Private health insurance: implications for developing countries

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Abstract Private health insurance is playing an increasing role in both high- and low-income countries, yet is poorly understood by researchers and policy-makers. This paper shows that the distinction between private and public health insurance is often exaggerated since well regulated private insurance markets share many features with public insurance systems. It notes that private health insurance preceded many modern social insurance systems in western Europe, allowing these countries to develop the mechanisms, institutions and capacities that subsequently made it possible to provide universal access to health care.

We also review international experiences with private insurance, demonstrating that its role is not restricted to any particular region or level of national income. The seven countries that finance more than 20% of their health care via private health insurance are Brazil, Chile, Namibia, South Africa, the United States, Uruguay and Zimbabwe. In each case, private health insurance provides primary financial protection for workers and their families while public health-care funds are targeted to programmes covering poor and vulnerable populations.

We make recommendations for policy in developing countries, arguing that private health insurance cannot be ignored. Instead, it can be harnessed to serve the public interest if governments implement effective regulations and focus public funds on programmes for those who are poor and vulnerable. It can also be used as a transitional form of health insurance to develop experience with insurance institutions while the public sector increases its own capacity to manage and finance health-care coverage.

Keywords Insurance, Health/organization and administration/trends; Private sector; Public sector; Health expenditures; Health policy; Public policy; Economic development; Developed countries; Developing countries (*source: MeSH, NLM*).

Mots clés Assurance maladie/organisation et administration/orientations; Secteur privé; Secteur public Dépenses de santé; Politique sanitaire; Politique gouvernementale; Développement économique; Pays développé; Pays en développement (*source: MeSH, INSERM*).

Palabras clave Seguro de salud/organización y administración/tendencias; Sector privado; Sector público; Gastos en salud; Política social; Desarrollo económico; Países desarrollados; Países en desarrollo (*fuente: DeCS, BIREME*).

الكلمات المفتاحية: التأمين، التأمين الصحي، منظمات وإدارة التأمين الصحي، الاتجاهات في منظمات وإدارة التأمين الصحي، القطاع الخاص، القطاع العام، الإنفاق الصحي، السياسات الصحية، السياسات العامة، التنمية الاقتصادية، البلدان المتقدمة، البلدان النامية. (المصدر: رؤوس الموضوعات الطبية – المكتب الإقليمي لشرق المتوسط)

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Introduction

As policy-makers consider how to move towards financing mechanisms that will protect their citizens from the financially catastrophic effects of illness, they have three broad options to consider: taxation, social security, and private health insurance (which consists of non-profit and for-profit plans as well as community health insurance schemes) (*1*, *2*).

Unlike taxation and social security, which are commonly viewed as promoting equity, private insurance often conjures up visions of unequal access, large numbers of uninsured people, and elite health care for the rich. Experience indicates that unregulated or poorly designed private health insurance systems can indeed exacerbate inequalities, provide coverage only for the young and healthy, and lead to cost escalation (*3*).

However, when appropriately managed, there are several ways in which private health insurance can play a positive role in improving access and equity in developing countries. First, out-of-pocket spending on health services is the most common form of health financing in developing countries and represents a significant financial burden for households (*4*). To the extent that private insurance gives households an opportunity to avoid large out-of-pocket expenditures, it can provide access to financial protection that is otherwise lacking.

Second, many developing countries have public expenditures for health of less than US$ 10 per person per year (*5*); however, the Commission on Macroeconomics and Health advises that it costs US$ 34 per person annually to provide a package of essential health interventions (*6*). Developing countries also have large informal sectors, which makes tax collection

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difficult. This limits the ability of developing countries to generate sufficient tax revenues or fund social insurance systems to provide broad financial protection for health care. Private coverage, when appropriately regulated, may be one way to move towards prepayment and risk-pooling until publicly funded coverage can expand sufficiently. It also allows policy-makers to aim limited public resources at the most vulnerable groups, while those who can afford to contribute towards their medical costs are required to do so.

Third, history shows that the social insurance systems in many developed countries evolved from voluntary private insurance schemes based on those of professional guilds or communities (*7*). These historical lessons in the gradual expansion of financial protection and the development of institutions may be useful in informing policy debates in developing countries as they consider moving towards public insurance systems.

Finally, private health insurance continues to be important even in countries where universal coverage has been achieved. Policy-makers who plan ahead for this supplementary role will be better prepared to ensure that private coverage complements public systems as they develop.

This paper provides an overview of the extent of private coverage around the world. It is not intended as an analysis of how voluntary insurance markets function, their historical development or how they are regulated. Rather, it highlights how widespread private insurance has become, and it is intended to encourage policy-makers and researchers to pay attention to private coverage and the role it can, and does, play in health-care systems.

Methods

Although most countries have some type of private health insurance market (*8*), only limited data are available on private insurance expenditure, populations covered, premiums charged and impact on the health-care system. This study uses data on private insurance available through National Health Accounts (Appendix 1, web version only, available at: http://www.who.int/bulletin). These data have several limitations: they are not available for all countries and may underestimate the role of private insurance, particularly in developing countries where the private market tends to be unregulated; trend data for private coverage is not reliable because reporting in this area began relatively recently; also, since little systematic data have been collected on insurance markets in developing countries, evidence tends to be anecdotal. Because of these limitations, the topic needs greater attention and would also benefit from the collection of more reliable data.

What is private health insurance?

In this paper we adopt the taxonomy of the Organisation for Economic Co-operation and Development (OECD) that distinguishes public from private insurance on the basis of the source of funds (*9*). Ultimately, all money comes from household or employer income, but in public insurance programmes this money is channelled through the state via a general or social insurance tax, whereas in private insurance the money is paid directly to the risk-pooling entity (Fig. 1).

Private health insurance is often characterized as voluntary, for-profit commercial coverage in contrast to mandatory, publicly financed and publicly managed insurance. However, a review of insurance arrangements around the world shows that a wide variety of forms exist under the umbrella of private insurance and that the boundaries between public insurance and private insurance are becoming increasingly blurred (*8*). The term public insurance is used here to encompass the full range of schemes that are variously described as "social insurance" or "national insurance". Fig. 2 suggests a spectrum of arrangements classified along three key dimensions:

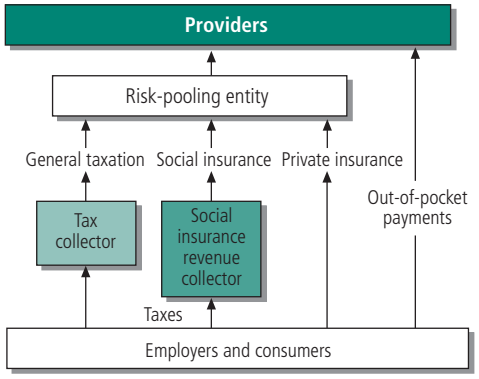
- whether insurance is mandatory or voluntary;
- whether contributions are risk-rated (minimal risk transfer), community-rated (transfers between healthy and sick), or income-based (transfers between higher income and lower income individuals);
- whether management of the scheme is commercial for-profit, private non-profit, or public/quasi-public.

This spectrum should not be construed as a causal or developmental model but one that highlights the variety that exists. Although private and public insurance are often discussed in terms of extremes, the most common arrangements are actually found in the centre. In the first dimension, as the spectrum in Fig. 2 shows, private insurance generally tends to be voluntary while public insurance tends to be mandatory, but this is not always the case. In Switzerland and Uruguay the purchase of private cover is mandatory (similar to public insurance systems), whereas in Mexico the new public insurance scheme (known as Seguro Popular) is voluntary (*10*).

In the dimension of contributions, private insurance premiums tend to be risk-rated or community-rated, while public insurance contributions tend to be income-based, but again there are exceptions, such as Chile where individuals can purchase private coverage with mandated income-based contributions. Variations are even more pronounced in the management of insurance schemes. In Australia, India and Ireland for example, the largest "private" insurance companies are publicly owned, and in many social insurance systems private entities manage publicly financed sickness funds.

In addition to the three dimensions outlined above, private insurance can be classified by the different roles it has in the health-financing system. The OECD Adhoc Group on Private Insurance identifies four categories of private health insurance: primary, duplicate, complementary and supplementary. For our purposes, we have chosen to emphasize the difference between systems in which private health insurance provides "primary

Fig.1. **Type of financing mechanisms**



Adapted from: Normand C, Busse R. Social health insurance financing. In: Mossialos E, Dixon A, Figueras J, Kutzin J, editors. *Funding health care: options for Europe*. Buckingham (PA): Open University Press; 2000. p. 59–79.

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Fig. 2. **Types of insurance**

	Privately funded (private insurance) ←						→ Publicly funded through some form of taxation (public insurance)			
Type of enrolment (Voluntary–mandatory)	Voluntary	Voluntary	Voluntary	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary	Mandatory	Mandatory
Type of contributions (Risk-rated–community-rated–income-based)	Risk-rated	Risk-rated	Community-rated	Community-rated	Community-rated	Income-based	Community-rated	Income-based	Income-based	Income-based
Type of management (Private for-profit–non-profit–public)	For-profit commercial	Non-profit	Non-profit community	Public	Non-profit	Non-profit	For-profit commercial	Public	Non-profit	Public
Examples	Tata AIG in India	BUPA in United Kingdom	Self-employed Women's Association health insurance in India	Medibank in Australia	Collective Heath Care Institutions (CHCI) in Uruguay	Some private health insurance plans (known as ISAPREs) in Chile	Various in Switzerland	Seguro Popular in Mexico	Various in the Netherlands	Slovakia

coverage" (corresponding to the OECD's category of "primary health insurance") and those in which it provides "secondary coverage" (corresponding to the other three categories) (*9*).

When it provides primary coverage, private insurance is the primary form of risk pooling for some portion of the population. For example, in the United States private insurance provides primary coverage for the non-poor who are younger than 65 years old, while in the Netherlands, households not eligible for public sickness funds purchase private coverage (*7*). Primary insurance usually covers a broad package of health services, often mirroring those financed in a public system.

In secondary coverage, private insurance complements the coverage provided by a publicly funded system, often covering a limited set of interventions that address particular gaps in a country's public coverage. Insurance policies may cover residual health care costs, such as co-payments; services not included in the basic publicly funded package, such as outpatient drugs or dental care; or allow easier access to services offered by public and private providers, such as in Australia and the United Kingdom, where private policies enable subscribers to gain faster access to specialists and elective hospital care.

The international situation

Variations by income level

In 2001, 39 countries in the world had private insurance markets contributing to more than 5% of total health expenditure, with almost half (46%) of these nations belonging to the low-income and lower–middle income categories (Table 1).

The role of private insurance differs depending on the country's wealth and institutional development. In many lower- and middle-income countries, private insurance is the only form of risk pooling available and provides primary coverage, largely to those who are employed. Historically, this is not unlike the situation in western Europe in the 19th century when the only significant forms of insurance were provided by mutual associations, employers, guilds or unions. For example, in 1885 10% of Sweden's workforce was covered by voluntary private insurance schemes called friendly societies (*11*), and in Germany, Bismarck established the first national social insurance system by knitting together voluntary, pre-existing occupationally and industrially based sickness funds (*12*).

By contrast, in most high-income countries, private insurance provides secondary coverage to predominantly publicly funded systems. In France, for example, 86% of the population purchases private policies to pay for co-payments, while in the Netherlands more than 90% of the population purchases either primary or secondary insurance plans (*13*) (Fig. 3). In high-income countries, private insurance, particularly when it provides primary coverage, is stringently regulated (*14*). Australia and Ireland strictly regulate their large secondary insurance markets as well (*15*, *16*).

Variations by region

Latin America

Latin America has the highest proportion of countries with private coverage that contributes over 5% to total health expenditure. In many countries, health-care reforms over the past two decades have used private insurance as an explicit strategy to attract private funds into the health sector. Several countries have encouraged investment from foreign insurers and managed care companies, but in opening their health insurance markets many have failed to enact adequate regulatory controls to achieve equity and ensure consumer protection (*17*). There have been efforts made to remedy this situation but enforcement of regulations remains weak and presents a challenge to policy-makers (*17*).

Africa and the Middle East

Private health insurance markets also exist in Africa, with Namibia, South Africa and Zimbabwe funding more than 20% of health-care costs through private insurance. Botswana, Côte

d'Ivoire, Kenya, Madagascar and Mali have relatively large markets as well. Community health insurance schemes, such as the mutuelles in Senegal (*12*, *18*), are extensive in some countries. In Africa, private coverage has often emerged as the result of market forces and laissez faire government policies towards the private sector. Regulation of insurers tends to be weak, bringing with it the danger of increasing inequity and cost escalation.

In north Africa and the Middle East, Bahrain, Lebanon, Morocco, Saudi Arabia and Tunisia have significant private health insurance markets. Other countries are exploring opening their markets to domestic and foreign insurers to address the needs of their large immigrant workforces and to deal with increasing demands for health services fuelled by rising income levels (*19*).

Asia

Asia presents particular challenges and opportunities in terms of private coverage. It is the region in which out-of-pocket expenditures account for the highest share of total health spending and where private insurance could play a part in moving towards greater prepayment and risk pooling. In many countries in Asia, private health insurance markets have developed without an adequate regulatory framework, and there is a risk that private coverage will result in cost escalation and cream skimming (i.e. actions by insurers aimed at enrolling only profitable low-risk clients). Data on private insurance from National Health Accounts are unavailable for many countries in this region, but it is estimated that India has the largest market with 3.3% of the population, or 33 million insured (*20*). In terms of contribution to total health expenditures, the Philippines leads the region at 10.8%, followed by the Republic of Korea (9.5%), Australia (7.8%), New Zealand (6.2%) and Indonesia (6.1%). Other countries, such as China, are opening their markets to private insurers. Several successful and well documented community health schemes also exist in this region (*12*).

Elsewhere: eastern Europe and central Asia

Several countries in eastern Europe and central Asia are considering opening their markets to private insurers for secondary coverage (*21*). Slovenia has one of the most well developed private insurance systems, funding almost 15% of total health-care expenditures in 2001; Albania's market funded 12% of its health expenditures in that year. Turkmenistan has a private insurance market that accounts for 7% of its total expenditure on health.

Countries with the highest private insurance expenditures

In 2001, seven countries stood out for funding more than 20% of their total health expenditure through private coverage (Fig. 4). Each of these countries used private insurance to provide primary coverage for a segment of its population. Interestingly, these countries included Zimbabwe, a low-income country that spent US$142 annually per capita on health care (in international dollars, which are US dollars adjusted for purchasing power parity), and the United States, which spent the highest amount on health care in the world (US$ 4887 per capita) (*22*). Three of these seven are adjoining nations in sub-Saharan Africa (Namibia, South Africa and Zimbabwe) and three are in South America (Brazil, Chile and Uruguay). These six countries all received significant numbers of European immigrants (*23*), but the countries in the Americas won their independence much earlier, and consequently developed health insurance institutions over a longer period of time and in parallel with similar developments in western Europe. By contrast, health insurance schemes in the African countries, which were established under colonial governments, have developed independently for only a few decades.

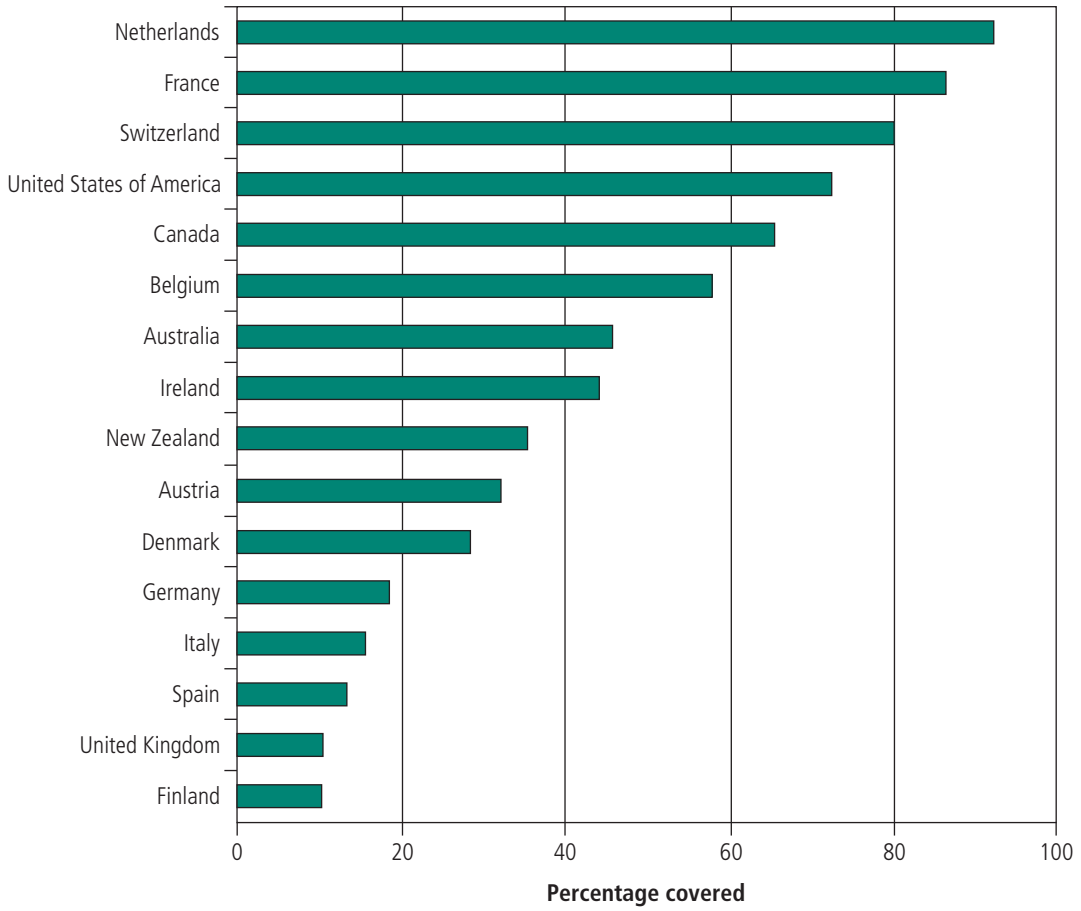
Table 1. **Countries with private insurance expenditures > 5% of total health expenditure by income level, 2001**

Income level	Country
Low-income countries	Côte d'Ivoire Indonesia Kenya Madagascar Mali Zimbabwe
Lower–middle-income countries	Albania Brazil Colombia Jamaica Morocco Namibia Paraguay Peru Philippines South Africa Tunisia Turkmenistan
Upper–middle-income countries	Argentina Botswana Chile Lebanon Panama Saudi Arabia Uruguay
High-income countries	Australia Austria Bahrain Barbados Canada France Germany Ireland Netherlands New Zealand Slovenia Switzerland United States

Source: National Health Accounts, 2001, World Health Organization.
Income categories were derived from information from The World Bank, 2004.

In the three African countries, private insurance covers a relatively small share of the population despite representing a large share of total expenditure. For example, in Zimbabwe in 2001, an estimated 8% of the population purchased private cover (*24*), accounting for 23% of total health expenditure. Formal sector workers benefited most from this coverage: 17% were insured through private schemes (*3*). In Namibia, private coverage also protects primarily those who are employed in the formal sector (*25*). South Africa has a history of more than 100 years of private insurance that is based largely on mutual insurers called medical schemes or medical aid societies. Wealthier people benefit most from this insurance, with 80% of those in the two highest income quintiles being covered compared

Fig. 3. **Percentage of population covered by some type of private health insurance including both primary and secondary coverage in selected high-income countries, 2000[a]**



Source: Ref. *13*

[a] Data for Australia, New Zealand and Spain are from 2001. Data for Denmark are from 1998. Data from Italy are from 1999.

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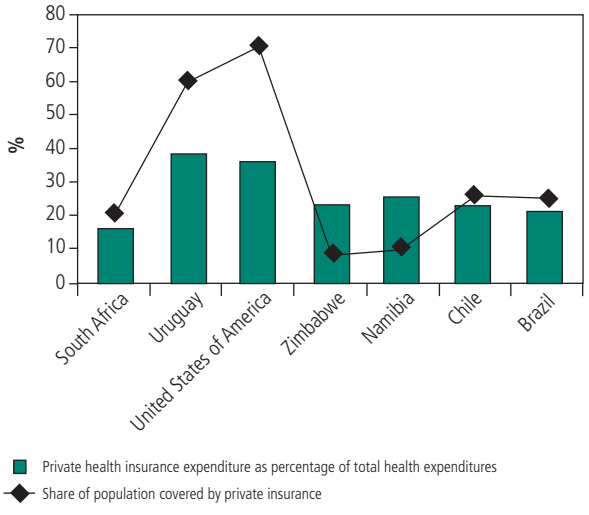
to only 2% of those in the lowest income quintile (*26*). In all of these countries, public systems exist to cover the poorest members of society, although quality and access to care in the public system varies. In the African countries only South Africa has a strong regulatory structure governing the private market. In 2002, the government proposed major reforms, aiming to achieve universal health coverage; this envisions a gradual evolution of the private insurance market into a mandatory social insurance system (*26*, *27*).

Unlike the sub-Saharan countries, the three Latin American countries have much larger private health insurance markets. Uruguay is unique in having a mandatory, private insurance system that covers over 60% of the population. This system is complemented by publicly funded programmes for elderly people and poor people (*28*). Uruguay has a long history of health insurance regulation aimed at making insurers serve public policy goals. In Chile, the role of private insurance in health-care financing is explicit and allows those who can afford it to opt out of the publicly funded health system and buy private cover (*29*). In contrast, Brazil's private health insurance market has grown despite public policies aimed at establishing a universal, publicly financed health-care system. In both Chile and Brazil, private insurers emerged in an arena with relatively little regulation, but since the late 1990s, as a result of market failures, both countries have been trying to impose more stringent regulations on insurers (*30*).

The United States is the only high-income country to rely on voluntary subscription to private insurance to provide coverage for most of its people. More than 70% of the population obtains health coverage through private insurers, with almost 64% of this being purchased through employment-based insurance plans (*31*). However, per capita public expenditure on health in the United States is on a par with the total health expenditure of most OECD countries and covers elderly, disabled, and poor people through public insurance programmes, such as Medicare and Medicaid, as well as through a system of public hospitals and community clinics. The United States' private insurance market is heavily regulated, and many states mandate community rating or do not permit premiums that are fully risk-rated. Altogether, 75% of states require insurers to offer coverage for certain segments of the population regardless of an individual's health status. Almost half of the states have set up insurance pools to cover high-risk populations that are funded through assessments on insurers (*8*).

While these seven countries differ significantly in income levels, the percentage of people covered through private insurance, and the extent of effective regulations governing the private market, they have two similarities worth noting. First, in each of these countries private insurance provides the primary form of financial protection available to those who are employed and their families. Second, in each of these countries, vulnerable populations are covered through publicly funded programmes.

Fig. 4. **Countries with highest private health insurance expenditures as a percentage of total health expenditures, 2001**



Sources: Expenditures from National Health Accounts, 2001, World Health Organization.
Share of Population Covered: refs. *13, 20, 24, 25, 26, 28.*

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Implications for policy-makers in developing countries

As this paper shows, private health insurance is more widespread than public debate may lead us to believe. Many developing countries have private insurance schemes that serve their middle class and may also afford some degree of financial protection for the poor. Many developed countries use secondary private insurance to fill gaps in their publicly funded systems and to pay for an increasing demand for health services.

As policy-makers in developing countries consider whether they will allow private insurance to emerge or, if it already exists, how they can better manage the market, a few lessons are worth noting. First, no high- or middle-income country uses private coverage as the primary method for insuring populations who are poor or at high risk. Even in the United States, which has the largest private insurance market in the world, poor people and elderly people are covered through large, publicly funded programmes. Thus, private insurance, like many social insurance programmes, provides an opportunity for those who are employed and those who can afford it to contribute directly to the costs of health care, and it serves as a mechanism to capture private funds to finance growing demands on the health-care system. In countries with limited public resources it allows tax revenues to be targeted at services to provide health care for the poor.

Second, government stewardship of health insurance markets is critical to their effective functioning. Developed countries that rely on private insurance to cover large segments of their population, or in which private insurance plays a prominent role, intervene significantly in the market to ensure adequate consumer protection and equity. Through policies, incentives and regulations they essentially "conscript private insurance to serve the public goal of equitable access" (*8*). Although we recognize that the institutions necessary for stewardship are often weak in developing countries, it can be argued that the challenge of regulating health insurance markets is no more complex than operating an efficient, high quality public system of hospitals and clinics. Indeed, the oversight of private insurers may conform more closely to the comparative advantages of government.

Finally, the experiences of Germany, the Netherlands and Sweden show that as countries move towards universal coverage the role of private health insurance may change (*7*, *32*). When public funding is low, private insurance can serve as a transitional mechanism by building capacity and providing financial protection for certain segments of the population, thus allowing limited tax revenues to be directed towards public goods and vulnerable groups. The institutional capacity, information systems, and skills involved in regulating private health insurance may later be useful in managing publicly funded schemes as they expand.

Whether a country considers private health insurance to be a transitional measure on the road to developing a comprehensive publicly funded system, a predominant form of insurance coverage in future, or an unwelcome but irrepressible guest, private health insurance will be a factor in health financing. The challenge is to choose how to use it wisely. ■

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Conflicts of interest: none declared.

Résumé

Assurance-maladie privée : conséquences pour les pays en développement

L'assurance-maladie privée joue un rôle croissant dans les pays riches comme dans ceux à faibles revenus, mais ce rôle est mal compris par les chercheurs et les décideurs politiques. Le présent article montre que la distinction entre assurances-maladie privées et publiques est souvent exagérée dans la mesure où les marchés de l'assurance privée bien réglementés présentent beaucoup de caractéristiques communes avec les systèmes d'assurance publics. Il note que l'assurance-maladie privée a précédé les systèmes d'assurance sociale modernes dans de nombreux pays d'Europe occidentale, ce qui a permis à ces pays de développer des mécanismes, des institutions et des capacités qui ont ensuite rendu possible un accès universel aux soins de santé.

Les auteurs ont également examiné les expériences internationales en matière d'assurance privée, en démontrant que le rôle de celle-ci ne se restreint pas à une région ou à un niveau de revenu national particulier. Les sept pays qui financent plus de 20 % de leurs soins de santé via des assurances-maladie privées sont le Brésil, le Chili, la Namibie, l'Afrique du Sud, les États-unis, l'Uruguay et le Zimbabwe. Dans chaque cas, l'assurance-maladie privée fournit une protection financière primaire aux travailleurs et

à leurs familles, tandis que les fonds affectés aux soins de santé publics sont principalement destinés à des programmes couvrant les populations pauvres et vulnérables.

Les auteurs ont formulé des recommandations concernant les politiques à adopter dans les pays en développement, arguant qu'il n'est plus possible d'ignorer l'assurance-maladie privée. Celle-ci peut au contraire être mise au service de l'intérêt public si les gouvernements appliquent des réglementations efficaces et concentrent les fonds publics sur des programmes destinés aux personnes pauvres et vulnérables. Elle peut aussi être employée comme forme transitoire d'assurance-maladie pour acquérir de l'expérience avec les organismes d'assurance, pendant que le secteur public développe sa propre capacité à gérer et à financer la couverture maladie.

Resumen

Seguros médicos privados: implicaciones para los países en desarrollo

Los seguros médicos privados están desempeñando un papel cada vez más importante tanto en los países de ingresos altos como en los países de ingresos bajos, pero los investigadores y los formuladores de políticas no comprenden bien todos sus aspectos. En este artículo se muestra que a menudo se exageran las diferencias entre los seguros privados y la salud pública, y es que los mercados de seguros privados bien regulados comparten muchas características con los sistemas de seguro públicos. Se señala que el seguro médico privado precedió a muchos sistemas modernos de seguridad social en Europa occidental, lo que permitió a los países de esa región crear los mecanismos, las instituciones y la capacidad que posteriormente hicieron posible el acceso universal a la atención de salud.

Examinamos asimismo las experiencias internacionales con sistemas de seguro privados, y mostramos que esta opción no se limita a determinadas regiones o niveles de ingresos nacionales. Los siete países que financian más del 20% de su atención sanitaria a través de seguros privados son el Brasil, Chile, los Estados Unidos, Namibia, Sudáfrica, el Uruguay y Zimbabwe. En todos esos casos, los seguros médicos privados garantizan una protección financiera básica para los trabajadores y sus familias, mientras se usan fondos públicos para financiar programas que cubren a las poblaciones pobres y vulnerables.

Hacemos algunas recomendaciones para la formulación de políticas en los países en desarrollo, sosteniendo que no es posible ignorar la existencia de los seguros privados. Antes bien, es preciso aprovecharlos en aras del interés público, siempre que los gobiernos implanten medidas de regulación eficaces y centren los fondos públicos en programas orientados a las poblaciones pobres y vulnerables. También se puede recurrir a ellos como una forma transitoria de seguro de enfermedad para adquirir experiencia con las instituciones aseguradoras, mientras el sector público aumenta su propia capacidad para administrar y financiar la cobertura asistencial.

ملخص

التأمين الصحي في القطاع الخاص: تأثيراته في البلدان النامية

الملخص: يؤدي التأمين الصحي في القطاع الخاص دوراً متزايداً في كل من البلدان المنخفضة الدخل والمرتفعة الدخل، إلا أن هذا الدور غير مفهوم بشكل جيد لدى الباحثين ولدى أصحاب القرار السياسي. وتستعرض هذه الورقة كيف يمكن أن يمتاز التأمين الصحي في القطاع الخاص عنه في القطاع العام وأن يزداد تميزه مع ازدياد التنظيم في أسواق التأمين في القطاع الخاص ليشارك في ملاءمه ما لنظم التأمين الصحي في القطاع العام من ملامح. وقد لاحظنا أن التأمين الصحي في القطاع الخاص كان يسبق الكثير من النظم المعاصرة للتأمين الاجتماعي في بلدان أوروبا الغربية، مما سمح لهذه البلدان بتطوير آليات ومؤسسات وقدرات سهلت من إتاحة الرعاية الصحية على نطاق واسع.

كما قمنا بمراجعة الخبرات العالمية في مجال التأمين الصحي في القطاع الخاص، مع إظهار أن دوره لا ينحصر في منطقة بعينها أو في مستوى واحد من الدخل الوطني. والبلدان السبعة التي تمول أكثر من 20% من الرعاية الصحية فيها بالتأمين الصحي في القطاع الخاص هي البرازيل، وشيلي، وناميبيا، وجنوب أفريقيا، والولايات المتحدة الأمريكية، والأورغواي، وزيمبابوي. وفي كل حالة من هذه الحالات، يقدم التأمين الصحي في القطاع الخاص الحماية التمويلية للعاملين ولأسرهم، فيما توجَّه تمويلات الرعاية الصحية في القطاع العام نحو البرامج التي تغطي الفقراء والسكان الأكثر تعرضاً والأشد تأثراً.

وقد انتهينا بإعداد توصيات خاصة بالسياسات في البلدان النامية، مع افتراض أن التأمين الصحي في القطاع الخاص لا يمكن إهماله؛ وبدلاً من ذلك يمكن استثمار التأمين الصحي في القطاع الخاص وتوجيهه لخدمة الصالح العام إذا ما نفذت الحكومات تشريعات فعالة وركّزت ما لدى القطاع العام من تمويلات نحو البرامج الخاصة بالفقراء وبالسكان الأكثر تعرضاً والأشد تأثراً. كما يمكن الاستفادة من التأمين الصحي في القطاع العام باعتباره شكلاً مرحلياً (انتقالياً) للتأمين الصحي، لتنمية الخبرات في مؤسسات التأمين، في الوقت الذي يزيد فيه القطاع العام من قدراته لإدارة وتمويل التغطية بالرعاية الصحية.

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Appendix 1. **2001 data from National Health Accounts used in this review**

Country	Total health expenditure as percentage of GDP[a]	Private health expenditure as percentage of total health expenditure	Private insurance as percentage of total health expenditure	Private insurance as percentage of private health expenditure	Out-of-pocket payments as percentage of private health expenditure	Out-of-pocket payments as percentage of total health expenditure
Afghanistan	5.2	47.4	0	0	100	47.4
Albania	3.7	35.4	12	33.9	65.3	23.1
Algeria	4.1	25	1.3	5.1	89.9	22.4
Andorra	5.7	29	NA[b]	NA	92.6	26.9
Angola	4.4	36.9	0	0	100	36.9
Antigua and Barbuda	5.6	39.1	NA	NA	100	39.1
Argentina	9.5	46.6	14.5	31.1	62.4	29.1
Armenia	7.8	58.8	0	0	100	58.8
Australia	9.2	32.1	7.8	24.2	59.6	19.1
Austria	8	30.7	7.1	23.3	61.3	18.8
Azerbaijan	1.6	33.1	0.8	2.3	97.7	32.3
the Bahamas	5.7	43	NA	NA	100	43
Bahrain	4.1	31	8.4	27.2	69.3	21.5
Bangladesh	3.5	55.8	0	0	93.2	52
Barbados	6.5	33.7	7.9	23.4	76.6	25.8
Belarus	5.6	13.3	0	0.3	99.7	13.3
Belgium	8.9	28.3	1.9	6.8	58.8	16.7
Belize	5.2	54.9	0	0	100	54.9
Benin	4.4	53.1	NA	NA	99.9	53
Bhutan	3.9	9.4	0	0	100	9.4
Bolivia	5.3	33.7	2.6	7.7	85.7	28.8
Bosnia and Herzegovina	7.5	63.2	0	0	100	63.2
Botswana	6.6	33.8	6.9	20.5	35.3	11.9
Brazil	7.6	58.4	20.9	35.9	64.1	37.5
Brunei Darussalam	3.1	20.6	0	0	100	20.6
Bulgaria	4.8	17.9	0	0	98	17.6
Burkina Faso	3	39.9	NA	NA	97.4	38.9
Burundi	3.6	41	0	0	100	41
Cambodia	11.8	85.1	0	0	84.6	72.1
Cameroon	3.3	62.9	NA	NA	81.6	51.3
Canada	9.5	29.2	11.5	39.3	52.3	15.3
Cape Verde	4.5	16.1	NA	NA	100	16.1
Central African Republic	4.5	48.8	0	0	95.4	46.6
Chad	2.6	24	NA	NA	80.9	19.4
Chile	7	56	22.6	40.3	59.6	33.4
China	5.5	62.8	0.2	0.4	95.4	59.9
Colombia	5.5	34.3	11.9	34.8	65.2	22.4
Comoros	3.1	40	0	0	100	40
Congo	2.1	36.2	NA	NA	100	36.2
Cook Islands	4.7	32.4	0	0	100	32.4
Costa Rica	7.2	31.5	0.5	1.5	92.1	29
Côte d'Ivoire	6.2	84	8.6	10.3	89.7	75.4
Croatia	9	18.2	0	0	100	18.2
Cuba	7.2	13.8	0	0	76.8	10.6
Cyprus	8.1	52.3	1	2	98	51.3
Czech Republic	7.4	8.6	0	0	100	8.6
Democratic People's Republic of Korea	2.5	26.6	0	0	100	26.6
Democratic Republic of the Congo	3.5	55.6	0	0	100	55.6
Denmark	8.4	17.6	1.6	9.2	90.8	16
Djibouti	7	41.2	0	0	55.2	22.7
Dominica	6	28.7	0	0	100	28.7
Dominican Republic	6.1	63.9	0.2	0.4	88.4	56.5

(Appendix 1, cont.)

Country	Total health expenditure as percentage of GDP[a]	Private health expenditure as percentage of total health expenditure	Private insurance as percentage of total health expenditure	Private insurance as percentage of private health expenditure	Out-of-pocket payments as percentage of private health expenditure	Out-of-pocket payments as percentage of total health expenditure
Ecuador	4.5	49.7	4.7	9.5	73.8	36.7
Egypt	3.9	51.1	0.3	0.5	92.2	47.1
El Salvador	8	53.3	2.6	4.9	94.9	50.6
Equatorial Guinea	2	39.6	0	0	52.3	20.7
Eritrea	5.7	34.9	0	0	100	34.9
Estonia	5.5	22.2	1.1	4.8	84.7	18.8
Ethiopia	3.6	59.5	0	0	84.7	50.3
Fiji	4	32.9	0	0	100	32.9
Finland	7	24.4	2	8.3	82.7	20.2
France	9.6	24	12.7	53.1	42.6	10.2
Gabon	3.6	52.1	0	0	100	52.1
Gambia	6.4	50.6	0	0	90	45.6
Georgia	3.6	62.2	0.2	0.3	99.7	62.1
Germany	10.8	25.1	8.4	33.5	42.4	10.6
Ghana	4.7	40.4	0	0	100	40.4
Greece	9.4	44	2	4.4	73.9	32.5
Grenada	5.3	28.1	0	0	100	28.1
Guatemala	4.8	51.7	2.7	5.3	85.7	44.3
Guinea	3.5	45.9	0	0	100	45.9
Guinea-Bissau	5.9	46.2	0	0	100	46.2
Guyana	5.3	20.1	0	0	100	20.1
Haiti	5	46.6	NA	NA	45.3	21.1
Honduras	6.1	46.9	3.5	7.5	88.9	41.7
Hungary	6.8	25	0.3	1.3	85.5	21.4
Iceland	9.2	17.1	0	0	100	17.1
India	5.1	82.1	NA	NA	100	82.1
Indonesia	2.4	74.9	6.1	8.2	91.8	68.8
Iran (Islamic Republic of)	6.3	56.5	1.5	2.6	94.2	53.2
Iraq	3.2	68.2	0	0	100	68.2
Ireland	6.5	24	6.8	28.4	55.2	13.3
Israel	8.7	30.8	0	0	100	30.8
Italy	8.4	24.7	0.9	3.6	82.1	20.3
Jamaica	6.8	57.9	13	22.5	73.4	42.5
Japan	8	22.1	0.3	1.4	74.9	16.6
Jordan	9.5	53	4	7.4	73.9	39.2
Kazakhstan	3.1	39.6	0	0	100	39.6
Kenya	7.8	78.6	7.5	9.5	67.6	53.1
Kiribati	8.6	1.2	0	0	100	1.2
Kuwait	3.9	21.2	0	0	100	21.2
Kyrgyzstan	4	51.3	0	0	100	51.3
Lao People's Democratic Republic	3.1	44.5	NA	NA	80	35.6
Latvia	6.4	47.5	0.2	0.3	99.7	47.3
Lebanon	12.2	71.9	11.8	16.5	81.2	58.4
Lesotho	5.5	21.1	0	0	100	21.1
Liberia	4.3	24.1	0	0	84.2	20.3
Libyan Arab Jamahiriya	2.9	44	0	0	100	44
Lithuania	6	29.5	0	0	91.7	27.1
Luxembourg	6	10.1	1.5	14.6	74.6	7.6
Madagascar	2	34.1	5.1	15	85	29
Malawi	7.8	65	1	1.6	43.7	28.4
Malaysia	3.8	46.3	3.3	7.2	92.8	43
Maldives	6.7	16.5	0	0	100	16.5
Mali	4.3	61.4	11.5	18.7	72.4	44.4
Malta	8.8	31.5	0	0	100	31.5
Marshall Islands	9.8	35.3	0	0	100	35.3

(Appendix 1, cont.)

Country	Total health expenditure as percentage of GDP[a]	Private health expenditure as percentage of total health expenditure	Private insurance as percentage of total health expenditure	Private insurance as percentage of private health expenditure	Out-of-pocket payments as percentage of private health expenditure	Out-of-pocket payments as percentage of total health expenditure
Mauritania	3.6	27.6	0	0	100	27.6
Mauritius	3.4	40.5	0	0	100	40.5
Mexico	6.1	55.7	2.7	4.9	92.4	51.5
Micronesia (Federated States of)	7.8	28	0	0	35.7	10
Monaco	7.6	43.9	0	0	100	43.9
Mongolia	6.4	27.7	0	0	73.4	20.3
Morocco	5.1	60.7	13.8	22.7	74.1	45
Mozambique	5.9	32.6	0.2	0.5	39.3	12.8
Myanmar	2.1	82.2	0	0	99.6	81.9
Namibia	7	32.2	25.1	77.9	17.9	5.8
Nauru	7.5	11.3	0	0	100	11.3
Nepal	5.2	70.3	0	0	93.3	65.6
the Netherlands	8.9	36.7	15.5	42.4	24.1	8.8
New Zealand	8.3	23.2	6.2	26.5	72	16.7
Nicaragua	7.8	51.5	2.1	4	93.1	47.9
Niger	3.7	60.9	1.8	2.9	85.4	52
Nigeria	3.4	76.8	0	0	100	76.8
Niue	7.7	3	0	0	100	3
Norway	8	14.5	0	0	96.8	14
Oman	3	19.3	0	0	42.9	8.3
Pakistan	3.9	75.6	0	0	100	75.6
Palau	9.2	8	0	0	100	8
Panama	7	31	5.8	18.7	81.2	25.2
Papua New Guinea	4.4	11	1	9.4	83.3	9.1
Paraguay	8	61.7	17.5	28.4	71.6	44.2
Peru	4.7	45	7.2	16.1	81.7	36.8
the Philippines	3.3	54.8	10.8	19.8	78.2	42.8
Poland	6.1	28.1	2.1	7.6	92.4	26
Portugal	9.2	31	1.3	4.3	58.5	18.1
Qatar	3.1	26.5	0	0	33.7	8.9
Republic of Korea	6	55.6	9.5	17.2	74.3	41.3
Republic of Moldova	5.7	50.3	NA	NA	100	50.3
Romania	6.5	20.8	1.6	7.9	92.1	19.1
Russian Federation	5.4	31.8	1.4	4.5	84.4	26.9
Rwanda	5.5	44.5	0.1	0.3	66.1	29.4
Saint Kitts and Nevis	4.8	33.7	NA	NA	100	33.7
Saint Lucia	4.5	35.4	NA	NA	100	35.4
Saint Vincent and the Grenadines	6.1	36.5	NA	NA	100	36.5
Samoa	5.8	17.8	0	0	87.5	15.6
San Marino	6.8	22	NA	NA	100	22
Sao Tome and Principe	2.3	32.3	0	0	100	32.3
Saudi Arabia	4.6	25.4	9.4	36.8	38	9.7
Senegal	4.8	41.2	3.5	8.4	91.6	37.7
Serbia and Montenegro	8.2	20.8	0	0	100	20.8
Seychelles	6	31.8	0	0	75	23.9
Sierra Leone	4.3	39	0	0	100	39
Singapore	3.9	66.5	0	0	97	64.4
Slovakia	5.7	10.7	0	0	100	10.7
Slovenia	8.4	25.1	14.6	58.3	41.7	10.4
Solomon Islands	5	6.5	0	0	49.2	3.2
Somalia	2.6	55.4	0	0	100	55.4
South Africa	8.6	58.6	42.4	72.2	22.1	12.9
Spain	7.5	28.6	4	14.1	82.8	23.7
Sri Lanka	3.6	51.1	0.6	1.1	95	48.6

(Appendix 1, cont.)

Country	Total health expenditure as percentage of GDP[a]	Private health expenditure as percentage of total health expenditure	Private insurance as percentage of total health expenditure	Private insurance as percentage of private health expenditure	Out-of-pocket payments as percentage of private health expenditure	Out-of-pocket payments as percentage of total health expenditure
Sudan	3.5	81.3	0	0	99.3	80.7
Suriname	9.4	39.8	0.3	0.7	57	22.7
Swaziland	3.3	31.5	0	0	100	31.5
Sweden	8.7	14.8	0	0	100	14.8
Switzerland	11	42.9	10.2	23.8	73.9	31.7
Syrian Arab Republic	5.4	56.1	0	0	100	56.1
Tajikistan	3.4	71.1	0	0	100	71.1
Thailand	3.7	42.9	4.1	9.6	85	36.5
Former Yugoslav Republic of Macedonia	6.8	15.1	0	0	100	15.1
Timor-Leste	9.8	40.5	0	0	20.8	8.4
Togo	2.8	51.4	NA	NA	100	51.4
Tonga	5.5	38.4	0	0	100	38.4
Trinidad and Tobago	4	56.7	4	7.1	86.5	49
Tunisia	6.4	24.3	5.4	22.4	77.6	18.9
Turkey	5	29	0.3	1.2	98.8	28.7
Turkmenistan	4.1	26.7	7	26.3	73.7	19.7
Tuvalu	5.4	46.6	0	0	100	46.6
Uganda	5.9	42.5	0.2	0.5	53.4	22.7
Ukraine	4.3	32.2	0	0	100	32.2
United Arab Emirates	3.5	24.2	4.6	19.1	65.6	15.9
United Kingdom	7.6	17.8	3.1	17.2	55.3	9.9
United Republic of Tanzania	4.4	53.3	2.4	4.4	83.1	44.3
United States of America	13.9	55.6	35.6	64.1	26.5	14.8
Uruguay	10.9	53.7	37.3	69.6	30.4	16.3
Uzbekistan	3.6	25.5	0	0	100	25.5
Vanuatu	3.8	40.8	0	0	100	40.8
Venezuela	6	37.9	1.8	4.6	95.4	36.1
Viet Nam	5.1	71.5	3	4.2	87.6	62.6
Yemen	4.5	65.9	0	0	88.7	58.5
Zambia	5.7	46.9	0	0	71.8	33.7
Zimbabwe[c]	6.2	54.7	23.0	34.8	52.2	28.5

Source: National Health Accounts, World Health Organization. Data are for the year 2001 and will be available in 2004.

[a] GDP = gross domestic product.

[b] NA = not available.

[c] Estimates not yet approved by Zimbabwean Government.