War II, the Latin American "direct pattern" of delivering care - i.e. care provided directly by personnel and facilities of the social security organization itself - was usually emulated. There were, however, numerous variations in adaptation to local circumstances. A major difference from Latin America was that the countries of Asia and Africa were generally poorer. Largely because of this, the patterns of both health care administration and delivery were often more fully integrated with ministries of health, in the interest of achieving economies, than was customary in Latin America.

In India, for example, starting in 1948, the Employees' State Insurance Corporation (ESIC) worked closely with the Ministry of Health and its state counterparts. Thus, ESIC did not employ its own doctors and other personnel, but contracted with the state public health authorities to engage the necessary health manpower as civil servants. ESIC constructs various dispensaries and hospitals in areas with large numbers of insured persons (including dependants), but the personnel are appointed and supervised by the public health authorities. All salaries and other expenses are covered through ESIC payments to the State Ministry of Health. Also, in areas without sufficient numbers of insured persons to warrant a special facility, ESIC beneficiaries obtain services, under contract, at the regular health centres or hospitals of the Ministry.⁽⁹⁾

In several large cities of India (Calcutta, Bombay and others), where ESIC has large numbers of beneficiaries and there are hundreds of private doctors, another pattern of care is used. Following the British model, insured persons select a private general practitioner for primary care and he is paid a fixed capitation amount monthly by ESIC for each person on his "panel". If specialist and/or hospital services are required, the patient is referred to one of the ESIC hospitals or a Ministry hospital under contract with ESIC. Thus in India, both the direct and indirect patterns of health care delivery are used, and the direct pattern is integrated closely with the resources of the Ministry of Health.

In Burma, statutory health insurance was introduced in 1954 for employees of firms with 5 or more workers in industry and commerce (not their dependants). The direct pattern of delivery is used, but this is entirely through contracts with the Ministry of Health. The only resources available to insured persons are those of the Ministry. In 1949, Iran introduced statutory health insurance, completely emulating the Latin American model; a separate social security agency established and operated its own polyclinics and hospitals, exclusively for insured persons and their dependants. Some years later, those facilities were transferred to the Ministry of Health, so that currently the health services are fully integrated, although funds are still derived from contributions of employers and workers, with some input from government. In 1950, Turkey started a statutory health insurance programme for employees of industry and commerce, including dependants. The direct pattern was used for providing all services through the programme's own resources, without any links to the Ministry of Health.

In 1951, the People's Republic of China enacted a social security law, including medical care, for employees in state-operated enterprises (nearly the total population), in government agencies, in schools, and also university students. At enterprises (factories, mines, etc.) health personnel and facilities are provided by the management, and elsewhere regular public resources for health care are used, with costs met by the school or agency. Dependents are protected only to the extent of 50 per cent. of the costs. At many of the agricultural communes, there had been health care cooperatives or voluntary health insurance schemes, but their current extent is not clear.

Libya introduced statutory health insurance in 1957 for both employed persons and self-employed and their dependants. All services are provided directly at health facilities of the social security organization, which also pays all the personnel by salary. Tunisia developed a programme in 1960, similar to the Indian model - that is, with all services provided by the Ministry of Health under contract. Pakistan, starting its programme in 1962, made use of various patterns of direct delivery - some services provided in its own facilities, some in facilities of the Ministry of Health, and some in facilities established by industrial managements. Mauritania started a programme in 1963, requiring simply that enterprises develop the resources (salaried personnel and facilities) required to serve employees and their families.

In spite of the predominance in developing countries of the direct pattern of health care delivery, a number of countries outside of Latin America started social security programmes after World War II, with health care provided by the indirect pattern. This was the policy in Algeria (1949), Guinea (1952), Indonesia (1957), and Lebanon (1963). Perhaps the previous ties of all these countries to European powers - particular France and the Netherlands - influenced the pattern of medical care delivery (through private doctors and existing hospitals) that they adopted. In 1969, the Philippines enacted statutory health insurance for privately employed persons and government employees, plus dependents, so long as they earned more than 1 800 pesos per year. Although not a former European colony, the Philippines were much influenced by the United States. The highly entrepreneurial character of the Philippine economy and the strong private market in its health care system may explain its choice of the indirect pattern of health care delivery. Under statutory insurance, however, even the indirect pattern allows certain regulatory standards for individual medical practice, not feasible when payments to doctors are purely private.

There were further developing countries that introduced statutory health insurance after 1970, but this was the year in which an important joint committee meeting of the International Labour Organisation and the World Health Organization was held on this subject. It is appropriate, therefore, to pause and review the conclusions of this committee, before proceeding to consider health insurance developments since 1970 up to the present.

The ILO/WHO Joint Committee - 1970

The International Labour Organisation (ILO) had been concerned with social security programmes - including those financing medical care - since its founding in 1919. Many of the Latin American and other countries that developed social security programmes received technical advice from the ILO. In 1944, the ILO Conference adopted Medical Care Recommendation No. 69, which advocated comprehensive curative and preventive health services for all persons in a country. It called for coordinated administration, linking social insurance agencies and ministries of health.

In 1952, the ILO Convention proposed "Minimal Standards for Social Security", inclusive of provisions for medical care. In 1969, ILO took action on a "convention" (agreement) specifically for "Medical Care and Sickness Benefits", calling for wider population coverage and a broader range of health services than the 1952 statement.

The meeting of November 1970, noted above, was the first occasion at which a Joint ILO/WHO Committee was convened to discuss the issues of "Personal Health Care and Social Security".⁽¹⁰⁾ The major thrust of the meeting was to call for the closest possible coordination between social security agencies and ministries of health in the administration and delivery of health services. The report categorized countries into three types - those in which (a) the two sub-systems were completely independent (such as Mexico and Guatemala); (b) the two sub-systems were moderately coordinated (such as India or Tunisia); and (c) the two sub-systems were fully integrated (such as the United Kingdom or the USSR). The Joint Committee concluded:

"The challenge to all countries is to achieve coordination in the operation or delivery of personal health services (hospitals, health centres, etc.), even if financial support is derived from multiple sources."

The Committee considered the various ways that doctors (and other care providers) may be paid for services under social security programmes, and it concluded that:

"in the developing countries, the payment of doctors and other health personnel by direct salary is, in general, the preferred method. This is not only because of the resulting greater economies and systematic control, but also because this method may avoid giving incentives for unnecessary hospitalization and favours maximum use of ambulatory services."

The Joint Committee faced the frequent allegation that social security programmes obstruct national health planning by spending large sums of money independently from ministries of health and allocating disproportionately great resources for the benefit of insured persons (who may be a small minority of the population). In response it states:

"The introduction of a social security programme need not, and probably does not, have the effect of reducing the amount of money going to the public health authorities; at least there is no evidence that it has such an effect. Rather it tends to divert money that would otherwise go on purely private spending (or perhaps to the government, to meet other competing demands) towards social (medical care) programme development. Seen in this perspective, social security expenditures for personal health care would not replace, but rather would be additional to, public health allocations."

In order to investigate the issue of social security impacts on ministry of health financing, an empirical study was made of 12 Latin American countries in 1976. The research question was whether strong social security health programmes were associated with weak ministries of health, and vice versa. The findings were just the opposite; among the 12 countries, those with the largest social security programmes also had the strongest ministries of health. Those with small social security programmes had the weakest ministries of health. From these findings, it could be inferred that depositing contributions into a social security fund captured money that would otherwise be spent less efficiently in the private sector. It had no effect whatever on tax appropriations for the ministry of health.⁽¹¹⁾ Moreover, it might be added that the devotion of social security funds principally to health services for urban families can have the effect of freeing Ministry of Health resources for greater concentration on services to rural families.

As quoted above, the Joint ILO/WHO Committee expressed explicit preference for the delivery of health services by salaried physicians under health insurance programmes in developing countries. The implication of salaried remuneration, of course, is that the health personnel are working in an organized framework, where teamwork can achieve both economy and quality. As observed already, the great majority of developing countries adopting statutory health insurance have, in fact, implemented the "direct pattern" of health care delivery - if only for its manifest economies.

Yet, health services provided by salaried teams of personnel are not necessarily without problems. If the salaries are low, the doctors and other personnel may not be motivated to work diligently. If a clinic session is crowded, each patient may be given perfunctory care, so that the doctor is not forced to work overtime. If the salaried work is part-time, along with a private practice, the doctor may cut corners even more, to maximize his time for private practice.

The "indirect pattern" of health care delivery, using doctors and others in private practice, has the advantage of encouraging the doctor to work hard and satisfy his patient. If he develops a good reputation and attracts many patients, he earns more money. On the other hand, the payment of a fee for each medical service can generate

abuses by the doctor. He may call back the patient for excessive consultations, since each one commands a fee. He may even perform diagnostic or therapeutic procedures (including surgery) which are not medically necessary. This is not simply conjecture; studies have shown that rates of surgery, under health insurance paying fees, vary with the supply of surgeons in an area, not with the rate of surgical disease.⁽¹²⁾

Whatever pattern of health care delivery is implemented under a health insurance programme, the coordination or integration of the services with those of the ministry of health can hardly be questioned. Non-duplicated administration is bound to be more economical, but more important is the value of supervision of health services by health experts. A ministry of health is oriented to emphasizing prevention, and this viewpoint should permeate medical care given under health insurance or any other form of financing. The expenditure of health insurance funds by a ministry responsible for the health of the whole population, furthermore, is more likely to be prudent and equitable. Spending by an autonomous social security body may lead to the purchase of unnecessarily elaborate technology.

The views of the Joint ILO/WHO Committee on the value of coordinated administrations were fortunately shared by health leaders in many countries. Perhaps the Committee report itself had an influence, or perhaps the time was ripe for a change of policy. In any event, the statutory health insurance programmes developing since 1970 have evidently shown greater recognition of the value of integrated management than those originating in earlier years. Perhaps the general maturation of ministries of health has been an important factor. These more recent developments will be explored in the next section.

Health Insurance Developments Since 1970

Since 1970, several additional countries have joined the "social security club" for financing general health services, and several other countries with established health insurance programmes have made significant changes in their administration.

Since 1970, at least 15 countries have established new statutory health insurance programmes or have made major organizational changes in existent programmes. Classified according to the relationships of the health care provided with the Ministries of Health, these countries are as follows:

<u>Separate Social Security Control</u>	<u>Coordinated with Ministry of Health</u>	<u>Under Ministry of Health Control</u>
Bermuda	Antigua	Cape Verde
Senegal	Iraq	Egypt
Uruguay	Seychelles	Iceland
	Trinidad	Italy
		South Korea
		Nicaragua
		Portugal
		Spain

It may be noted that all but three of the 15 countries are developing, and these three (Italy, Portugal and Spain) have relatively modest wealth among the industrialized countries. In these three countries, the change since 1970 has been to extend health insurance coverage to the entire population, including non-contributors. More important, in 12 of the 15 countries with major health insurance developments since 1970, the delivery of health service is closely coordinated with the Ministry of Health (4 of them) or is placed fully under the control of that Ministry (8 of them).

Beyond these events, closer relationships between social security organizations and ministries of health have been established in still other countries in recent years. In Bolivia the National Social Security Fund has been placed under the control of a combined Ministry of Social Security and Public Health. Insured persons make use of facilities built originally by the Social Security Institute, as well as those built originally by the Ministry of Health. In 1979, the new combined Ministry was made responsible for

overall coordination of the resources of both previously separate programmes.⁽¹³⁾ In 1977, Colombia established a "Health Insurance Supervisory Authority" within the Ministry of Health, empowered to apply uniform national standards for medical care and coordinate all activities of both social security and ministry programmes.

Panama made a constitutional change in 1972 calling on the Ministry of Health to harmonize all health activities in the country, including those of social security. On a province-by-province basis, administration of both programmes would be under unified Ministry of Health direction. By 1978, eight of the country's nine provinces were "integrated", so that large numbers of people in these provinces receive extensive medical services without having contributed to the insurance fund. The same applies to Nicaragua, where the Sandinista Revolution in 1979 resulted in a unification of all health activities, including social security, under the Ministry of Health. Every resident is entitled to health service, the financing of which is largely by the social security fund (to which only a minority make contributions).

Brazil took major action to consolidate six separate social security funds into one national fund (INPS) in 1966. Then, after several re-organizational steps, a national medical care institute (INAMPS) was established to provide medical care or to contract with other public agencies (including the Ministry of Health) or private bodies to do so. By 1978 the services of the original social security programme, plus those subsidized in the Ministry of Health, plus those purchased from private or other public providers, were reaching more than 80 per cent. of the Brazilian population. From the viewpoint of the Ministry of Health, the social security programme was financing most of the personal health services - including those in depressed rural areas - of the Ministry.

In Chile, a major re-organization was launched in 1952, when the National Health Service (emulating the British NHS of 1948) was formed from amalgamation of the social security programme (started in 1924), the network of charitable or "beneficencia" hospitals, and the Ministry's own resources - all unified under the Ministry of Health. The country was divided into zones, headed by a ministry of health official, who was made responsible for all health care activities of the three agencies in his area. About 70 per cent. of the population (most of them being rural and not contributors to social security) were covered, and additional groups of urban employees were covered by other schemes; by 1973 almost 100 per cent. of the population had health care protection. The military coup in 1973 changed the structure of the Chilean health system again, so that higher income people could choose to have health insurance through various private schemes, but the NHS remains available to serve the poor.

In Mexico, the social security programme since 1942 gradually extended its coverage. In the late 1970s the Mexican Institute for Social Security (MISS) set out to cover more of the rural population. Rather than joining with the Ministry of Health, however, it took subsidy from the Government, called on the rural people to contribute labour for construction of health centres, and extended services to the rural areas. Most of the operating funds were actually drawn from the contributions of workers and employers in the cities. Known as COPLAMAR, the Mexican programme is applying the "primary health care" approach, by stressing busy ambulatory and preventively oriented services and providing for specialist and hospital care by referral to an IMSS facility in the nearest city.

Argentina, it will be recalled, was the one Latin American country to lack a social security programme prior to 1970, having instead hundreds of voluntary and autonomous sickness funds or "obras sociales". In 1972 a major law was passed to coordinate and promote all these schemes under a national institute (INOS), which would also set standards and supervise various technical and administrative procedures. In 1980, further steps were taken to promote efficient provision of health services. The Ministry of Health was not involved in these developments but they represent, nevertheless, a major movement toward coordinated health services. By 1980 INOS had achieved coverage of 80 per cent. of the Argentine population.

Costa Rica is a unique case of integration of health services, in which the major responsibilities were transferred from the Ministry of Health to the social security programme. In 1973, the Ministry of Health, as well as the Public Assistance Board, were

required to transfer all their health facilities (hospitals, health centres, etc.) to the Costa Rican Social Security Fund (CCSS). Population coverage by 1977 became 82 per cent., most of whom were non-contributing rural people. The Ministry of Health remained responsible for planning, standard-setting, and general health policy, but the actual delivery of services was by the CCSS. Other Latin American countries with a high population coverage after 1970 were Bolivia (26 per cent.), Venezuela (30 per cent.), Uruguay (50 per cent.), Panama (47 per cent.) and, Mexico (56 per cent.).

Outside of Latin America, the statutory health insurance programme in South Korea is the only post-1970 one supervised by a ministry of health, which contracts with private providers for care. The programme is compulsory for employees of firms with 16 or more workers and voluntary for employees in firms with 5-15 workers. Cost-sharing is rather steep, being 20 per cent. for hospitalization and 30-50 per cent. for ambulatory care. (It will be recalled that the Philippines programme, starting in 1969, also uses private providers by the indirect pattern, but its administration does not involve the Ministry of Health). All the other countries among the eight launching statutory health insurance since 1970 under Ministry of Health management, apply the direct pattern of health care delivery.

Regarding all the developing countries, starting their statutory health insurance schemes since or before 1970, a general comment is required on coverage. Except for Latin America, where eight countries have come to exceed 25 per cent. in population coverage, the proportions of national population covered are small. The programme in India, while covering about 28 million people, reaches about 4 per cent. of the country's huge population. Coverage data are difficult to find for developing countries, but a fair estimate for the statutory health insurance systems as a whole outside of Latin America would be well under 10 per cent. of the population. Nevertheless, the trend has been toward expanded coverage and wider scopes of service. In 1981 South Korea was reported to cover 15 per cent. of its people with insurance, and in 1983 the Philippines report 19 per cent. coverage. More will be said about this question in the following section.

Appraisal of Health System Financing by Social Security

This may be enough information on the background of social security for medical care and the experiences of such programmes in various countries to permit some appraisal of these strategies in developing countries. Any absolute appraisal is not easy, in so far as so much depends on the particular patterns of delivery, coverage, and administration in a country.

The most frequent negative criticism of social security that is voiced concerns equity. It is claimed that, by its restriction initially to industrial and/or commercial workers, social security (or medical care, or, indeed, other benefits) favours one population group over another. Workers have regular wages, from which contributions (really earmarked taxes) can be collected, along with equivalent or even higher contributions from employers. Since peasants or farm workers seldom have such regular wages, they are not covered and suffer a disadvantage. This effect, it is argued, aggravates the already serious handicaps of rural populations.

Secondly, it is argued that the relatively abundant funds collected from industrial wages and employer payrolls result in health care financing which is "unfairly competitive" with that available to ministries of health. The hospitals of social security institutions almost invariably have greater amenities than those under ministries of health, and social security personnel receive higher salaries. Operating mainly in cities, furthermore, social security health programmes can more easily recruit all types of personnel.

Thirdly, social security contributions are sometimes condemned as a "regressive tax", since the percentage of wages collected (e.g. 3 or 4 per cent.) is the same for low and high income employees. This contrasts with general revenues, where the percentage of taxation is typically higher for high income groups.

Fourthly, some critics are sceptical of any insurance financing of health services, on the ground that it puts no constraint on the consumer and leads to over-utilization. (This argument, of course, would apply to voluntary health cooperatives, as well as to social security.)

Fifthly, the customary independence and autonomy of social security are condemned as wasteful and duplicative. In each nation, there should be a single health system, in which all sub-divisions are coordinated. Resources should be allocated on the basis of need, not according to the source of the money.

Finally, social security in developing countries can reach, at best, only a small fraction of the population, for whom extravagant technology and other resources may be provided. The same funds could be used much more effectively for providing primary health care to rural populations.

These are the principle objections commonly voiced about use of the social security mechanism for financing medical care. In spite of them, as we have seen, some 85 countries have employed this mechanism, more than half of which are developing countries. What are the reasons for the widespread use of this strategy of "statutory health insurance" in both developed and developing countries.

* * * * *

First, it must be recognized that health service financing is, in large part, a political matter. In countries where no social revolution has caused any abrupt change in social values, there are obviously strong constraints on the expenditure of general tax revenues for health purposes. In free market societies, this has been around 4 or 5 per cent. - ranging perhaps from 2 to 10 per cent. - of the total government budget.⁽¹⁵⁾ In recent years, there has even been a tendency for this percentage to decline, particularly in African countries. (This may happen, while the overall per cent. of gross national product or GNP for health increases, due mainly to a rise in private market spending.) The demands for politically prominent purposes, such as national defence, education, or agricultural development, exert much stronger claims on national revenues than health care.

In the light of these realities, a financial source separate from and non-competitive with general revenues is highly attractive politically. This probably explains why, ever since the German legislation in 1883, social security has been so widely enacted mainly by conservative governments. (It has been said that governments establish social security "not to make a revolution but to stop one.") Thus, even when general government revenues seem tight, funds may be raised from a special tax on workers and employers.

Secondly, the very separateness of social security funds endows them with great stability over the years. These funds are legally earmarked for specific purposes, such as health care, and are not susceptible to claims for other purposes. If high requirements suddenly occur for military expenditures, or some other purpose, the health insurance fund still remains inviolate.

Thirdly, social insurance captures funds for health purposes that otherwise (a) might not be spent at all for health or, if so spent, (b) would go into the private medical sector, where the expenditure would be much less efficient or even extravagant. This may be illustrated by examples of countries shown below, in which the national GNPs are roughly similar, but one group has established statutory health insurance and the other group has not:

GNP per Capita US\$ 1981

As % of all Government Expenditures

Country without Health Insurance

Yemen Arabic Republic	(\$460)	3.9 (1978)
Nigeria	(\$870)	2.2 (1977)
Congo P.R.	(\$1 110)	4.2 (1978)

Country With Statutory Health Insurance

Senegal	(\$430)	5.2 (1981)
Honduras	(\$600)	8.0 (1979)
Guatemala	(\$1 140)	10.9 (1980)

Insofar as health insurance funds are spent directly in organized programmes (rather than to purchase private services), as is the prevailing pattern in developing countries, the health services are more likely to be efficiently provided, with greater concern for quality and a preventive orientation.

Fourthly, the allegation of inequity through social security's focus on urban families is a two-sided coin. The other side means that by special financing of health services for urban people, statutory health insurance frees the ministry of health to devote more of its resources to serving the rural population. This contention is not so easy to quantify, but common sense indicates that workers and their dependants, served by a social security polyclinic in a city, cease to be a burden on a ministry of health centre or hospital out-patient department; the funds saved can be used to strengthen rural services.

Fifthly, regardless of the short-term effects, the long-term dynamics of social security are to strengthen the nation's basic resources for health. Hospitals and polyclinics are built, which may eventually serve the entire population. Additional doctors and other personnel are trained, and they typically serve many other people beyond the insured. The great expansion of medical school output in Brazil and Mexico, for example, has been attributed squarely to the opportunities for employment provided by social security programmes in those countries. In India, South Korea, and the Philippines, social security programmes have been credited with halting the "brain drain" from those countries.

Sixthly, the argument about incoordination of a separate and autonomous health insurance programme is well taken in theory, but not necessarily in practice. As we have observed in previous pages, the trend in recent years, particularly since 1970, has been toward various forms of coordination. In fact, in many countries (such as Chile, Egypt, or South Korea), the administration of insured health services has been placed entirely under ministries of health, so that social insurance contributions serve essentially as a supplementary form of financial support to the Ministry.

Seventh, the initial neglect of rural populations by social insurance in developing countries has been shown to be subject to important changes. As social security programmes grow stronger, they have been used actually to subsidize rural people, who have made no insurance contributions. This has been done in Panama, Brazil, Costa Rica, and Mexico. Such subsidies are philosophically justified by the inherent advantages (in higher per-person productivity) of industrial employment, compared with agricultural. Moreover, in Japan it has been possible to collect insurance contributions from rural households, with supplements from the government.⁽¹⁶⁾ Similar strategies in Chinese communes have been described as "rural health cooperatives".⁽¹⁷⁾

The claim that prepayment or insurance of any type encourages excessive utilization by the consumer has, of course, been made for centuries. It calls for an eighth argument, which should hardly be necessary in the world of public health. Countless social efforts are addressed to encourage people to seek health care early in any illness, when it can be more effectively treated. If a payment (fee) must be made at the time of sickness, this

often inhibits the patient from seeking care, especially if he or she is of low income. The prepayment of costs by people when they are well, in relatively small regular installments, has everywhere promoted ready access to medical care. In order to prevent "frivolous" or unnecessary demand, many insurance programmes impose co-payment requirements on the patient, but numerous studies have shown that this only deters low income people from seeking care and has no effect on others. To the patient, a pain or anxiety is a reasonable justification for seeking help, even though the doctor finds the condition trivial and the call "unnecessary". To the patient the symptom is real. A rational response to "unjustified" utilization is the education of people about health and self-care.

Ninth, it must always be kept in mind that in the great majority of developing countries with social security programmes, the direct pattern of delivery of health service through salaried personnel in organized frameworks is used. This means that the expenditures are made for planned and efficiently provided services, rather than through the private market, where inefficient practices and even unnecessary services are quite common under the profit motive. Moreover, by mobilizing funds in a health insurance account, money is used for health services, which otherwise might be spent for other less essential purposes. In organized sub-systems, drugs, diagnostic tests, etc. can all be provided according to rational standards.

Tenth, insofar as statutory health insurance favours resources for urban industrial families in the short run, this is consistent with the natural utilization patterns in all countries. For many reasons (education, transportation, attitudes, etc.) urban people make higher demands on the health care system than rural. Health insurance programmes help to respond to those higher demands. Also national socio-economic development depends, in a large measure, on industrialization, so that economic growth is very much dependent on good health in a skilled workforce. Even in agriculture, effective production and growth are dependent on farm machinery, fertilizer, and other resources originating in the cities.

Finally, the health benefits financed by social security can be highly flexible and - as has been shown in India, Mexico and Nicaragua - can be oriented to emphasis on primary health care. The emphasis in previous years on building large urban hospitals with social security funds was understandable, when such facilities were seriously lacking. But present policies in many countries share the same philosophy as ministries of health, to assure primary health care as the top priority, with hospital back-up to the extent necessary.

Statutory health insurance has the political and social attractiveness of constituting self-help and self-reliance on a group basis. Workers and their families are not seeking benevolence from general government revenues nor from charity. They, with their employers, are taking action to help themselves. Moreover, in many programmes the workers or their representatives have a voice in policy determination, so that this constitutes a type of community participation, although different from the conventional form.

In all developing countries, statutory health insurance starts necessarily with coverage of a small proportion of the population, since regular wage-earners are typically a minority. Starting with only about 5-10 per cent. population coverage, or even less, is common. With time, as countries industrialize, or even as agriculture strengthens, the percentage of population covered increases. As we have noted, in several Latin American countries, more than 50 per cent. of the population has been reached. When social security grows this strong, its resources often permit subsidy of the rural population, even though they have made no insurance contributions.

The claim that social security is a "regressive" form of taxation is more rhetoric than reality. A 2.0 percent tax, for example, on a 300 peso wage, means half of the same percentage tax on a 600-peso wage. Many developing countries levy general income taxes with no greater progressivity than that. Moreover, in the 85 countries with statutory health insurance, and an additional 55 countries with other (non-health) forms of social security, the various spokesmen of labour (Labour Parties, Social Democratic Parties, etc.) have everywhere been willing and eager to trade this conservative form of "taxation" for the clear and stable benefits resulting from the contributions paid.

Trends

We have considered the historic background of social security financing of health care, observed its introduction and growth in developing countries, analyzed the various patterns of health care delivery in different types of country, reviewed the findings of the ILO/WHO Joint Committee on the subject in 1970, noted the extensive growth of the statutory health insurance concept in developing countries since 1970, and then have attempted to make an appraisal of the defects and the advantages of the entire movement in the developing world.

What is now happening in the social security movement which relates to the WHO goal of achieving Health for All by the Year 2000? In recent years, WHO has become more sharply conscious of the basic importance of financing, if this goal is to be achieved in countries. A report, prepared for submission to the January 1986 Executive Board, outlines nine possible options for increased financing of health services. These are as follows:(18)

1. Attract more tax revenue possibly from earmarked taxes;
2. Attract more external cooperation;
3. Introduce or extend compulsory health insurance;
4. Require employers to provide defined services;
5. Introduce or raise charges for government services;
6. Encourage money-raising by non-governmental organizations;
7. Stimulate community financing and voluntary health insurance;
8. Find savings from more efficient use of resources;
9. Reorient priorities or select less costly methods of delivering services.

The third of these options, "compulsory health insurance" is, of course, synonymous with "statutory health insurance". (The adjective "compulsory" has been used principally in a pejorative and negative sense). There is no doubt that world trends in the health insurance option have been positive. The numbers and percentages of populations covered have been increasing everywhere, although the greatest rate of growth has been in Latin America. The resources for primary care, specialist care, hospital back-up, and rehabilitation have also been increasing.

Several countries, not examined above, have been actively discussing the introduction of statutory health insurance. This applies in Thailand, Malaysia, Liberia, and Sri Lanka. The success of so many developing countries with social security programmes are suggesting lessons to others.

Compared with the trends in social security financing, one must regretfully report that progress in the other eight options has not been impressive. Attraction of more tax revenues to health programmes has not been noticeable. The trends of percentages of national budgets allocated to health during the 1980s and even the 1970s have more often than downward than upward. Work by de Ferranti from the World Bank shows that from 1973 to 1980, the percentage of national public budgets going to health in developing countries declined in 25 countries, rose in 14, and fluctuated unevenly in the rest. The declines were most numerous in the lowest income countries.(19)

Regarding external cooperation, the prospects of aid for health are equally discouraging, especially in the light of the world-wide problem of foreign debts.

All six other strategies probably have greater psychological and political than economic value. The amounts of money collected from user charges in developing countries has always been small, not to mention the political objections to such charges. (If low income people are exempted from such charges, the collections are even less). Money-raising by non-governmental organizations has always been slight in developing countries; more often those agencies are receiving subsidies from governments.

Community financing schemes and voluntary health insurance perhaps have greater potential, but many of these schemes come to an end after a few years. Their greatest hope is evolution into compulsory schemes, which are equivalent to social security. The administrative leadership necessary to keep voluntary schemes alive must be very strong.

Savings from more efficient use of resources or selection of less costly patterns of delivery should always be pursued. In general, however, savings from more efficient use of hospitals, for example, are spent on more generous support of preventive services or primary health care. In the end, the savings increase needed services, but seldom reduce budgets.

If the above assessments are correct, adoption of statutory health insurance stands out as the most practical strategy for increasing expenditures in health systems - especially expenditures on organized patterns of delivering health care. If objective trends may be regarded as confirmation of this judgement, the facts are encouraging. Among the 45 developing countries with statutory health insurance, where coverage data are available, the trends have everywhere been upward. More people are being covered both absolutely and as a percentage of the total population. Where fiscal problems have been faced, as in South Korea, they have been met not by reducing coverage but by increasing patient co-payments.

In past years, social security programmes were criticized for spending their abundant funds on elaborate medical technology. (In this respect they were not different from many ministries of health). In recent years, however, the thrust of social security for health service in developing countries has been toward emphasis on primary health care and, in this way, to increase outreach to rural populations. The International Labour Organization has been actively promoting this policy.⁽²⁰⁾ One may hope that WHO will correspondingly recognize the great potential of statutory health insurance for extension of primary health care.

References

1. Sigerist, H.E., "From Bismarck to Beveridge: Development and Trends in Social Security Legislation". Bulletin of the History of Medicine, 8: 365-388, 1943.
2. Field, Mark G., Soviet Socialized Medicine: An Introduction. New York: Free Press, 1967.
3. Robb, Douglas, Health Services of New Zealand, 1943.
4. Mesa Lago, Carmelo, Social Security in Latin America. Pittsburgh: University of Pittsburgh Press, 1978.
5. Roemer, Milton I., "The Evolution of Medical Care under Social Security in Latin America". International Labour Review, (ILO), July 1973
6. U.S. Department of Health and Human Services, Social Security Programs Throughout the World - 1983. Washington: Social Security Administration Research Report No. 59, 1984.
7. Sand, René, The Advance to Social Medicine. London: Staples Press, 1952.
8. Roemer, Milton I., Medical Care in Latin America. Washington: Organization of American States (Studies and Monographs III), 1963.
9. Roemer, Milton I., The Organization of Medical Care under Social Security. Geneva: International Labour Office (Studies and Reports New Series No. 73), 1969.
10. World Health Organization, Personal Health Care and Social Security: Report of a Joint ILO/WHO Committee, Geneva: WHO (Technical Report Series No. 480), 1971.
11. Roemer, Milton I. and N. Maeda, "Does Social Security Support for Medical Care Weaken Public Health Programmes?" International Journal of Health Services, 6: 69-78, 1976.
12. Lewis, C.E., "Variations in the Incidence of Surgery." New England Journal of Medicine, 291: 880-884, 1969.
13. Tamburi, G., Social Security in Latin America: Trends and Outlook. July 1983 (unpublished paper presented at the University of Pittsburgh, Pa, USA).
14. Zschock, D.K., Medical Care Under Social Insurance in Latin America. New York State University at Stonybrook, 1983 (unpublished document).
15. de Ferranti, David, "Strategies for Paying for Health Services in Developing Countries". World Health Statistics Quarterly, 37 (4): 428-450, 1984.
16. Higuchi, T. "Medical Care through Social Insurance in the Japanese Rural Sector". International Labour Review, 109: 251-274, 1974.
17. Wen, C.P. and Hays, C.W., "Health Care Financing in China". Medical Care, 14 (3): 241-254, 1976.
18. World Health Organization, Financing Health for All: Economic Strategies to Support the Strategy for Health for All. (unpublished document prepared for Executive Board, Seventy-seventh Session), Geneva, 1985.
19. de Ferranti, David, "Strategies for Paying for Health Services in Developing Countries". World Health Statistics Quarterly, 37 (4): 432, 1984.
20. Oficina Internacional del Trabajo, La Estrategia de la Atención Primaria de Salud en la Seguridad Social de America Latina: Avances y Perspectivas. Ginebra: ILO (unpublished document), mayo de 1985.