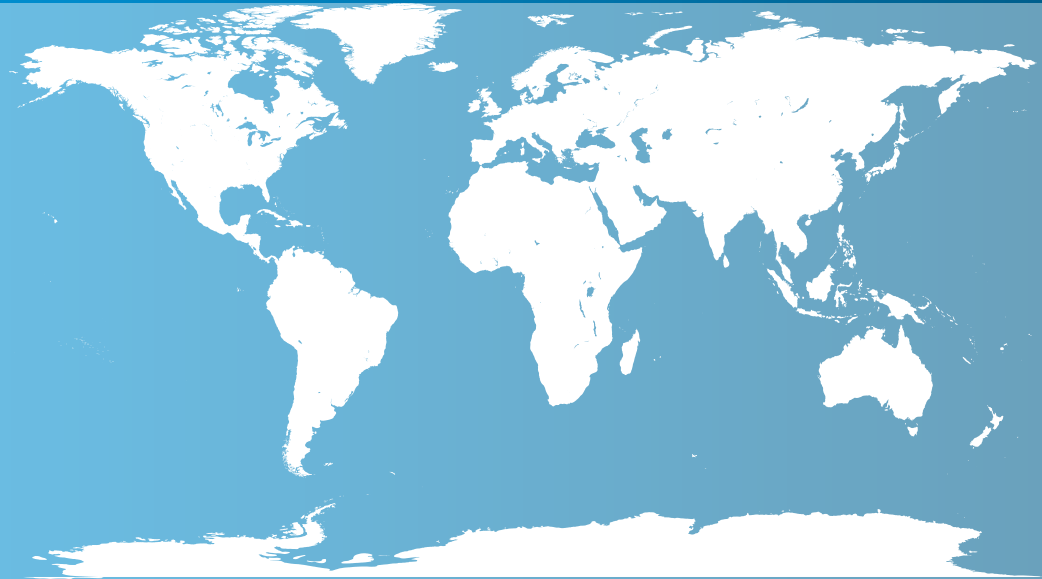


# International Health Care Funding Report

# 2020



International Actuarial Association  
Association Actuarielle Internationale



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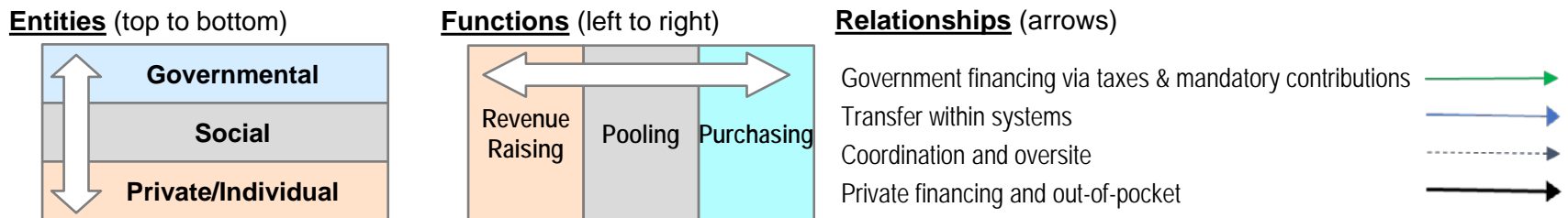
# International Health Care Funding Report

The following report is the first iteration of a project to illustrate international models of health care funding. The exhibits herein reflect the state of 36 health funding systems as of December 31, 2019. We will revisit these diagrams periodically to create a longitudinal study, showing refinements and changes over time.

This report is a joint effort of volunteers of the following organizations (full list on page 49):

- International Actuarial Association Health Section (IAAHS);
- the Society of Actuaries (SOA) International Section; and
- the American Academy of Actuaries Health Practice International Committee (HPIC)

Each exhibit has been developed by the country contributor to reflect the high-level financing structure of a health system, as it was in December 2019. The layout of these slides take inspiration from the Health Systems in Transition (HiTs) templates built by the European Observatory on Health Systems and Policies.



As each health system is unique, you may see some variations that reflect the author's view of how best to represent their country's health care system.

The purpose of this project is strictly to educate the public on the various arrangements for health care financing in different countries in an easy-to-follow and visual fashion. *Commenting on aspects of care such as quality, access and cost of care as well as the merits and defects of each system are beyond the scope of this exercise and report.*

# Introduction to Health Financing

Health financing arrangements in each country are as unique as the countries themselves, and are determined by a multitude of historical, social, economic and political factors. Over the decades, academics and others have made many attempts to classify countries' health systems, however, with limited success; labels (such as the “Bismarck” or “Beveridge” models) do little to capture nuances of different systems and have not always been used in a consistent manner. Furthermore, it has been observed that each country is likely to have a number of different health and care financing schemes operating in parallel. The health financing system as a whole – of any country – is therefore typically a patchwork of different mechanisms involving different permutations of both public and private sector stakeholders.

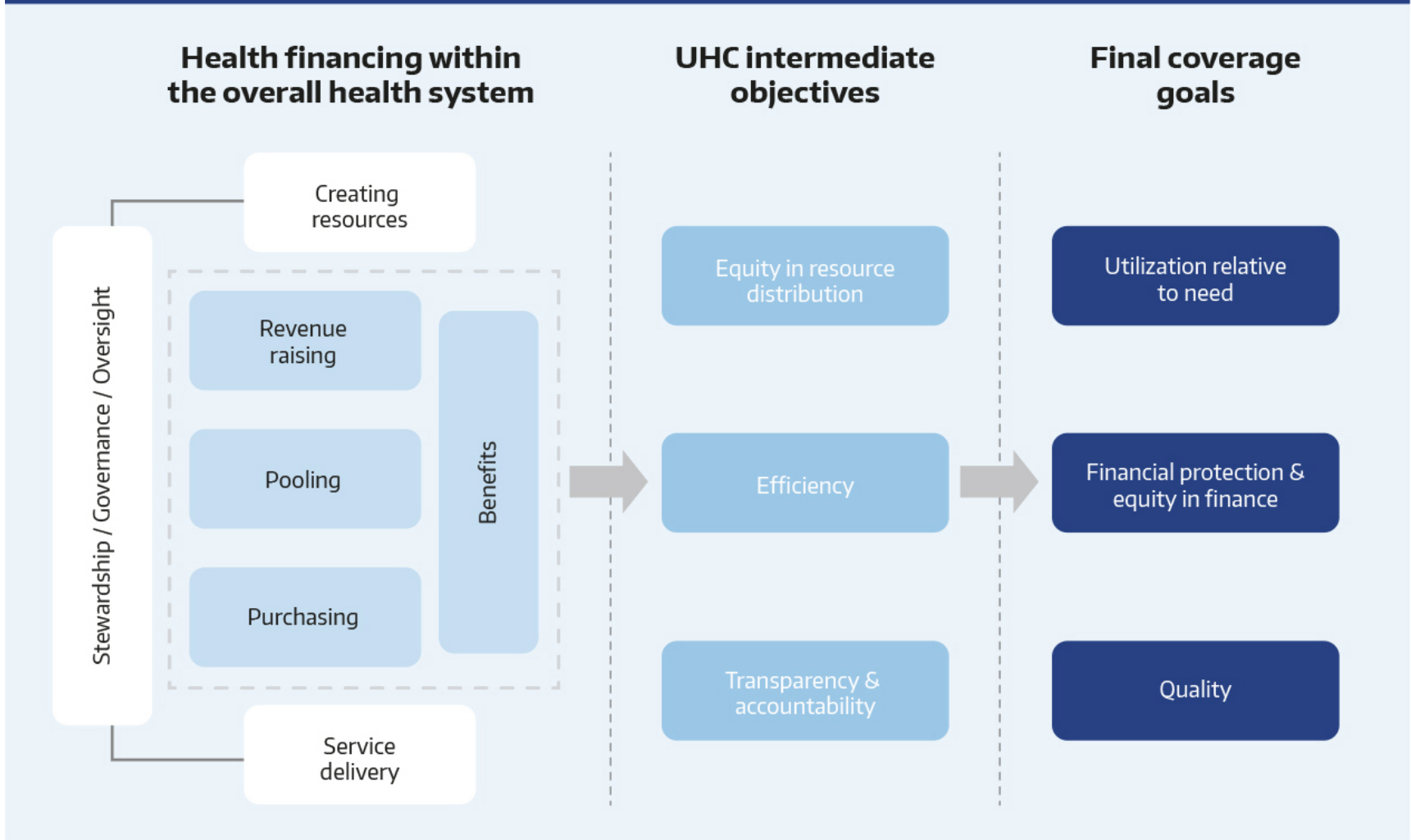
Therefore, for the purpose of this report, we have not attempted to classify the countries into distinct country-level systems. This is to acknowledge the difficulty in doing so and also the point raised by the World Health Organization (WHO), that such labels are not necessarily helpful for health policy evaluations and decisions. The WHO thus recommends focusing on the different functions of the overall system:

- the sources and methods of raising revenues;
- the pooling of funds; and
- the purchasing/delivery of healthcare.

A major theme which cuts across all of the United Nations' health-related Sustainable Development Goals (SDGs), is Universal Health Coverage (UHC). Under UHC, all people and communities can access the health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose them to financial hardship. Rather than dictating a health system's structure, UHC provides us with a set of goals; this recognizes that the approach to organizing a health system in one country will not necessarily work in another, even though both may be working toward the same objective (as depicted in the illustration on page 4).

# WHO Framework: Health Financing

UHC goals and intermediate objectives influenced by health financing policy



Source: *Developing a national health financing strategy: a reference guide* (World Health Organization, 2017)

# Introduction to Health Financing

While we have not attempted to classify **country-level systems or models** for each nation we examine, it is possible to classify each of the different health care financing schemes within country systems.

Health care financing schemes are a principal structural component of health care financing systems: they are the main types of financing arrangements through which people obtain health services. Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements. Third party financing schemes are distinct bodies of rules that govern the mode of participation in the scheme, the basis for entitlement to health services and the rules on raising and then pooling the revenues of the given scheme\*.

The table to the right shows the full classification as is used in the System of Health Accounts (SHA), a framework for the systematic description of the financial flows related to health care as used by the WHO and OECD.

\*Source: A SYSTEM OF HEALTH ACCOUNTS 2011 © OECD, EUROPEAN UNION, WORLD HEALTH ORGANIZATION.

## Classification of health care financing schemes

Code	Description
<b>HF.1</b>	<b>Government schemes and compulsory contributory health care financing schemes</b>
<b>HF.1.1</b>	<b>Government schemes</b>
HF.1.1.1	Central government schemes
HF.1.1.2	State/regional/local government schemes
<b>HF.1.2</b>	<b>Compulsory contributory health insurance schemes</b>
HF.1.2.1	Social health insurance schemes
HF.1.2.2	Compulsory private insurance schemes
<b>HF.1.3</b>	<b>Compulsory Medical Saving Accounts (CMSA)</b>
<b>HF.2</b>	<b>Voluntary health care payment schemes</b>
<b>HF.2.1</b>	<b>Voluntary health insurance schemes</b>
HF.2.1.1	Primary/substitutory health insurance schemes
HF.2.1.1.1	Employer-based insurance (other than enterprises schemes)
HF.2.1.1.2	Government-based voluntary insurance
HF.2.1.1.3	Other primary coverage schemes
HF.2.1.2	Complementary/supplementary insurance schemes
HF.2.1.2.1	Community-based insurance
HF.2.1.2.2	Other complementary/supplementary insurance
<b>HF.2.2</b>	<b>NPISH financing schemes</b>
HF.2.2.1	NPISH financing schemes (excluding HF.2.2.2)
HF.2.2.2	Resident foreign government development agencies schemes
<b>HF.2.3</b>	<b>Enterprise financing schemes</b>
HF.2.3.1	Enterprises (except health care providers) financing schemes
HF.2.3.2	Health care providers financing schemes
<b>HF.3</b>	<b>Household out-of-pocket payment</b>
<b>HF.3.1</b>	<b>Out-of-pocket excluding cost-sharing<sup>13</sup></b>
<b>HF.3.2</b>	<b>Cost sharing with third-party payers</b>
HF.3.2.1	Cost sharing with government schemes and compulsory contributory health insurance schemes
HF.3.2.2	Cost sharing with voluntary insurance schemes
<b>HF.4</b>	<b>Rest of the world financing schemes (non-resident)</b>
<b>HF.4.1</b>	<b>Compulsory schemes (non-resident)</b>
HF.4.1.1	Compulsory health insurance schemes (non-resident)
HF.4.1.2	Other compulsory schemes (non-resident)
<b>HF.4.2</b>	<b>Voluntary schemes (non-resident)</b>
HF.4.2.1	Voluntary health insurance schemes (non-resident)
HF.4.2.2	Other schemes (non-resident)
HF.4.2.2.1	Philanthropy/international NGOs schemes
HF.4.2.2.2	Foreign development agencies schemes
HF.4.2.2.3	Schemes of enclaves (e.g. international organisations or embassies)

# Featured Countries

## North America (2)

- **Canada**
- **United States**
  - Private Insurance
  - Public Insurance

## Latin America (6)

- **Argentina**
- **Brazil**
- **Chile**
- **Colombia**
- **Mexico**
- **Uruguay**

## Asia/Oceania (10)

- **Australia**
- **China**
- **Chinese Taipei**
- **Hong Kong**
- **India**
- **Indonesia**
- **Japan**
- **Republic of Korea**
- **Singapore**
- **Sri Lanka**

## Africa / Middle East (7)

- **Egypt**
- **Ghana**
- **Israel**
- **Kenya**
- **Nigeria**
- **Saudi Arabia**
- **South Africa**

## Europe (11)

- **France**
- **Germany**
- **Ireland**
- **Italy**
- **Netherlands**
- **Poland**
- **Romania**
- **Spain**
- **Switzerland**
- **Turkey**
- **UK - England**

# North America

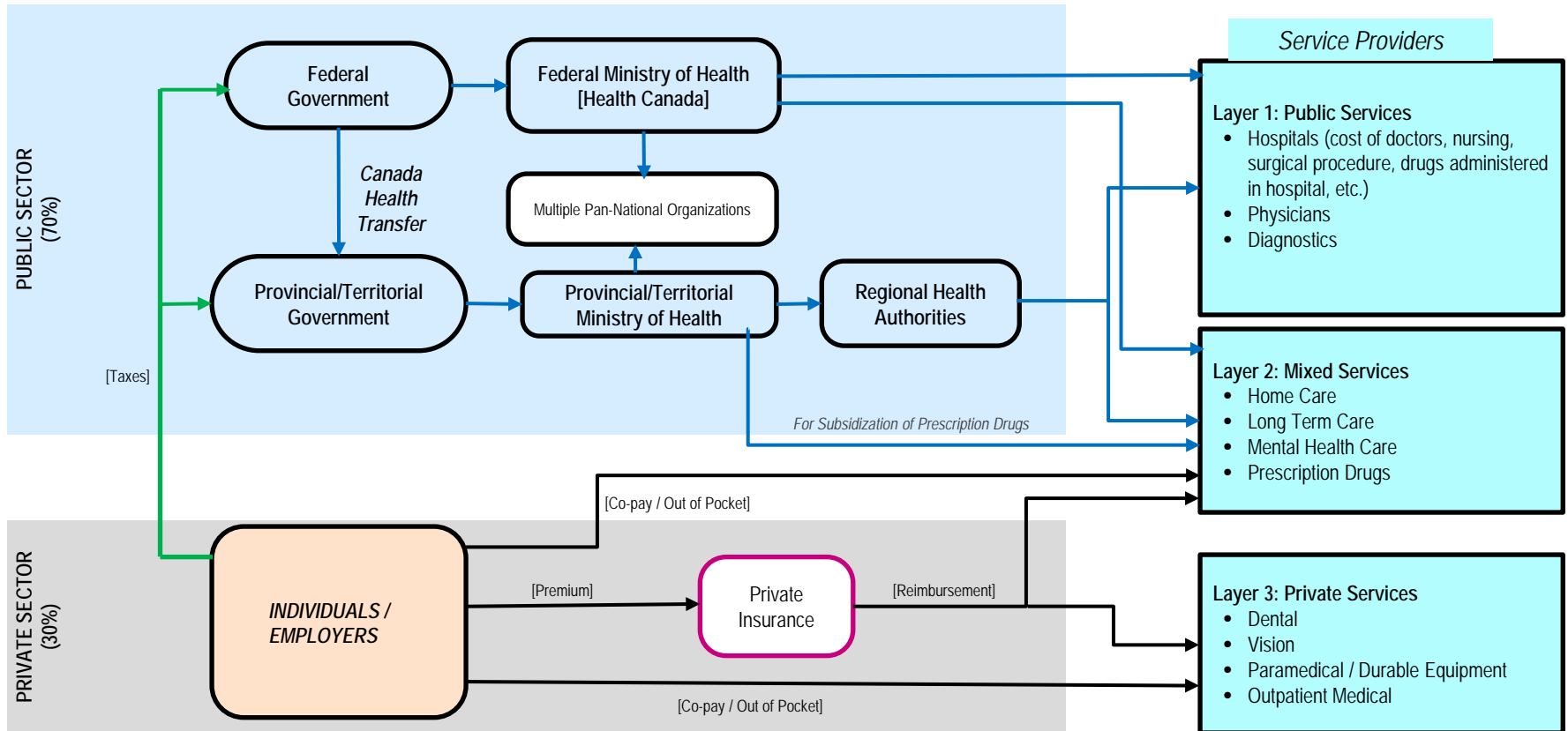


		Canada	United States of America
<b>Gov't Schemes</b>	Government schemes	69.1%	26.3%
	Compulsory contributory health insurance schemes	1.5%	58.3%
	Compulsory Medical Saving Accounts (CMSA)	0.0%	0.0%
	Other government/compulsory schemes	0.0%	0.0%
<b>Voluntary Schemes</b>	Voluntary health insurance schemes	13.2%	0.0%
	NPISH financing schemes	1.1%	0.0%
	Enterprise financing schemes	0.9%	0.2%
	Other Voluntary health care payment schemes	0.0%	4.3%
<b>OOP</b>	Household out-of-pocket payment	14.2%	11.0%
<b>Foreign</b>	Rest of the world financing schemes (non-resident)	0.0%	0.0%
<b>Other</b>	Other Financing Schemes	0.0%	0.0%

Values shown as a % of Current Health Expenditure (CHE) in 2017

Source: World Health Organization Global Health Expenditure Database (<https://apps.who.int/nha/database>)

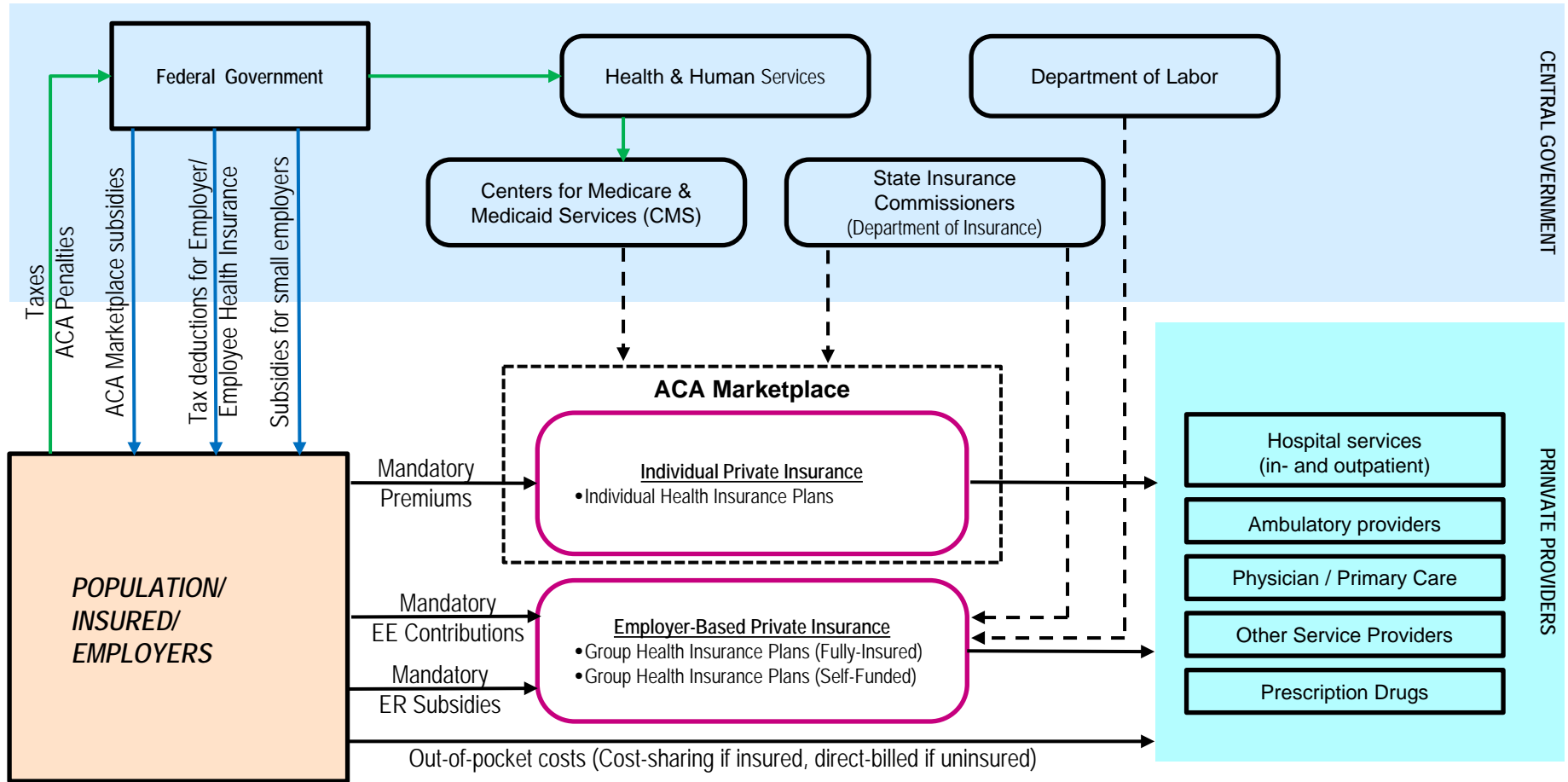
# Canada



- About 70% of total health care cost in Canada is paid from Public Sector, of which more than 90% is from Provincial/Territorial government
- Taxes refer to payroll taxes and income taxes (incl. health premiums for province of Ontario)
- **Canada Health Transfer** – The money the federal government sends to the provinces and territories to help pay for health care. The Canada Health Act dictates criteria and conditions that the provinces/ territories must meet before they can receive federal contributions
- Federal and provincial/territorial ministries of health jointly contribute to **Multiple Pan-National Organizations**, such as Canadian Agency for Drugs and Technologies in Health, Canadian Institute for Health Information, Canada Health Infoway
- **Regional Health Authorities** – Manage all hospitals and publicly funded care facilities in a geographic area
- **Layer 1 services** - Funded by public tax revenue, delivered by private for-profit and not-for profit facilities, and public arms length facilities
- **Layer 2 services** - Funded by a combination of public tax revenue and private funding similar delivery of services as Layer 1
- **Layer 3 services** - Almost all private funding; Services delivered by private professional for-profit facilities



# United States (Private Insurance)



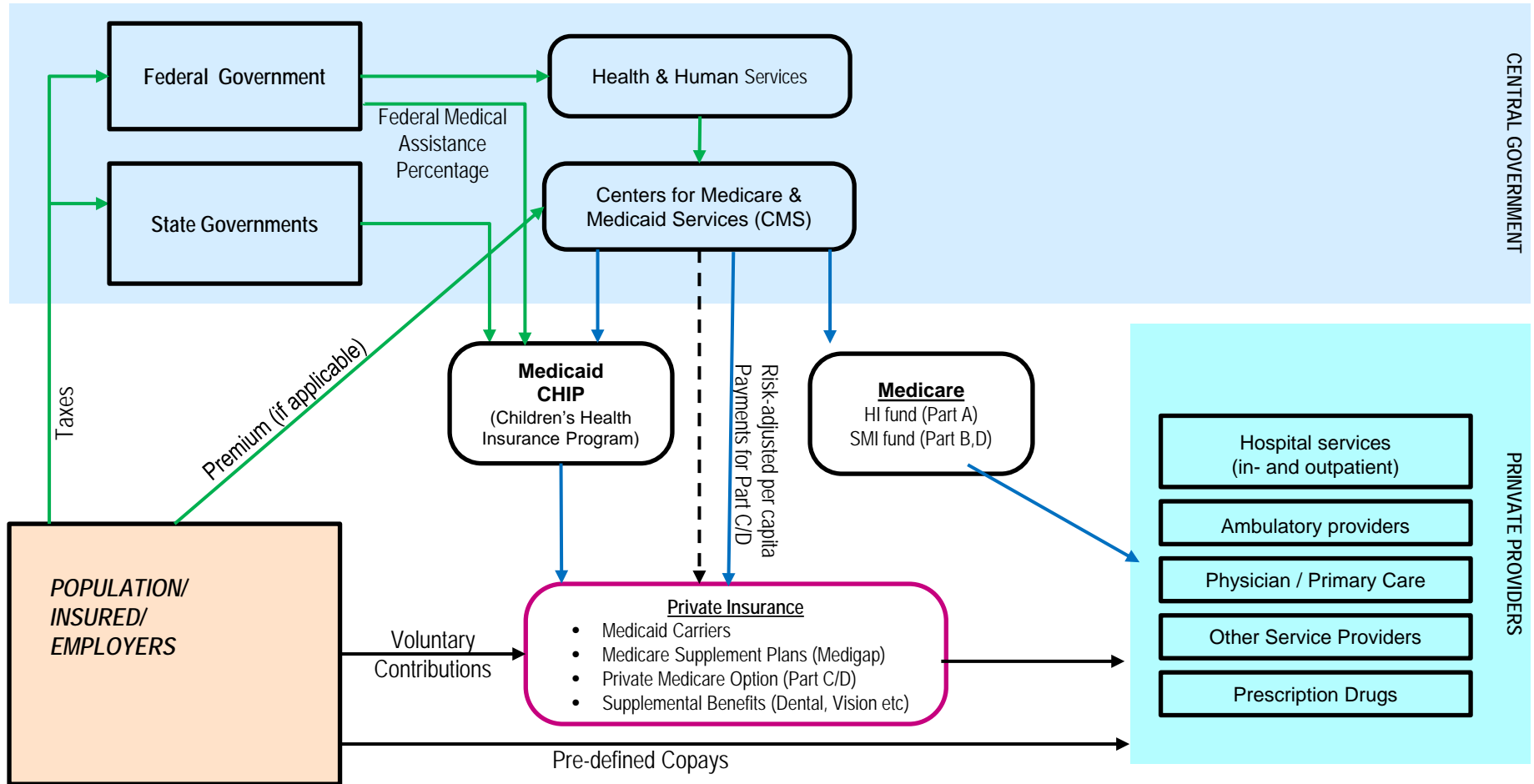
## The Employer-Based Group Insurance Model

- Employers with 50 or more employees may incur a penalty if they do not provide adequately subsidize employee health insurance.
- The employer selects the insurance carrier(s) and plan(s) available to its employees and their families, individuals typically elect coverage during an annual enrollment period.
- For fully-insured coverage, the employer will deduct employee medical contributions directly from payroll. The employer then pays the full plan premium to the insurer.
- Large employers may choose to self-insure. Rather than paying a premium to an insurer, the organization will assume responsibility to pay for its employees claims. These arrangements often continue to pay an administrative fee to an insurer who will manage the plan, process claims, and negotiate costs with providers.

## The Individual Insurance Market

- The Affordable Care Act (ACA) made it mandatory that individuals have insurance, though the penalty for not having coverage has subsequently been reduced to \$0
- Those without affordable employer-based coverage, may be eligible for subsidized private insurance through online state/federal ACA Marketplaces (there is no public insurance option)
- Individual and Small group plans are guarantee-issue, community-rated, subject to underwriting rules/State DOI oversight, and subject to a state-level risk-adjustment scheme
- Employees who are self-employed can purchase individual coverage through the ACA marketplace or directly from private insurers

# United States (Public Insurance)



**Medicare is a government run single payer system for the aged and disabled. It was created by Congress in 1965 (extended in 1997-2003 to additional private payers)**

- Medicare (for age 65+) is funded primarily from general revenues (43%), payroll taxes (36%), and beneficiary premiums (15%)
- 'Original Medicare' is divided into Part A (Hospital Insurance), Part B (Supplemental Medical Insurance), and Part D (Prescription Drug coverage)
- There is also Part C (Medicare Advantage) which offers Medicare-type plans through Private Insurers, and Medigap which covers out-of-pocket costs which Original Medicare does not.
- The Medicare trust fund comprises two separate funds. The hospital insurance (HI) trust fund is financed mainly through payroll taxes on earnings and income taxes on Social Security benefits. The Supplemental Medical Insurance (SMI) trust fund is financed by general tax revenue and the premiums enrollees pay.

**Medicaid is a means-tested system managed by states and administered through private insurers. It was also created in 1965, and has been expanded**

- Nationally, about 60% of the program is federally funded (the Federal Medicaid Assistance Percentage varies by state), with the remainder being funded by the state.

# Latin America

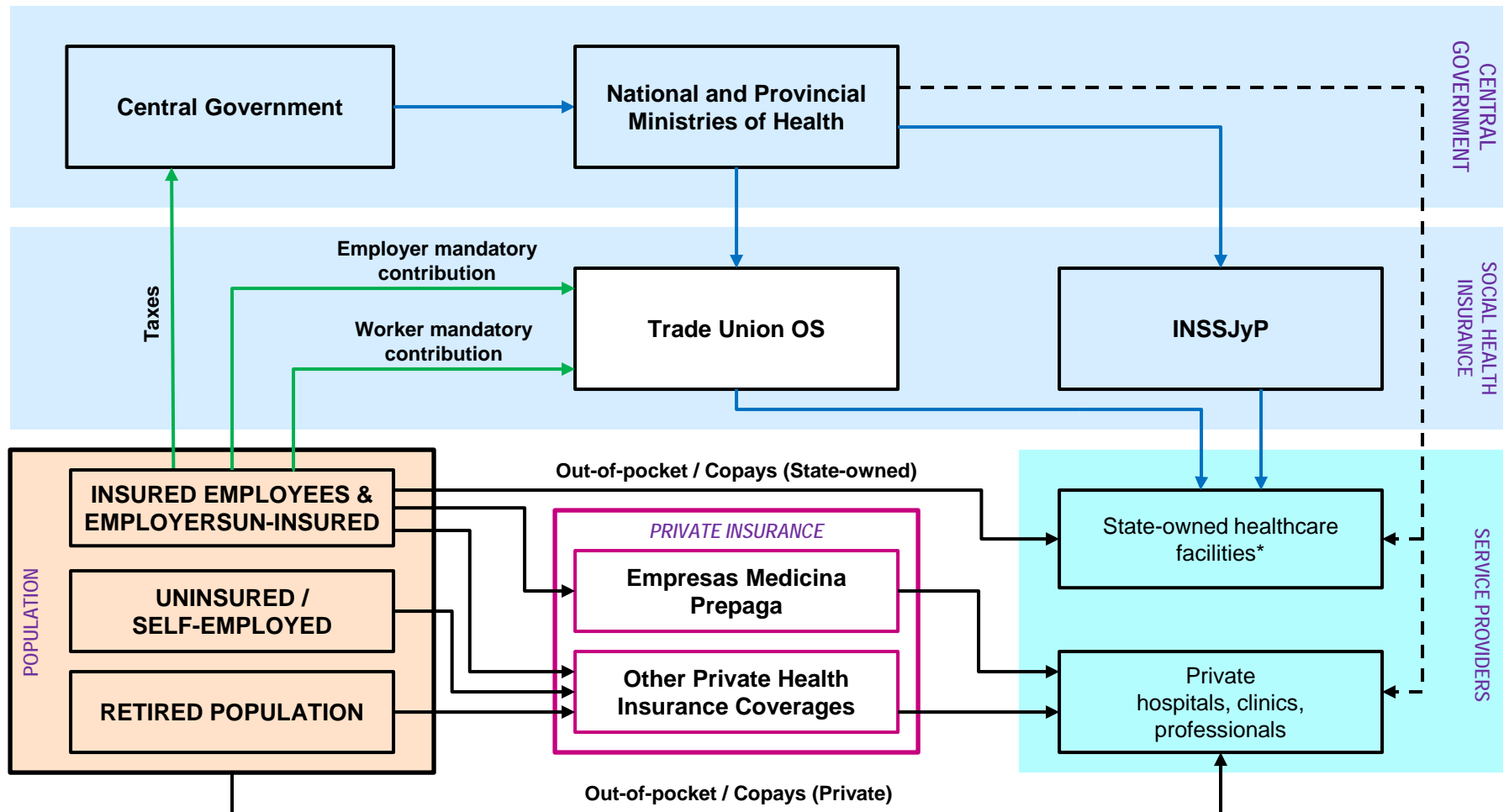


		Argentina	Brazil	Chile	Colombia	Mexico	Uruguay
<b>Gov't Schemes</b>	Government schemes	29.7%	41.9%	2.0%	5.5%	24.0%	16.6%
	Compulsory contributory health insurance schemes	43.2%	0.0%	57.8%	68.0%	27.6%	49.8%
	Compulsory Medical Saving Accounts (CMSA)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Other government/compulsory schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Voluntary Schemes</b>	Voluntary health insurance schemes	9.2%	29.2%	6.3%	10.2%	5.5%	15.5%
	NPISH financing schemes	2.3%	1.4%	0.2%	0.0%	1.7%	0.1%
	Enterprise financing schemes	0.5%	0.0%	0.0%	0.0%	0.0%	0.4%
	Other Voluntary health care payment schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>OOP</b>	Household out-of-pocket payment	15.0%	27.5%	33.5%	16.3%	41.3%	17.5%
<b>Foreign</b>	Rest of the world financing schemes (non-resident)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Other</b>	Other Financing Schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Values shown as a % of Current Health Expenditure (CHE) in 2017

Source: World Health Organization Global Health Expenditure Database (<https://apps.who.int/nha/database>)

# Argentina



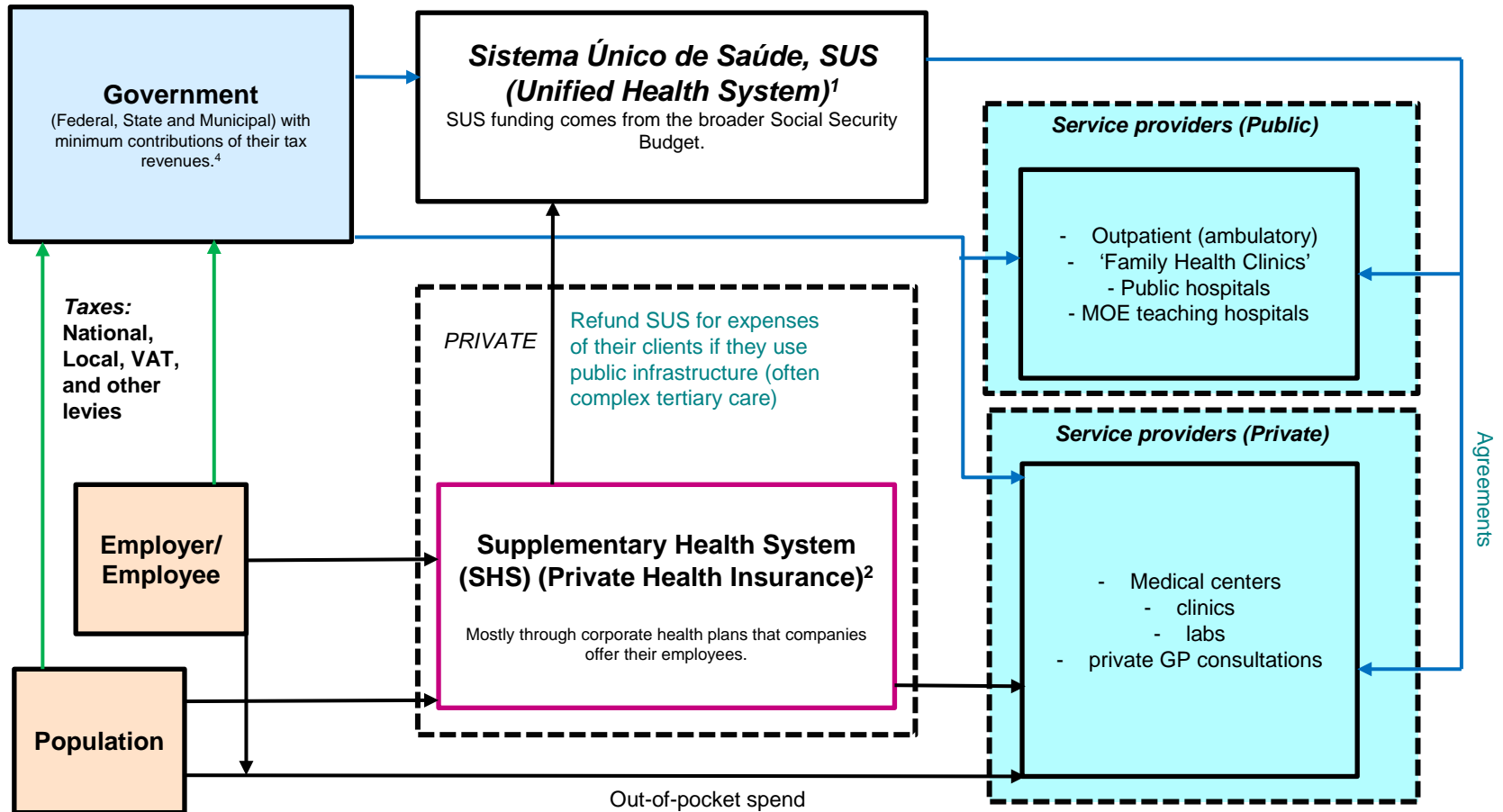
**OS – Obras Sociales** – National and provincial healthcare and other social services organizations, established to manage tax-funded social security services.

**INSSJyP – Instituto Nacional de Servicios Sociales para Jubilados y Pensionados** – National social security organization serving the retired population.

**Empresas Medicina Prepaga** – Private insurance carriers, offering comprehensive indemnity healthcare, pharmaceutical and dental insurance plans to groups and individuals.

\*Free services for retiree, un-insured and self-employed populations

# Brazil



1. The SUS is Brazil's publicly funded health care system, which was created in 1989. It is the largest (by number of beneficiaries/users : virtually 100% of the Brazilian population ; 220 million people) geographically (3.3 million square miles of contiguous land mass) by affiliated provider networks nondiscriminatory, government run public health care system in the world. ([https://en.wikipedia.org/wiki/Sistema\\_%C3%9Anico\\_de\\_Sa%C3%BAdade](https://en.wikipedia.org/wiki/Sistema_%C3%9Anico_de_Sa%C3%BAdade))

2. 25% of the population also pay for private health insurance. This is made up of more than 1,500 private health insurers.

3. Universal access targets are being supported by results-based financing (RBF) mechanisms primarily in relation to transfers from the federal government to municipalities.

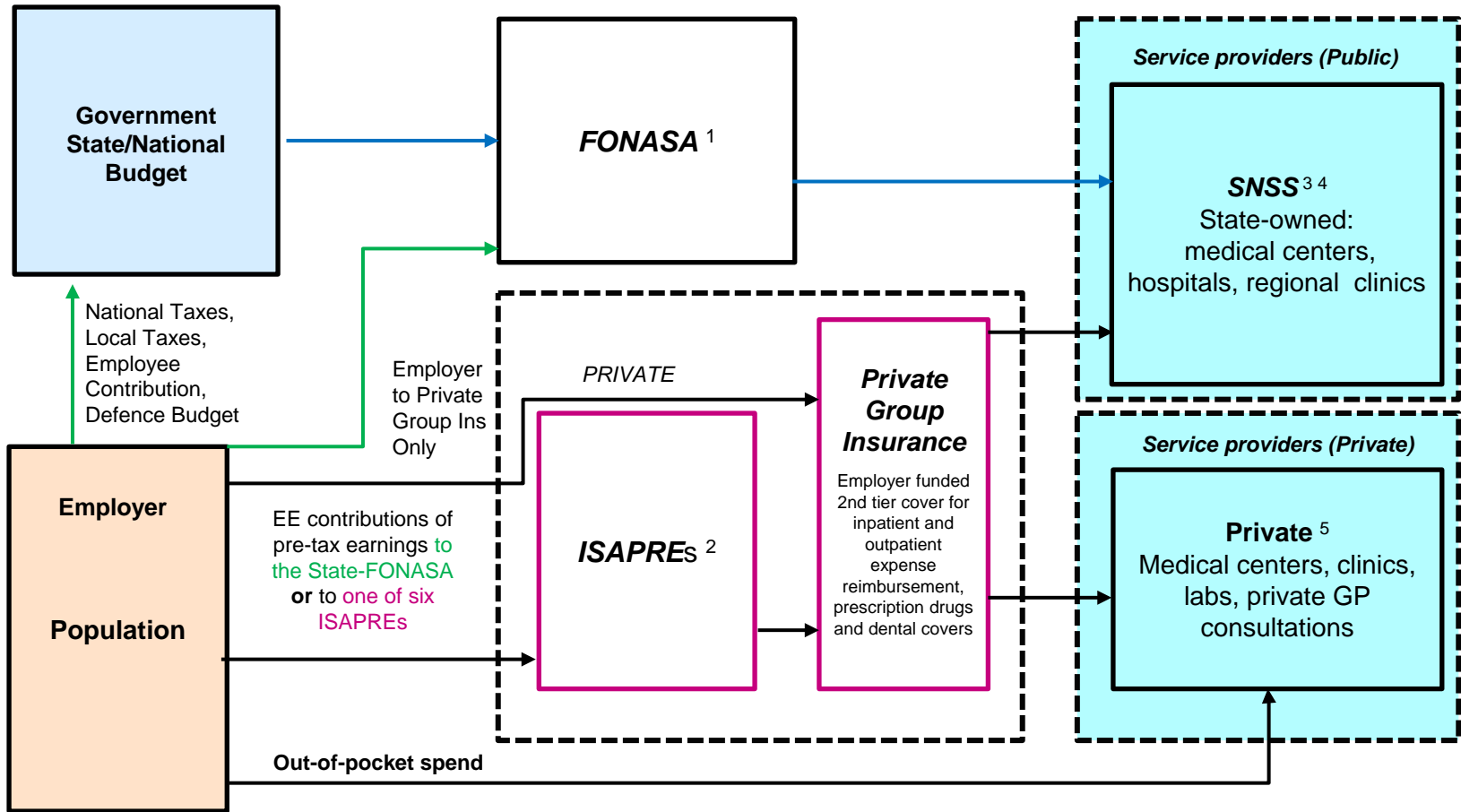
4. Source: <http://documents.worldbank.org/curated/en/638281468226148870/pdf/883440BRI0P1230I0final0January02014.pdf>

5. Services under the public SUS system are available to all Brazilians without user fees, copayments or financial contributions, except for the People's Pharmacy Program where copayments are necessary.

6 Approximately 67% of the Ministry of Health's budget for "Public Health Services and Actions" goes towards SUS (20% for primary care actions and 47% for secondary and tertiary actions defined as being of 'medium and high complexity').

The remaining 33% of the MOH budget goes towards Public Health Services such as health and epidemiological surveillance, assistance for nutritional deficiencies, human resources capacity within SUS, scientific and technological development of SUS institutions, production, procurement and distribution of pharmaceuticals, blood (and blood products), medical equipment, etc. (Same source as point 4.)

# Chile



Healthcare contributions are 7% of pre-tax earnings up to contribution ceiling (around USD2,700). There is no Employer healthcare contribution. However, most large employers fund supplementary group healthcare insurance programs.

<sup>1</sup> **FONASA**, *Fondo Nacional de Salud*, is the central State national health fund, financed from 7% and central government, covering employees who are not covered by ISAPREs and the rest of the population - other the active and retired armed forces. Levels of out-of-pocket copayment depend on declared earnings. In and out-patient cover within the SNSS managed/funded healthcare centers is free at point of delivery.

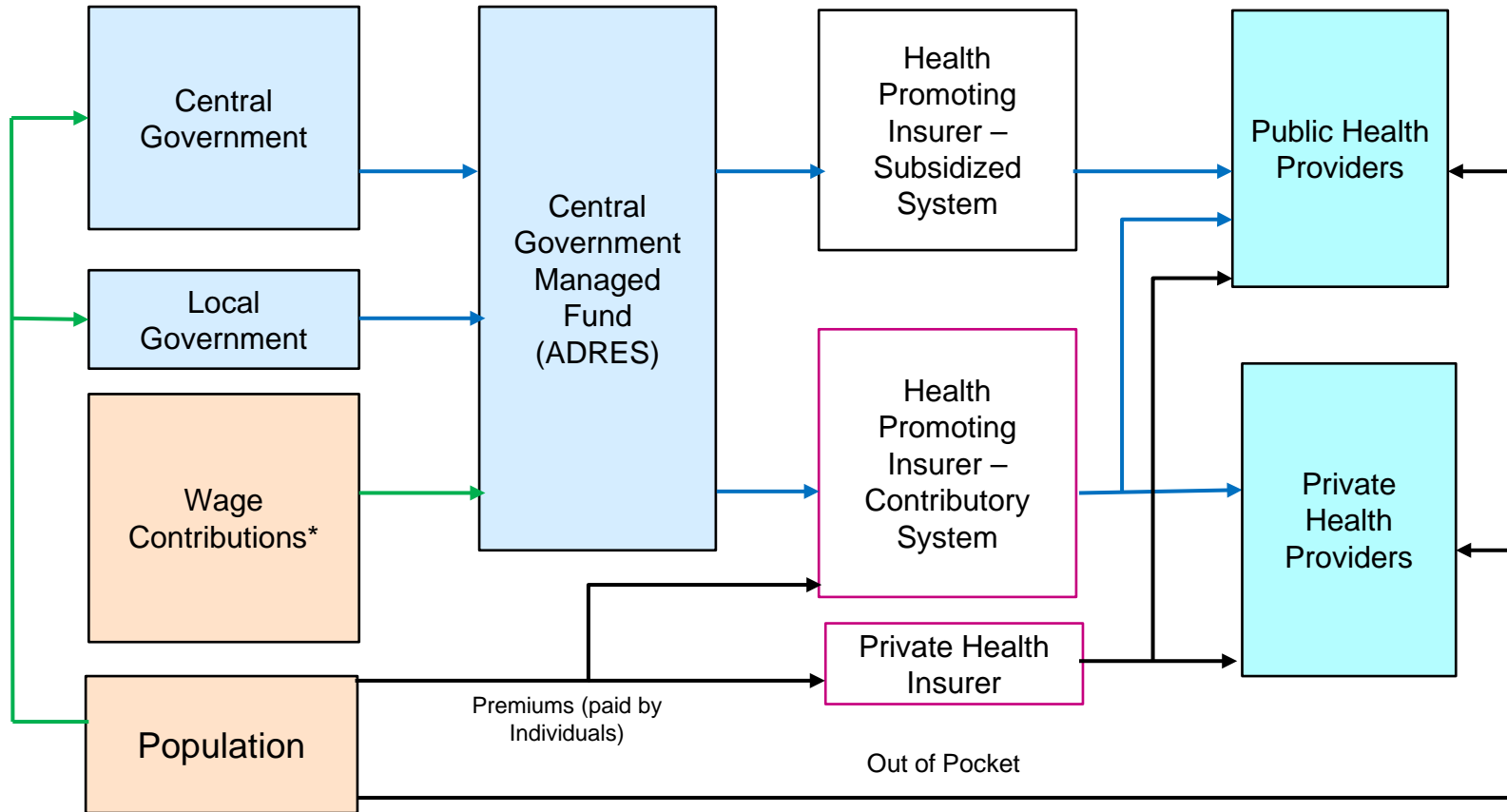
<sup>2</sup> **ISAPREs**, *Instituciones de Salud Previsional*, are private specialist, regulated healthcare and sick-leave insurers, established in law in 1981, charging age/sex-banded premiums (7% or more) to individuals and their dependents for comprehensive in-patient and outpatient from private healthcare providers. Members are not entitled to use the SNSS managed/funded State healthcare infrastructure.

<sup>3</sup> **SNSS** – *Servicio Nacional de Salud* – public healthcare (hospitals, regional and municipal medical centers and public health employees as dependency of Health Ministry.

<sup>4</sup> **Armed Forces** - active and retired members of each of the 4 services have dedicated hospitals, medical centers and staff, funded from State defense budget.

<sup>5</sup> **Workers' Compensation** – Employers pay risk-based premiums for work-related industrial accident and professional disease insurance through not-for profit private agencies with dedicated hospitals, medical centers and staff.

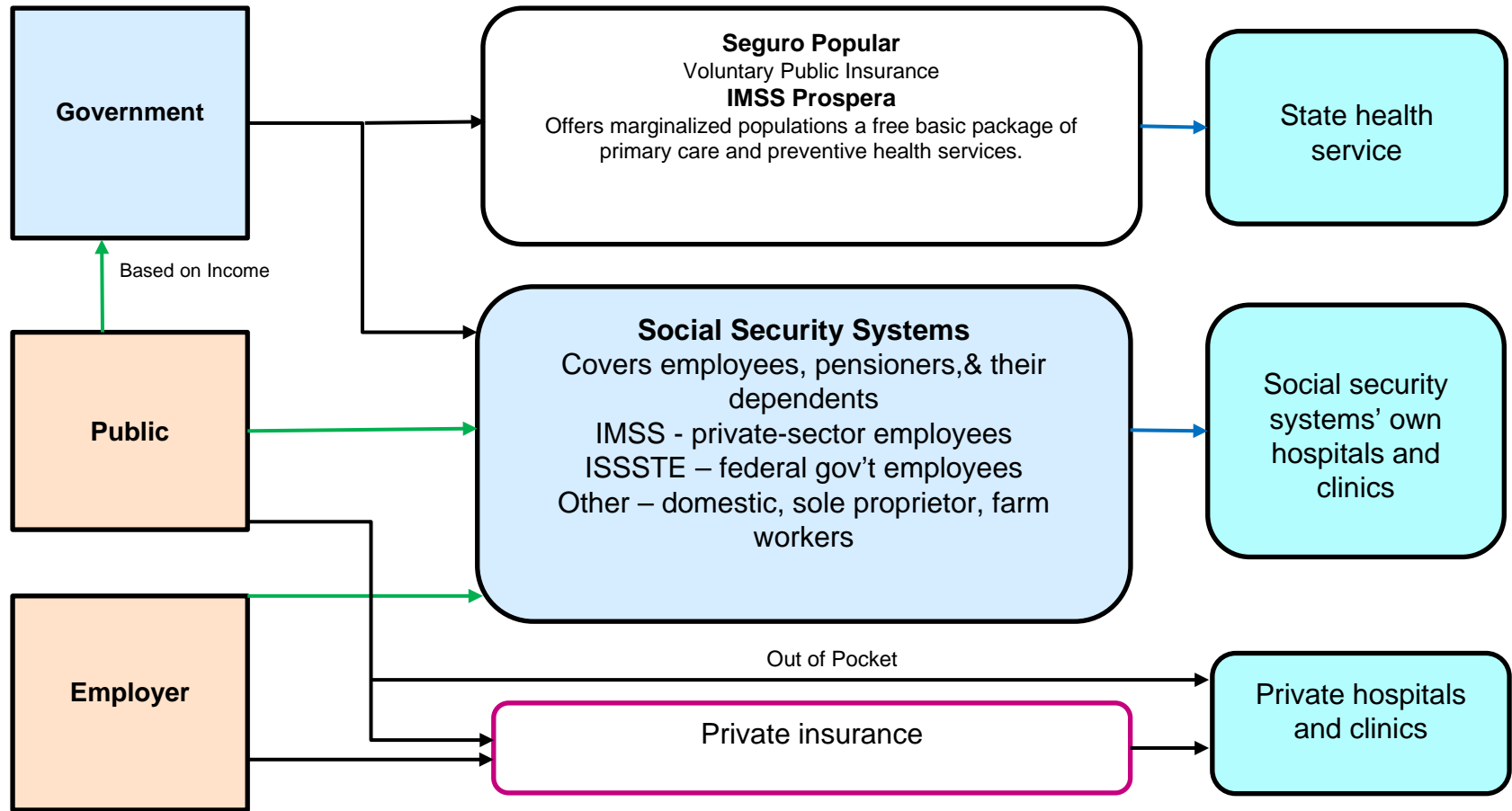
# Colombia



**Colombia's health system** is made up of a social security sector and a private sector. The backbone of the **system** is the General Social Security **Health System**, which has two plans, contributory and subsidized; workers from certain institutions (5.4%) are covered by a third plan.

\*at 12/31/2019, 12.5% of Salary - 8.5% Employer, 4.0% Employee

# Mexico



**Public healthcare** - Seguro Popular is a form of public and voluntary insurance that reduces OOP costs due to catastrophic expenses.

Account for 1/3 of all hospitals in Mexico, Funded by the federal government of Mexico

Can be publicly insured by a social security subsystem or by SP (voluntary public insurance)

21.5% of the Mexican population reported to be without any national public health insurance

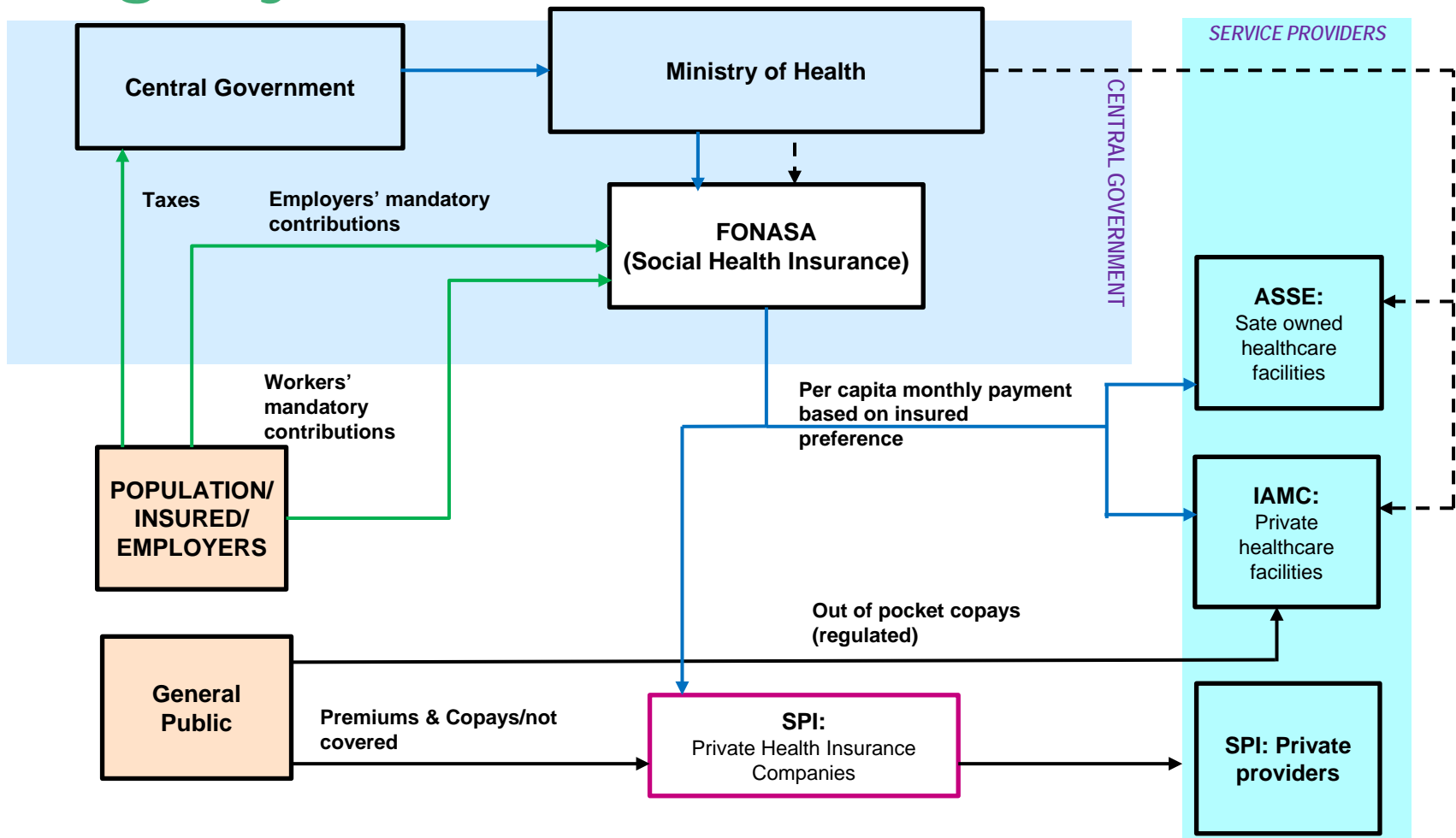
## Private healthcare

Account for 2/3 of all hospitals in Mexico with 2988 institutions, Less than 10% of the population has private insurance coverage

Out-of-pocket constitutes 44.7% of health system revenue and 4.0% of household expenditure



# Uruguay



**Fonasa:** "Fondo Nacional de Salud": universal & mandatory health coverage introduced in 2007, funded by workers, retirees and companies' contribution. Provides coverage for all workers and retired, spouses and underage children. Freedom to choose service provider, between Private providers (IAMC), and public healthcare (ASSE). FONASA is administered by BPS ("Banco de Prevision Social"), state pensions bank. Contributions from 3 to 8% for individuals and 5% (with a minimum) for employers.

**ASSE:** Public healthcare system. Provides coverage to Fonasa Users and insured population (no income nor retirement).

**IAMC:** "Instituciones de Asistencia Médica Colectiva": Private non-profit health care institutions. Provide full health care coverage to insureds, and get paid individual premium based on age/gender, cannot charge additional premium to users. Service level bonifications. Level of out of pockets copays are regulated.

**SPI:** "Seguros Privados Integrales": private healthcare insurance companies, voluntary for the general public. Get a subsidy from FONASA for the users to choose and SPI. Not regulated in their benefits not premium charged.

Police and Military force have their own health system and providers, funded by each minister's budget.

# Asia / Oceania

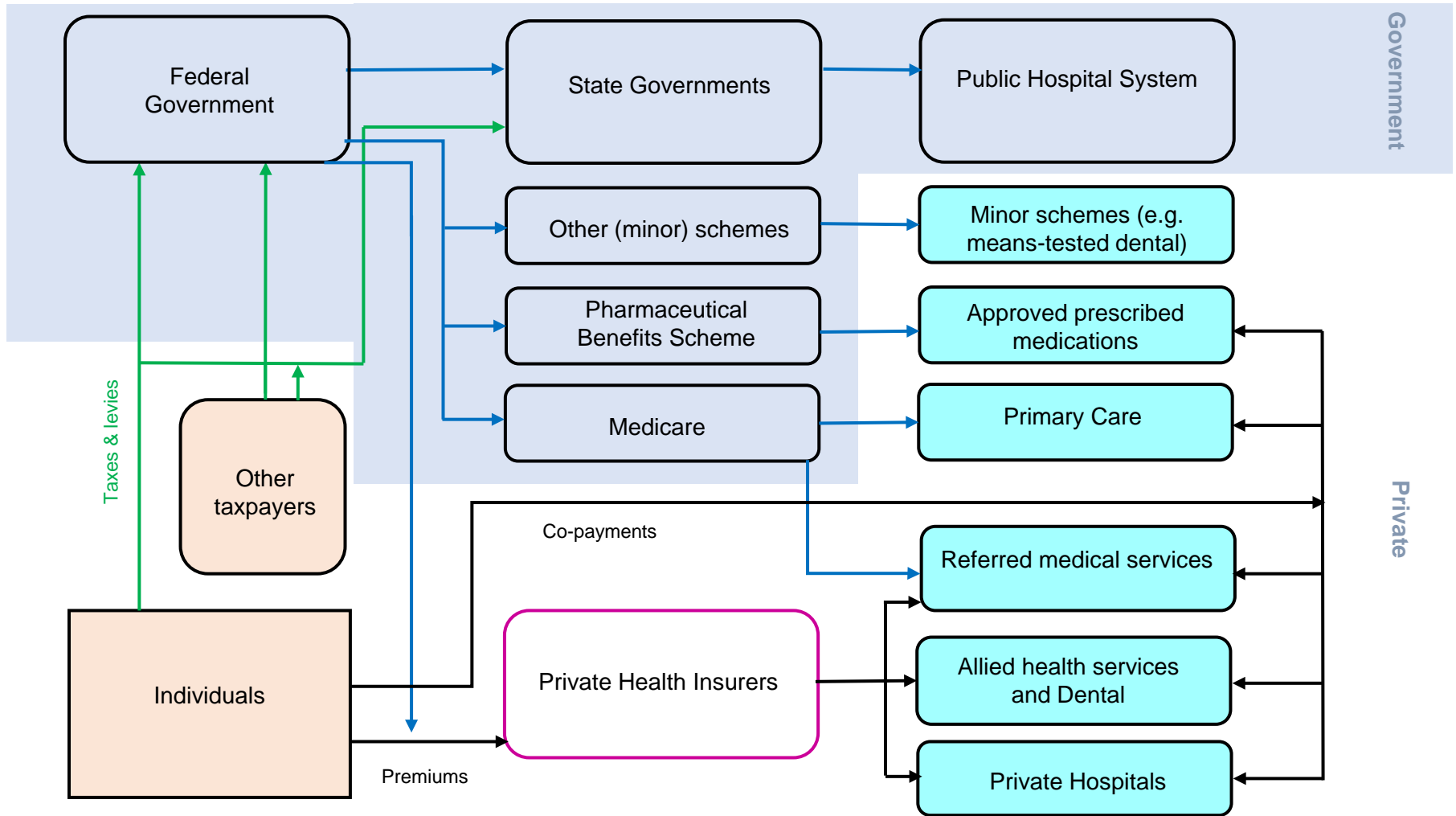


		Australia	China	India	Indonesia	Japan	Republic of Korea	Singapore	Sri Lanka
<b>Gov't Schemes</b>	Government schemes	65.5%	18.2%	22.9%	26.5%	8.5%	10.3%	40.1%	43.9%
	Compulsory contributory health insurance schemes	0.0%	38.5%	4.6%	22.6%	75.5%	48.5%	8.1%	0.4%
	Compulsory Medical Saving Accounts (CMSA)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.7%	0.0%
	Other government/compulsory schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Voluntary Schemes</b>	Voluntary health insurance schemes	13.1%	4.7%	5.0%	3.9%	2.2%	6.8%	2.0%	2.0%
	NPISH financing schemes	1.0%	0.3%	1.9%	1.1%	0.0%	0.6%	0.0%	0.2%
	Enterprise financing schemes	2.3%	2.3%	2.7%	11.7%	0.8%	0.1%	11.9%	3.7%
	Other Voluntary health care payment schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%
<b>OOP</b>	Household out-of-pocket payment	18.2%	36.1%	62.4%	34.1%	12.8%	33.7%	32.1%	49.8%
<b>Foreign</b>	Rest of the world financing schemes (non-resident)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Other</b>	Other Financing Schemes	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%

Values shown as a % of Current Health Expenditure (CHE) in 2017

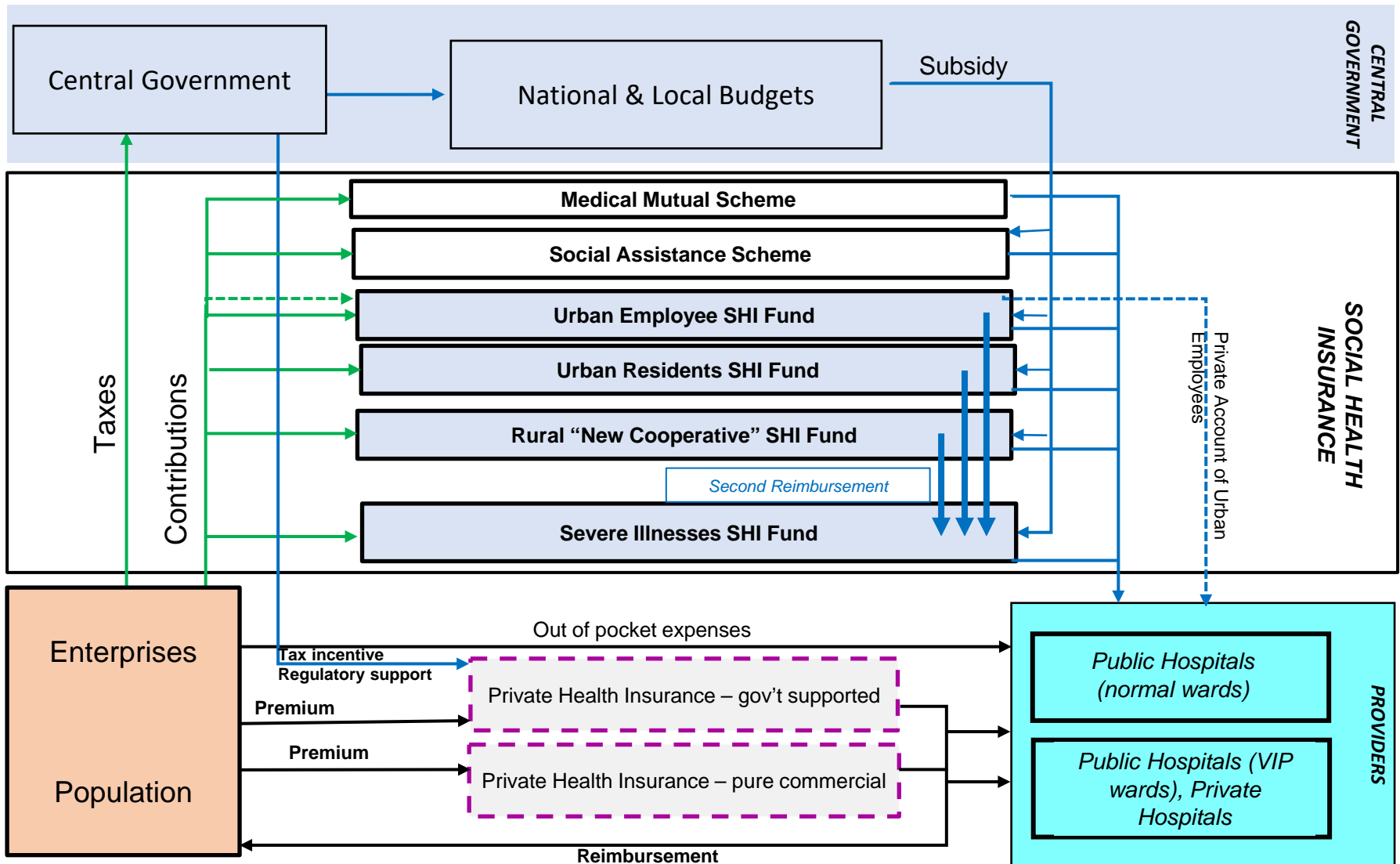
Source: World Health Organization Global Health Expenditure Database (<https://apps.who.int/nha/database>)

# Australia



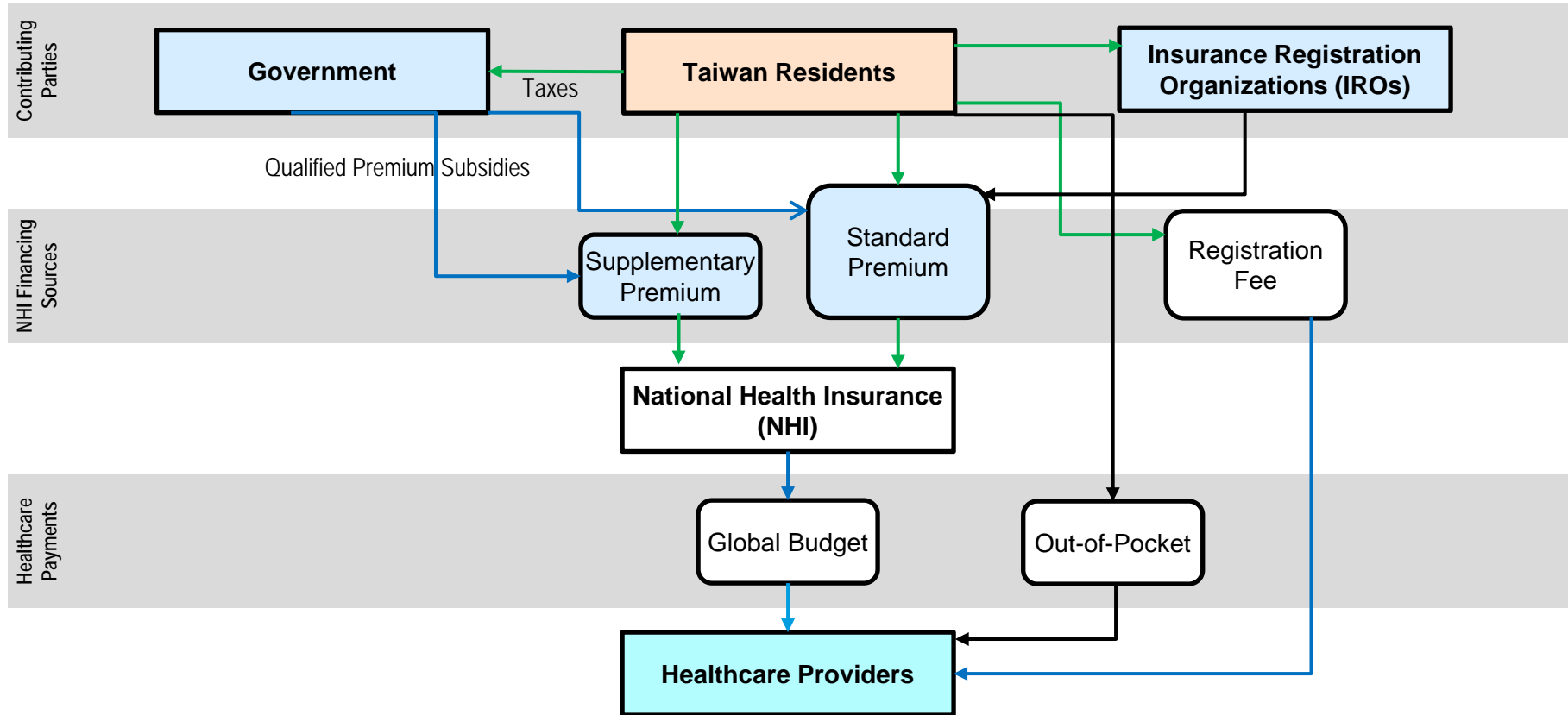
**Public healthcare:** Every Australian can be treated in a public hospital at no personal cost; significant federal schemes support primary care and pharmaceuticals  
**Private healthcare:** A mix of tax penalties (higher incomes) and premium rebates (lower incomes) encourage take-up of PHI (40%-50% of population); apart from public hospitals, most service providers are private enterprises  
**Funding:** Federal government 41% (incl 3% support for PHI Premiums); State governments 27%; Individuals 26% (including 9% PHI premiums); Others (eg workers comp) 6% (Source: Australian Institute of Health and Welfare 2017-18).

# China



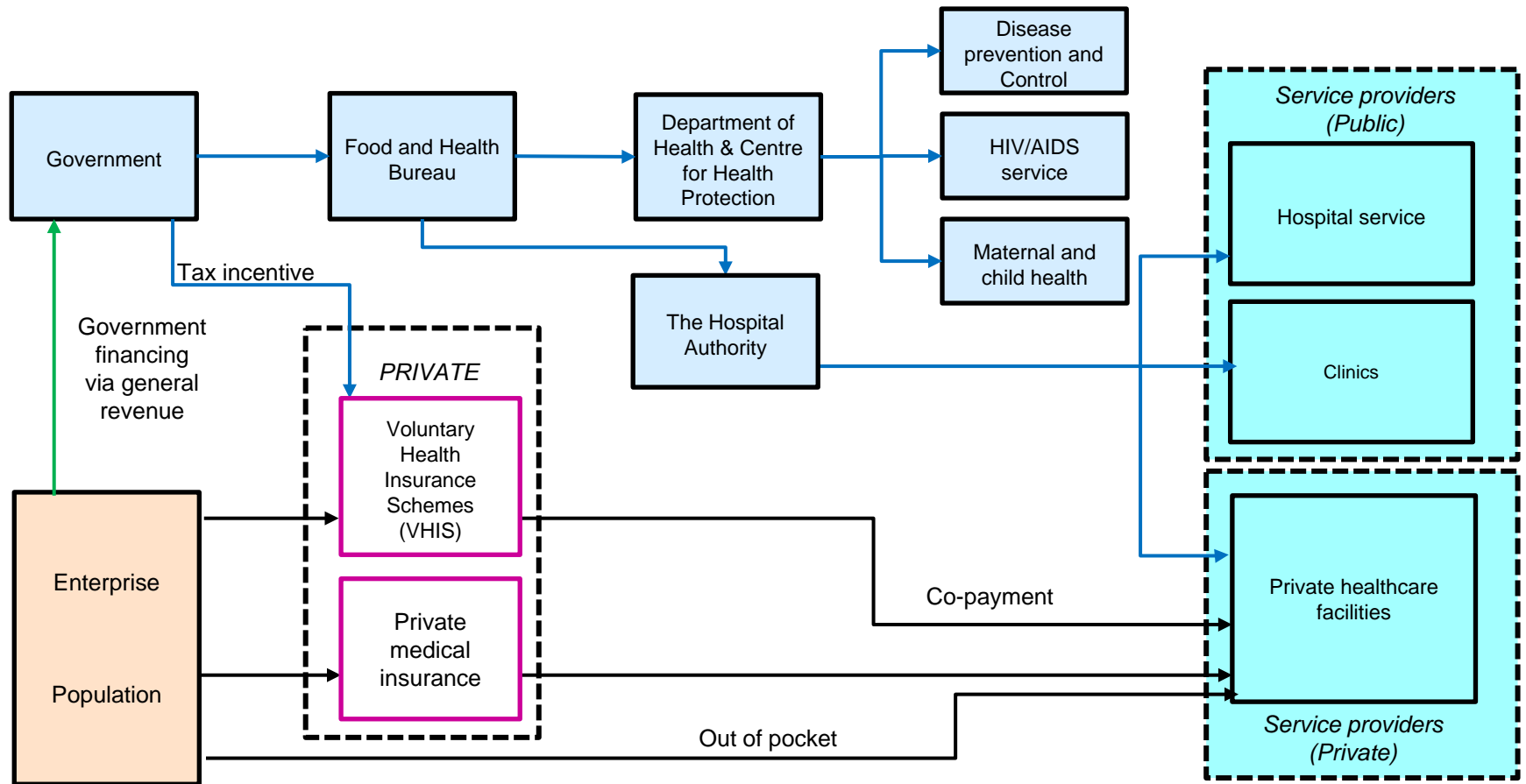
- Social Health Insurance system could be categorized as 3 layers:
- 1) Basic layer – social assistance schemes for people in poverty
  - 2) Social Health Insurance (SHI) schemes for mass public
  - 3) Supplementary to SHI schemes, provide extra indemnities to critical illnesses.

# Chinese Taipei

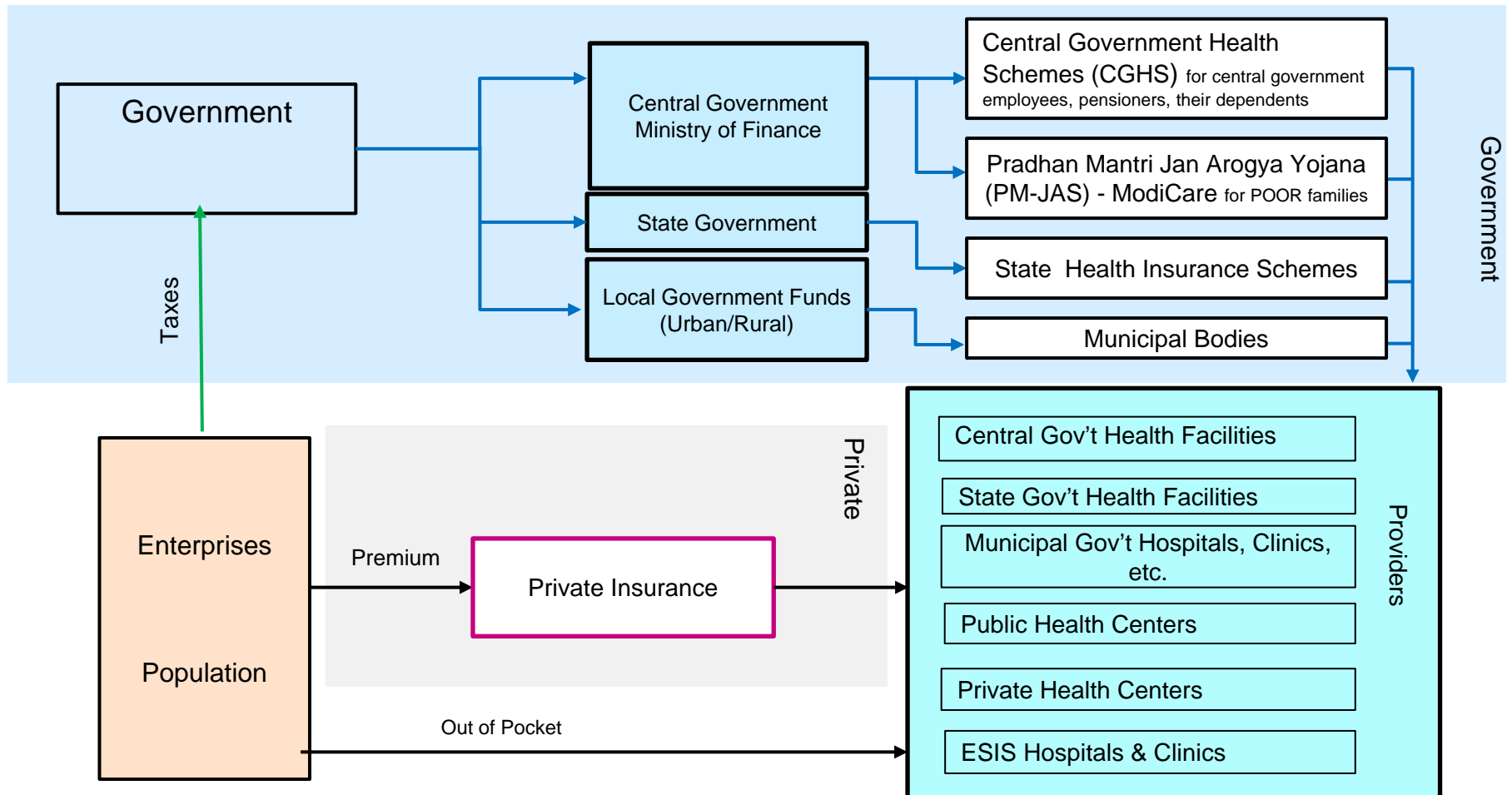


- The IROs are the employers, unions, associations, or the local household registry offices, who are responsible for enrolling and collecting premiums from their respective constituents.
- The NHI receives most of its funding from income-based premiums as opposed to general tax revenues. The Standard Premiums are based on a progressive contribution schedule, consisting of 52 brackets, where individuals with higher income pay higher premiums.
- Supplementary Premium is a percentage of non-regular income, such as high bonuses, wages from part-time jobs, ad hoc professional fees, interest income, stock dividends, and rental income.
- Tax Revenue consists of cigarette tax, national lottery contributions, and emergency relief fund.

# Hong Kong

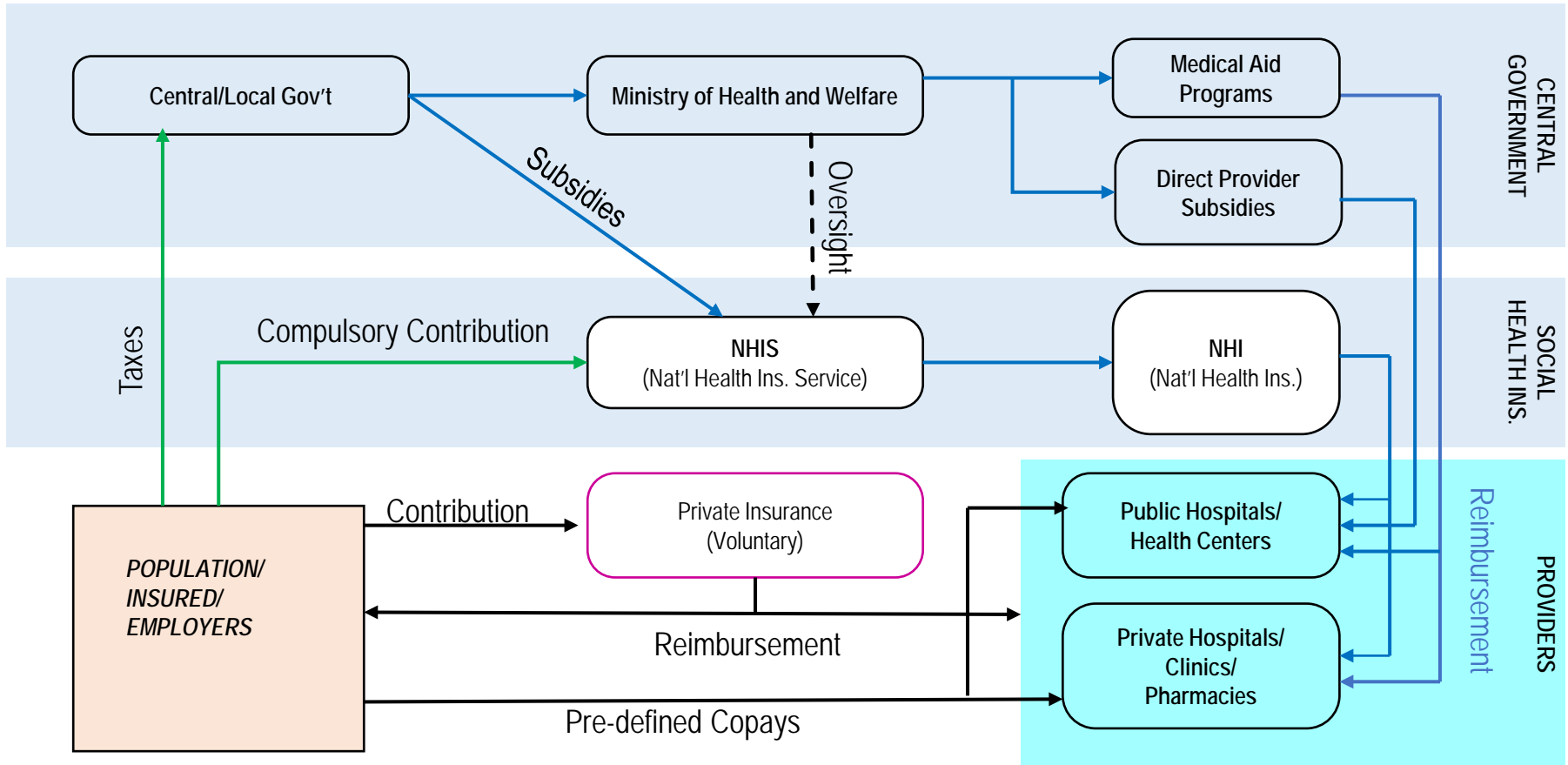


# India



- In August 2018, the Government of India has approved Ayushman Bharat-National Health Protection Mission (AB-NHPM) as a centrally Sponsored Scheme contributed by both centre and state government at a ratio of 60:40 for all States, 90:10 for hilly North Eastern States and 60:40 for Union Territories with legislature. The centre will contribute 100 per cent for Union Territories without legislature.
- In Sept. 2018, Government of India launched Pradhan Mantri Jan Arogya Yojana (PMJAY) under AB-NHPM, to provide health insurance worth INR 500,000 (US\$ ~7,000) to over 100 million **families** every year.

# Indonesia



**BPJS** Mandatory national universal health insurance scheme (BPJS), introduced in 2014.

- Funded by mixture of contribution from government and members (i.e. population)
- Membership is compulsory for all Indonesian citizen and foreigner who stays in Indonesia for at least 6months.
- Government is final guarantor for BPJS

**BPJS's benefits for members** Cover all payments which are required until patient is cured, including chronic drugs, kidney dialysis, chemotherapy etc.

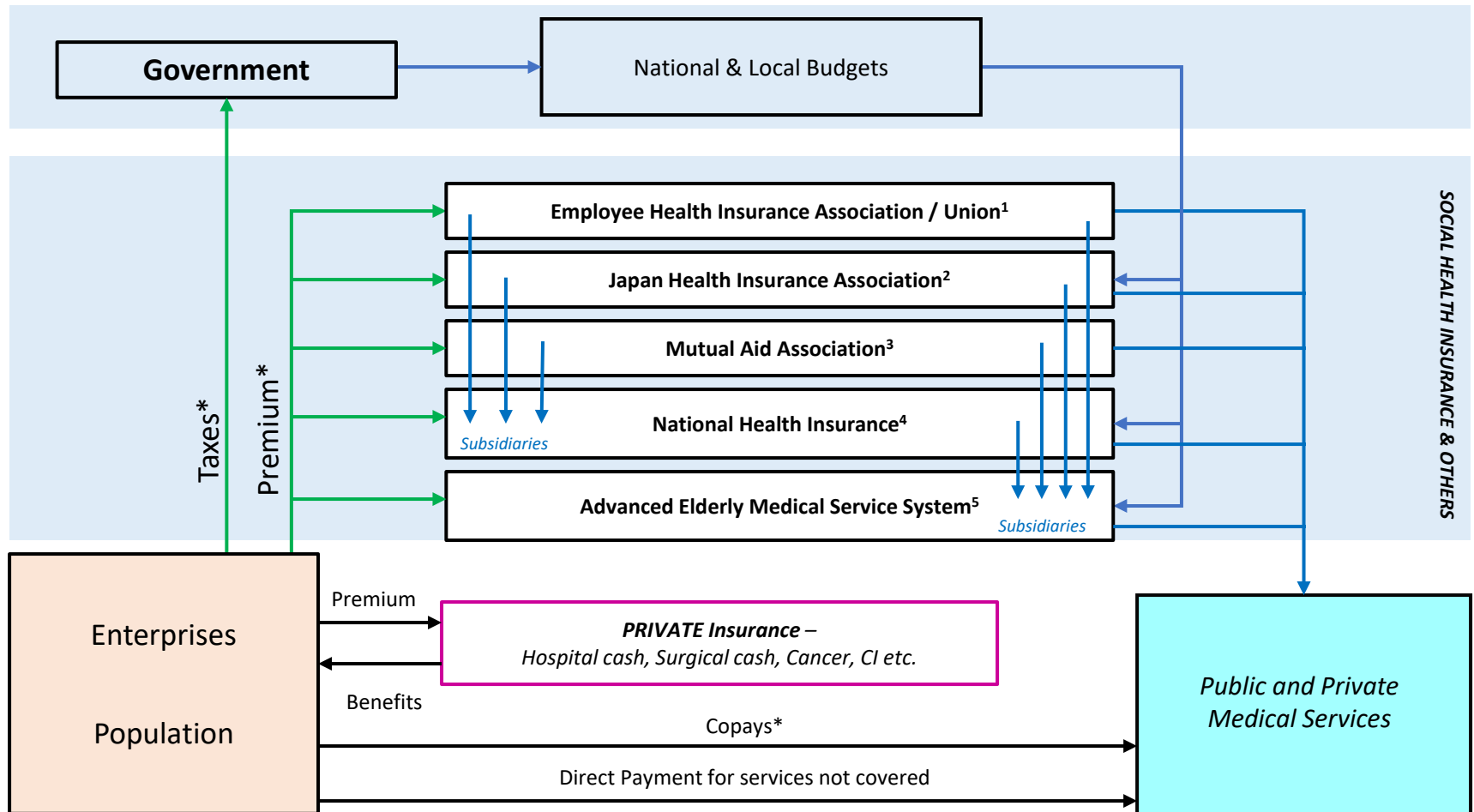
- There is no out-of-pocket expense or cost-sharing for member.
- Available only in all participating BPJS' network providers. In practice, this includes all public GP, polyclinic and hospitals. Include some but not all private hospitals.

**Role of BPJS in managing healthcare expenditure**

- Gate keeper & referral system for member (i.e. member has to choose GP as first point of contact. Access to specialist depends on referral from GP. Access to inpatient care depends on referral from specialist)



# Japan



<sup>1</sup> **Employee Health Insurance (EHI) Association/Union** is an association/union that provides employee-based health insurance. Relatively large employers have this association/union.

<sup>2</sup> **Japan Health Insurance Association** is an association that provides health insurance. Companies **without** EHI Association/Union must join this association.

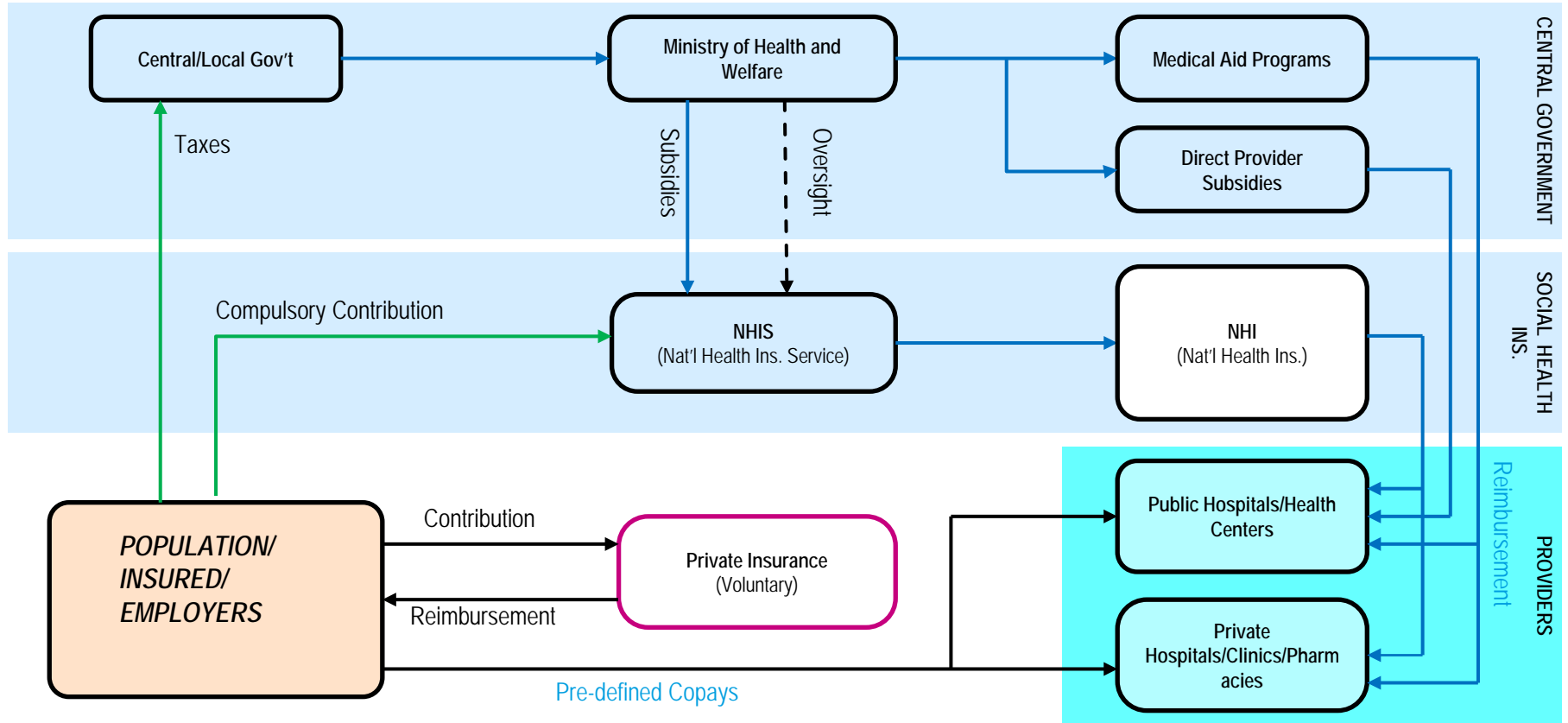
<sup>3</sup> **Mutual Aid Association** is an association that provides health insurance for national/local public employees, private school teachers, etc.

<sup>4</sup> **National Health Insurance** covers those who aged 75- and either unemployed, self-employed, or retired, as well as the dependent family members of them.

<sup>5</sup> **Advanced Elderly Medical Service System** covers those who aged 75+ or aged 65+ with certified disability.

\*Taxes fund 38%, Premium 49%, Copays are 12%

# Republic of Korea



**NHI** – A mandatory national universal health insurance scheme, introduced in 1989.

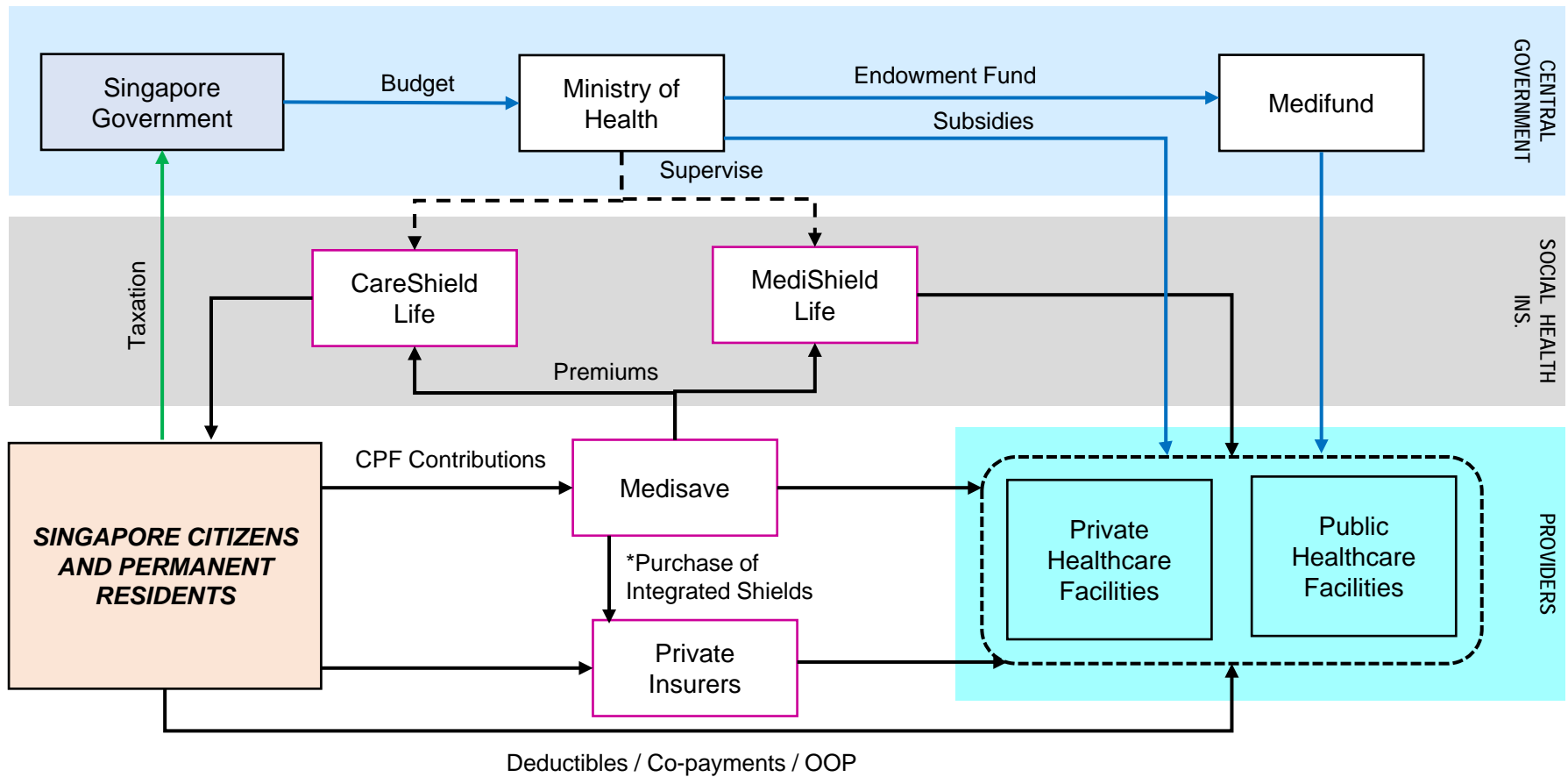
**NHIS** - A quasi-public organization (overseen by the MoHW) that manages the NHI

- Funded by employers/employee contributions, government subsidies, and tobacco surcharges
- Membership is compulsory for all South Korean citizen and foreigners who stay in South Korea for at least 6 months

**NHI Benefits** – Patients may access any provider.

- Cover part of payments which are required until patient is cured, including chronic drugs, kidney dialysis, chemotherapy etc.
- There is cost sharing based on a pre-defined copayment by type of service.
- New type of services opted by providers cause a concern to the funding.

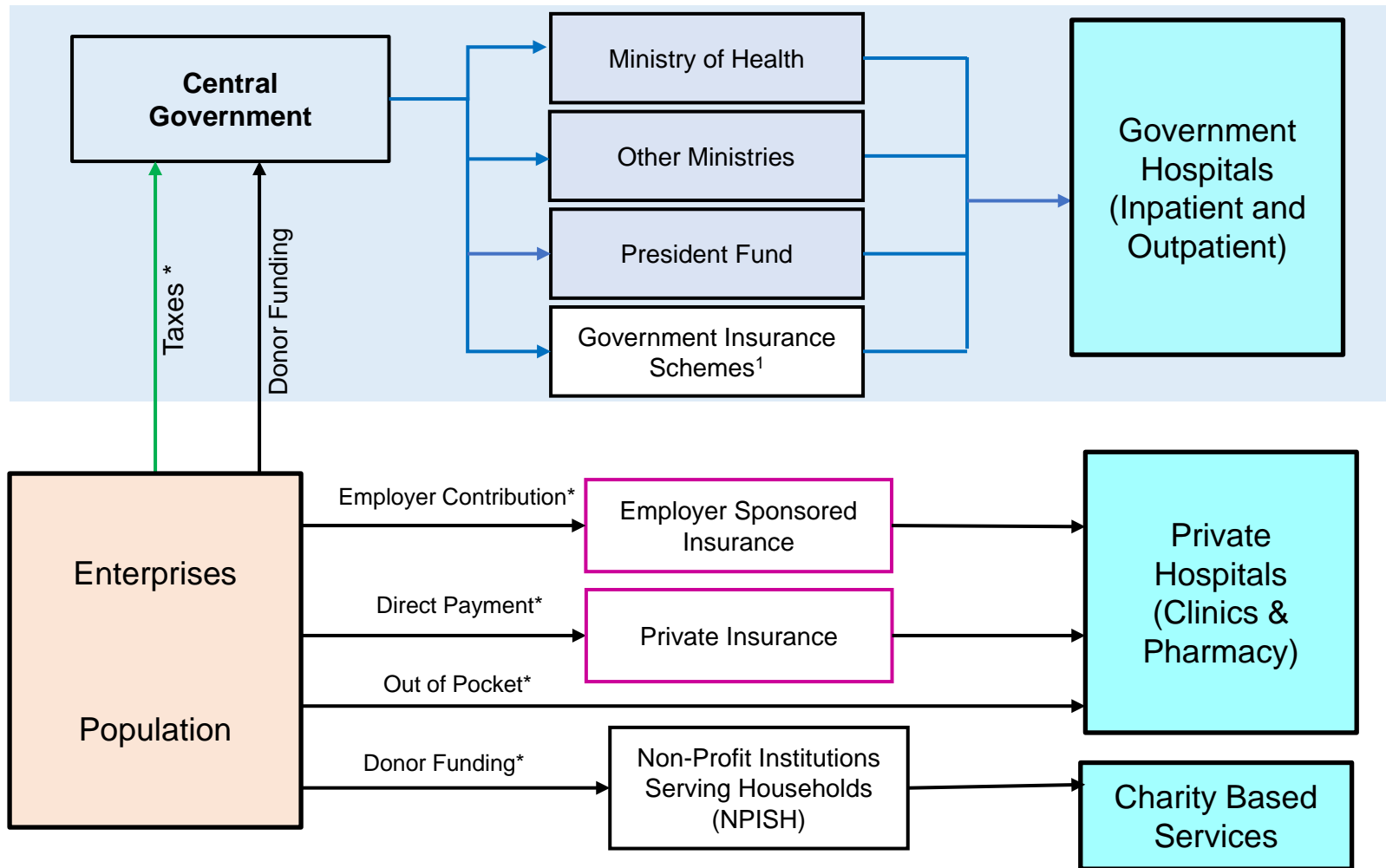
# Singapore



Singapore's Healthcare Financing System is made up of a multi-pillared system

- **Government Subsidies:** Various schemes and subsidies available to reduce medical bills and keep costs affordable
- **Medisave:** Medical savings account under an individual's CPF account that can be used for self and family's medical bills, and to pay premiums of medical insurance policies
- **Medishield Life:** Basic health insurance plan that helps pay for hospitalization bills and selected outpatient treatments. Can be supplemented with additional coverage by purchasing an Integrated Shield Plan from private insurers
- **Medifund:** Means-tested safety net for the poor; only available to SG citizens who have depleted their Medisave and MediShield
- **Careshield Life:** Disability Insurance for long-term care
- For Integrated Shield, The MediShield Life Component is fully payable by Medisave, while the additional private insurance component is payable using Medisave up to the Additional Withdrawal Limits.

# Sri Lanka

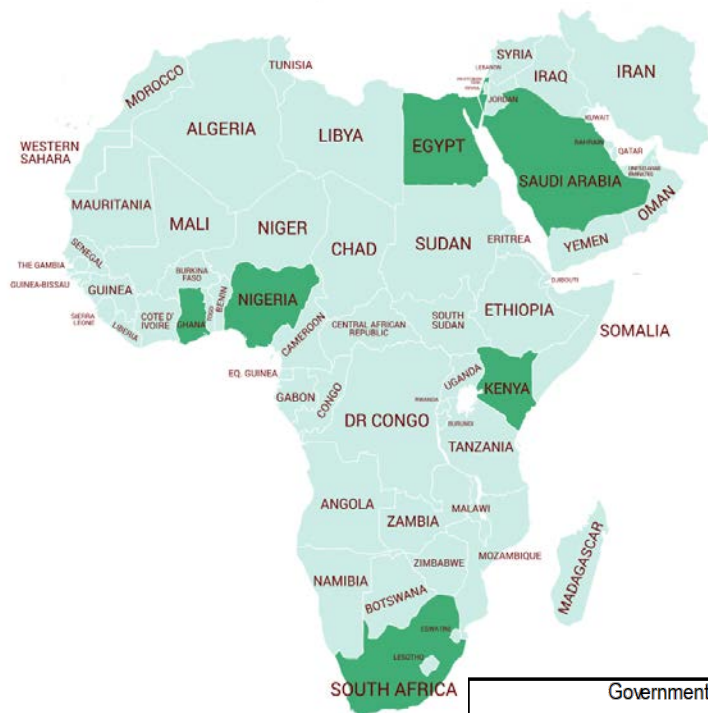


<sup>1</sup> Examples of these Schemes are Government Employees- "Agrahara" Fund and School Children- "Suraksha" Insurance scheme

- Donor Funding is local and international

At 31/12/2019, Healthcare funding is comprised of: Taxes 27%, Employer Contributions 8%, Donor Funding 2%, Private Insurance 5%, and Out of Pocket 58%

# Africa / Middle East



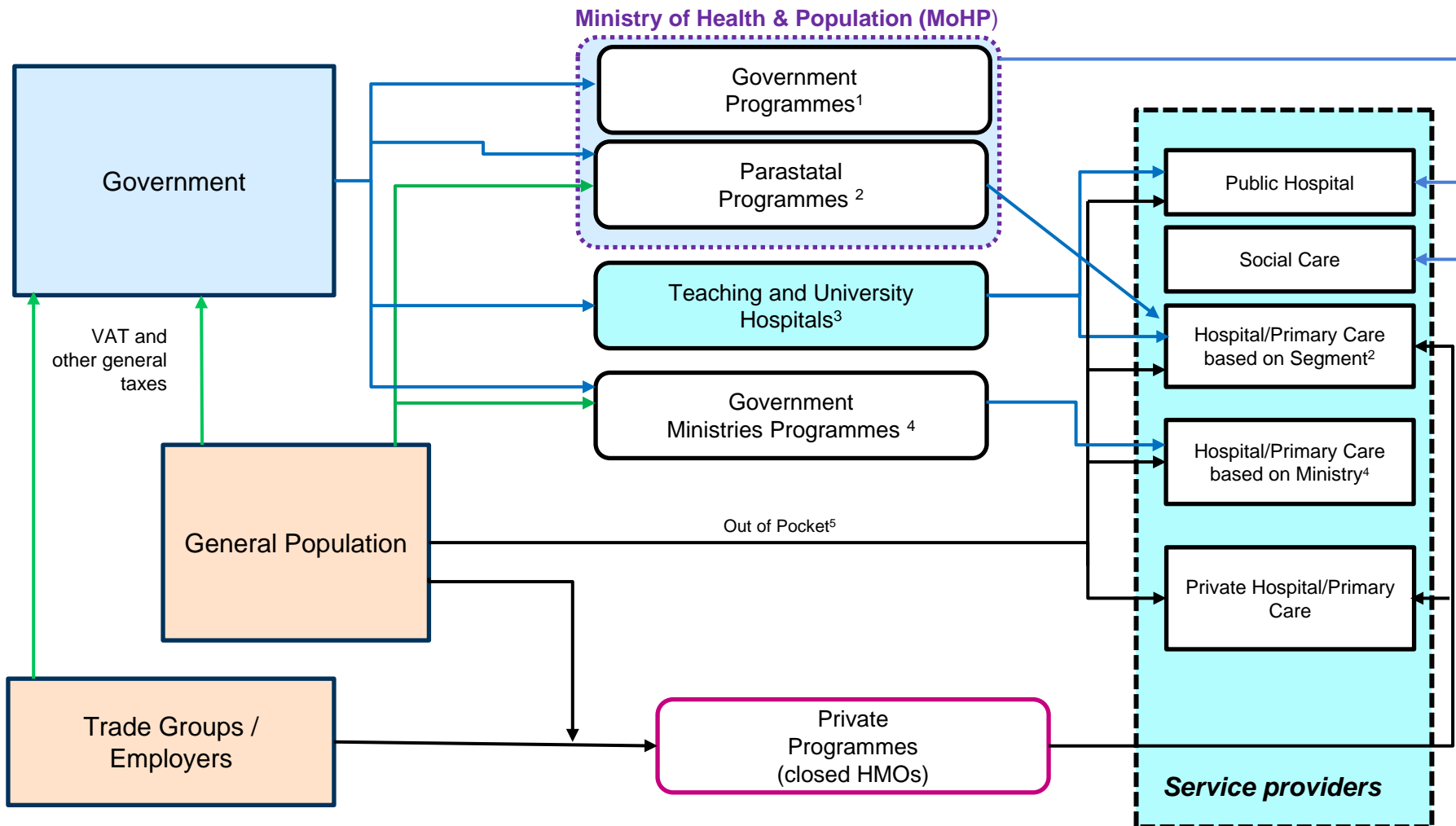
		Egypt	Ghana	Israel	Kenya	Nigeria	Saudi Arabia*	South Africa
<b>Gov't Schemes</b>	Government schemes	29.0%	30.5%	15.9%	41.6%	13.7%	66.7%	42.8%
	Compulsory contributory health insurance schemes	4.1%	10.3%	47.7%	7.6%	0.7%	0.0%	0.0%
	Compulsory Medical Saving Accounts (CMSA)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Other government/compulsory schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Voluntary Schemes</b>	Voluntary health insurance schemes	0.8%	1.8%	11.2%	9.7%	0.4%	13.2%	47.0%
	NPISH financing schemes	0.8%	5.9%	0.6%	14.1%	7.6%	0.2%	1.9%
	Enterprise financing schemes	5.2%	11.2%	0.6%	2.9%	0.2%	4.2%	0.6%
	Other Voluntary health care payment schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>OOP</b>	Household out-of-pocket payment	60.1%	40.3%	22.3%	24.0%	77.2%	15.7%	7.8%
<b>Foreign</b>	Rest of the world financing schemes (non-resident)	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%	0.0%
<b>Other</b>	Other Financing Schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Values shown as a % of Current Health Expenditure (CHE) in 2017\*

\*Saudi Arabia data reflects 2016

Source: World Health Organization Global Health Expenditure Database (<https://apps.who.int/nha/database>)

# Egypt



<sup>1</sup> Open to all citizens but poor quality

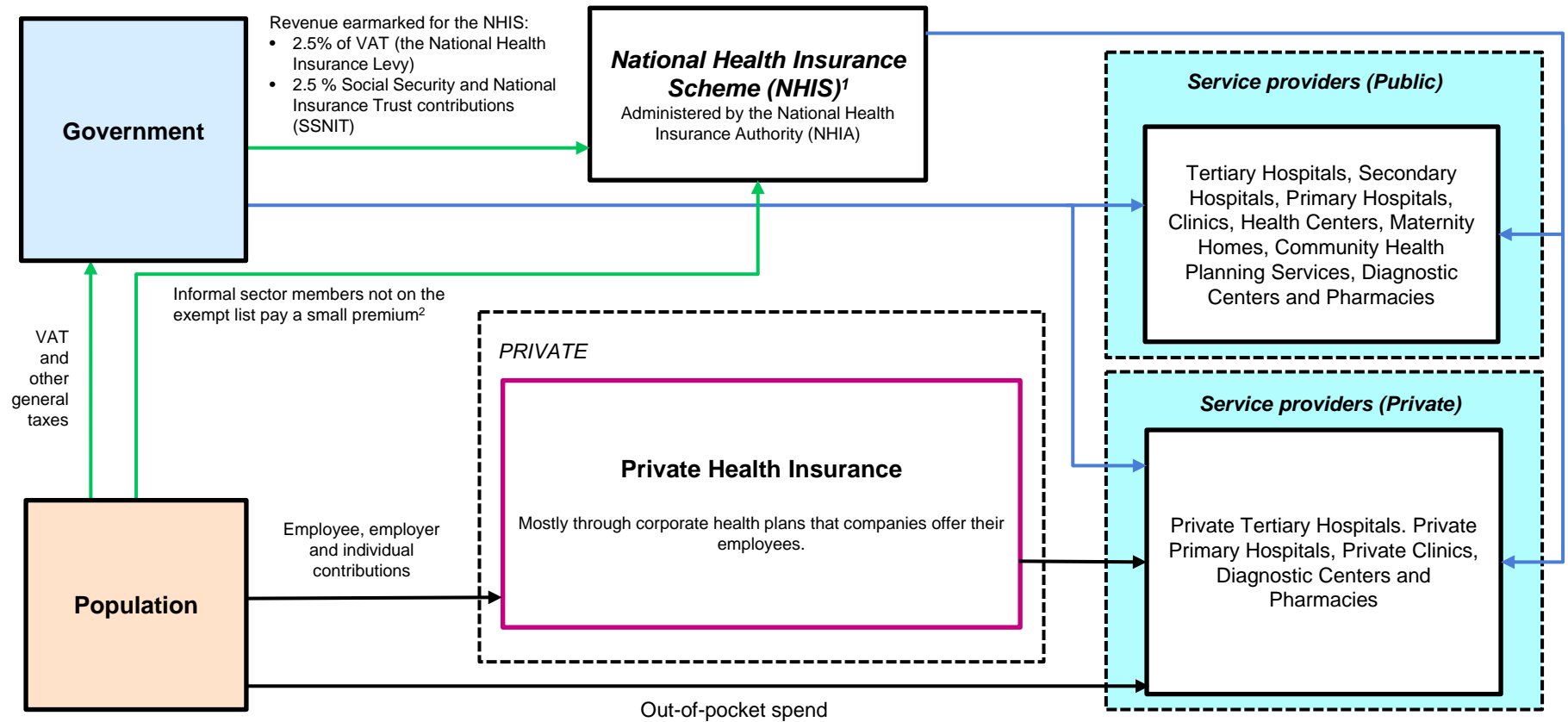
<sup>2</sup> Semi-autonomous, gov't owned like National Insurance Organization (NIO), Curative Care Organization (CCO)

<sup>3</sup> One of the targeted hospitals for the poor people and also for the workers and employees in the public sector

<sup>4</sup> Separate risk pools and providers for each ministry (Interior, Transportation, Agriculture, Defense, Religious Affairs, etc.), some open to the public with higher OOP.

<sup>5</sup> Citizen may pay OOP directly to providers

# Ghana



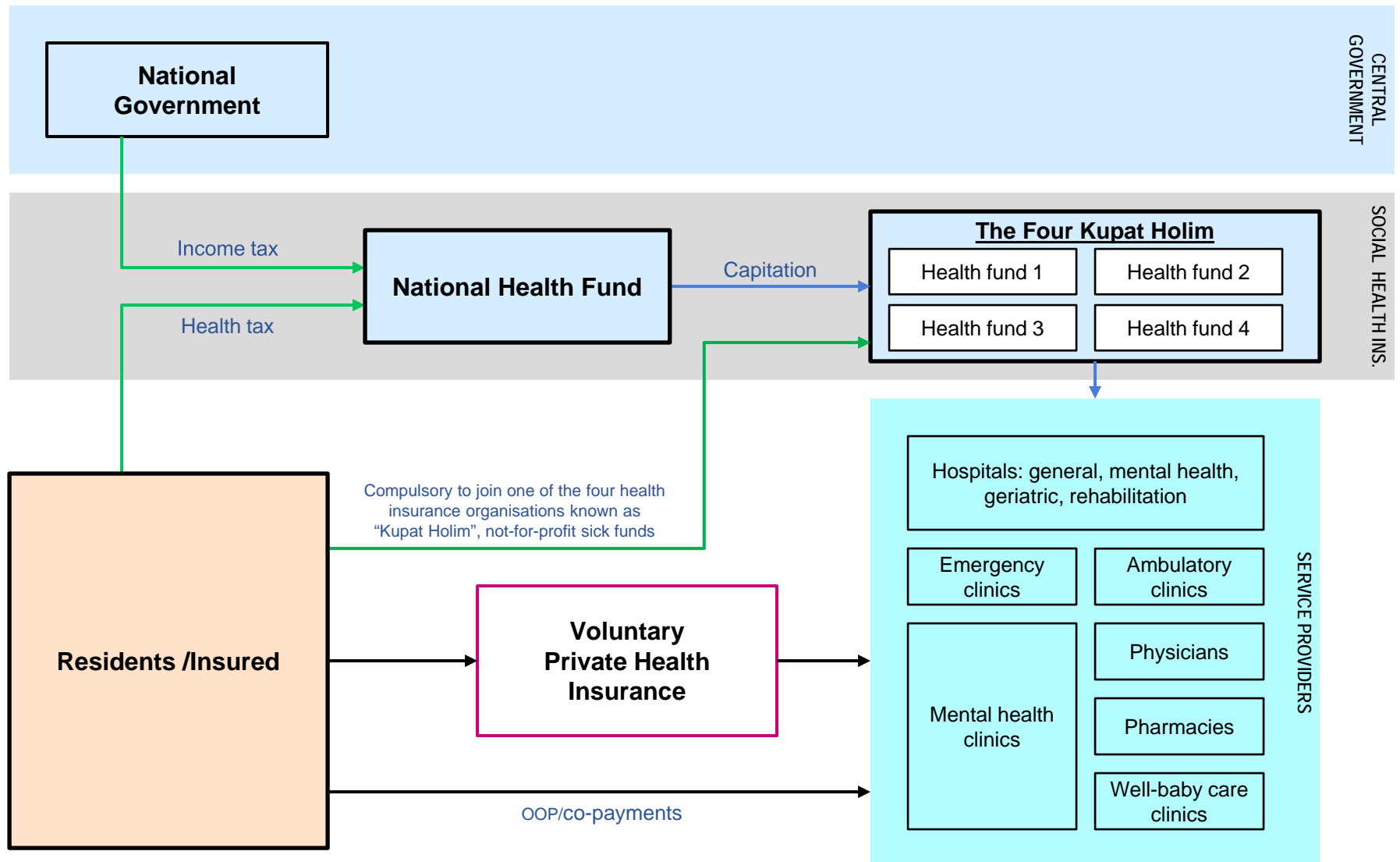
Health sector is administered by the Ministry of Health. Ghana Health Services is another agency that reports to the MOH and is a major player in service delivery.

<sup>1</sup> The NHIS was established in 2003. The National Health Insurance Authority which licenses, monitors and regulates the operation of health insurance schemes in Ghana. The NHIS covers about 95% of diseases in Ghana. The benefit package includes outpatient, inpatient, dental, optical, maternity and emergency services.

<sup>2</sup> Those exempt from premiums include: Pregnant women, Indigents, Categories of differently-abled persons determined by the Minister responsible for Social Welfare, Persons with mental disorder, SSNIT contributors, SSNIT pensioners, Persons above seventy years of age (the elderly), Other categories prescribed by the Minister

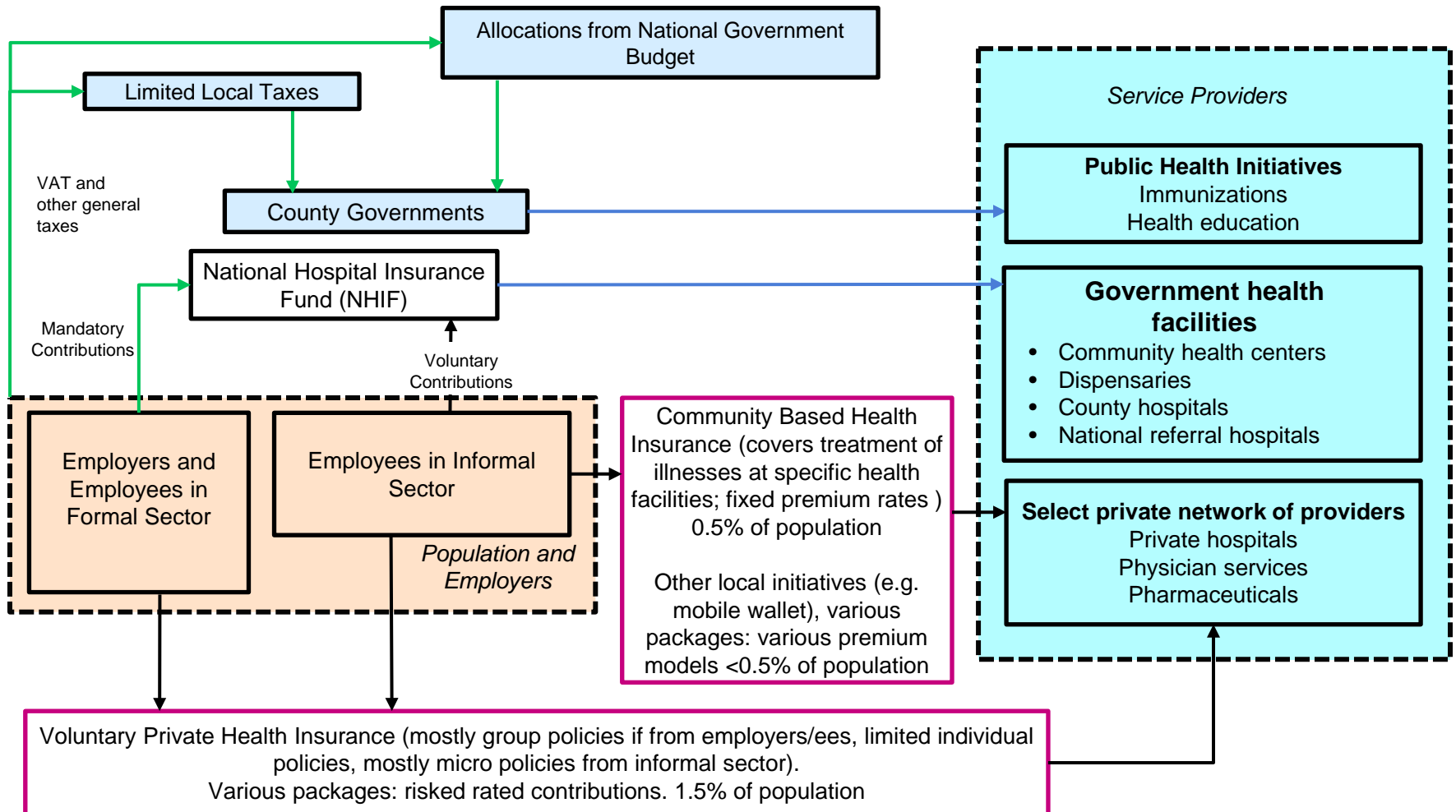
<sup>3</sup> As of May 2020, the NHIS covered around 40% of Ghana's population. (roughly 12.3 million people).

# Israel



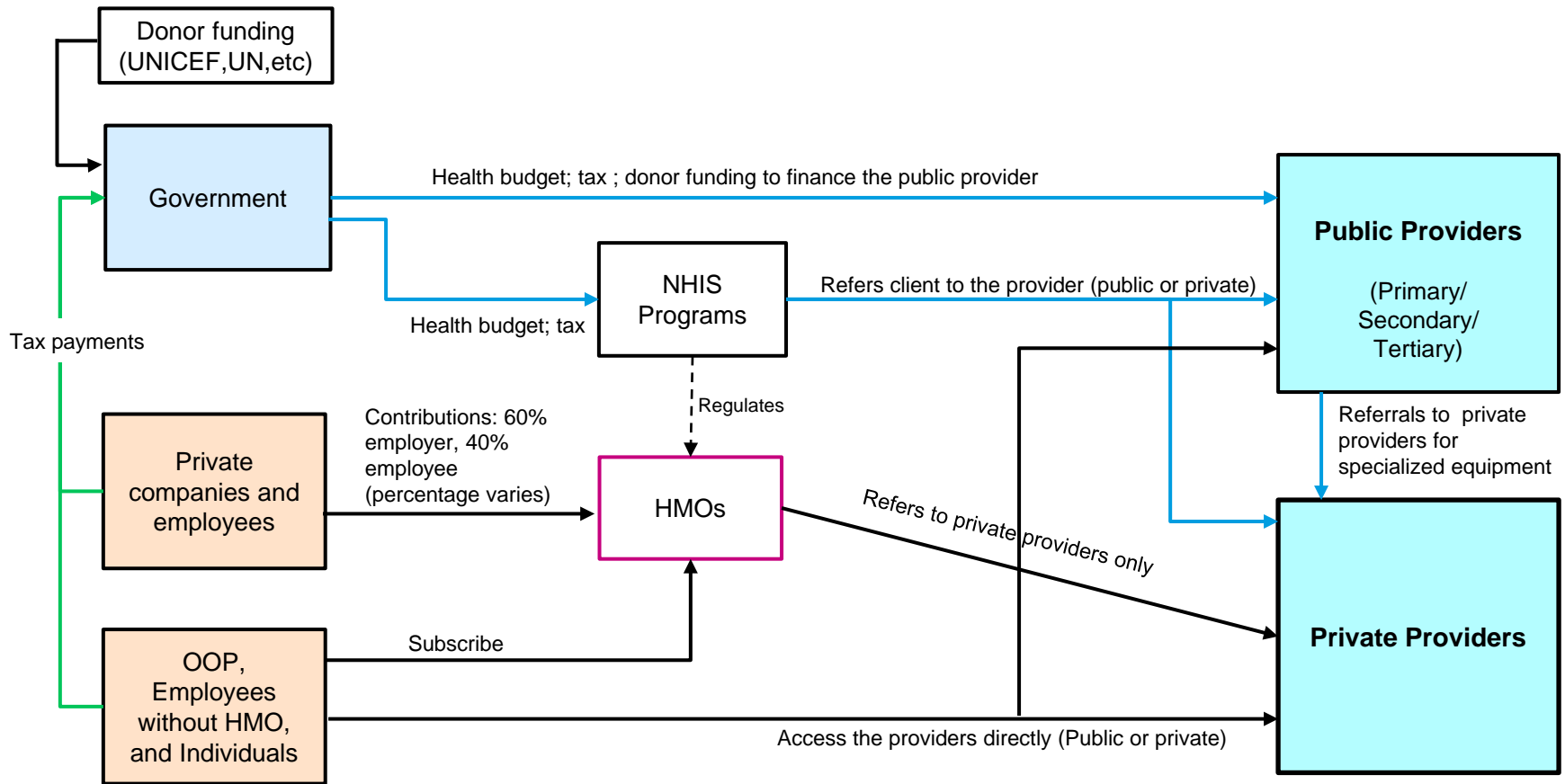


# Kenya



- National Hospital Insurance Fund (NHIF) is the predominant form of health coverage
- Around 20% of the population is covered by the NHIF (Source: <https://www.pharmaccess.org/wp-content/uploads/2018/01/The-healthcare-system-in-Kenya.pdf>)
- Required NHIF annual member contributions range from KES 1,800 (17 USD) to KES 20,400 (USD 198)
- About 5% of the population has other forms of health insurance coverage

# Nigeria

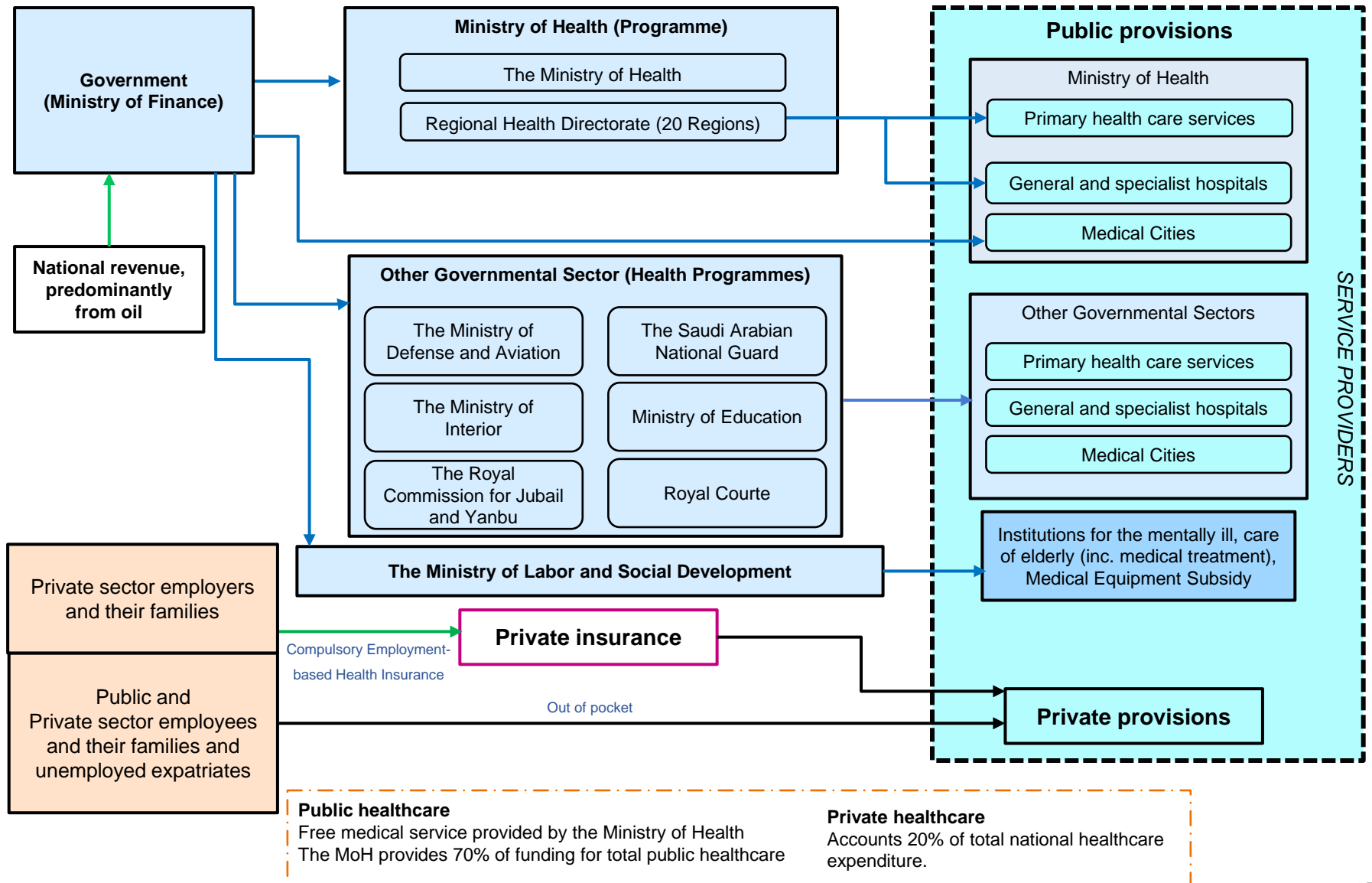


NHIS: National Health Insurance Scheme Programmes (Formal Sector, Informal Sector and Vulnerable Groups)

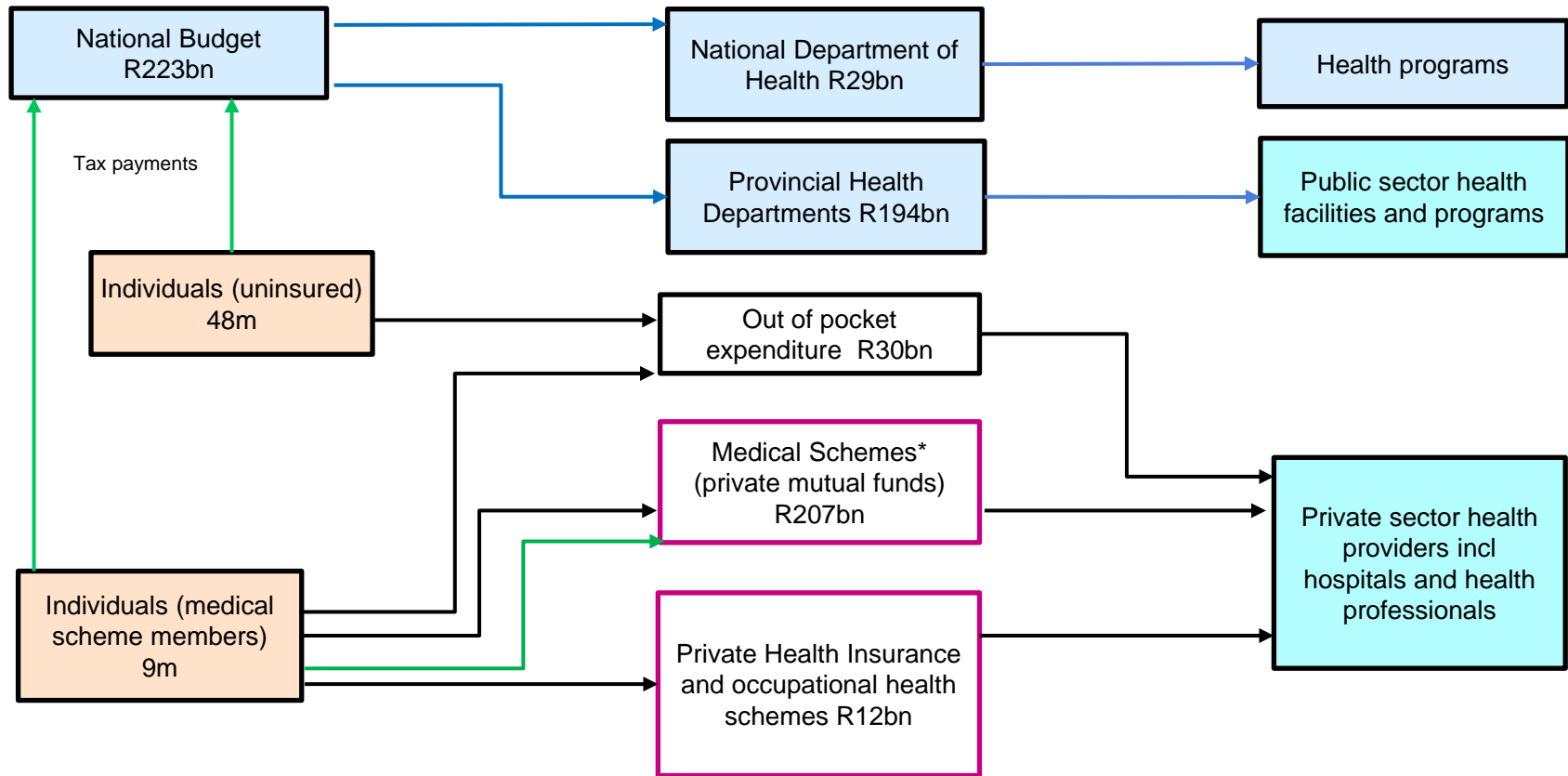
OOP: Out of pocket payment.

Health care financing in Nigeria is currently in transition with reform towards Universal Healthcare Coverage.

# Saudi Arabia



# South Africa



2019 Figures (ZAR)

9.2% of GDP

\*Medical schemes are regulated mutual funds that are required to cover prescribed minimum benefits but can also offer supplemental cover

# Europe

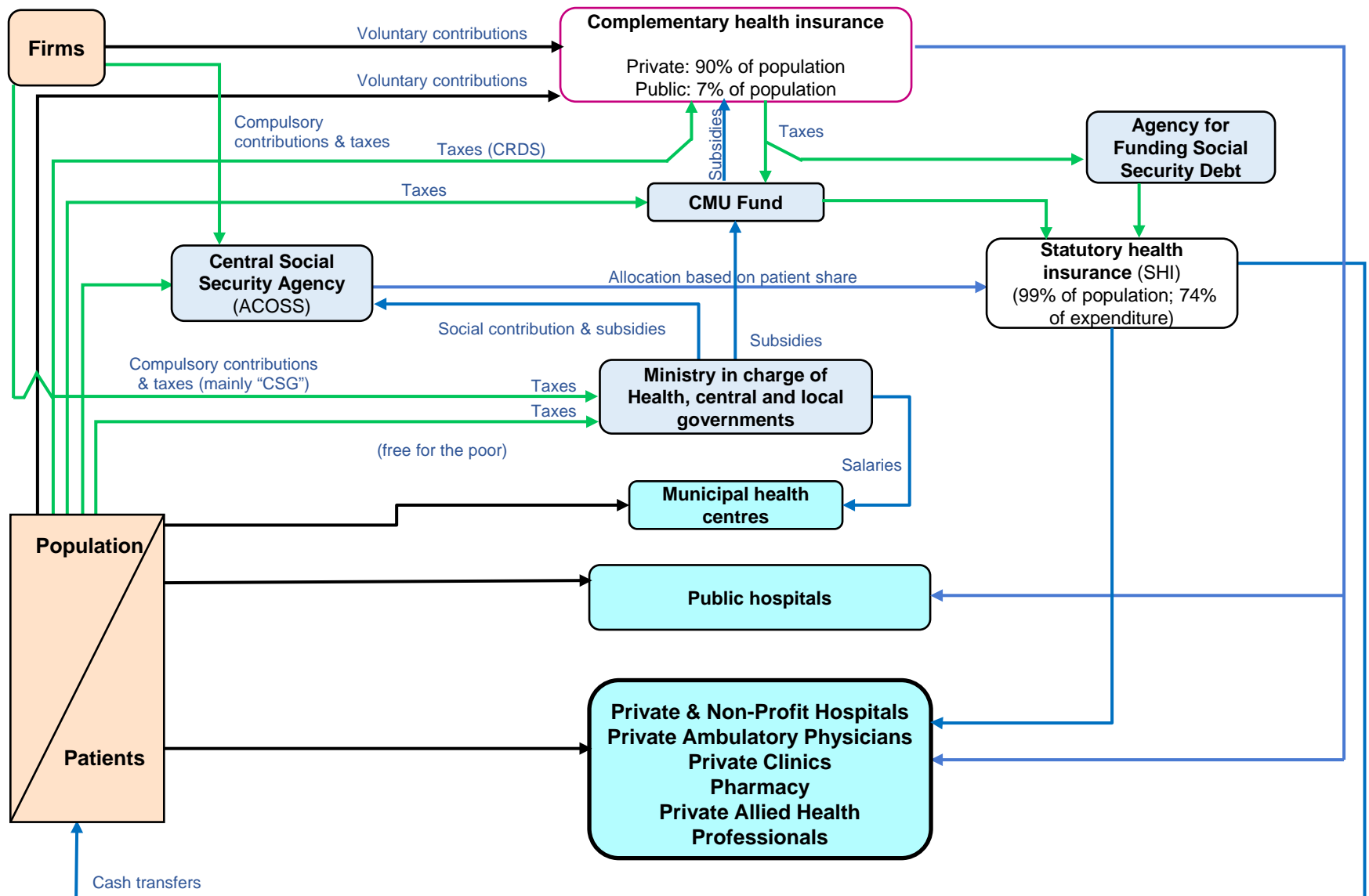


		France	Germany	Ireland	Italy	Poland	Romania	Switzer- land	Spain	Nether- lands	Turkey	United Kingdom
Gov't Schemes	Government schemes	5.3%	6.3%	72.9%	73.7%	10.4%	15.5%	21.8%	66.5%	6.3%	22.1%	78.8%
	Compulsory contributory health insurance schemes	78.1%	78.1%	0.4%	0.2%	59.1%	63.2%	41.8%	4.1%	75.3%	55.6%	0.0%
	Compulsory Medical Saving Accounts (CMSA)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Other government/compulsory schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Voluntary Schemes	Voluntary health insurance schemes	6.6%	1.4%	12.7%	1.8%	5.7%	0.5%	6.5%	5.4%	5.9%	2.5%	3.1%
	NPISH financing schemes	0.0%	1.3%	0.0%	0.4%	0.8%	0.2%	0.4%	0.4%	0.0%	0.0%	1.6%
	Enterprise financing schemes	0.6%	0.4%	1.8%	0.4%	1.2%	0.1%	0.5%	0.0%	1.4%	2.4%	0.5%
	Other Voluntary health care payment schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OOP	Household out-of-pocket payment	9.4%	12.5%	12.3%	23.5%	22.8%	20.5%	28.9%	23.6%	11.1%	17.4%	16.0%
Foreign	Rest of the world financing schemes (non-resident)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	Other Financing Schemes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

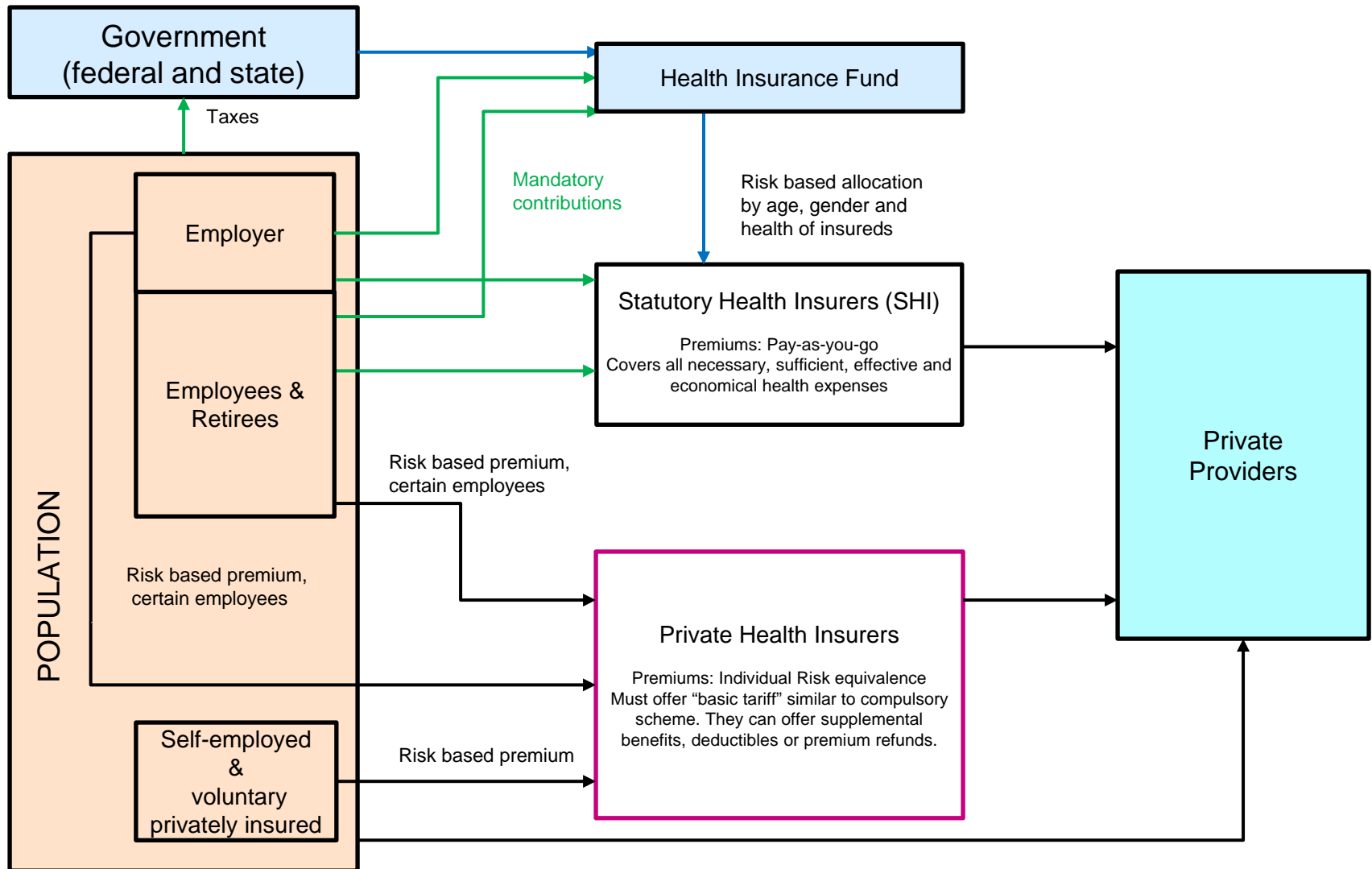
Values shown as a % of Current Health Expenditure (CHE) in 2017

Source: World Health Organization Global Health Expenditure Database (<https://apps.who.int/nha/database>)

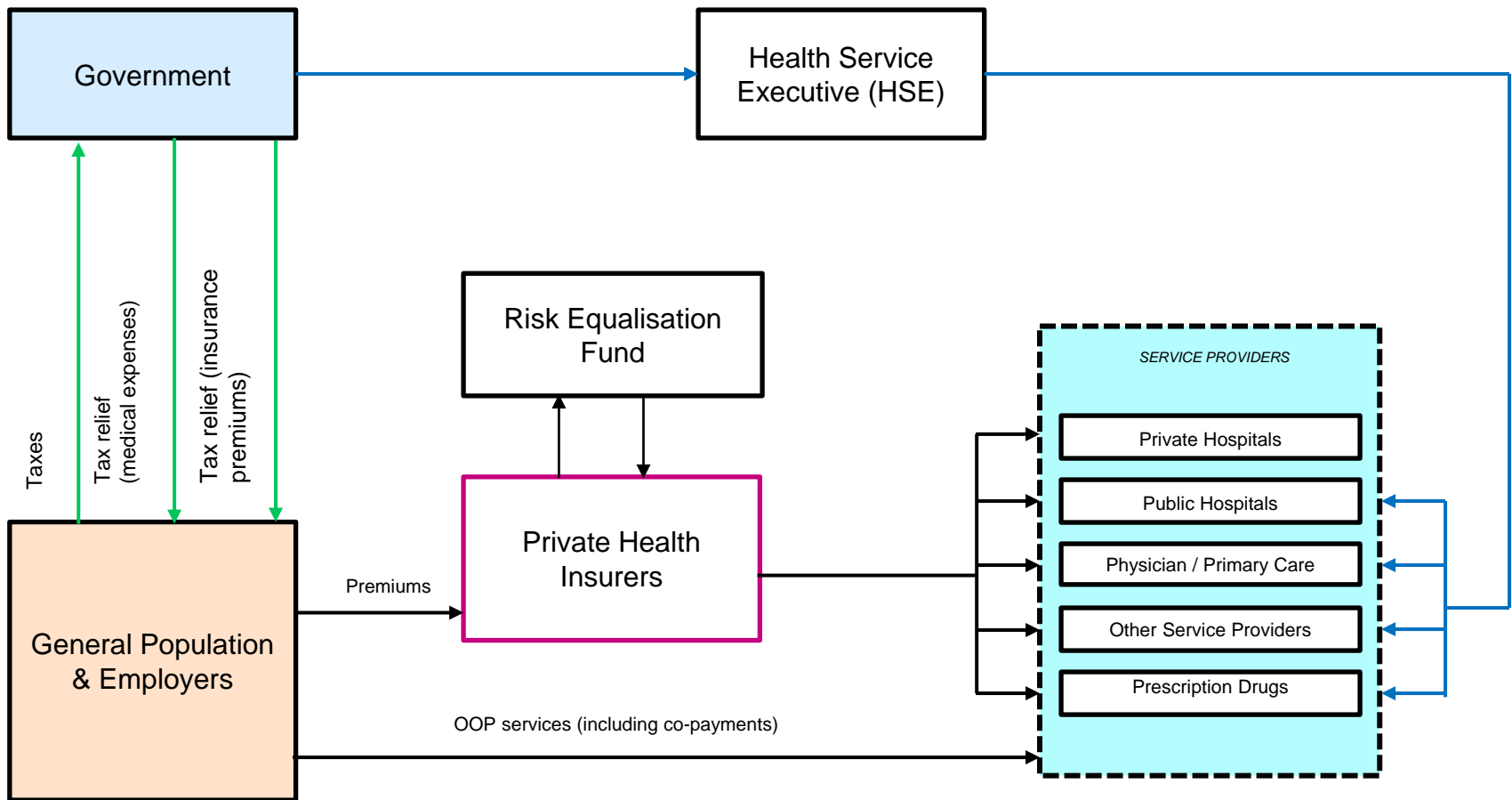
# France



# Germany

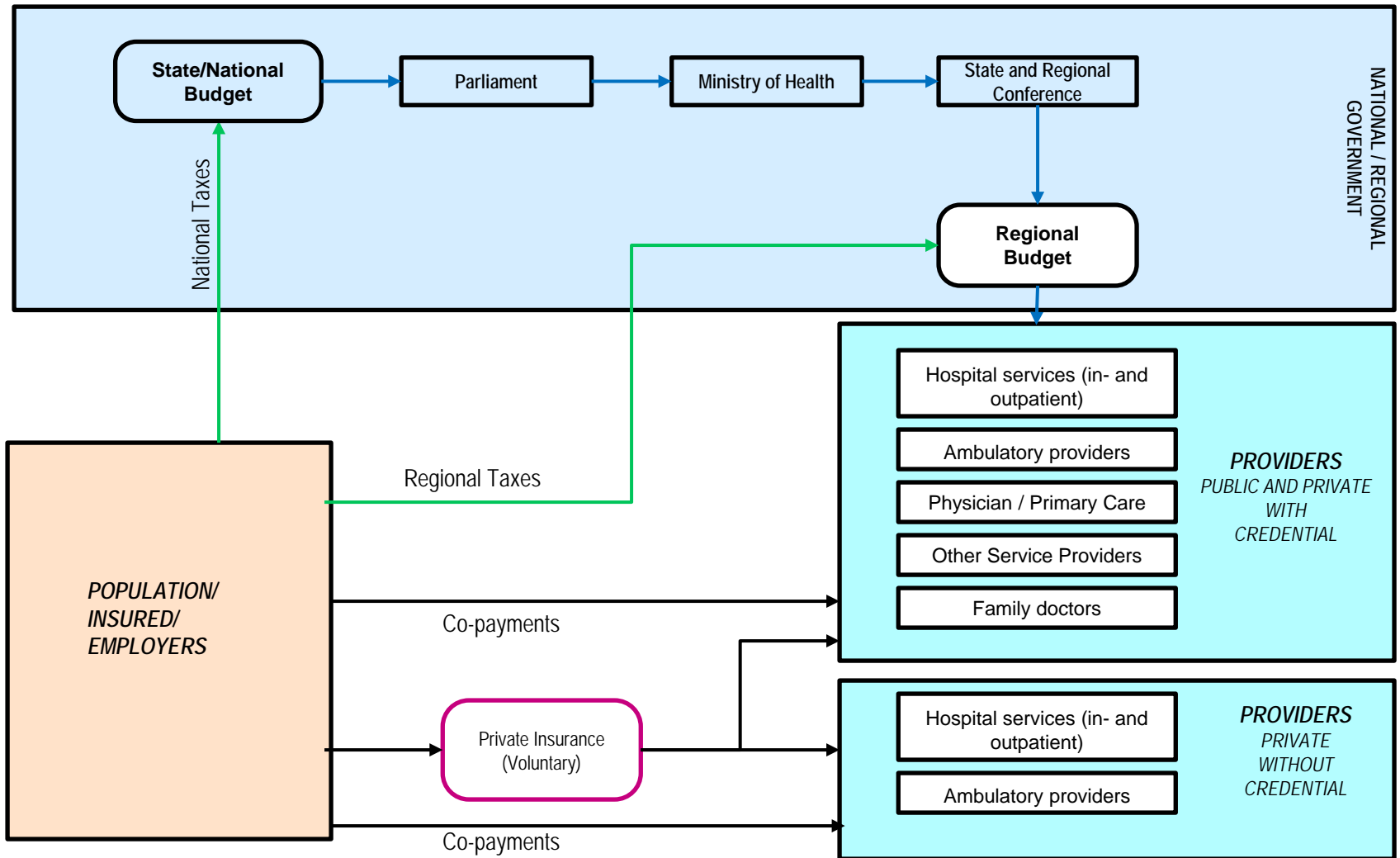


# Ireland

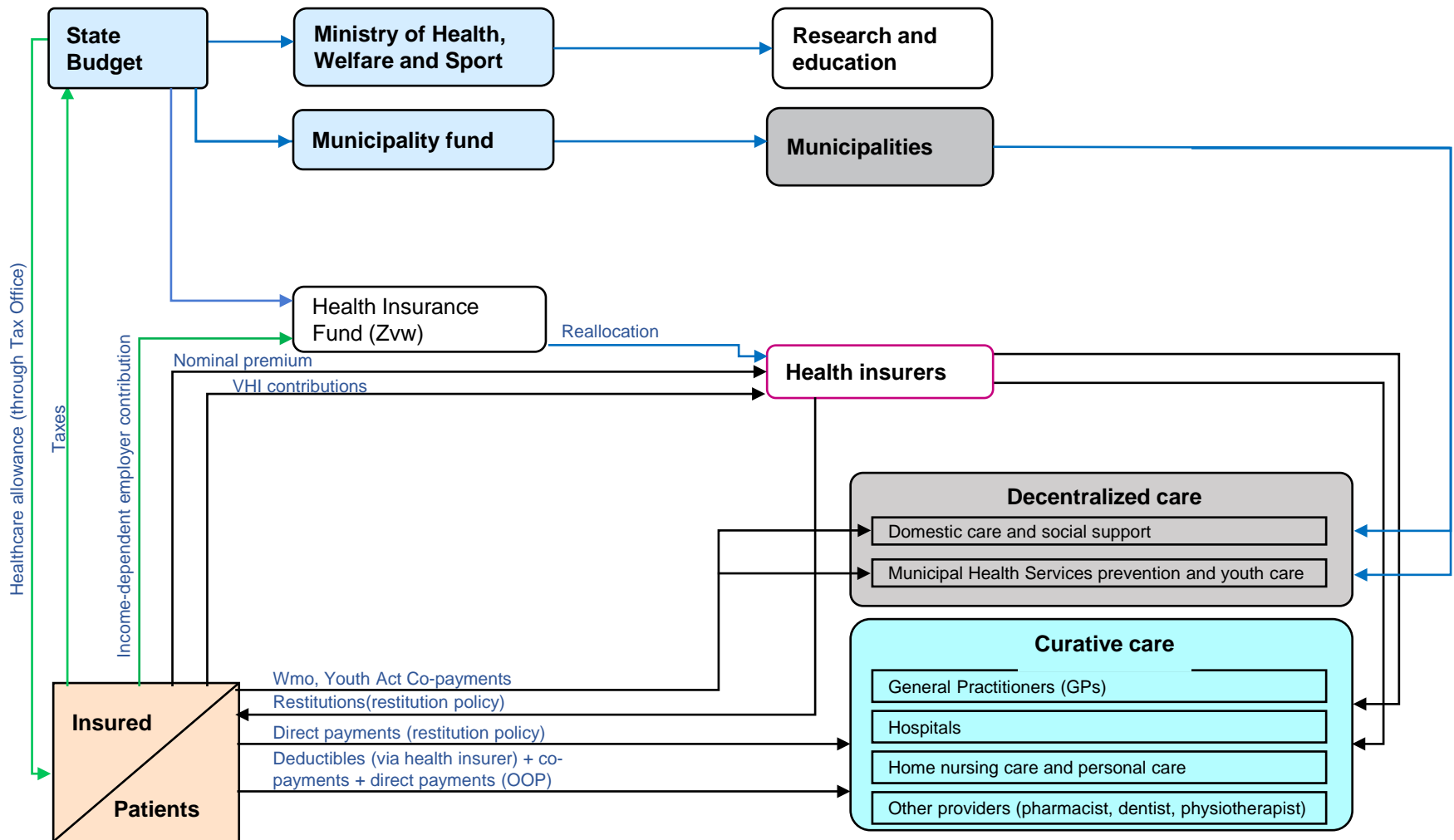




# Italy

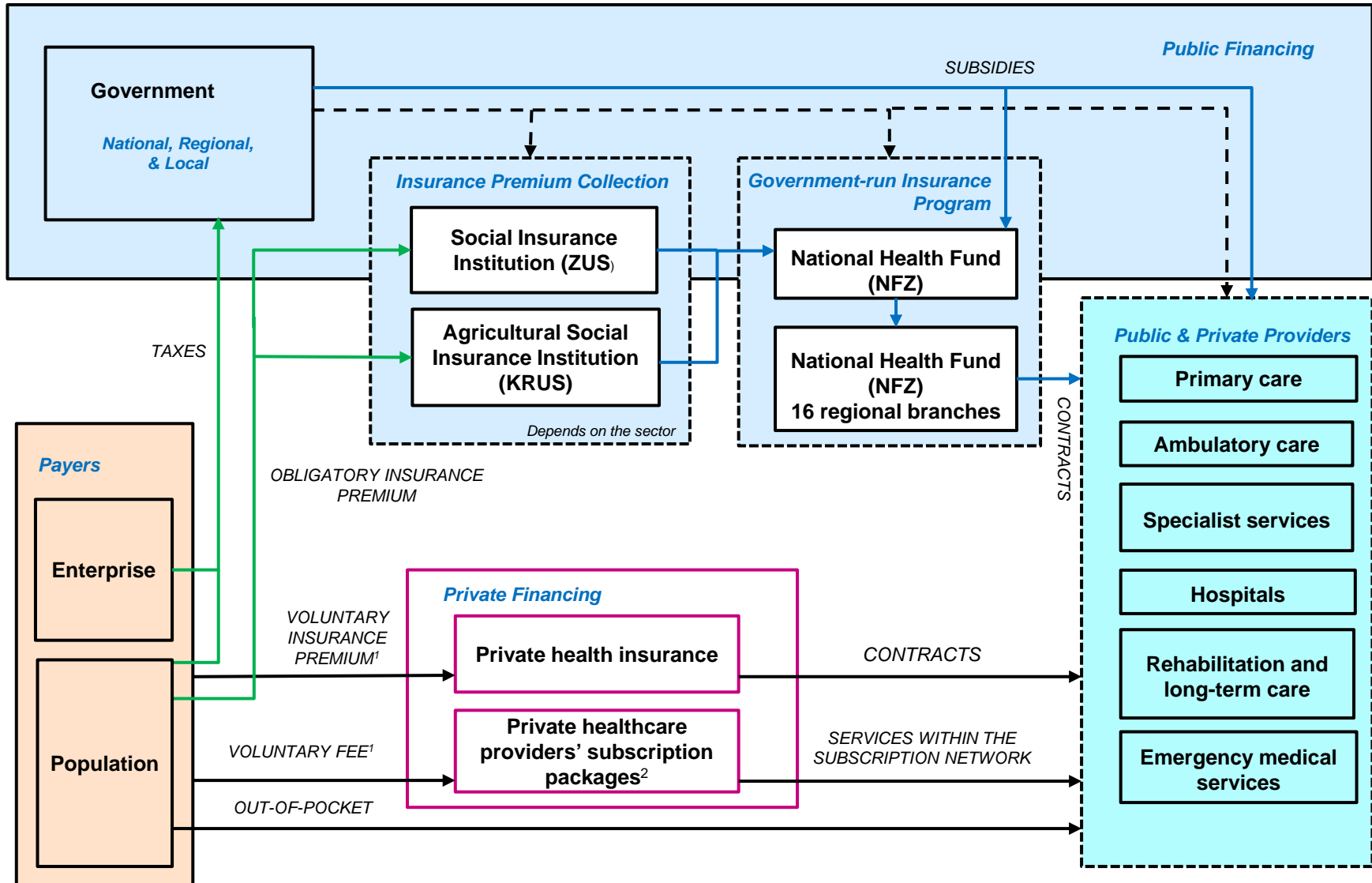


# Netherlands



- Health Insurance Act (Zvw)
- Public Health/Social Support (Wmo)/Youth Act

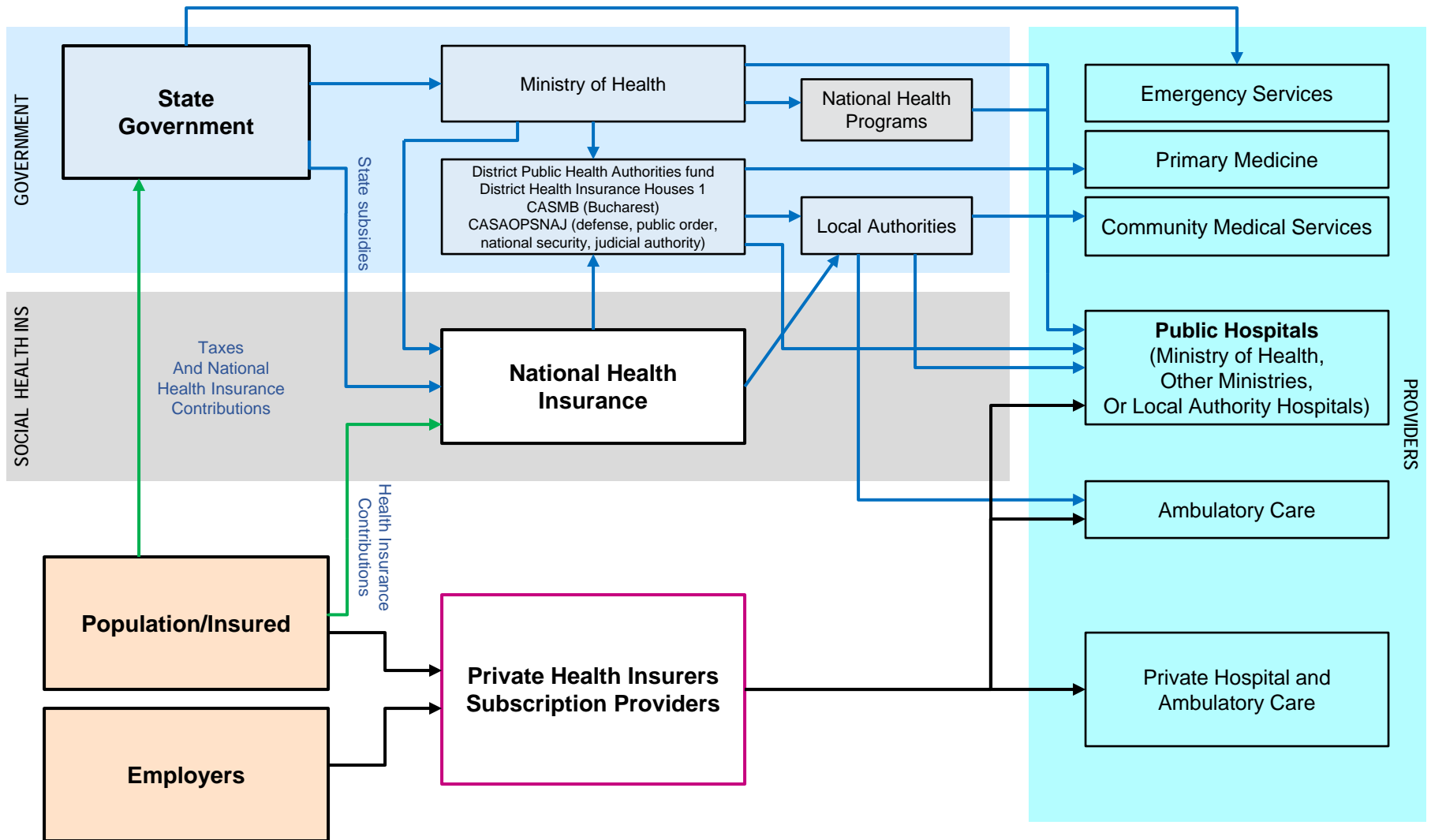
# Poland



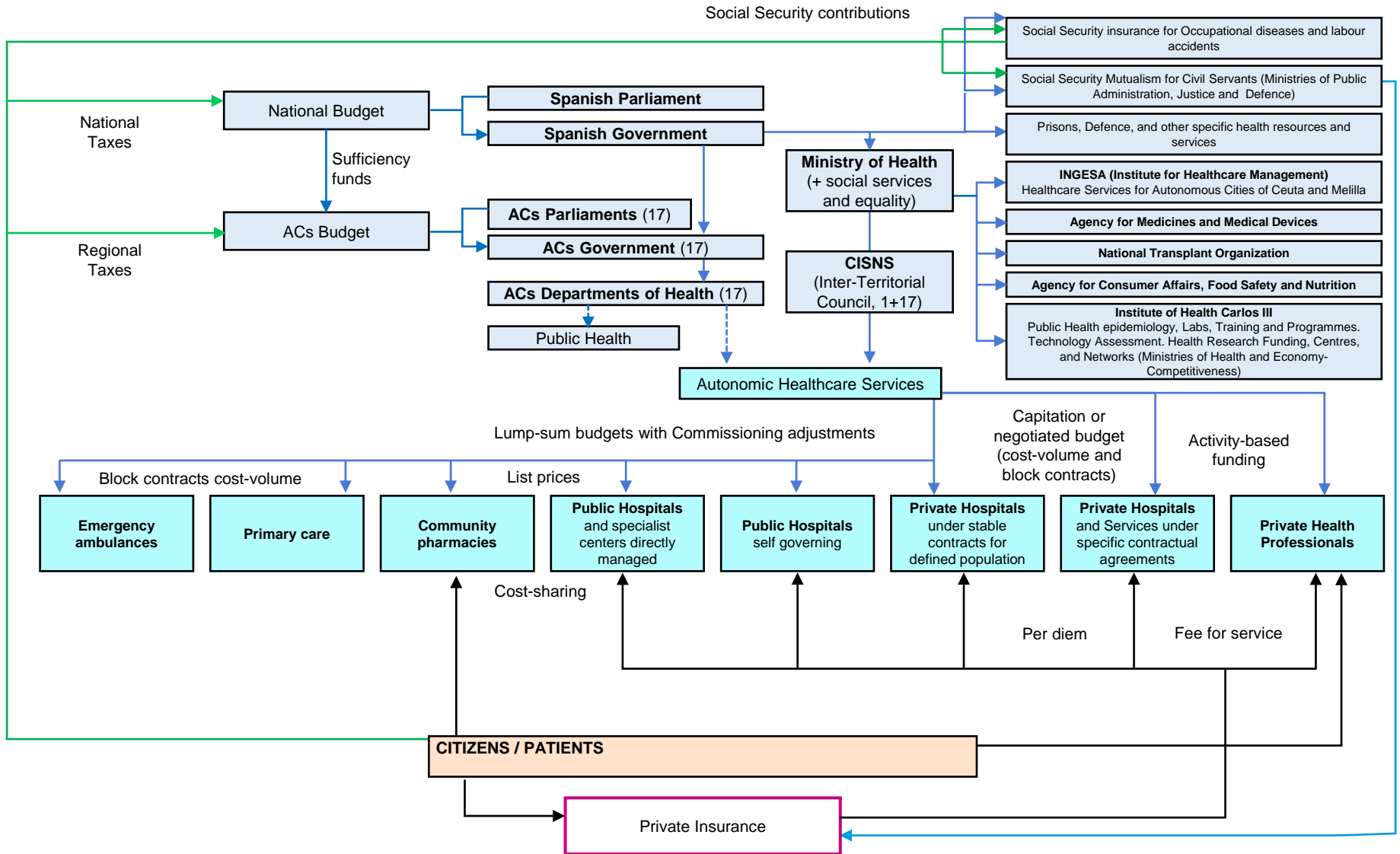
<sup>1</sup> possible cost-sharing with employers

<sup>2</sup>Not formally recognised as insurance products

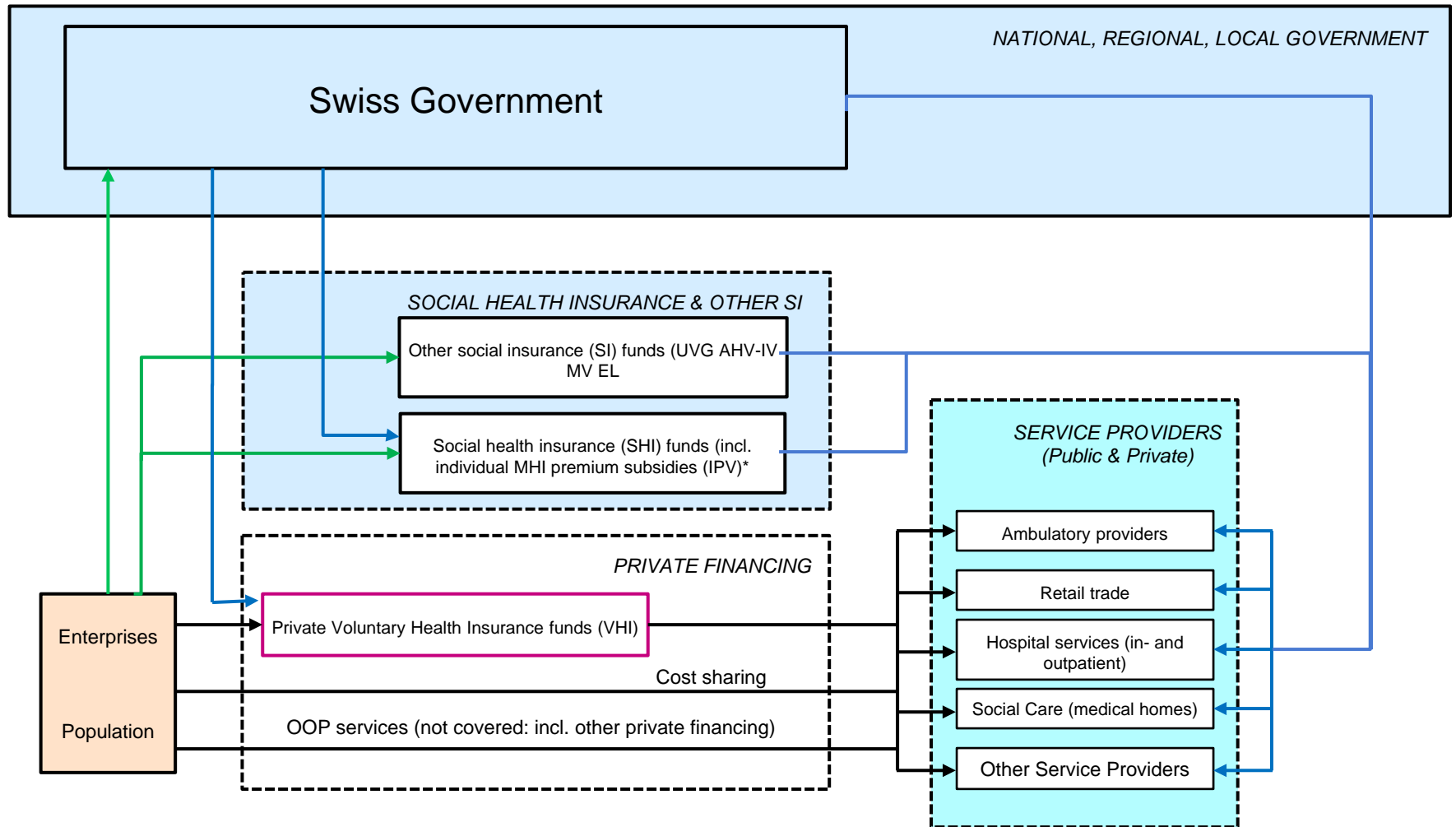
# Romania



# Spain



# Switzerland

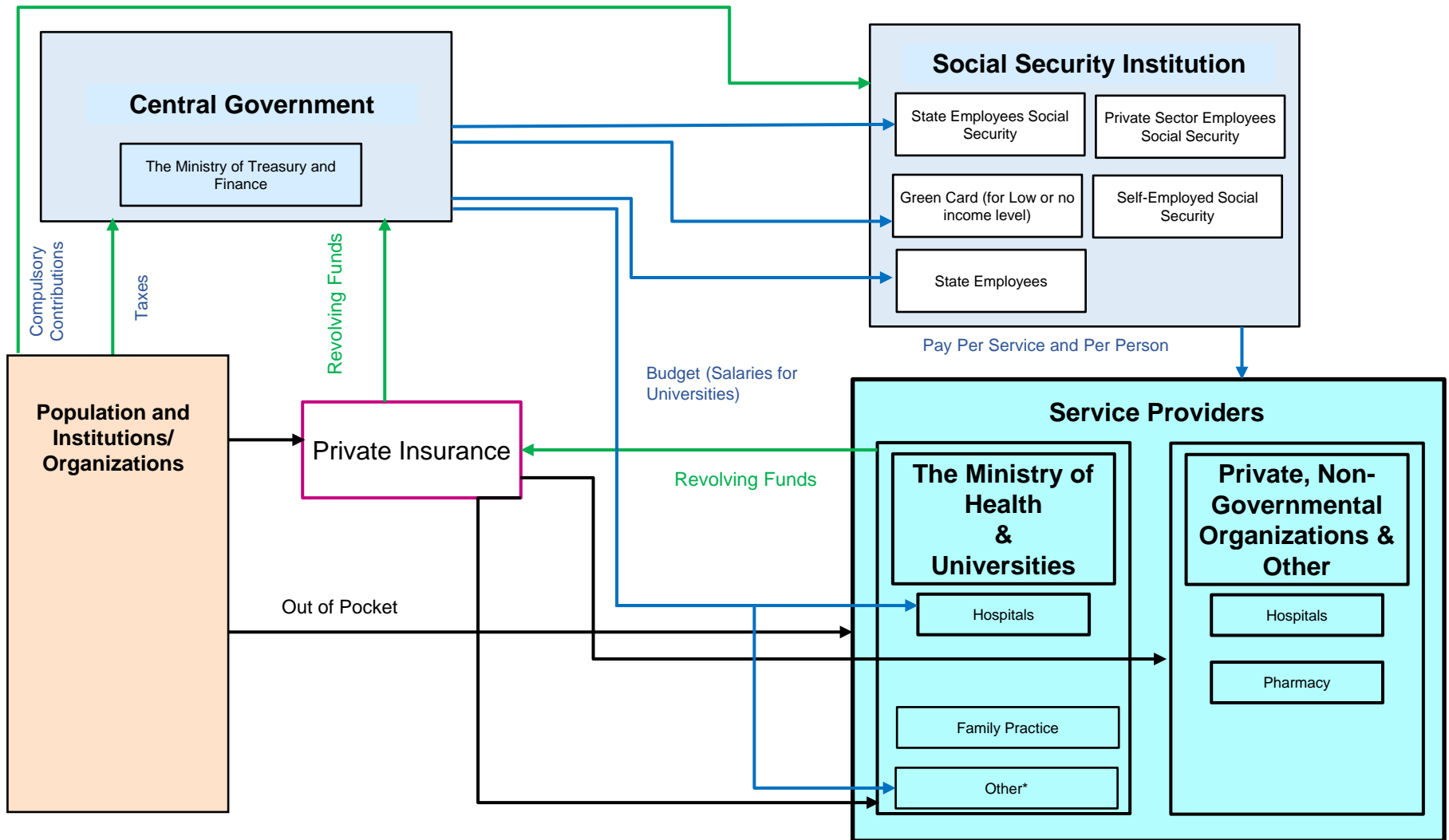


UVG = Federal Law on Accident Insurance; MV = military insurance;

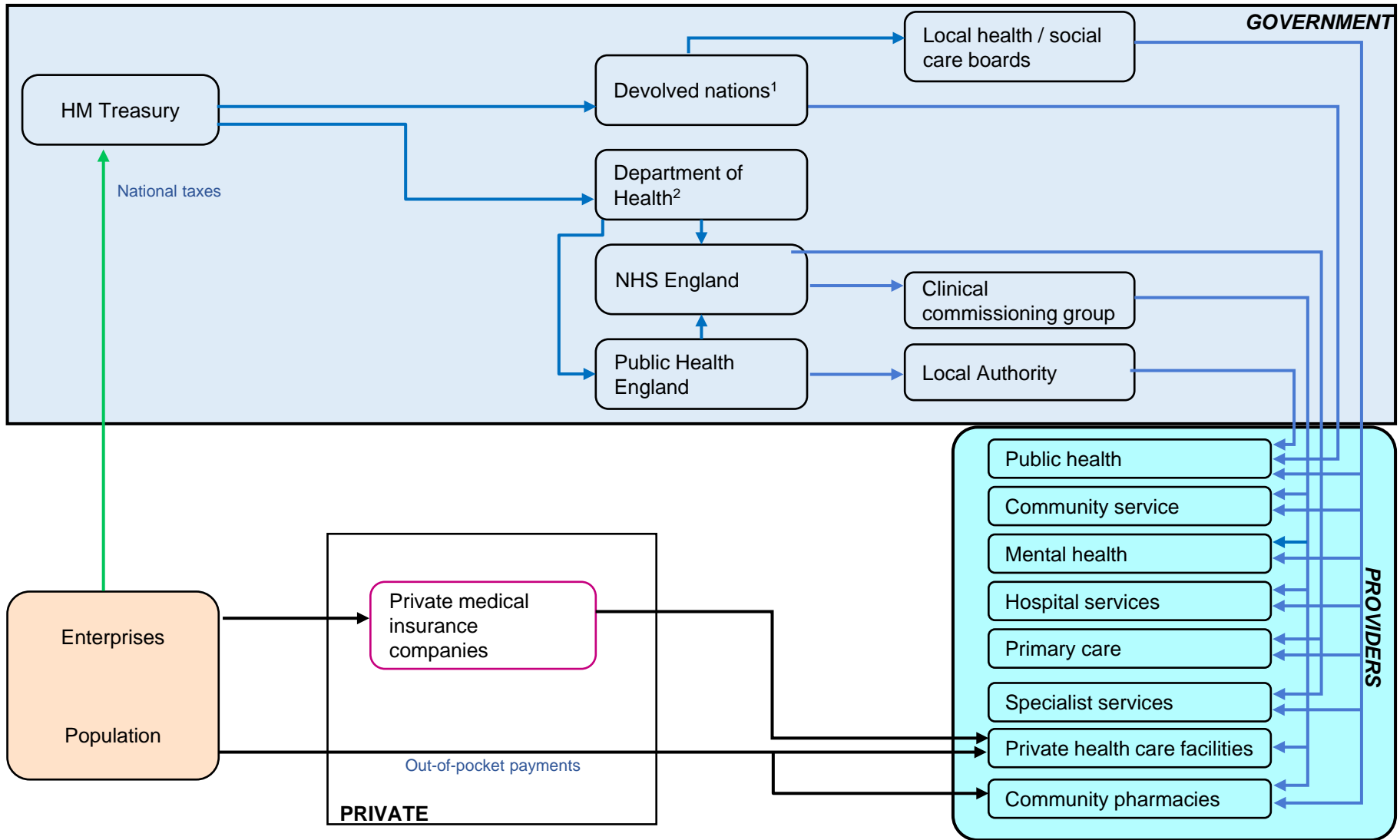
AHV-IV = old-age and survivor's insurance; EL = complementary payments of AHV-IV/AVS-AI; MHI = mandatory health insurance

\* SHI has a risk reallocation system: age and sex within canton

# Turkey



# United Kingdom (England)



<sup>1</sup> Wales, Scotland, and Northern Ireland

<sup>2</sup> England only



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