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Seeking universal health coverage of social health insurance in three Asian countries: China, Thailand, and Viet Nam

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What do countries do to achieve universal health coverage? What problems do they encounter? What can the Philippines learn from them? This essay seeks to provide some answers to these questions by reviewing lessons from select examples.

While social health insurance (SHI) schemes vary according to country circumstances, they remain the chief means to achieving widest inclusion of people who are in dire need of health care. SHI schemes in various countries initiated by governments—and sometimes by private entities—are meant as an alternative to tax payments and out-of-pocket (OOP) expenditures in times of medical needs. They are expected to reduce OOP by pooling members' contributions into a fund where payments for health-care services will be drawn. Such pooled money, which constitutes the bulk of SHI funds, is in the hands of the government.

SHI is generally supported by different forms of state subsidy, sometimes foreign funded as in the case of Viet Nam, or by taxes on alcohol and tobacco products. Recently, SHIs are employed to achieve universal health coverage (UHC) so that no person is left without the means to access or even pay for health care. While advanced economies have achieved UHC, SHIs in developing countries are "typically characterized by large-scale exclusion" (Oxfam 2013, p.1).

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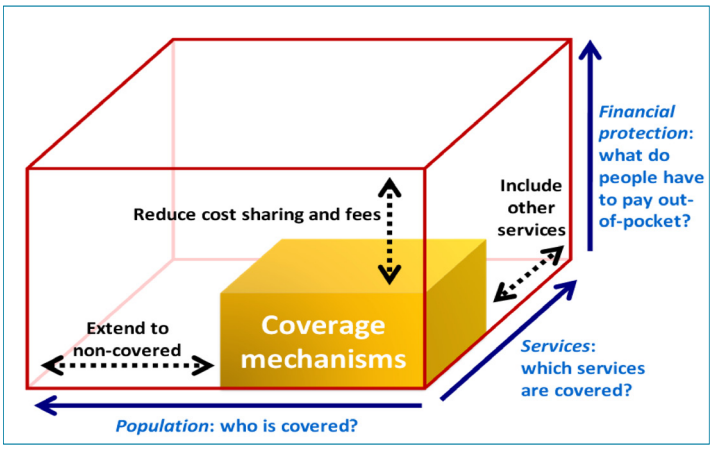
Figure 1. Toward universal coverage



Source: WHO (2010)

Measuring SHIs: WHO's "UHC cube"

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

The definition highlights the importance of health financing as a key component of the health system. Relative to this, financing is typically linked to the question of OOP expenses (especially of the poor and near poor) and risk-pooling efforts to finance health insurance costs (MMI 2013). Over and above the financing issue, WHO raises the question of the equity impact of SHI (Gilson 2012), one that implies that poor-inclusive UHC continues to be burdened by sustainability factors (WHO n.d.), and also one that seeks to equate UHC with health for all.[1]

To assess SHI progress toward UHC, WHO recommends using the UHC cube (Figure 1) with dimensions not impossible to achieve (Rabovskaja 2012). Here, the X-axis indicates how inclusive the insurance has become, the Y-axis measures how much people share in the cost of health care, and the Z-axis shows the services available to those in the scheme.

Kieny (2013) itemizes the axes of this cube as shown in Box 1.

Why them?

With universal interest in achieving UHC, efforts have been exerted to draw lessons from many SHI experiences. Among others, WHO studied the transition of a few countries to UHC by looking into seven key design issues that policies ought to address, namely, population coverage, the method of finance, the level of fragmentation, the composition of risk pools, the benefit package, provider payment mechanisms and administrative efficiency (Carrin and James 2004). A World Bank-commissioned review of existing SHIs concluded, with some reservation, that "UHC often has a positive effect on financial protection, and that, in some cases it seems

[1] See a contrary view in Mukhopadhyay (2013).

to have a positive impact on health status" (Giedion et al. 2013, p. 99).

Meanwhile, UHC attempts in seven Southeast Asian countries have specific funding for particular groups that benefited differently under varied schemes (Tangcharoensathien et al. 2011). Even if positive health outcome, financial protection, or access outcome were not assuredly linked to SHI, achieving UHC has been endorsed almost by every country that sought to define its own policies and implementations based on actual conditions (Sengupta 2013).[2] Among the Asian countries that are continuously studied for SHI progress toward UHC include China, Thailand, and Viet Nam (Table 1).

Together with Viet Nam, China has been ruled by the Communist Party since the Cold War days but has experimented opening to market forces in recent years. The country's embrace of the new liberal economic order and its own successes in that regard have exemplified almost 100-percent health insurance coverage in various forms in a relatively short period of time, but with lingering issues like OOP expenses (Zhang and Liu 2014).

On the other hand, Thailand's tumultuous democratic politics (reds, yellows, military, monarchy are major actors) lasts till reading time. It was a frontrunner in SHI among developing countries, covering a huge majority of informal workers and poor people who were uninsured under any scheme. Apart from its famous UHC version of 30-Baht scheme, Thailand gained prominence in the ASEAN+3 countries for its willingness to share its UHC lessons (Ghislandi et al. 2013).

Box 1. Cube axes explained

Axis 1 (Z): Coverage with needed health services
- Promotion, prevention, treatment, rehabilitation, palliative care
- Population-based and personal interventions
- Interventions at different levels of the system: community, primary, secondary, tertiary
- Quality as an overarching consideration

Axis 2 (Y): Financial risk protection indicators
- Incidence of catastrophic health expenditure due to out-of-pocket payments
- Incidence of impoverishment due to out-of-pocket payments

Axis 3 (X): Population and equity
- UHC is fundamentally about equity – all people get what they need and all people pay only an affordable price.
- Each of the indicators described earlier needs to be disaggregated by key socioeconomic factors: income, age, sex, rural/urban, etc.

Source: Kieny (2013)

The beginnings of health insurance in the Philippines and Viet Nam were two years apart in the early 1990s. The two countries' differentiated health system settings would showcase not only the attempts to make the poor the principal beneficiaries but also the distinct challenges toward the realization of their own targets (Tangcharoensathien et al. 2002; Lieberman 2004). The participation of the different stakeholders at the different levels of the Philippine and Vietnamese health systems would produce interesting questions not only about SHIs but also their associations with key success indicators.

[2] UHC deemed the silver bullet to health-care needs especially in poor countries, but it simply shifted the question to one of financing instead of rebuilding the public health system that has fallen under the spell of the market.

Table 1. Selected country statistics: China, Thailand, and Viet Nam, 2012

Characteristics	China	Thailand	Viet Nam
Population	1,350,695,000	66,785,001	88,775,500
GDP (USD)	8.227 trillion	365.6 billion	141.7 billion
GDP per capita (USD)	6,188	5,480	1,596
NHE as % of GDP	5.2	4.1	6.8
Health expenditure per capita (USD)	278	202	95
Infant mortality rate (per1,000 live births)	13	11	17
Out-of-pocket health expenditure (% of private expenditure on health) (2011)	78.8	55.8	93.3
Life expectancy (2011)	75	74	75
Percent of population 65 years old and above	9	9	7

GDP – gross domestic product; NHE – national health expenditure
Source: World Bank (2013)

China: Insuring the millions

The developments in China's integration of pre-existing schemes toward universal coverage are summarized in Box 2.

Jiwei (2012, p. i) summarized the features of the Chinese SHI as follows: "First, all social insurance schemes in China are managed by the local government. Second, the central government and lower level governments provide subsidies to some of these schemes according to the number of enrollees. Third, enrollment into many social health insurance schemes is voluntary."

The country's huge population, now turning more urban than rural, not to mention more mobile, faces a great challenge in utilizing SHI coverage. Nearing total population coverage, costs are still very much an issue, despite state assurances of heightened reimbursements in recent years: 75 percent for inpatient care and 50 percent for outpatient care. Households continue to be at a disadvantage in terms of location, sex, age, income, and education, among others. Wealthier and urban households are said to be more likely to be protected from sinking into indebtedness and/or poverty.

Episode-based payment and fee-for-service payment have advanced in the light of liberalization (Li et al. 2012). Thus, Chinese hospitals and doctors have sought to make profit by adding technology-dependent procedures. Case-mix payment system has been the goal of introducing clinical pathway system (*linchuang lujing*) intended for standardization of health-care service (Jingwei 2010).

In this regard, the *National Schedule of Medical Services* third edition was released in May 2011 with the intention of becoming the national standard of pricing in the near term (Boynton et al. 2012). Fee categories in these latest editions (2007 and 2011) have been expanded from 6 to 11 "in order to reflect the efforts of medical personnel and technical risks in a reasonable way" (Boynton et al. 2012, p. 7).

It was in early 2016 when more than a billion rural people and unemployed city dwellers were consolidated under a basic insurance program. As urban residents have been covered

since 2007, per State Council action, some 40 projects were rolled out in rural areas experimenting in different payment schemes (WB 2015).

However, intentions and their mechanisms do not seem to work well. Chen et al. (2012) and O'Donnell et al. (2008) explained that OOP in China was progressive but not equitable. Public health insurance coverage has expanded but financing equity has decreased. O'Donnell et al. (2008) hypothesized: "If (the) aim (of the subsidy) is to ensure (that the) poor get most of public health services, then (it is) failing."

Box 2. China

1998 – Implemented the Urban Employee-Basic Medical Insurance (UE-BMI)
2003 – Implemented the New Rural Cooperative Medical Scheme (NCMS)
2007 – Implemented the Urban Residents-Basic Medical Insurance (UR-BMI) among 79 pilot cities
2010 – The UR-BMI targeted all cities
2009 – Integration of the three existing social health insurance schemes (UE-BMI, NCMS, UR-BMI) that covered 87 percent of the population
2010 – 93 percent of the population had some health insurance coverage
2011 – 95 percent of the total population had some form of insurance coverage
2012 – Introduced a supplementary scheme to cover critical diseases of rural and unemployed rural folks
2013 – 99 percent coverage (800 million) of the rural population reportedly under the NCMS

Source: Author's compilation

Thailand: 30-baht health coverage

The key developments in the Thai SHI are given in Box 3.

Thailand has developed a near-UHC for its people when it became one of Asia's fastest growing economies. Its UC scheme for a decade (2001–2010) has the following features:

- a tax-financed scheme free at the point of service (the initial co-payment of THB 30 or USD 0.7 per visit or admission was terminated in November 2006); and
- a comprehensive benefits package with a primary care focus, which is a fixed annual budget with a cap on provider payments.

Outpatient care was accessed at about 3.01 times per person per year at an average expense of THB 1,572.33 per time. For inpatient, it was 1.14 times per person per year and 3.89 days per time at 15,656.25 Baht per time. This was intended for 45 years old and above (Kananurak 2013).

The 30-baht premium collection was terminated in 2006 due to technical feasibility issues and was replaced by a general tax to cover UC scheme premiums. Premiums for SHI for public and private sector employees remained as independent schemes and were fully covered by enrollees (Tangcharoensathien et al. 2013).[3]

Capitation is the main mode of payment by government to contractors and their contracted service providers for outpatient services and prevention and health promotion (Srithamrongsawat n.d.). Under the UC scheme, the payment has risen from about

[3] For more on the UC scheme, see Suchonwanich (2010).

Box 3. Thailand

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

Source: Author's compilation

THB 1,200 in 2002 to about THB 1,900 in five years. Hence, inpatient services are paid by global budget plus diagnosis-related groups at provincial level (Srithamrongsawat n.d.). Global budget is planned to be operated at the national level. The National Health Security Office maintains and manages fee schedule for outside-registered provider of accident and emergency services. Although co-payment has not been provided for, the civil servants' medical benefit scheme is reportedly introducing it for long private room stays and boarding (Tangcharoensathien et al. 2006; Sricharoen 2008). The National Economic and Social Development Board proposed that the patients share cost of inpatient services in terms of co-payment under the UC (30-baht) scheme that covers about 48 million people. But in May 2013, activists protested against co-payments for people living with HIV/AIDS (Wangkiat 2013; Nitayarumphong, n.d.).

Viet Nam: How to pay for cure

While liberal policies under *doi moi* increased gross domestic product, they also negatively affected health by increasing cost of health services and medicines. (Marriott 2011; Nguyen 2011; *Viet Nam News* 2011; Vian et al. 2012; Nguyen 2013).[4] Increased government spending not only covered more people who were poor and near poor but also those under six years old, elderly, and students. Care utilization has steadily risen. The public sector still dominates the health scene with more human resources, hospitals, and beds, among others, than the private sector. It also covers all levels of health-care provision down to the communes. User fees, capitation, co-payment, and subsidies have seen rising cost of health care and also improvements in health status.

Since January 2010, Viet Nam has implemented a new schedule of premium rates for different categories of enrollees of insurance schemes. The schedule came with qualifications for

[4] Shortly after implementing the insurance law, at least one assessment spoke negatively on the poor's attitude toward enrollment. Corruption, too, has been expected to derail Viet Nam's SHI. Government's medicine procurement system is also deemed problematic.

government subsidies, some of them up to 100 percent for select categories.

Primary care and general district hospital care use capitation, whose rates depend on previous periods costs. The pyramidal service delivery structure places widespread community health centers at the base that are underutilized, their users being poor rural folks. The base quality of care is said to be inferior, adding to the preference for higher level care elsewhere up the pyramid. In the end, lower utilization maintains lower capitation and, consequently, poor use (Somanathan et al. 2013).

In 2009, the financing mix was estimated as consisting of large OOP at almost 70 percent and about 27 percent from the government. In one Vietnamese commune, as reported, "1 inpatient treatment (cost) is equivalent to 81 percent of mean annual income per capita for the uninsured and 37 percent for the insured who use the insurance. Five outpatient treatments equal 26 percent of mean annual income per capita for the uninsured and 12 percent for the insured who use the insurance" (Nguyen et al. 2012, p. 1459–1460).

Balance billing is reported widely prevalent and justified in pursuit of better quality technical services, pharmaceuticals, and supplies that are not part of the official price list and package. Likewise, informal payments to individual doctors and nurses are reported to be quite common at higher-level hospitals (Somanathan et al. 2013).

While Viet Nam indeed has improved in getting more people covered through existing schemes, it still has to address the improvements in services in a number of areas as suggested in assessments, critiques, and plans. Nonetheless, having mandatory and voluntary SHI schemes still has to contend with incidence of self-selection as people may or may not see or feel that they need coverage.

Some lessons

New challenges have confronted the Thai, Vietnamese, and Chinese health insurance systems as studies have indicated different outcomes of responses of the different SHIs. Lingering and worsening OOP expenses of the poor and near poor, corruption, health manpower and health technology availability, and financial sustainability problems haunt all three SHIs in varying degrees and forms (Nguyen 2005).[5]

Attempts to pool resources in order to expand services and coverage in the three countries have to contend with political and structural issues. The same is true for the Philippines. It is unfortunate that the thinking that more people covered would mean higher utilization and more resources has actually given rise to incidence of abuse, fraud, and selective benefit. Changing demographics also has impacts on the SHI transition to UHC. Bigger countries like China seem to have more

[5] Curiously, more than half of injured Vietnamese prefer OOP to cover medical cost.

challenges than smaller ones. Liberalizing regimes also keeps the authorities busy with moderating the impact of market forces, sometimes to little avail. Once unleashed, these forces compete with goals and objectives of inclusiveness and effectiveness. Good thing the Philippines has its Philippine Health Insurance Corporation as a state agency. All it has to do is keep to its true mandate.

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