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INTERREGIONAL CONSULTATION

ON

HEALTH INSURANCE REFORM

Seoul, Republic of Korea

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WORLD HEALTH ORGANIZATION

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NATIONAL HEALTH SYSTEMS AND POLICIES UNIT
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LIST OF CONTENTS

1. INTRODUCTION 1

2. EQUITY 2

3. EFFICIENCY 3

4. QUALITY ASSURANCE AND PATIENT SATISFACTION 5

5. IMPLICATIONS FOR THE DEVELOPMENT OF SOCIAL HEALTH INSURANCE 7

6. CONCLUSIONS AND RECOMMENDATIONS 10

ACKNOWLEDGMENTS 12

ANNEX 1 13

ANNEX 2 19

ANNEX 3 24

ANNEX 4 28

ANNEX 5 31

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1. INTRODUCTION

The focus of the meeting was on social or national health insurance systems, in which payments are not related to the individuals' risk of illness. Issues discussed ranged from contributions of equity and solidarity through risk-pooling, to enhancing efficiency, quality and satisfaction, both of patients and providers.

This report comprises six Sections and five Annexes. Section 1 is the introduction. Sections 2 to 4 summarize discussions of countries' experience of equity, efficiency and quality in relation to social health insurance, with special emphasis on recent reforms. Section 5 draws some lessons from those countries' experience. Section 6 makes recommendations for countries, and for WHO. Annexes 1 to 3 summarize the existing situation in each of the participating countries' social health insurance schemes, covering equity, efficiency and service quality issues respectively. Annexes 4 and 5 contain the programme of work and list of participants.

In his opening remarks Dr S.T. Han, Regional Director of WHO for the Western Pacific, observed that health insurance is a major topic in health reform in all parts of the world. Some countries are planning to introduce insurance for the first time, others are working to expand existing schemes, and yet others are struggling to contain the costs or improve the performance of long established national programmes. WHO's concern is to ensure that the design and assessment of reforms in general, and insurance in particular, is in terms of health objectives. Equitable access to care of adequate quality, affordability, sustainability and acceptability remain unrealized goals in many countries. Some of the countries participating in the meeting, such as Germany, Japan and Costa Rica already have "mature" health insurance systems covering the whole population with a comprehensive range of services. Others have more recently established universal systems (Republic of Korea, Czech Republic). In Thailand, Indonesia, Morocco, Viet Nam and Egypt, insurance mechanisms range from protection of a small fraction to the majority of the population. South Africa and Ghana are currently considering the introduction of social insurance mechanisms. Policy priorities differ according to each country's circumstances, but the meeting was expected to clarify the conditions which enable or retard health insurance systems in reaching the nation's health objectives.

His Excellency, Dr Sang Mok Suh, Minister of Health and Welfare, Republic of Korea, welcomed participants and confirmed that health insurance can play an important role in the achievement of Health For All. He affirmed the usefulness of international sharing of experience to facilitate the reform of health care. The Republic of Korea achieved universal health insurance coverage in 1989, only twelve years after the initiation of social insurance in 1977. The recommendations of a 1994 Health Care Reform Committee are presently being implemented.

2. EQUITY

The equity impacts of health insurance reforms are of two types: equity in financing and equity in the provision of services. The equity issues in financing are related to the level of coverage achieved, to the manner in which that level of coverage has been achieved, and the benefit package and contribution structure chosen. The equity impacts from the standpoint of service provision are related mainly to the historical distribution of health services across regions, between urban and rural areas, and between public and private sectors.

In countries with less than universal coverage, such as Indonesia, Thailand, Viet Nam, Morocco and Egypt, participants observed that those that are insured are those who tend to be better-off economically than those who are not covered. The insured include typically the civil servants and employees in private or state enterprises. Usually excluded in the early phases of health insurance development are the farmers and other self-employed in the rural areas, whose incomes are likely to be lower on average, although in the case of Thailand and Indonesia, coverage of these groups had expanded through community-based schemes.

Among those who are covered by insurance, a further source of inequity in financing is the mix of sources of revenue, with contributions from members, employers and government. In China, three different insurance schemes have different levels of government contribution. The scheme for civil servants and non-enterprise sector staff is funded totally by the government (and is therefore an employment fringe benefit), the schemes for workers in urban state and collective enterprises are funded totally from enterprise welfare funds which vary with the financial capability of the enterprises, and the schemes for rural areas are mostly funded from the contributions of the insured and local government. A similar situation exists in Indonesia with respect to health insurance for civil servants, and in Thailand where government subsidies and contributions vary by groups of the insured, with poorer groups receiving lower subsidies than the better-off groups, e.g., civil servants. For the latter health care is a fringe benefit of employment, and is not covered by an insurance mechanism.

Several participating countries have achieved universal coverage. These include Germany, Japan, Czech Republic, Republic of Korea and Costa Rica. In Germany, Japan and the Republic of Korea, near- universal coverage was achieved through the formation of many independent insurance or sickness funds or insurance societies. In Germany there are more than 1,000 autonomous sickness funds; in Japan there are some 5,300 insurance societies, and in the Republic of Korea there are some 379 insurance societies. Each scheme has different benefit packages and contribution structures. Some groups of the population are better off in terms of benefits when they belong to financially stable insurance funds (e.g., workers funds) but others are worse off when they belong to insurance funds with a large proportion of the aged, or certain regional insurance schemes in the case of Japan. A similar case but involving different groups is found in the Republic of Korea. Inequities further arise when government subsidizes certain insurance funds. In the case of the Republic of Korea, it was noted that the government subsidizes health insurance societies for the self-employed by approximately 50% of their funds, yet the self-employed groups include high income persons such as medical

doctors and lawyers. Current reforms include changing the subsidy from a flat rate to differentiated rates to reduce the financial imbalance without compromising equity.

In addition to different contribution structures among different insurance schemes, equity impacts arise from the level of contributions, as observed in the Republic of Korea and Morocco. In the Republic of Korea, the low contribution rates have led to high co-payment rates and a limited benefit package, which in turn leads to the limited access of low income groups.

Equity is also an issue in Thailand where the relatively wealthy pay relatively less due to a contribution ceiling which is accepted as being too low. In the Netherlands there is a progressive contribution rate with an income ceiling above which workers have to purchase private insurance.

Even in universal coverage systems with comprehensive care, the interplay of free services, inadequate referral systems and perceptions of low quality in primary care facilities - quite correct at times - sometimes lead to long waiting times for access to care. As observed in Costa Rica, long waiting time has the perverse effect that the rich can quickly obtain care from the private sector, but the poor cannot. In recognition of this, Costa Rica expanded its network of health services to strengthen comprehensive primary health care. This has helped reduce overcrowding in central facilities. The health insurance system in Costa Rica has a direct delivery system, having taken over responsibility for running the hospitals and clinics from the Government.

An issue common to several countries is how to identify the poor, for the purposes of contribution subsidies or exemption. The difficulty of establishing clear criteria which could be applied effectively and accurately was recognized by participants. The system adopted in Indonesia, which uses several criteria in assessing poverty, involving village-level organizations, was noted.

With respect to the second type of inequity, that arising from the provision of services, many countries observed that such unequal access to quality services stems principally from the historical maldistribution of health facilities and manpower between urban and rural areas and among regions. Even in countries which have significantly expanded their health infrastructures, such maldistribution in terms of urban and regional biases still remain. Other countries, however, such as Germany, Japan, and the Czech Republic do not consider such access problems a major issue in their systems because they claim that the quality of medical staff and services are not much different between urban and rural areas .

3. EFFICIENCY

Participants found that this varies, in a predictable pattern, according to the way in which providers, and particularly doctors, are paid.

The most cost-effective model appeared to be the system used in Thailand for the compulsory insurance scheme for private sector employees. Under this scheme,

hospitals receive capitation payments for each insured person and arrange contracts with primary care clinics or for more specialized services with tertiary hospitals. Virtually by definition, costs are kept firmly under control and providers have clear incentives to be economical in the use of resources. While there appears to be some under-utilization, utilisation of ambulatory care has increased where the contracting hospital has contracted a considerable number of primary care clinics.

This was contrasted with the scheme in the same country for civil servants, where providers are paid on a fee-for-service basis. Under this scheme, costs are high and constantly increasing and providers over-charge. They are responding, as elsewhere, to the clear opportunity to raise their incomes. In all participating countries, fee-for-service payment had similar results. The only partial exception seemed to be Germany, where costs were kept under control by a fixed budget for payments to doctors on a provincial basis. Extra services provided by doctors leads, on a quarterly basis, to a proportionate reduction in the level of fees. But the underlying pressure to provide more services is still evident. Excessive services are not limited to what the doctor does for patients but what he/she authorizes for them - drugs, diagnostic tests and referrals for hospitalization. In South Africa, the voluntary (Medical Aid) insurers, complain of excessive prescription of brand-named drugs and over-use of expensive equipment. There is the same complaint in the insurance scheme in Viet Nam. It is also the case in the universal schemes in the Czech Republic, Japan and the Republic of Korea.

Further discussion revealed that the form that excessive services takes depends on the relative values within the fee-for-service payment system. Where the payment for the consultation is low and the payment for diagnostic tests, which take up little of the doctor's time relatively high, excess services are concentrated in that direction. This is because payment for the use of expensive equipment is often established at a high level to enable the provider to recover the capital cost. But as the cost of using it is low, such equipment inevitably gets over used. This is particularly the case in China. It seems virtually impossible to prevent some perverse incentives arising from a fee-for-service payment system.

The response of most insurers is to introduce co-payment in the attempt to contain patients' demands. This is about to be done for adults in the Czech Republic, where co-payments will pay for 13 per cent of the cost of the whole scheme. Co-payment is 20 per cent in South Africa, 30 per cent of drug costs for the 15 million students recently given access to the Egyptian insurance services, and as high as 55 per cent in the outpatient departments of teaching hospitals of the Republic of Korea. The introduction of co-payment is also being considered in Viet Nam. High co-payments inevitably have adverse effects on equity.

Participants found that some fee-for-service payment systems are prone to various forms of fraud. This was the case in the Czech Republic and South Africa. Fraud can take the form of claims for services which are not given; or two claims for the same service. It can also take the form of doctors deliberately writing expensive prescriptions for drugs, so that the patient can take them to the pharmacist and exchange them for cosmetics. This behaviour pattern on the part of the insured tends to be concentrated at

the end of the contribution year in South Africa, as healthy members seek to get some return for the money they have paid in contributions. Participants reported that it was difficult to introduce an effective referral system when doctors are paid on a fee-for-service basis. When there is no referral, patients tend to use the tertiary hospitals, even for minor ailments, as in the Republic of Korea. When groups of doctors own private hospitals, as in South Africa, there is an obvious tendency to refer patients to them and, on arrival, for the hospitals to treat them as inpatients.

A further effect on efficiency which was noted was to involve both providers and insurers in high administrative costs. This was particularly the case where there is a large number of health insurers, some of them relatively small, as in the Republic of Korea. All these extra costs may, of course, raise the level of contributions required for the schemes, or limit benefits.

At first sight, it may be thought that salary payment of doctors and budget-financed health facilities are a good way of containing costs. Participants felt that this was, however, not necessarily the case: salaried doctors can also waste resources. This is not carried to extremes where doctors are well-trained, carefully supervised and decently paid, as in Costa Rica. The salaried doctors in the compulsory insurance scheme in Egypt, however, are very high prescribers. Many of the doctors have two hour contracts with the scheme and want to get their work done as quickly as possible to return to private practice. Nearly half of the total costs of the scheme are for drugs. Over-prescribing is so excessive that the administration has taken the draconian step of making the doctor pay for any drugs prescribed in excess of three. In Indonesia it is calculated that 40 per cent of drugs are prescribed unnecessarily. Salaried doctors often have no incentives to assess and treat patients with proper care and may be offered big incentives by drug companies to prescribe brand-name drugs.

Salaried doctors can be made to operate a referral system, which, in theory, should save costs as specialists alone can be allowed access to expensive diagnostic tests. But it was reported that patients found ways of evading this system by inappropriate use of the Accident and Emergency departments of hospitals, as in Morocco and Saudi Arabia.

A form of inefficiency which is not related to the payment system is the use of hospitals for long stay nursing and geriatric patients. This occurs in Japan and Germany where only recently have provisions for nursing homes, homes for the elderly and home care been given increased priority. In the Czech Republic, it is calculated that 30 per cent of beds are misused in this way.

4. QUALITY ASSURANCE AND PATIENT SATISFACTION

It is the responsibility of the social health insurance fund to ensure that health care is available to the insured population. While not necessarily providing that care directly, it is important that the fund has control of the quality, level and types of services provided. To ensure this, the health insurance fund has to set the standards of service, clinical care and facilities to be available to insured persons. These standards

may then be used as the basis for accrediting providers; further refinement of the standards are adopted as part of a continuing quality assurance programme.

Participants pointed out that there are differences in service provision between urban and rural areas; because of this, it is critical to ensure that an accreditation process established within the social health insurance scheme reflects the practical realities of prevailing circumstances as well as makes a commitment to providing improved health care in all areas.

An accreditation process should be established during the planning phase and certainly prior to choosing providers or implementing the scheme for both primary care providers and for hospitals providing secondary and tertiary care. But what is meant by accreditation? It is a tool for ensuring that the individuals and facilities accepted by the social health insurance scheme to provide care to the insured population meet a set of specified criteria. The criteria for accreditation should reflect the minimum standards acceptable to the social health insurance scheme for inclusion on a list of providers. Participants agreed that criteria for a social health insurance scheme should be established, even where a licensing and registration system are used by the Ministry of Health. Accreditation by the social health insurance scheme provides a guarantee to the insured population that the providers available to them meet a set of specific criteria.

Ministries of Health often have specifications for public health facilities. These specifications will be useful starting points to enable the development of criteria for social health insurance providers, but it should not be presumed that all public health facilities actually meet these official criteria. All facilities proposing to provide services to beneficiaries should go through the social health insurance accreditation process. Exceptions should not be made for any person or facility. This is so, even where the Ministry of Health contracts with the social health insurance scheme to provide a range of services to the insured through public facilities: a 'block' accreditation should not be accepted.

All of the health insurance systems represented at the consultation had a registration and accreditation programme, in various stages of development. The accreditation process is applied either implicitly or explicitly in the selection of facilities considered appropriate to provide care to the insured, and some insurance schemes will only contract with accredited facilities. (In Indonesia the process is called "credentialling".)

Moving from an accreditation programme into a Quality Assurance programme implies a major commitment to improving and sustaining services. Whereas an accreditation process guarantees the patient a minimum set of standards, implementation of a Quality Assurance programme presumes that those minimum standards are well met and that facilities are now in a position to move forward.

Participants noted that more discussion was needed on the impact of consumer choice on the quality of services provided and further noted that where individual choice of provider is available quality of care is often better.

Only one of the participant countries - Germany - has written regulations for a Quality Assurance programme and even there it is not fully implemented. Thailand, Costa Rica and China are at different stages in development of the criteria for a quality assurance programme. The Czech Republic is working with professional associations to develop a set of quality standards.

One of the elements of Quality Assurance which is used by a number of the participant countries is the analysis of patient and provider satisfaction through surveys. Some countries have a policy of surveying patients systematically, while others undertake sporadic surveys, based on a particular concern raised through an increase in complaints or as a follow-up to an earlier survey, to assess the impact of advice, guidelines or instruction being given to providers.

Indonesia, in the compulsory civil service insurance scheme, has undertaken a series of patient satisfaction surveys. It also has a transparent complaints and grievance procedure which guarantees a response to complaints within two weeks. Thailand has used the research units of universities to undertake a series of patient satisfaction surveys on behalf of the social health insurance organization. Viet Nam has undertaken a number of studies on patient and provider satisfaction. Complaints identified from surveys undertaken by participant countries included the need to make unofficial out-of-pocket payments in order to receive adequate treatment; poor attitude of health care staff, both administrative and clinical; queueing; and a lack of confidence in primary care services.

The main issues raised by surveys of providers related to reimbursement, including slow payment of claims; unrealistic fee schedules and bureaucracy involved in making claims.

Participants also noted that the larger the number of insured the more leverage they had with providers in terms of quality of care and services given to the insured.

5. IMPLICATIONS FOR THE DEVELOPMENT OF SOCIAL HEALTH INSURANCE

Participants pointed out that there are no generally usable lessons because of the particular socio-economic and political circumstance of each country. Variations in culture, history and institutions impose limits on the transfer of experience between countries, but some generalizations may be drawn from those countries with total insurance coverage -

1. Planning and implementation takes time: the Republic of Korea took only 12 years to move from inception of social insurance to complete coverage, in the perhaps most favourable economic conditions, with real per capita annual growth of over 10 per cent. Other countries (Germany, Japan, Czech Republic, Costa Rica) trace the evolution of their full coverage back for periods of 40 to over 100 years.

2. Economic growth also facilitates the development of insurance, as more and

more people move into formal employment and therefore become more accessible in terms of registration and compliance in payment of contributions. Health insurance can help to avoid sickness-induced poverty.

3. A health insurance system requires an efficient national banking system and a high level of administrative capacity. General skills (literacy and numeracy) are needed as well as specific skills in decision-making, data analysis, negotiation and management, and specialist skills in accounting and auditing. More skills are needed than can be produced through ad-hoc study tours: this requires a programme of continuous human resource development within developing countries.

4. Countries with national health insurance schemes can be characterized as having a high level of solidarity. Historical and cultural factors, together with low initial levels of inequality may be explanations of such solidarity, which is more than simply a political issue, but is something which reflects the character of social relations in a country, and may not easily be influenced.

5. Also required is a degree of integrity in public and corporate affairs. As many countries have experienced in relation to the management of revenue from user-charges, the creation of new funds also generates opportunities for misappropriation and misuse. Large funds may mean large opportunities. Though integrity, like social solidarity, may be hard to measure, it is nevertheless real and an important requirement for insurance to function as a health financing mechanism.

In countries with inequitable tax structures and a large proportion of health expenditures made on an out-of-pocket basis, social insurance may offer a more equitable means of financing health services. But a competing priority in such countries will often be the need to develop a better health infrastructure, rather than simply shifting the method of financing. Experiences from Costa Rica, where the surplus from urban health insurance has been used to develop the rural infrastructure, and from Viet Nam, where undistributed surplus from health insurance was used to buy basic equipment for hospitals, shows that, with careful management, health insurance funds can be used to contribute to infrastructure development. This implies a clear link between the revenues from contributions and the health services system.

6. The payment mechanism adopted can have a major impact on the potential for control of costs. There is a great deal of international experience available which should be taken into account when making decisions about payment mechanisms.

The meeting also noted that countries were adopting different ways of mobilizing community resources to improve funding for health care. These included:

- community financing schemes, such as the Thai rural health card scheme or those in Indonesia, with uniform or specific community rating contributions;

- community rating, i.e. sharing risks among a sub-national but geographically defined population, such as a district (in rural Viet Nam or in large cities in Indonesia);

- beginning social insurance with easily identified (for contribution collection) groups such as the formally employed;

Experience from Japan and other countries shows the difficulties that may be encountered in merging small-scale insurers with larger ones. There is a common tendency of partial coverage to remain partial, with the initial participants capturing improvements in services. Plans for expanding the scheme, e.g. from the employed to the self-employed, should be made in a phased manner.

Many countries (for example, Thailand) have started with larger employers in the formal sector of employment and then extended coverage to enterprises with fewer employees. For this to be worth the major administrative effort involved, there need to be several hundred thousand insured persons (employees and their families) in the formal sector of employment. If they are mainly in government, most of the extra cost will fall on the government as employer, which is already in difficulties in finding adequate finance for its health services. Secondly, there need to be enough trained staff for appropriate services to be provided for insured persons, without robbing scarce staff from the services provided for the rest of the population. Thirdly, the services must seem to the insured to be of a quality which it is worth paying for. Fourthly, the pay from health insurance should not be so attractive that it becomes more difficult to find staff to work in unpopular areas within the main government services. Most important, the government needs to be determined to use any savings of resources in its main services, or any income received for services provided to insured persons, to improve the health services provided for the rest of the population.

For countries with no or limited coverage by social insurance, capitation was recommended by participants as the preferred payment system. Where capitation cannot be negotiated, budget ceilings should be imposed on fee-for-service payments. It was also pointed out that the payment mechanism can influence the quality of care provided.

The inclusion of both primary health care as well as hospital-based services were felt to be essential components of the benefit package. Mechanisms are needed to ensure that the referral systems between levels of care operates. If co-payments are to be used, different co-payment levels could encourage the use of primary services; but people would need less of a co-payment incentive if such services were both easily accessible (low time cost), friendly and of good quality. Limited lists of drugs and rationing mechanisms for the purchase of expensive equipment are essential. For this reason, quality assurance should be developed from the very initiation of insurance systems where it does not already exist. Treatment and service protocols should be developed, and their use monitored.

Where there exists competition among providers and insurers, guidance was felt to be desirable, to obtain best performance or value for money, while ensuring that the regulatory framework is observed. It was not felt that the potential advantages of increased competition should be pursued in the early stages of insurance schemes.

Low utilization was reported at the outset of implementation of social health insurance schemes: it was felt that this was a symptom of the scheme covering workers

only and not dependents.

6. CONCLUSIONS AND RECOMMENDATIONS

Before making plans and commitments for the introduction of social insurance financing, governments should look more widely at the existing health care financing and provision arrangements. Insurance should not be seen as a way of shifting core responsibilities for overall regulation and policy making, and for ensuring access to services for the poor, away from government. In many developing countries, the physical resources are inadequate, inequitably distributed and of poor quality. Staff in the health infrastructure are poorly trained, with inadequate resources. Their improvement makes a strong claim on public resources and skills as a priority. The supporting conditions required for successful development of social insurance are stringent: time to properly design and implement the scheme, economic growth, capacity, solidarity and integrity.

In the right conditions, however, insurance may provide a more equitable method of financing health than out of pocket payments, private insurance or even tax-funding.

Recommendations

Countries should:

Appraise the prospects for social health insurance in the light of the overall state of health systems financing and development, and build on existing social insurance or other mechanisms of financial solidarity.

In the context of economic development, be prepared to begin with implementation of social insurance for health at less than national scale, but should pool risks among geographical or employment populations.

Dependents should be covered as beneficiaries of the scheme from the outset.

Make careful assessments of the scale and timing of different skill needs for managing the social insurance system.

Ensure discussion and consultation with and - within the appropriate administrative framework - between the major interest groups likely to be affected by and involved in social insurance.

Ensure that contributions including state participation or subsidies are in rough balance with expenditure on benefits and administration of the scheme.

Ensure that preventive and promotive services of good quality are a component of a comprehensive package of benefits.

Design the scheme in relation to planned or recent changes in social insurance policy in terms of their effects on overall equity, efficiency, quality and satisfaction.

Plan the timescale and process of expanding coverage on a phased basis. The WHO/ILO publication "Social Health Insurance" provides a good basis on which to undertake such assessments.

WHO at regional level should:

Support countries in all of the above, by:

Providing opportunities for appropriate capacity building and technical support in human resources development.

Provide technical assistance in countries for the appraisal, design and implementation of social health insurance programmes.

WHO at global level should:

Support Regional Offices in all of the above.

Promote the development of methods based on countries' experience for assessing the effects of health insurance development on overall health system equity, efficiency and quality, and support the use of these methods.

Disseminate the experiences of countries at different stages of social health insurance development; in order to identify the conditions in which health insurance, as one type of financing reform, supports the use of these methods and contributes to the achievement of Health for All objectives.

Collect and disseminate data and experience on community financing schemes.

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EQUITY: Country Notes

CHINA

Government insurance: for government staff and students from universities and colleges, financed by government. Beneficiaries get free medical care. Started in 1952, it covers 30 million people.

Labour insurance: for workers in state and collective enterprises, financed entirely by enterprises half of total welfare funds earmarked for medical expenses). Established in 1951, it covers 140 million workers and 60 million dependents. Dependents pay half price. The scheme is managed by the enterprise.

Cooperative medical service in rural areas: funds are collected from farmers and local government. The current scheme covers about 100 million.

Reforms are currently planned in all three sectors; to expand coverage and benefits.

COSTA RICA

Crisis in the outpatient system: because public health services are provided essentially free of charge to most patients, there is no deterrent to overuse, leading to overcrowding. Visits also tend to be concentrated in higher level facilities in the central region due to the lack of an adequate referral system and the perception that lower-level facilities do not have sufficient resources such as drugs and medical supplies. The long waiting lines have the following effects: the rich can obtain quick care from the private sector, the poor cannot.
Solution: establishment of 74 health areas and designation of about 800 basic health teams for the provision of comprehensive primary health care. Each area would include various types of existing facilities from health posts to hospitals to cover the full range of services from primary to tertiary levels of care.

Although CCSS health services are available to the indigent population, no appropriate means test were developed. The health care system is unable to distinguish between the poor and non-poor, the insured and the non-insured. A conservative estimate is that the CCSS provided services to nearly 15 percent of the population without their having contributed their required share of the plan. Other users of services: tourists and illegal migrants.

Solution: new registry of CCSS of insured population and identification cards, new MIS.

Coverage: 86 percent or 2.8 million people are insured together with 49 percent of dependents or 1.6 million. Insurer owns facilities and staff are salaried. It also contracts services such as equipment maintenance, diagnostic test, outpatient care, drug

dispensing.

Contribution: the revenues of the social security are generated from: 85% from compulsory social security contributions from the payroll tax on salary and wages: (5.5% from worker, 9.25% from employer and .25% from government. Other revenues from sale of goods and services (e.g., care from private patients, transfers from the Central Government and other income).

CZECH REPUBLIC

Coverage: all citizens are covered by health insurance by law (Constitutional mandate). This applies to permanent residents or employment with an employer headquartered in the Czech Republic.

Contribution: for workers, premiums are set as 13.5% of the income before tax: employers pay 9% and 4.5% is paid by the employee. Self-employed pay 13.5 percent of only 35 percent of their pre-tax income. The government uses the state budget to pay the insurance premiums of persons who do not have any income, such as children, pensioners, unemployed, handicapped, persons dependent on social support, soldiers and prisoners.
There is equalization between the 26 insurance funds by 60 percent of contribution income being paid into a central fund which redistributes it back paying three times more for a person 60 or over than those under 60.

Access to services: evenly distributed health services. The insurance funds with a high income per head, (e.g., banks) are able to offer extra services such as spa treatment, rest homes and family planning services.

EGYPT

Coverage: government employees, private sector employees, pensioners (must apply to be eligible), widows, family members only in Alexandria (must apply), all pre-university students numbering around 14.5 million. In all, 23.3 million are insured out of 56.4 million population in 1993.

Contribution: two separate budgets

For the adult population:
1% of salary from employee and 3% from employer widows can apply and pay 2% of the three monthly pension pensioners and employee can include family members provided they pay 0.5% for each member.

For the student population:
4 Egyptian pound for each student in public schools and 10% of the student fees for private school student with a 50 pound maximum.
Government pays 12 pounds per student 10 piaster tax is collected for every

cigarette tax students pay 30% of the price of the drugs

Thus sources of financing: payroll tax, earmarked taxes (from cigarettes), co-payments and registration fees.

Access: maldistribution of health facilities

GERMANY

Coverage: comprehensive and compulsory statutory health insurance divided into more than 1,000 autonomous sickness funds. Membership is compulsory for workers whose gross income does not exceed a certain level (in 1995 around $4,000 per month) and voluntary for those above that level. Opting out as a equity issue is not an issue in Germany.

Contribution: all members of a sickness fund contribute the same percentage of their income which is on average about 13%, although percentages vary between 9% and 16% among sickness funds. Retired persons pay the same percentage as workers out of their pensions; the unemployment funds pay for the unemployed. Dependent family members are covered at no additional costs. For the 0.3% of the population not covered by health insurance (homeless, refugees), the town councils pay medical bills as part of the social welfare. 89% are covered by sickness funds, 9% by private health insurance, 2% by others, and 0.3 do not have insurance (very poor and very rich).

Access: members of sickness funds have access to all health care facilities which can be used without advance payments since the sickness funds reimburse the providers. Health resources are equitably distributed throughout the country. For ambulatory services, the regional ambulatory care physicians' associations have the monopoly to provide services but also the obligation to offer them evenly throughout their region. For hospitals, the state ministries responsible for health services maintain a "hospital plan" to ensure services throughout the state. Only hospitals listed in that plan are eligible to have their investment costs covered by the state.

INDONESIA

Coverage: 82% of the population is currently not covered by any type of insurance. 9% are covered by compulsory JPKM /managed care schemes for civil servants (ASKES) and formal sector workers (ASTEK). 0.2% are covered by private JPKM, 5.3% are covered by basic health care ("Dana Sehat") schemes, 3.2% are covered by the government funded health card system, and 0.09% by private health insurance.

Contribution: health insurance inequitable in the sense that stratified premium that favour the rich and healthy rather than the poor and ill. Deductibles, co-payments and co-insurance arrangements favour the rich. In contrast the JPKM provides a mandatory basic benefit package with mechanisms for cross subsidization between rich and poor and between health and sick. The premium for the basic benefit is (will be)

regionally rated and for government and formal sector employees is based on a percentage of wages. No deductibles, co-payments or co-insurance are permitted for the basic benefits. The voluntary JPKM provides expanded benefits where risk and experience rating, co-payments, deductibles are permitted.

Access: historical uneven geographical distribution of health facilities. Health insurance makes no provision for the health care of the poor. However, JPKM promotes more equitable distribution of services through cross subsidization, reallocation of MOH budgetary funds to areas of need, although currently, provider network is limited. Moreover, under the JPKM, the certified poor receive health care benefits.

JAPAN

Coverage: universal coverage. Every resident is entitled to received basic insurance benefits at any time and any place. For the poor, medical aid is provided by the government.

Contributions and benefits: there are some 5,300 insurers categorized in three major schemes. The benefit packages and contribution structures are set in legislation to ensure fairness: however, they differ slightly among insurers.

Access: there is freedom to choose the place of treatment.

MOROCCO

Coverage: currently health insurance in not mandatory. Only 15 percent of the population is insured on a voluntary basis with mutual or insurance companies. Health insurance is managed by mutual societies, established mainly in the public sector and by insurance companies. The latter provide insurance to private sector firms. The mutual societies cover three-fourths of the 15% covered, mostly state employees, public sector employees and those in the local communities. The remainder is taken by the insurance companies which insure mostly private sector employees. The population insured are mostly men, married, relatively young (34 to 49 years), mainly in urban areas, and mainly in the northwest and central region.

Contribution and benefits: the average employees and employer contributions is low (slightly more than $80 per year. The average amount of services provided is low (equivalent to the average spending for health care per person in 1987).

Reform contemplated : mandatory insurance towards universal coverage but first starting with coverage of salaried employees, pensioners and dependents. The insurance should cover at least half of the cost of minimum mandatory benefit package. Consumers would have a choice of health providers and insurers. The premium will be equally shared by employers and employees.

Access: uneven distribution of health resources. Urban areas more favoured

than rural areas, the North-West region obtains a greater share of MOPH resources relative to its population. To correct these situations, the reform package include hospital reforms to improve quality of service and provide similar quality across regions, reallocation of MOPH resources towards primary care to benefit the poor, particularly in rural areas.

REPUBLIC OF KOREA

Coverage: universal coverage achieved by 1989 from 10% coverage in 1977. There are some 400 insurance societies belonging to three general categories: health insurance for government officials and private school employees, health insurance for industrial workers, and community-based health insurance schemes for rural and urban self-employed.

Contributions and benefits: the different heath insurance societies are administratively and financially independent. This has several consequences: (1) different rates of contributions among insurance societies; and (2) financial imbalances among the insurance societies with some accumulating large reserves. In addition, the government subsidizes health insurance societies for the self-employed by approximately 50% of their funds, yet the self-employed include high income persons such as medical doctors and lawyers. Current reforms include changing the subsidy from flat rate to differentiated rates among societies to reduce imbalances among insurance societies.

The low rate of contributions has lead to high co-payments and limited benefit package, which in turn lead to the following:

(1) limited access of low income groups due to high co-payments;
(2) inability of the poor to afford services outside the limited benefit package. Current reforms include expanding the benefits and reducing co-payments.

Access: despite rapid expansion of health facilities and human resources for health, there still exist regional disparities which prevents greater equitable access to residents in rural areas. There is still a tendency of health resources to be concentrated in urban areas.

SOUTH AFRICA

Coverage: private health insurance covers only 19% of the population, of which 80% is white, through medical aid societies (many of which are non-profit).

Contribution: employers contribute between 50 and 100 percent of medical scheme contributions.

Access: uneven geographical distribution of health infrastructure and human resources. Providers are concentrated in urban areas. The poor who cannot afford private insurance have access only to public sector facilities.

THAILAND

Coverage: various health insurance schemes and free care for special groups of the population cover about 70 percent of the total population. These schemes include the Civil Servant Medical Benefit Scheme for civil servants and state enterprise employees including dependents (no contributions required from insured); Social Security Scheme which is compulsory for formal sector employees (employee, employer and government equally contribute 1.5% of the payroll to the fund); Workmen Compensation Scheme which is compulsory, covers work-related injuries (employer contributes 0.2% to 2% of payroll to the fund; Health Card Scheme and private health insurance, which are voluntary health insurance schemes.

Contribution and benefits: each of the schemes have different benefit package and contribution structures. Government subsidies vary by groups, with the poorer groups receiving less subsidy.

Access: uneven distribution of health facilities and human resources favouring urban areas.

VIET NAM

Coverage: compulsory health insurance implemented in 1992 covers civil servants, including retirees, private sector employees and persons under special social protection. Of the 7 million eligible population, only 4.2 million or 59 percent are now covered. Among the self-employed, peasants and those who can afford to pay for health care, 0.4 million out of 32 million have so far enrolled in voluntary insurance while the rest pay out-of-pocket. The remaining 33 million low income people needing social assistance are provided free health care by the government and by charitable organizations.

Contribution and benefits: Contributions are 3% of salary for compulsory insurance and flat rates set at different amounts (by province) for voluntary insurance, which is administered by the same scheme. The health insurance agency reimburses providers only the cost of services at the prevailing subsidized prices (about 50% of real costs). Government subsidizes the insured to the tune of 50% of cost of services used and two-thirds of the premium. However, over 25% of health insurance funds were unused.

Access: urban bias in the distribution of human facilities and human resources. There are also quality differences between urban and rural services. Among insured, there are differences in access and quality of services depending on residence. The lack of facilities also explain the low utilization rate of health insurance funds.

EFFICIENCY: Country Notes

CHINA

Payment system of hospitals leads to excessive use of expensive diagnostic tests and drugs, as this is where the hospitals derive income.

Long lengths of stay in hospitals.

Insurers tend to make contracts with tertiary hospitals.

Co-payment is between 5 and 10 per cent depending on the province. In the rural areas co-payment is higher, depending on the level of contributions.

COSTA RICA

Dissatisfaction of users with long waiting time for specialists.

Inadequate continuity of care.

Lack of incentives for providers to use resources economically.

CZECH REPUBLIC

Excessive costs and over provision induced by the fee-for-service payment system, though user satisfaction and attitude of providers greatly improved. The government regulates the prices of providers' services.

There are false claims by providers which insurers find it hard to control as the doctors' inspecting records also work within the system as providers.

Inefficient, useless and irrational provision of health care and drugs. This is being modified from the middle of 1994 by co-payment from which those up to 18 are excluded.

Direct access to specialists is allowed and the latter work also in the community.

Hidden unemployment due to excessive employment of staff in the health facilities.

There is an excess of beds which also provide care for those no longer needing to be in hospital. About 30 per cent of beds are used in this way. There are no queues.

High administrative costs of the smaller funds - 17 per cent of income and some delayed payment of providers. A new law takes powers to limit administrative costs.

EGYPT

The recent addition to insurance of 15 million students has led to long queues and waiting time.

Excessive use of drugs which absorb 48 per cent of the costs of the scheme (though there is now a 30 per cent co-payment for students and the doctor is charged the cost of prescribing more than three drugs).

Pharmacists offer cosmetics etc. instead of drugs.

Low paid doctors on part-time contracts arrive late and leave early and give poor attention to patients. Capitation payment has been introduced in one area.

The salary system of payment gives no incentives to assess and treat patients correctly (it is hoped that the new quality assessment system and treatment protocols will remedy this).
Duplicated hospitals from those owned by the insurance scheme, many built for political reasons, some with very low occupancy.

The problems of an over-centralized bureaucracy, as the scheme is under the Ministry of Health (being remedied by assessing patients who present more than once a week).

Over use of services by patients.

Specialists, acting as general practitioners, refer patients to their private hospitals or colleagues in private facilities.

GERMANY

Over-use of specialists for general practice, as patients have direct access to specialists without referral.

Fee-for-service payment system encourages excessive services.

Repeated diagnostic tests outside and then inside the hospital.

Long lengths of stay, though relatively low staffing levels by European standards (prospective payment is to be introduced for surgical cases from 1996).

Under-development of day surgery (now made possible by introduction of payment system for it from 1993).

Under-development of home care (new home care/nursing home insurance funds, as separate parts of sickness funds, were introduced from 1 April 1995).

The administrative costs of the sick funds are about 5 per cent but considerable administration is done by the doctors' associations.

INDONESIA

In the government services:

- considerable waiting time;
- lack of supplies and personnel;
- poor provider attitudes to patients;
- poor quality of services;
- inappropriate use of higher levels of care;
- no provider incentives for efficiency;
- bureaucratic management;
- excessive drug and hospital costs.

In the insurance scheme, the introduction of capitation payment for doctors and an essential drug list have reduced the increase in costs. A reform of the provider payment mechanism from 100% reimbursement to capitation for primary care has further reduced cost increases. The long lengths of stay in hospital for insured persons led to cost sharing being introduced for the first 10 days of inpatient care to reduce the length of stay.
It is calculated that one-third of inpatients could be treated as outpatients and that 40 per cent of drugs are prescribed unnecessarily.

JAPAN

Under-development of home care and other facilities for the aged.

Inadequate nursing services in many hospitals so that patients have to hire nursing assistants at their own expense. There is some uses of high technology equipment for which the patient has to pay. Excessive use of high technology.

MOROCCO

Poor geographical availability of health manpower and facilities.

Delays in reimbursement by mutual voluntary health insurers.

Low salaries leading to low motivation of personnel.

Lack of equipment and drugs.

Centralized decision-making and poor management of hospitals.

Over-use of Emergency and Accident departments to by-pass the referral system.

Some firms and CMIM offer three to four times the level of reimbursement provided by CCNOPS.

REPUBLIC OF KOREA

Fee-for-service payment leading to an excessive volume of services.

Over-use of specialized urban hospitals due to inappropriate demand from patients with minor ailments leading to excessive use of expensive diagnostic equipment and long queues,

Deliberate provision of those services to patients which are not price controlled as they are not covered by the insurance scheme.

Lack of provision for long term care, home care and facilities for the mentally ill.

No day surgery.

Inefficient administration in some societies leading to administrative costs as high as 15 per cent of income of some societies. The average is 6 per cent for the employed and 9 per cent for the self-employed.

Patients have direct access to specialists without referral.

SAUDI ARABIA

Over-use and inappropriate use of Accident and Emergency departments of hospitals.

SOUTH AFRICA

The 180 Mutual Aid Societies have:

- fee-for-service payment system which gives no incentives to save costs and this leads to increases of about 15 per cent per year in real terms;
- doctors allowed to charge patients above negotiated rates up to a ceiling;
- excessive supply of services and brand name drugs and inappropriate use of high technology. But, recently, a co-payment was introduced of 20 per cent for all services. There are no other cost containment measures. Groups of doctors who own private hospitals have obvious incentives to over-hospitalize;
- the proliferation of Societies results in high administrative costs;

- there are fraudulent and duplicated claims, particularly towards the end of the year when doctors will give prescriptions which patients take to pharmacists who give them cosmetics instead;

- there is no referral system;

- the large number of Societies leads to high administrative costs.

THAILAND

Excessive and rising cost, partly due to hospitals over-charging, in the scheme for civil servants.

Excessive use of secondary and tertiary care and mainly curative services. The referral system is not strictly followed or enforced.

Inadequate satisfaction in the scheme for private sector employees, as indicated by the low utilization of it.

VIET NAM

Supply-induced excessive provision of services by providers.

Low quality of services and rising costs for the insured.

Over-use of X-ray, ultra sound and lab. tests.

Choice of facility limited for patients.

Incentives introduced for health centres to treat patients at commune and district levels. Health insurers have staff in hospitals to determine whether services provided are necessary.

QUALITY ASSURANCE AND PATIENT SATISFACTION: COUNTRY NOTES

CHINA

There are quality assurance measures stipulated by the health administration for hospitals.

Health personnel are dissatisfied with salaries and other job conditions.

Providers complain of obsolete and malfunctioning equipment and poor working environments, particularly in small hospitals and clinics.

There is satisfaction with the level and type of preventive health care available. Patients complain of poor attitude and rudeness of staff in hospitals.

COSTA RICA

There is an intention to develop quality assurance but no concrete plans for its implementation, after 50 years of social health insurance.

Patients who want or need quicker service than that available from the public system pay doctors from the public system who undertake out-of-hours private practice.

CZECH REPUBLIC

A system of quality assurance is not yet established. However some satisfaction surveys have been carried out which reflect an overall satisfaction among patients both for the service and with their doctors: 80% are reported fully satisfied with the services and 60% fully satisfied with their doctors. Of the respondents to the survey 60% think they should pay more for health care.

The relationship between the health system and users has improved significantly since the introduction of improved provision of outpatient services and the need for hospitals to compete to secure "loyalty" of patients.

Health personnel in the public sector are dissatisfied with their salaries, when compared with salaries in the private sector. This results in poor motivation. Doctors, although reasonably well paid, have to spend a large proportion of their income paying back loans on premises bought in which to practice.

Quality of care is patchy across the specialties: most specialties are developing quality standards, in association with professional organizations and expert societies.

An accreditation process is being developed and may form part of the draft act on health service, which strengthens the rights of citizens in relation to access and provision of health care.

EGYPT

There is no formal quality assurance programme.

The health insurance organization has autonomy but has had numerous complaints when salaries of health personnel were raised as part of a policy to improve working conditions and motivation. Providers complain of poor salaries. Doctors are paid on a sessional contract basis, usually of two hour duration. Salaries are very low and doctors often encourage patients to go to private facilities, where their remuneration is much higher. Recruitment of doctors on a full time basis, at four times the previous salary, is in process.

Patients complain of lack of continuity of care, with different personnel available at each successive visit. Often ambulatory care is available only between 8.00 and 14.00, which is inconvenient for most workers.

GERMANY

There is a quality assurance programme laid down by legislation but there is no regulation as to when or how it should be implemented. Quality is the responsibility of physicians, hospitals and sickness funds. There is an increasing interest in the collection and utilization of data on quality issues and 'quality circles' have been introduced by physician peer groups.

There is general satisfaction among users of the services even though co-payments have risen since 1993. There are no queues and no waiting lists for non-urgent admissions. Ambulatory care providers now receive fixed budgets for provision of care and report that it is low. Spending targets with limited growth were introduced in 1993 and a prospective payment system will be introduced from 1996. Providers would like a return to full reimbursement under the fee-for-service system.

INDONESIA

There is no formal quality assurance programme.

The Ministry of Health is in the process of introducing a grievance procedure at every unit, as part of the hospital risk management programme. The ASKES health insurance scheme has undertaken a planned series of consumer surveys of both providers and users, to identify issues which require intervention and have an established data collection process which includes data on quality issues. These data are analyzed and used to determine the subject of further surveys. A grievance procedure is in operation, which aims to fully respond to complaints within two weeks.

Consumer surveys have shown that the major complaint, though only made by 42.5% of the 4.5% who responded, relates to waiting time of greater than one hour. Other complaints included poor attitude of health personnel, especially in pharmacies. In 1994 a follow-up survey showed a marked decrease in dissatisfaction with health personnel and a particular satisfaction level with preventive care services.

JAPAN

There is no formal quality assurance programme.

There are some complaints from patients who have to hire nurse attendants from out of pocket payments. Staffing shortages, particularly of nurses, are widespread.

REPUBLIC OF KOREA

There is no formal quality assurance programme.

Providers express dissatisfaction with the scheme due to long delays in reimbursement of claims and the very low rate of the fee schedule. There is a belief that the fee-for-service system causes poor quality of service because the fee schedule is so low. Health personnel complain of long hours and poor salary. Community hospitals complain that they cannot compete with larger hospitals for patients, as they have no access to the expensive equipment patients want to have available.

Patients have to wait in long queues to get access to care, particularly in teaching hospitals. However, there are few complaints.

MOROCCO

There is no formal quality assurance programme.

Providers express greater satisfaction with the current negotiated fee structure than when prices were fixed by the Ministry of Health.

SOUTH AFRICA

There is no formal quality assurance programme.

Patients who are covered by insurance programmes are reported as fairly satisfied with services but object to the rising cost of premia, which is now at 10% of salary, equally split with employers and covering dependents.

Providers express satisfaction with the fee-for-service system available from the Medical Aid Societies.

THAILAND

There is no formal quality assurance for the public service or for any of the insurance schemes, although one is planned for the social security health insurance scheme.

The poor, who have access to a voluntary health card are dissatisfied with the services available to them. Particular complaints relate to long queues for service, lack of availability of primary care services and poor attitude of health staff: these complaints come mainly from the poor using the health card scheme and civil servants using their health insurance scheme. A much greater degree of satisfaction is reported from users of the social security health insurance scheme, who have access to a wide choice of primary care providers and speedy treatment in public hospitals, via a priority queuing system.

Providers report a lack of incentives to improve services, except under the social security scheme, which offers a guaranteed income under the capitation system and which uses both public and private facilities, creating a degree of competition among providers. Utilization under the civil service scheme, which pays on a fee-for-service basis, is low, due to the long queues at public hospitals: users complain of bad attitude of staff.

VIET NAM

There is no formal quality assurance programme. The Viet Nam Health Insurance provincial offices have doctors attached to the large hospitals to review utilization.

Surveys are carried out on an intermittent basis to determine patient and provider satisfaction on specific issues. An inspection board has been established at the Ministry of Health and in each province, to determine whether or not hospitals have met standards set down by Ministry of Health.

Providers prefer fee paying patients to insured patients, as the health insurance scheme pays a low rate of reimbursement. Users report a poor attitude of staff when they identify themselves as health insurance patients. For historical reasons patients are often **willing** to pay an unofficial fee to doctors, nurses and hospitals when they have received successful treatment and good service. This is recognised as an "unofficial co-payment".

ANNEX 4

PROGRAMME OF WORK

Monday, 3 April 1995

08.15-09.00	Registration: Coral Room, 18th Floor
09.30-10.00	Opening Ceremony 1) Introduction and Welcome - Mr A. Creese 2) Opening of the Meeting - Dr S.T. Han, Regional Director, WPRO 3) Welcome Address - H.E. Dr Suh, Sang Mok, Minister of Health and Welfare, Korea Introduction of participants and nomination of officers
10.00-10.30	COFFEE BREAK
10.30-11.00	Adoption of programme of work
11.00-12.00	Presentation of background paper (Professor B. Abel-Smith)
12.00-14.00	LUNCH BREAK
14.00-14.30	ILO perspective on health insurance - Ms Monica Burns
14.30-15.15	General Discussion - Introduced by Mr Creese
15.15-15.45	COFFEE BREAK
15.45-17.00	Presentation and discussion of country papers - Republic of Korea, Morocco, Japan
17.15	Secretariat Meeting

Tuesday, 4 April 1994

09.00-10.15	Presentation and discussion of country papers - Thailand, Czech Republic, Viet Nam
10.15-10.45	COFFEE BREAK
10.45-12.00	Presentation and discussion of country papers - Indonesia, People's Republic of China, Egypt
12.00-14.00	LUNCH BREAK
14.00-15.15	Presentation and discussion of country papers - Costa Rica, South Africa, Germany
15.15-15.45	COFFEE BREAK
15.45-17.00	Group work on selected issues: Equity Efficiency Quality and Satisfaction
17.15	Secretariat Meeting

Wednesday, 5 April 1994

09.00-12.00	Group work on selected issues (continued)
12.00-14.00	LUNCH BREAK
14.00-15.00	Group work on selected issues (continued)
15.00-15.30	COFFEE BREAK
15.30-17.00	Presentation by working groups and discussion, (including recommendations)
17.15	Secretariat Meeting

Thursday, 6 April 1994

08.30 -	Field trip
09.30-	Arrive at Korea Federation of Medical Insurance (KFMI)
09.0-11.00	Presentation and Discussion
11.00-11.30	Visit to Claim Review Organization
12.20-13.30	L U N C H
13.30-16.00	Visit to Insurance Societies (3 groups) 1. Industrial workers 2. Regional (Urban) 3. Regional (Rural)
17.00-18.00	Visit to Seoul National University Hospital (SNUH) and group photograph

Friday, 7 April 1994

09.00	Presentation and Review of Draft Report
12.00	Closure of the Meeting

* * * * *

ANNEX 5

LIST OF PARTICIPANTS

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