COMMISSION ON MACROECONOMICS AND HEALTH
A WHO commission examining the interrelations among investments in health, economic growth and poverty reduction

6

CMH Working Paper Series*

Draft

Title

Trade Liberalization in Health Insurance: Opportunities and Challenges: The Potential Impact of Introducing or Expanding the Availability of Private Health Insurance within Low and Middle Income Countries

Author

John A. Sbarbaro
Professor of Medicine and Preventive Medicine, Medical Director, University Physicians, Inc, University of Colorado Health Sciences Center, Denver, Colorado
john.sbarbaro@upi.uhcolorado.edu

Date : December 2000

* This paper will also come out as ICRIER Working Paper No. 63. This paper has been funded by the WHO.

Investment opportunities, new technologies, and the expansion of global trade rules to cover services have expanded opportunities for international trade in health insurance.

Globalization of health insurance is highly relevant to the issue of macroeconomics and health because health insurance is one model – and a powerful one – by which health services (doctors, nurses, and other personnel) and pharmaceuticals are financed. As health services are much more complex public outputs than intermediate goods and services, they are subject to increasing challenge on both efficiency and equity grounds. These challenges are exacerbated with the introduction of private health insurance. Moreover, there are no patent issues to delay cross-boarder implementation.

Low and middle-income countries are becoming international markets for private health insurance, a movement that will increase as more and more people move into income brackets that allow them to purchase private health insurance. And as their profit potential shrinks in other countries, it is reasonable to expect many international companies that offer private health insurance to enter this new sizable market. Some also believe that multilateral trade agreements, negotiated by countries through the World Trade Organization, could accelerate the trend towards expansion of private health insurance companies into developing country markets. (See the background paper on GATS and Trade in Health Insurance Services submitted by Debra J. Lipson, Health Policy Analyst, Department of Health in Sustainable Development, World Health Organization.)

In addition, large multinational industrial organizations, seeking to develop and maintain a stable and healthy work-force within a developing country can be expected to encourage international trade in health insurance. These multinational organizations have the capability to exert significant influence on national and international insurance companies already serving their current employees to expand multi-nationally to serve their full work force. This issue might be greatest in those countries in which traditional health services are considered insufficient or incapable of prioritizing care to adequately serve the employed population.

Because health insurance is commonly viewed as enhancing access to health care, the introduction of competitive private health insurance systems into middle and low income nations could be considered to be a positive product of globalization. The World Bank has encouraged a reduction in government services and increased privatization of health care. *(World Bank. Investing in health: World development report. 1993 Washington D.C World Bank)* However, the anomalies intrinsic to the private health insurance market have well-documented equity and efficiency implications that must be considered. With no trade limitations, private health insurance could enter the market just at a crucial turning point of health system development resulting in serious ramification on these often-fragile health care systems.

For example, there is a significant potential for physicians, seeking higher incomes, to move away from government service reducing both access and availability. Rapid and uncontrolled introduction of expensive diagnostic and high tech medical services into middle and low income countries could result in progressive disinterest in common community diseases and the diversion of scare funds away from public health programs.

Why would there be an interest in health insurance in developing countries?

According to the 2000 World Health Report, low and middle income countries account for only 18% of world income and 11% of global health spending, yet 84% of the world's population live in these countries and they bear 93% of the world's disease burden. In most of these countries, public revenues have leveled or decreased and the governments are facing difficult challenges in meeting the basic public health needs of their populations such as vector control, water and food safety, and immunizations to control infectious disease. Even when resources are focused on measures to sustain population health services, most of the governmental budget is still spent on basic curative care, especially drugs. As a result, the financing and delivery of higher levels of individual medical care becomes the province of the private sector leaving low and middle income individuals with limited access to providers and liable for paying the entire cost of the services. This ultimately creates a demand for financing mechanisms that will expand the private sector infrastructure and cover the costs of health care for larger numbers of individuals.

Historically, as the economy of a country develops, the proportion of health expenditures that is "risk-pooled" also increases – "pools" of designated funds set aside to pay for a defined range of health services for a specific population. "Risk-pooling" occurs in health systems throughout the world and in various organizational structures and combinations of these structures. Examples range from national health services funded by general taxation and social security systems based on salary-related contributions to private health insurance relying on voluntary contributions paid by the individual (or on his/her behalf by an employer). The rational for developing countries to look to private health insurance over the other forms of "risk pooling" is the relatively weak service infrastructure required by private health insurance. Governmental tax-based national health services require a larger administrative and service structure, often burdened with a succession of bureaucratized "checks and balances".

However, there are also several limiting factors involved with the implementation of private insurance in low and middle-income countries:

1) sizable informal sectors, which make it difficult to charge/collect premiums,
2) the need for a significant share of the population market with the means to purchase coverage and

3) little capacity of governments to perform even the most basic regulatory functions e.g. setting and enforcing financial standards for entry and operation of private insurers.

Understanding the basics of private health insurance:

Just like automobile insurance, health insurance companies annually balance the anticipated risk of expense against pre-paid income ("premiums"). Simply - what comes into the company as income through monthly premium payments must equal the expenses associated with payment for treatment, the administrative costs of operating the health plan, and the funds wanted for reserves and/or profit. When expenses exceed income, the premiums for the subsequent year(s) are increased.

In recognition that diseases and health care problems change throughout the life span of a person, individual premium charges reflect age and gender and can further vary by location of inhabitance, prior and existing illnesses, and even employment.

Medical expenses are controlled through established fee structures, a careful and detailed description of what services ("benefits") will be provided, and a list of the services or health conditions that will not be covered within the benefit package of the health insurance plan ("exclusions"). Specific rules on how benefits are to be obtained, and from whom, may vary from health plan to health plan.

For example, most Health Maintenance Organizations (HMOs) require their members to obtain care only from physicians and hospitals with whom the health plan has negotiated a discounted fee structure and the member is often required to obtain pre-approval from the health plan before actually procuring a high cost service. Pre-approval is subject to the company's decision as to whether the requested service is truly "medically necessary".

Unlike direct salary arrangements with professionals, fee-for-service health insurance requires the creation and maintenance of an administrative structure to review claims, authenticate the service, match claims to benefits, and pay the valid claims. The costs of supporting this administrative overhead can range widely depending on the sophistication and technical support available to the company. The funds to support this administrative structure come from premium payments and obviously reduce the total amount available for health services to patients.

Potential advantages and disadvantages of private health insurance

The entry or expansion of private health insurance throughout a country or community has both positive and negative aspects. Healthcare financing involves mechanisms for

sharing the risk of costly and unpredictable health care and providing financial protection. By pooling the contributions of many individuals, the risk of expense can be spread across the group and the risk to the individual is limited as the financial burden is shared. Participating in a private health insurance plan protects its participants from potentially devastating financial debts resulting from serious and unexpected illness or injuries. Large unforeseen bills are replaced by relatively small monthly payments to the insurance company

Private health insurance also gives its participants increased freedom of choice in selecting physicians who are secure in the knowledge that their services will be reimbursed and unlikely to discriminate based on family income or socioeconomic level. And because coverage by health insurance is usually portable throughout a county, participants can seek care from advanced specialists and institutions when their disease condition warrants such care.

> *(Note: at the present time private health insurers will only reimburse their members for "medically necessary" emergency services received in other countries. However, cross-border investment and ownership by these insurance companies could provide the opportunity for the development of health insurance policies offering international access to a wider scope of providers and services)*

And finally, in countries where two or more private health plans exist, individuals unhappy with their existing coverage can change to the competing company, allowing market forces to control premium costs and the extent of benefits.

However, on the negative side, it is to the advantage of a private health insurance company to only insure healthy individuals whose age, gender and lifestyle are unlikely to be associated with high health costs. It is well recognized that 10% of an insured population consumes over 80% of the health care resources. Therefore, unless barred by law, regulation, or contract, private health insurance companies can be expected to terminate their relationship with high cost members or refuse coverage for "pre-existing" disease conditions – thus keeping their premiums below those of their competitors. An additional option is to reduce the scope of "benefits" and increase the "exclusions".

> The recognition that low family income is commonly associated with an increased rate of illness and disease is a significant deterrent to any effort to induce insurance companies to offer health insurance within needy communities. Unless supported with large amounts of governmental funds, a fee-for-service health insurance program could not generate sufficient capital to address the needs of populations with potentially large numbers of sick, as exemplified by communities with high unemployment and older aged residents. The premiums paid by the healthy could not offset the expenses of the sick.

Implications of expanding health insurance into middle and low income countries:

The very introduction of insurance as a third party that pays for healthcare services could significantly change the dynamics of a country's healthcare market. Since private health insurance provides an alternative to out-of-pocket payments for health care services, the financial barriers to seeking health care services would be lessened and consumer demand increased. Perceived quality would join cost as a determining factor in consumer demand, resulting in increased competition and potentially driving rapid investments by hospitals in high-technology equipment to attract physicians and patients. The result is an increase in health care expenditures

Except for a few HMOs, most health insurance companies operate on a fee-for-service basis, paying health professionals for performing specific individual services. Fee-for-service payments create a strong incentive to provide care, and perhaps all too often, to provide more care than is actually necessary – occasionally even resulting in harm to the individual patient. Such behavior further consumes scare health resources (personnel time, diagnostic capacities and supporting funds) thereby reducing their availability to the non-insured within a community.

Lower income countries are already experiencing the out-migration and relocation of their most talented health professionals to more developed countries ("brain drain"). These professionals move to gain access to both the increased income and the high technologies that are available in these higher income countries. International medical journals, all of which focus on the advanced capabilities of new equipment, diagnostic tools, and pharmaceuticals, further stimulate those with a desire for personal recognition, prestige, or advancement of professional skills to seek access to more professionally exciting environments.

Health insurance, by providing a resource through which hospitals can capitalize the purchase of high tech equipment, might give in-country institutions significant ability to attract both physicians and higher paying patients. This could lead to the retention of scarce professionals within a country – reducing their impetus to migrate. However, while the introduction of fee-for-service health insurance might serve to slow out-of-country migration it would undoubtedly result in significant relocation of professionals from the low-income areas of that country. The expected result would be a diminution in health services directed at control of the ten major diseases* WHO has identified as most impacting the poor of these countries.

> (* malaria, HIV/AIDS, tuberculosis, acute respiratory infections, diarrheal diseases, vaccine-preventable illness, mother and infant care, tropical parasites and helminthic infections, nutritional deficiencies, and tobacco-related illnesses)

Moreover, it is likely that these developments would also speed the growth of a two tiered system of health care (high tech for those with the insurance; limited for all others) -- and again, redirect scare health resources away from the control of the ten basic community diseases designated by WHO. The removal of an employed healthy population and their medical providers from a country's general health services would create additional and damaging pressure ("adverse selection") on the remaining basic resources.

Nationally sponsored health insurance programs:

One alternative to the development of competitive private health insurance plans within a country is the development and implementation of a publicly financed national health service – considered by many as the most cost-effective way to deliver universal high-quality medical care. However, driven by new cost-increasing technologies, even those industrialized countries with a history of effective universal health plans are now facing strong pressures for reform e.g.: freedom to purchase supplemental or alternative private insurance that covers extra amenities or expensive services.

A review of a few industrialized countries gives insight into the strengths and weakness of a single national health program and the challenges now being faced by such programs.

Canada:
Initiated in 1957, Canada's publicly financed health program provides first dollar coverage. The health service began to experience soaring budget deficits in the early 1990s and has sought to control them through a combination of fiscal and regulatory measures designed to reduce inpatient care capacities and expanded community based services and primary care centers. Unlike other industrialized nations, Canada has essentially no parallel private system of health care because investor-owned carriers have been barred from covering any services that were publicly insured. Instead, Canada has sponsored a system of private services delivered through both nonprofit and investor-owned providers while depending upon public financing to contain costs and maintain equity.

Canada's public system is based on:

1) universal coverage of all residents on uniform terms and conditions
2) public non-profit administration
3) portability of benefits throughout all provinces and regions of the country
4) comprehensive coverage of all "necessary" services provided by medical practitioners, hospitals, and some drugs. (of note: many Canadians purchase some form of supplemental private insurance, usually for prescriptions drugs and dental services)
5) maintenance of reasonable access to insured services

   This approach however requires the government to contract with providers on a fee-for service basis, setting up the recurrent potential for collective bargaining and strikes/sick-outs by providers.

Competing demands from education and other social programs have continued to limit the funds available to expand Canada's health services into new technologies yet Canada's growth of expenditures remain difficult to control as the demand for, and utilization of services have increased.

Great Britain:
In the early 1990s Great Britain replaced its National Health Service bureaucracy with an internal quasi-market in health care. Although the state continued to provide the finances from taxation, a competitive market was created by permitting semi-independent provider groups to deliver health services and manage their own budgets. In a recent review of this process LeGrand concluded that the impact was negligible because of the retention of central government control and partly because the experiment was based on inadequate understanding of professional and managerial motivations. *(LeGrand Julian. Competition, Cooperation, or Control? Tales from the British National Health Service. Health Affairs 1999 18:27-39).* Patients could only change their health provider group by moving out of the district thus minimizing any real competition. In addition, the central government continued to promulgate directives concerning priorities, waiting lists etc.

Because the provider groups could not keep their trust surpluses and because their deficits were covered by the central authority (thereby eliminating any risk to the independent providers), the incentives for change were too weak compared to the political pressures for stability. In reality there was no change in the core system of health care despite the separation of the purchaser role from the provider role

Japan:
The Japanese government began providing health insurance in 1927 and by 1961 universal coverage was achieved. Japan's health insurance system is in reality a social insurance system in which nearly everyone is assigned to a specific plan via employment or place of residence. The nation has more than 5000 independent insurance plans that fall into three major groups - each enrolling about a third of the total population:

1) large firm employees and their dependents are covered by Society-Managed Health Insurance and the public sector employees by Mutual Aid Associations. (There are nearly 2000 of these independent plans jointly managed by representatives of the employer and employees – premiums vary from about 6 to 9.5% of monthly wages with half paid by the employer.
2) small firm employees are covered by Government Managed Health Insurance in a single national pool operated by the Ministry of Health and Welfare – again the employer pays half of the premium
3) self-employed persons and pensioners are covered by Citizens Health Insurance --- with the full premium collected directly by the municipal government.

Benefits are essentially the same for all plans and include medical services, hospitalizations, pharmaceuticals, long-term care, dental and some preventive service.

Overall about 50% of the revenue comes from tax revenues; the fee structure is established by government and is the major factor in controlling health are costs. In recent years the total cost of health care has risen steadily even in the face of a declining

economy putting serious pressure on small firm employees. Japan is presently considering a wide variety of reforms including increasing the patients' share of costs.

Germany:

After decades of a non-competitive health care system in which citizens were enrolled in one of more than a thousand "sickness" funds (among which citizens were allowed to choose), in 1997 Germany enacted provisions to encourage competition. Again health care costs were the driving force – too little money was going into the "sickness "funds to support the level of services that medical technology had made possible and the public preferred.

The German social insurance system was financed though collections from employer profits and workers' wages and salaries. However, growth in these areas had not kept up with growth and utilization within the health-sector. Rather than re-capitalize this social insurance program through heightened taxation, increased contributions from employers and employees, reductions in the compensation package, shifting additional costs to the consumers, or price-fixing, Germany decided that managerial efficiencies induced within the "sickness" funds by means of competition would resolve the problem. All Germans were given the right to choose from among a range of "sickness" funds – with fund revenues tied to member enrollment. – thereby creating competition

However, the funds lacked the tools of health care competition. They could not selectively contract with physicians and hospitals. They could only negotiate fee schedules and work related issues with national and regional associations of physicians. They were also unable to selectively terminate a physician from providing care to fund members. Their ability to negotiate with physicians was also hampered by national limits on the number of physician training slots, which kept Germany's physician labor relatively small and powerful.

The "sickness" funds were further confined by requirements that hospitals had to charge all but private sickness funds the same amount. Patients, not the plan, had the right to choose the hospital they wanted to go to, thereby further minimizing provider competition. There was no utilization management program, nor did a structure exist through which to establish one. Professional groups establish guidelines, many of which justify doing everything medically possible –no matter what the cost. And finally, there was no expertise or formal training in health care management required for leadership roles of the "sickness" funds. Wide differences in policy opinions insured political paralysis with little movement to create real competition.

****

These four countries exemplify the challenges now being faced by governmental health systems – financial pressures from new health technologies and new pharmaceuticals; competition from other federal agencies for tax dollars; continuing management and reimbursement struggles with physicians; and bureaucratic resistance to change

The most difficult problem faced by all of these governmentally sponsored health programs is their inability to limit benefits. Some countries have sought to control the expansion of cost-increasing new technologies by relying on global budgets and strong regulatory programs to e technology adoption (Canada and the United Kingdom). Others use fee-for service controls such as patient co-pays, patient deductibles, and premium costs – systems used extensively by private health insurance plans.

However, as political pressures mount for access to new technology and medications, it is all too easy for elected officials to "mandate" their availability as has been evidenced in the United States of America. The United States represents a pleuristic health care system – a combination of private health insurance and government funded national insurance plans for those over the age of 65 (Medicare) and for specific segments of its low income population (Medicaid). The government controls the costs of its programs by price-fixing, thereby forcing providers to shift their costs to private insurance companies and other consumers.

> Within the United States there is also a hodgepodge safety net of governmentally funded (federal, state, county and city) facilities including community based health centers, public hospitals, and public health departments that serve the uninsured. These facilities control costs by directly rationing care – in essence these facilities serve an "unlimited demand" with a "fixed resource" by prioritizing caring for those patients most in need, while those whose illnesses are less life or limb threatening are required to wait (days to months) until the service becomes available.

However, there are significant lessons that emerge from the USA experience. As the costs of health care rose, private health plans - both indemnity and "managed care" - introduced "deductibles" and "co-pay" requirements into their insurance coverage. A "deductible" is a pre-defined amount that a patient must pay before any insurance coverage goes into effect: e.g. the first $300 of accumulated charges. A "co-pay" is the percentage of each charge or a pre-established amount that must be paid of each bill: example: the patient pays $10 every time he or she sees a physician. Both are "user fees" – out-of-pocket costs that must be borne by the individual – usually at the time the patient is seeking care. Both are designed to diminish the use of health services by patients who are seeking care for minor disease problems. However, when these techniques were introduced into publicly funded programs and safety-net facilities such as community health centers, public hospitals, and health departments, even small dollar amounts became significant barriers to needed health care.

The introduction of user-fees into public or private health insurance programs within lower and middle-income countries, while increasing the revenue available to support health services, could create devastating hurdles to access by the poor. *(McPake,B. User Charges for Health Services in Developing Countries: A Review of the Economic Literature. Soc.Sci.Med.1993 36:1397-1405.)* Thus, it is imperative that user-fees not be applied to those health services directed at the ten diseases identified by WHO as critical to the overall health of a community: e.g. malaria, HIV/AIDS, etc.

Korea:
The introduction of health insurance into developing nations has tended to widen rather than reduce the gulf between the privileged and underprivileged within the country. Although Korea has a higher per-capita income and more health care resources than many other developing nations, a brief review of its health care experience gives insight into the problems that follow the introduction of insurance. In 1976 Korea first introduced its first national health insurance, compulsory Korean Medical Insurance, – directed at workers in its manufacturing industries, government employees, teachers, and military personnel. A voluntary, community based insurance program, Korean Medical Assistance, was instituted during the same year to serve the needs of the self-employed and others such as farmers and family workers.

Although the Korean health policy was initially designed to facilitate universal access to medical care, the system actually benefited those best able to make premium contributions. Fourteen years after its inception, significant system inequities had become apparent, with those in the voluntary Medical Assistance program receiving fewer benefits then the industrial workers. Heavy reliance on the private sector of health care had resulted in diminished and very weak public control over the delivery system. A serious maldistribution of health manpower and facilities had developed. And because the medical insurance programs were administratively separated from the central government - which had primary authority for public and preventive health serviced - there were major deficits in the coordination of preventive and acute care services. Expensive hospital-based and specialized physicians' services had become predominant with emphasis on acute care services. The result was large increases in medical costs. *(Flynn, M.L.& Chung, Y. Health Care Financing in Korea: Private Market Dilemmas for a Developing Nation. Journal of Public Health Policy - Summer 1990)*

Public health services or the private practice of medicine.

Studies have consistently found that most people – of all social strata - believe that private medicine is better than government / public programs. In many countries, physicians working in government clinics refer patients that they identify as having the ability to pay, to themselves as a "private" physicians – suggesting that the care and medications that they will receive as a private patient will be far superior to that provided through the government system. Such behavior further strengthens the belief that private care is better than those provided through government. Private health insurance will

obviously aggravate this situation – encouraging patients to move from government and public programs into the private sector of health care.

If a parallel private sector is truly able to provide superior access to essential services, then the governmental health care system will obviously become less attractive and less equitable and a slow but progressive dissolution will result. Wherever there is a

perception that public services are deteriorating there is a rise in the call for private services. Equally damaging, a private tier of health service might become parasitic – limiting itself to highly remunerative services, luring away some of the best and brightest clinicians from the public sector, while depending on the public sector to provide basic care. The result would be further erosion of support for publicly funded health care.

There is a significant difference between health insurance and public health. Health insurance is individual focused. "Public health", while inclusive of sick individuals, is primarily focused on improving the conditions impacting the health of the entire community. – for example: containing the spread of contagious diseases. Public health services have the greater effect on a community's economic development.

> Uplekar reports treatment cure rates of only 55% among pulmonary tuberculosis patients treated in the private sector (India, Korea, and the Philippines) compared to effective National Tuberculosis Programs where cure rates under directly observed treatment regimens can be expected to reach 85%. *(Uplekar,M.W. Private Health Care. Social Science and Medicine 2000 51:897-904)*
> Inadequate treatment of tuberculosis results not only in chronic illness and death but in the emergence of drug-resistant organisms – highly difficult and expensive to treat, yet as contagious as drug sensitive organisms. This air-transmitted disease primarily attacks the working age group of a country and can have a devastating impact on the economy of that country. *(Murray,C.J.L.,Lopez,A.D.,& Jamison,D.T. The global burden of disease in 1990: summary results, sensitivity analysis and future directions. In C.J.L. Murray & A.D. Lopez. Global comparative assessments in the health sector. Disease burden, expenditures and intervention packages. pages 97-1381. Geneva: World Health Organization)*

Therefore, international health organizations should have serious concern that the emergence of international trade in health insurance, by encompassing the middle and upper social classes, could significantly reduce governmental (and public) interest in addressing WHO's "10" basic community diseases. The rise in private health insurance could also reduce governmental opposition to increases in pharmaceutical prices --- increases that may occur as a result of TRIPS related patent protections.

Analysis and Conclusions:

Health care resources are limited in low and middle-income countries. Unfortunately, the health care needs and disease conditions that afflict the citizens within those countries are unlimited. Conceptually the best way to serve an unlimited demand with a fixed resource should be a government program with salaried employees – employees given the ability

to prioritize the services they give, based on individual patient need. However, history is replete with instances where government programs, under-funded and overburdened with bureaucratic costs have broken down. And as a result, public trust in government sponsored health care is low.

Moreover, when funds are limited, emergency care will always take the first priority with urgent illness next in line to be served. Public health programs, especially those designed to prevent illnesses, cannot compete directly with life and limb threatening diseases and therefore need to be protected with dedicated funding. This is especially true for the ten major community diseases designated by WHO.

Private health insurance introduces incentives that not only impact the level of demand for health services but also ultimately influence the supply of health services as well as the extent and composition of private/public services. The challenges faced by developing countries with the introduction of private health insurance are:

- preventing the exclusion of the poor
- preventing "dumping" of sick/expensive patients from private health plans back to public insurance/services or "onto the streets"
- controlling escalating health care costs and
- preserving the appropriate elements of the public health sector.

It is generally accepted that a reduction in health inequities and improvement of health status is linked to enhanced economic performance of a region. Therefore, the impetus for development of healthcare financing in developing countries should not override the concern for equality of access to healthcare services among all income groups and assuring a minimum level of health status for the entire population.

While the introduction of private health insurance would draw additional money into health services, unless carefully regulated it would not support an organized public health approach. Health insurance, would of course, pay for the care of its members with respiratory infections, active pulmonary tuberculosis, AIDS, etc, but not in a community wide programmatic manner. Appropriate regulation, requiring reporting of diseases, adherence to national guidelines of treatment such as directly administered treatment of patients with active pulmonary tuberculosis, screening for and treatment of helminthic infections, malaria prophylaxis etc could overcome the gap between private and public programs.

Recommendations:

The introduction of private health insurance does represent a threat to the control of, and care for, WHO's ten basic community diseases, especially if the insurance plans are accompanied by new technologies and treatments.

In countries where provider payments are "fixed" there has been limited growth in the progressive use of invasive procedures. This suggests that regulation of the introduction of, and the capacity for, high tech procedures and the addition of required incentives for cost control could be important determinants in minimizing the negative impact of private health insurance. However, many low and middle-income countries have no experience in this area.

WHO should take the lead in initiating a process that will assist countries in determining the potential of private health insurance models as financiers of healthcare. WHO, in conjunction with WHO Member States, could establish a tool that could be used:

- to identify and evaluate the infrastructure and financing of current healthcare systems and
- assess different healthcare system reforms according the degree of improvement such reforms would likely have in strengthening the overall healthcare system.

While there is no healthcare blueprint that is applicable to all counties, there are common elements that can be incorporated into an overall strategy that can be implemented in accordance with the history, development, and idiosyncrasies of a country.

WHO should be encouraged to develop an international consultation group that can assist the governments of low and middle-income countries in the regulation of private health insurance companies including licensing requirements; adherence to benefit design; integration and cooperation with basic public health and preventive services; and the establishment of customer appeal processes.