



Sustainable Health Care Financing in the Republic of Palau

Asian Development Bank



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Sustainable Health Care Financing in the Republic of Palau

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Abbreviations

ADB	–	Asian Development Bank
BNH	–	Belau National Hospital
FSM	–	Federated States of Micronesia
FY	–	fiscal year
GDP	–	gross domestic product
MOH	–	Ministry of Health
MSA	–	medical savings account
PDMC	–	Pacific developing member country
PHI	–	Palau Health Insurance
PIC	–	Pacific island country
PNG	–	Papua New Guinea
PRC	–	People's Republic of China
SSA	–	Social Security Administration
TA	–	technical assistance
US	–	United States

In this report, “\$” refers to US dollars unless otherwise stated.

Foreword

Financing health care is challenging and costly in the Pacific developing member countries (DMCs) of the Asian Development Bank (ADB). Financing sources are limited, and are dominated by general tax revenues. In the face of fiscal constraints, national health systems have been perennially underfunded, limiting the quality and equitability of health care. These problems, common to all developing countries, are compounded in most PDMCs by their small, dispersed populations and by health care needs that are growing faster than in other regions.

Equitable delivery of quality basic social services, especially health care, is essential for sustainable development. Many countries in the Pacific region are devoting attention to reform of health care financing arrangements with the aim of relieving funding constraints, achieving funding sustainability, and improving the quality and equitability of service delivery.

The Republic of Palau has for some time been among the Pacific DMCs looking to reform its health care financing arrangements, with reform proposals dating back to 1995. Health care delivery in Palau was satisfactory in many respects, but the cost was high and unsustainable. Efforts to reform financing arrangements came in 2008 with the emergence of a small group of dedicated national leaders that guided the undertaking. This group's vision of how reform should advance was tempered with pragmatism in transforming that vision into a workable scheme for health care financing. Complementing the group's vision and talents, in 2008, ADB approved provision of technical assistance for sustainable health care financing. Improvements in social services, institutions, and public financial management have been shown to enhance development outcomes and contribute to sustainable development, all of these being strategic goals of ADB assistance to the Pacific region.

This policy brief describes the successful development in 2008–2009 of draft legislation aimed at reforming health care financing in Palau, and its enactment by the legislature and signature by the President of the country in 2010. The brief was prepared by ADB to disseminate experience and lessons learned in Palau that may be found applicable elsewhere in the Pacific, in keeping with ADB's Pacific Approach 2010–2014.

This policy brief was prepared by ADB's Pacific Department under the supervision of Andrea Iffland, director of the Urban, Social Development and Public Management Division. Anthony Gill, senior country specialist, led the preparation and publication. Consultants Jim Knowles and Jean-Claude Hennicot also assisted in preparing the draft of the brief. Barry Lanier and Lynette Mallery edited, while Leticia de Leon proofread the publication. Ophie Iriberry provided editorial assistance, Cecilia Caparas coordinated the publishing process, and Johanna Benavente provided overall administrative assistance.



Robert Wihtol
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Executive Summary

The health care system in Palau, particularly provisions for its financing, was successfully reformed through the work of a small group of dedicated national leaders who were supported by a technical assistance (TA) from the Asian Development Bank (ADB). While health care delivery in Palau was satisfactory in most respects and health indicators were relatively good prior to the reform, spending on health care was high, and existing financing arrangements were not sustainable.

Use of the national health system model, financed mainly out of general tax revenues, has been generally successful in developed countries but less so in developing countries including Palau due to fiscal constraints. The challenges faced by Palau and most Pacific island countries (PICs) parallel those faced by other developing countries, but are compounded by the problems posed by small populations and health care needs that are growing faster than in other regions. Government spending on health care by Palau and most other PICs accounts for a large share of gross domestic product, total government spending, and total expenditure on health care. The scope for diversifying health care financing sources in most PICs is thus considerable.

Prior to reform, health care delivery costs in Palau were not only high, but were increasing due to the rapid epidemiological transition to noncommunicable diseases—which are costly to treat—and to certain treatment, procurement, and subsidy practices. Existing financing sources had reached their limits.

Work in Palau on reform of health care financing started in 1995, but stalled in 2008 when proposed legislation passed the Senate but not the House. ADB TA for health care financing was approved in 2008. The main objective of the TA was to work with stakeholders to develop a sustainable plan for health care financing by assisting with TA formulation of reforms, assessment of reform alternatives, and drafting proposed reform legislation and associated rules and regulations. Financial and policy analyses were prepared that were critically important. This particularly included actuarial analysis of the proposed reforms, which assessed them as financially sustainable, and projections of the fiscal impact of the reforms, which indicated that their future net fiscal impact would be positive.

The draft health care reform legislation was submitted to Congress in July 2009. Affordable health care for all residents of Palau at a financially sustainable cost was its aim. A National Medical Savings Fund would be established to receive mandatory contributions by the employed, employers, and the self-employed. Fund contributions would be invested, but would also finance the Palau Health Insurance (PHI) for catastrophic costs, individual medical savings accounts (MSAs) for outpatient care, and administration costs. The government would fund PHI costs for the nonworking elderly

and nonworking disabled. MSAs would be used to pay for outpatient care and certain private health insurance costs of MSA holders and their spouses and children. PHI benefits would include inpatient care at Belau National Hospital and approved off-island care including associated medical evacuation. The Social Security Administration would be responsible for day-to-day operation of the Fund and PHI under the oversight of a newly established National Healthcare Financing Governing Committee.

The legislation was enacted by Congress in January 2010 and signed by the President in May 2010. The Rules and Regulations were finalized and published in September 2010 and adopted in February 2011. The withholding provisions of the new health care financing scheme became operational in October 2010, with MSA funds and coverage by PHI commencing in April 2011.

The reform legislation partly addressed Palau's health care financing problems. MSAs were given the incentive to curb costs and encourage equitable access to services. The risk of catastrophic health care expenses was eliminated, and access to expensive care improved. Foreign worker access to health care was also improved. The legislation likewise provided scope for widening private sector participation in some aspects of the system. Finally, system financial sustainability was promoted through diversification of financing sources.

An important lesson learned in the Palau experience is the value of the reform effort being led by a small group of dedicated national leaders. The value of external expert advice was also clearly demonstrated. An effective representative governing body for the health care system was found to be essential.

As to the applicability of the Palau experience to other PICs, social health insurance may be a relevant option for many PICs in view of the limits of existing financing sources and the rapid growth in demand for health care. However, such an option may not be practicable where certain preconditions do not exist and would require detailed consideration. The underdeveloped use of health care user fees, for example, would effectively bar this option in many PICs. In PICs where health care user fees are in use, however, MSAs may be an option. The limitations or absence of social security systems in most PICs makes it unclear how a social health insurance scheme would be administered in those countries; in such cases, alternative management arrangements would need to be thoroughly investigated.

Introduction

This policy brief describes how the health care system in the Republic of Palau, particularly provisions for its financing, was successfully reformed through the work of a small group of dedicated national leaders who were supported by a technical assistance (TA) from the Asian Development Bank (ADB).

While health care delivery in Palau was satisfactory in most respects and health indicators were relatively good prior to the reform, spending on health care was high and existing financing arrangements were not sustainable. Work on reform of health care financing had been under way since 1995. In 2008, a bill aimed at such reform was approved by Palau's Senate, but was rejected in the House. That same year, ADB approved a TA for Development of a Sustainable Health Financing Scheme (ADB 2008).

The successful development and enactment in 2010 of the legislation reforming health care financing in Palau is described in this policy brief with the hope that Palau's accomplishments and lessons learned can be applied elsewhere, particularly in other Pacific island countries.

Despite generally satisfactory delivery of health care in Palau, its cost was high and unsustainable. The successful reform of financing arrangements is described in this policy brief.

Health Care Financing in Pacific Island Countries—Challenging and Costly

Use of the national health system model, financed mainly out of general tax revenues, has been generally successful in developed countries, but less so in developing countries due to fiscal constraints.

Most PICs face the same challenges as other developing countries. However, for the PICs, these challenges are compounded by the problems posed by small populations and health care needs that are growing faster than in other regions.

Existing Arrangements and Challenges

Most health care systems in the Pacific island countries (PICs) are financed domestically, mainly out of general tax revenues—i.e., the “national health system” model is used. Experience in many developed countries—e.g., Australia, Canada, New Zealand, Sweden, and the United Kingdom—has demonstrated that this approach to health care financing is at least as efficient, equitable, and sustainable as the principle alternative, which is employment tax financing (Wagstaff 2007, 2009). However, experience in developing countries has been less positive with this approach to financing government health care systems. Due to fiscal constraints, national health care systems in these countries have been perennially underfunded. Where income growth has been rapid, and where health care needs have begun to shift away from relatively low-cost maternal and child health care, and the prevention and treatment of communicable diseases toward the more costly treatment of noncommunicable diseases and injuries, the demand for health care has outstripped the capacity of governments to finance it through general taxes alone. Most developing countries have had to add other sources of financing, including user fees and employment taxes. Some have had to rely heavily on foreign assistance.

Most PICs face the challenges common to all developing countries in financing their mainly general-tax-based health care systems. However, PICs face at least two additional challenges to sustainably finance these systems. First, the populations of most PICs are too small to support a full range of modern tertiary health care services. As a result, increasing numbers of PIC residents must obtain such care offshore—in Australia, for example, or in New Zealand, the Philippines, or the United States (US). Off-island health care is relatively expensive due to the additional cost of transportation and the frequently higher cost of such care. As a result, the demand for off-island health care has far outstripped the resources that most PIC governments have allocated to pay for it. Thus, access to publicly subsidized off-island care has necessarily been rationed, sometimes inequitably. Some PIC health systems have overinvested in expensive tertiary care services (such as computerized imaging systems) with very high unit costs due to low levels of utilization.

Second, PIC health care needs are growing more rapidly than in most other developing countries due to rapid growth in the incidence of diseases associated with obesity and a sedentary life style—including cancer, diabetes, hypertension, and heart disease. The expenses of the health care required for addressing these problems (e.g., kidney dialysis and/or kidney transplants) place an additional burden on PIC health systems.

Burdensome Costs

Most PICs currently spend a relatively large share of their gross domestic product (GDP) on health care. In 2006, the country average for PICs was 8.9% of GDP, compared with 4.2% of GDP in selected Asian countries (Table 1). Absolute levels of health care spending are also relatively high in PICs. Absence of economies of scale in the delivery of health care in most PICs accounts for some of these differences. For example, Fiji, with a population of 833,000 (third largest among PICs) and per capita GDP of \$3,725 (approximating the PIC average), spent \$149 per capita on health care in 2006, compared with the PIC average of \$296. Similarly, Kiribati, with a population of 94,000, spent \$117 per capita on health in 2006, compared with only \$29 in Papua New Guinea and \$34 in the Solomon Islands. These latter two countries have levels of per capita GDP similar to Kiribati, but much larger populations.

Government spending on health care in most PICs also accounts for a relatively large share of total government spending, with a country average of 13.3% as compared with 6.4% in selected Asian countries. This reflects the fact that direct government budget financing accounts, on average, for 82.2% of all health care expenditure in PICs, compared with only 40.0%, on average, in selected Asian countries (Table 2). Notably, PIC health systems on average derive only 17.8% of their financing from social security programs, household out-of-pocket expenditure, and private prepaid plans, whereas the health systems of selected Asian countries derive 60.1% of their financing from these sources on average.

The data in Tables 1 and 2 show that health sector financing is already a substantial burden on government budgets in most PICs. Further, health sector financing in several PICs is also heavily dependent on external financing. This is especially true of the Marshall Islands, the Federated States of Micronesia (FSM), Niue, Timor-Leste, and Tonga. There is thus considerable scope for diversifying sources of health sector financing in most PICs. Among the 15 PICs listed in Table 2, only 5 (Fiji, FSM, Nauru, Tonga, and Vanuatu) derive 24% or more of their health sector financing from sources other than the government budget. In contrast, all eight of the selected Asian countries listed in Table 2 derive more than 24% of their health sector financing from sources other than the government budget. Further, only two PICs (FSM and Samoa) derive at least some of their health financing from all four of the sources listed in Table 2, as compared with all of the selected Asian countries except Sri Lanka.

What accounts for these patterns? Historical and cultural factors are important in this regard. Among the former are PIC ties to Australia,

Most PICs spend a relatively large share of GDP on health care. Health care spending per capita is high in PICs with small populations.

Government spending on health care in most PICs accounts for a large share of both total government spending and total expenditure on health.

There is considerable scope for diversifying health financing sources in most PICs.

Historical and cultural factors and underdeveloped social security systems largely explain health financing patterns in PICs.

New Zealand, and the United Kingdom—all three having a tradition of government-financed national health systems.¹ Strong cultural commitment to social solidarity is also a common cultural trait in most PICs, which translates into staunch political support for free or at least heavily subsidized health care. In addition, social security is not well developed in PICs. Only 9 of the 15 PICs listed in Tables 1 and 2 have social security programs, and only a few of those programs provide medical benefits.²

1 According to the World Health Organization Statistical Information System, the corresponding sources of health financing in Australia and New Zealand, respectively, are: direct government financing (67.2% and 77.8%); social security financing (0% in both countries); household out-of-pocket financing (18.3% and 16.4%); and private prepaid plan financing (7.2% and 4.7%).

2 The PICs listed in Tables 1 and 2 without social security programs include Cook Islands, Nauru, Niue, Timor-Leste, Tonga, and Tuvalu.

**Table 1: Health Expenditure and Government Spending
in Pacific Island Countries and Selected Asian Countries, 2006**

Country	Population ('000)	Per Capita GDP (\$)	Total Health Expenditure Per Capita (\$)	Total Health Expenditure as % of GDP	Government Health Expenditure as % of Total Government Expenditure ^a
Pacific Island Countries					
Cook Islands	14	9,489	427	4.5	12.4
Fiji	833	3,725	149	4.0	9.1
Kiribati	94	921	117	12.7	13.0
Marshall Islands	58	1,948	298	15.3	13.0
Federated States of Micronesia	111	2,217	266	12.0	14.7
Nauru	10	5,602	605	10.8	25.0
Niue	2	7,684	1,045	13.6	10.8
Palau	20	7,804	835	10.7	16.4
Papua New Guinea	6,202	906	29	3.2	7.3
Samoa	185	2,449	120	4.9	10.4
Solomon Islands	484	723	34	4.7	12.6
Timor-Leste	1,114	317	52	16.4	16.4
Tonga	100	2,241	121	5.4	11.1
Tuvalu	10	2,465	281	11.4	16.1
Vanuatu	221	1,619	68	4.2	10.9
Country average	631	3,341	296	8.9	13.3
Population-weighted average ^b		1,194	55	5.3	9.2
Selected Asian Countries					
People's Republic of China	1,328,474	2,000	90	4.5	4.5
Indonesia	228,864	1,545	34	2.2	4.2
Malaysia	26,114	5,930	255	4.3	6.9
Mongolia	2,605	1,039	53	5.1	8.1
Philippines	86,264	1,364	45	3.3	4.7
Sri Lanka	19,207	1,429	60	4.2	8.3
Thailand	63,444	3,229	113	3.5	9.9
Viet Nam	86,206	697	46	6.6	4.2
Country average	230,147	2,154	87	4.2	6.4
Population-weighted average ^c		1,943	82	4.2	4.8

GDP = gross domestic product.

a Excluding social security expenditure.

b Average population of Pacific island countries is dominated by Papua New Guinea.

c Average population of the selected Asian countries is dominated by the People's Republic of China.

Source: WHOSIS.

Table 2: Sources for Financing Health Expenditure of Pacific Island Countries and Selected Asian Countries, 2006 (%)

Country	Directly by the Government	Social Security	Households	Private Prepaid Plans	Total	Domestic	External	Total
Pacific Island Countries								
Cook Islands	91.4	0.0	8.6	0.0	100.0	97.8	2.2	100.0
Fiji	70.9	0.0	23.0	6.1	100.0	98.1	1.9	100.0
Kiribati	92.4	0.0	7.6	0.0	100.0	99.6	0.4	100.0
Marshall Islands	83.8	13.3	2.9	0.0	100.0	26.9	73.1	100.0
FSM	70.5	20.0	4.3	5.2	100.0	39.0	61.0	100.0
Nauru	55.3	0.0	29.3	15.4	100.0	100.0	0.0	100.0
Niue	98.6	0.0	1.4	0.0	100.0	33.7	66.3	100.0
Palau	92.5	0.0	7.5	0.0	100.0	87.5	12.5	100.0
PNG	82.7	0.0	7.4	9.9	100.0	88.7	11.3	100.0
Samoa	80.1	0.9	15.0	4.0	100.0	95.8	4.2	100.0
Solomon Islands	93.0	0.0	3.8	3.2	100.0	75.2	24.8	100.0
Timor-Leste	88.8	0.0	4.2	7.0	100.0	55.4	44.6	100.0
Tonga	75.3	0.0	20.9	3.8	100.0	67.1	32.9	100.0
Tuvalu	92.3	0.0	1.5	6.2	100.0	96.0	4.0	100.0
Vanuatu	64.7	0.0	17.7	17.7	100.0	91.2	8.8	100.0
Country average	82.2	2.3	10.3	5.2	100.0	76.8	23.2	100.0
Population-weighted average ^a	82.3	0.3	8.7	8.7	100.0	84.0	16.0	100.0
Selected Asian countries								
PRC	19.3	22.7	53.9	4.1	100.0	99.9	0.1	100.0
Indonesia	40.3	10.1	32.9	16.7	100.0	97.7	2.3	100.0
Malaysia	44.8	0.4	40.2	14.6	100.0	100.0	0.0	100.0
Mongolia	61.2	22.4	13.8	2.6	100.0	98.0	2.0	100.0
Philippines	28.8	10.8	48.4	12.0	100.0	96.7	3.3	100.0
Sri Lanka	49.2	0.0	43.6	7.2	100.0	98.8	1.2	100.0
Thailand	56.4	8.0	27.3	8.3	100.0	99.7	0.3	100.0
Viet Nam	19.8	12.6	60.5	7.1	100.0	97.8	2.2	100.0
Country average	40.0	10.9	40.1	9.1	100.0	98.6	1.4	100.0
Population-weighted average	24.4	19.1	50.1	6.5	100.0	99.4	0.6	100.0

FSM = Federated States of Micronesia, PNG = Papua New Guinea, PRC = People's Republic of China.

a Average population of Pacific island countries is dominated by Papua New Guinea.

b Average population of the selected Asian countries is dominated by the People's Republic of China.

Source: WHOSIS.

Palau's Health Sector and Pre-Reform Financing Problems

Palau's main governmental health care system comprises an 80-bed hospital (Belau National Hospital [BNH]) located in the capital, Koror; four primary care superdispensaries; and four community-based dispensaries on the outlying islands. There are three private primary clinics: two located in Koror and one in neighboring Airai state, which is a free clinic operated by the United States (US) Navy. Palau's four private pharmacies are all located in Koror, two of these being located in the two private primary clinics in Koror. Physical access to health facilities is generally good, with most of the population residing less than 30 minutes from Koror by car. Health care delivery in Palau is thus satisfactory in most respects, and health indicators are relatively good. However, the estimated level of total spending on health care is relatively high, at \$835 per capita in 2006 (10.7% of GDP); this includes Ministry of Health (MOH) spending of \$680 per capita (16.0% of the total government budget) (Azzam 2008b).

Palau is in the midst of a rapid epidemiological transition. Although the population is relatively young, adult health outcomes are deteriorating rapidly as increasing rates of noncommunicable diseases take their toll on the aging population.³

Although the government strongly encourages healthy lifestyles (e.g., avoiding smoking, improving one's diet, and increasing exercise levels), rates of obesity are high, as are rates of consumption of alcohol and tobacco, the latter being related to the widespread chewing of betel nut.

The relatively high cost of treating noncommunicable diseases has placed increased pressure on government health budgets. For example, the cost of dialysis alone equaled 11.3% of total government expenditure on curative health care in 2008 (Table 3). While MOH does not consider public expenditure on dialysis to be as cost effective as health interventions, the government is required to continue providing dialysis services, even though 100% of the cost of dialysis is borne by it. Apart from dialysis, important issues need to be resolved concerning the cost effectiveness of both on-island and off-island services. Most primary care, for example, is provided by the hospital outpatient department instead of by family medicine units. The hospital thus has little flexibility in managing its budget. Further, more consideration needs to be given to the financial implications of procuring

Health care delivery at Palau's national hospital and network of dispensaries, clinics, and pharmacies is largely satisfactory and equitable, but the cost is relatively high.

A rapid epidemiological transition to noncommunicable diseases is occurring.

Government health budgets are under increasing pressure due to the high cost of treating noncommunicable diseases as well as certain treatment, procurement, and subsidy practices.

³ According to the US Bureau of the Census population projections (updated in December 2008), the proportion of Palau's population aged 55 and above is projected to increase from 12.0% in 2007 to 20.1% in 2020.

**Table 3: Cost Recovery at Belau National Hospital, Palau
Fiscal Year 2008**

Type of Care	(A) Estimated Cost ^a	(B) Standard Charges	(C) Billed Amounts	(D) Collected Amounts	Billing Rate [(C)/(A)]	Collection Rate [(D)/(C)]	Cost Recovery Rate [(D)/(A)]
	\$				%		
Outpatient care	2,290,607	2,405,578	885,975	764,508	38.7	86.3	33.4
Emergency care	637,108	754,796	346,567	183,415	54.4	52.9	28.8
Dialysis ^b	715,354	855,719	217,693	0	30.4	0.0	0.0
Inpatient care	3,562,720	3,403,191	847,657	481,967	23.8	56.9	13.5
Off-island referrals	734,214	712,045	391,625	210,424	53.3	53.7	28.7
Total	7,940,002	8,131,330	2,689,517	1,640,314	33.9	61.0	20.7

^a Ministry of Health costs exclude fixed capital costs—e.g., the cost of the Belau National Hospital building; it is assumed that these costs are covered by the government.

^b No user fees are currently collected for dialysis.

Source: Hennicot 2009a and Knowles 2009.

User fees for health care services have increased to levels that have caused concern that access by the poor to needed care is limited.

expensive medical equipment, some of which is donated. The generous and currently untargeted subsidies for drugs and medical supplies need to be reduced and targeted to lower income groups, though MOH is currently investigating these issues. In addition, some uncertainty exists about Palau's continued access to US grant funding, which accounts for about 30% of total health spending (mainly for public health and preventive services). This is because Palau must compete with the US states for these funds, as well as with current and former US territories.

Palau has gone about as far as it can go in terms of raising additional revenue through user fees, which account for about 20% of expenditure on curative medical care. Despite its equitable sliding fee scale (Box 1), there is concern that user fees (especially charges for inpatient and off-island care) limit access to needed care, particularly among relatively poor Palauans and foreign workers,⁴ and lead to catastrophic expenses for some individuals.⁵ Problems of limited access are mitigated to some extent by lax enforcement of the payment of user fees. (Hospital staff insist that no patient is ever refused treatment for financial reasons, including unpaid bills.) However, this has resulted in the accumulation of more than \$12 million in accounts receivable at BNH.

⁴ Foreign workers account for about half of Palau's labor force and are mostly employed in low-wage jobs. Their limited access to health care places not only their own health at risk, but also that of Palauans to the extent that communicable diseases may go untreated.

⁵ Since mid-2005, Palauans have been required to make a deposit equal to 50% of the estimated cost of their overseas medical treatment. They are ultimately responsible for 55% of the actual treatment cost as well as all transportation costs (including additional transportation costs in cases requiring medical evacuation). In 2008, off-island medical treatment costs alone averaged \$8,961 per referred patient. If medical evacuation was needed, the patient was usually required to purchase nine airline seats.

Box 1: Palau: Sliding Fee Scale for Health Services

Under Palau's sliding fee scale, uninsured Palauans under age 55 pay between 20% and 75% of Belau National Hospital (BNH) standard fees for professional and ancillary services (including room and facility charges), depending on family income and family size. Palauans 55 years of age and older (as well as the disabled and behavioral health patients) pay only 5% of standard fees for professional and ancillary services, regardless of family income and family size. The sliding fee schedule and the 95% discount provided to vulnerable groups do not apply to dental care or to medicine. Fixed fees (independent of family income and family size) are charged to all patients for medicine (the charge for most drugs is \$5). Palauans with private health insurance pay 50% of standard fees through their insurer, based on agreements between the Ministry of Health (MOH) and the three private health insurers operating in Palau. Foreign residents pay 80% of standard fees, although some foreign workers pay only 50% if groups to which they belong or their governments have a special agreement with MOH. Foreign visitors pay 100% of standard fees. MOH reduced hospital user fees by 20% across the board in 2006 and began using income data obtained from the Social Security Administration to correctly classify patients by income group when applying the sliding fee scale. These measures increased the collection ratio marginally, but about \$1 million in accounts receivable continued to accumulate each year. For example, according to the data in Table 3, BNH patients were invoiced \$2.7 million (including the cost of off-island referrals) during 2008, but paid only \$1.6 million, leaving additional accounts receivable of \$1.1 million (in addition to the approximately \$10 million previously accumulated).

Source: Knowles and Hennicot 2009.

Health Care Reform in Palau: How It Was Accomplished

Work on reform of health care financing started in 1995, but stalled in 2008.

Work on reform of health care financing began in 1995. In July 2006, the National Healthcare Coverage and Savings Act was introduced in the Senate. Its aim was to establish individual medical savings accounts (MSAs) as an alternative to household out-of-pocket expenditure for routine medical care. The original version of this bill was drafted by the Ad Hoc Committee on Healthcare, which included representatives of the Social Security Administration (SSA), the ministries of health and finance, the Chamber of Commerce, and private health insurers. The bill was modified extensively before the Seventh Palau Senate passed it as the National Healthcare Coverage and Savings Act in January 2008. However, Congress deferred consideration of the second bill until a detailed analysis of its financial implications had been undertaken, a task for which the government requested of the Asian Development Bank (ADB) assistance.

Developing Health Care Reform Legislation

ADB technical assistance for health care financing was approved in 2008. Important groundwork was completed during Phase 1 of the technical assistance.

ADB Technical Assistance and Drafting Health Care Reform Legislation

In April 2008, ADB approved a grant with funding from the Japan Special Fund that provided technical assistance to Palau for sustainable health care financing (ADB 2008). The technical assistance (TA) was carried out in two phases. In Phase 1, which was completed during the second half of 2008, an extensive database was assembled that included primary data on private health care; preliminary national health accounts was also completed during this phase (Azzam 2008b). Also prepared was a detailed financial and policy assessment of the proposed National Healthcare Coverage and Savings Act, which included recommendations for improving its scope and fiscal sustainability (Azzam 2008a). A stakeholder workshop was held at the end of Phase 1 to present the findings of the TA, and to solicit feedback. Stakeholders indicated strong support for a national health insurance scheme that would complement the MSAs included in the proposed National Healthcare Coverage and Savings Act.

The main objective of Phase 2 was to work with the TA Steering Committee and other stakeholders to develop a sustainable health care financing plan for Palau. To this end, the TA team consulted with the TA Steering Committee and government officials on proposed reforms, and assisted in drafting the proposed legislation. Briefing materials and a policy analysis were prepared and disseminated, the latter including presentations

to key stakeholders. Assistance with estimates of costs at Belau National Hospital (BNH) was provided, and actuarial and fiscal impact analyses of the proposed legislation were prepared. The Rules and Regulations for implementing the proposed legislation were also drafted.

The main features of the proposed reform of the health care system were developed during Phase 2, during the TA team's second mission to Palau in April 2009. At an initial meeting with the President and his advisers on 17 April 2009, a draft bill was presented that would establish the MSAs, as well as the principal features of a complementary social health insurance scheme.⁶ The proposed MSA scheme would be funded by mandatory contributions of 5.0% of quarterly earnings (2.5% from employees and 2.5% from employers), without any ceiling. The MSAs would be used to finance health care of the employee and his/her family members, and would eventually pay "subscriptions" (premiums) into a social health insurance scheme that would provide universal coverage for catastrophic health care costs.

The response of the President and his advisors to the draft bill was generally supportive and encouraging. However, questions were raised about the short-term fiscal impact of the proposed MSAs in view of Palau's fiscal crisis. In particular, concern was voiced that the MSAs would have a negative fiscal impact because government funds that were urgently needed to close a financing gap at BNH would instead accumulate in the MSAs. The addition of an equitable health insurance scheme was requested, with the recommendation that the scheme provide 100% coverage of overseas medical care—instead of the proposed 50% coverage—subject to only three different levels of copayments, instead of applying the sliding fee scale to copayments, as initially planned.⁷ The question was also raised as to whether the health insurance scheme could be voluntary in order to avoid possible opposition from employers. It was further requested that both the MSA bill and the requested health insurance bill be introduced in Congress at the same time. A follow-up meeting was scheduled the following week to discuss new drafts of the two bills that addressed the concerns, questions, and recommendations that emerged during the first meeting.

The new drafts of the MSA bill and the health insurance bill were quickly prepared by the TA Steering Committee and discussed at the follow-up meeting with the President and his advisors on 24 April 2009. Also in attendance were the current and former ministers of health, who both strongly supported the proposed MSA and social health insurance schemes. Questions were again raised about the short-term fiscal impact of the proposed schemes as well as the possibility of making them voluntary

Supporting materials and analyses, as well as the major features of the proposed reforms, were developed during the first part of Phase 2 of the technical assistance.

Legislation for reform of Palau's health care system and its financing was refined in consultation with stakeholders during the latter part of Phase 2 of the technical assistance.

⁶ Social health insurance is not easily defined because of the many variations of the concept found in more than 60 countries. Compared with both health financing schemes financed out of general tax revenues (e.g., in Australia, Canada, and United Kingdom) and private health insurance schemes, social health insurance schemes can be most sharply differentiated by the following characteristics: (i) contributions are publicly mandated, earmarked payroll contributions; (ii) the funds are managed by independent or quasi-independent insurance funds (as distinct from government agencies); (iii) there is a direct link between the contributions and the receipt of medical care benefits; and (iv) the concept of social solidarity (i.e., cross-subsidization between rich and poor, young and old, healthy and unhealthy) is imbedded in social health insurance schemes. See Gottret and Schieber 2006.

⁷ This recommendation obviated concern by the Steering Committee and TA team that use of the sliding fee scale and the low rate of 5% for the elderly under the scale would create too much demand for overseas treatment.

Additional assistance was provided, and the draft health reform legislation submitted to Congress before completion of the technical assistance.

instead of compulsory. Both the TA team and the TA Steering Committee representatives advised strongly against a voluntary scheme because of the likelihood it would fail due to “adverse selection.”⁸

Following the second meeting, the TA team prepared a new set of preliminary financial projections under the assumption that the health insurance scheme would be implemented at nearly the same time as the MSA scheme, in order to offset any negative fiscal impact of the MSAs during the first few years. This work was eventually incorporated into a briefing document on the proposed schemes that was distributed to members of Congress in July 2009, following introduction in Congress of the draft MSA bill and draft health insurance bill.

The TA team actuary and a member of the TA Steering Committee testified at a joint session of Congress on 17 July 2009. Their presentations were followed by a question-and-answer session. Although many questions were asked, the reception was generally positive. The joint session was recorded and later shown on television many times, providing the public with an opportunity to learn about the proposed legislation.

A key senator supporting the two bills requested that they be combined into a single, consolidated bill that would be proposed as an amendment to Senate Bill No. 8-48, the National Healthcare Coverage and Savings Act. The latter bill had been reintroduced in the Senate on 18 March 2009, after passing the Senate (but not the House) in 2008. The Social Security Administration completed the requested consolidation on 20 July 2009. The consolidated bill, the National Healthcare Financing Act, was subsequently presented at a general membership meeting of the Palau Chamber of Commerce on 21 July, where it received a generally favorable reception.

Substance of the Proposed Health Care Reform Legislation

The objective of the proposed National Healthcare Financing Act was to provide affordable health care to all of the people of Palau, while managing health care costs and ensuring that the system was financially sustainable. The proposed legislation would establish a National Medical Savings Fund to receive mandatory quarterly contributions amounting to 5.0% of quarterly earnings of the employed and self-employed, without any ceiling. The contributions would come from employees (2.5%) and employers (2.5%), and from the self-employed (5.0% of earnings). Fund contributions would be used to finance (i) Palau Health Insurance (PHI) that would cover catastrophic health care costs (i.e., on-island inpatient care and off-island referrals), (ii) the individual MSAs of the employed/self-employed for funding outpatient care, and (iii) the administrative costs of both schemes (up to a maximum of 10% of annual contributions and investment income). Both the employed and the self-employed would be permitted to make additional tax-exempt contributions to their MSAs without limit.

Affordable health care for all Palauans at a financially sustainable cost was the legislation’s aim. A National Medical Savings Fund would be established to receive mandatory contributions by the employed, employers, and the self-employed.

⁸ Adverse selection refers to the tendency for high-risk individuals to enroll disproportionately in a voluntary health insurance scheme. The result is an increase in the scheme’s costs and, ultimately, its premiums, thereby discouraging low-risk individuals from enrolling. While the scheme’s costs and premiums spiral upward, enrollment spirals downward, ultimately pushing it into insolvency. Private health insurers try to avoid adverse selection by providing coverage only to groups, restricting coverage for preexisting conditions, insisting on a medical examination prior to enrollment, and/or charging different risk-rated premiums to different groups. These avoidance measures are not usually available in voluntary social health insurance schemes.

PHI would be a social health insurance scheme designed to complement the MSAs by providing coverage for catastrophic health care costs. The entire population residing in Palau would be covered by PHI. This was possible because most of the labor force was employed in the formal sector and already enrolled in the social security system.⁹ The spouse and dependent children of MSA holders would be enrolled automatically in PHI. The PHI subscriptions (premiums) would initially be set at 2.25% of quarterly earnings (of the total quarterly Fund contribution of 5% of quarterly earnings), but with the possibility of adjustment after two years of operation. The PHI subscriptions of nonworking citizens aged 60 and above, and of the nonworking disabled would be financed by the government at a cost of 2.25% of the mean annual remuneration of all contributing workers. Self-employed workers not required to make social security contributions because their annual income was less than \$10,000 would be required to pay a quarterly or annual premium equal to 5% of their earnings, if their earnings were above full-time equivalent earnings at minimum wage. A covered individual would lose eligibility to receive benefits if the subscription was not paid for two consecutive quarters.¹⁰ Discounts on PHI subscriptions would be provided to individuals who were certified by the Ministry of Health (MOH) to have followed prescribed preventive health practices.

PHI benefits would include

- the cost of inpatient care at BNH (excluding government salaries for BNH employees, which would continue to be financed by the government and subject to coinsurance¹¹ as established under the scheme's Rules and Regulations);
- the cost of off-island medical care approved by the MOH Medical Referral Committee, including the cost of approved medical evacuation services, and subject to coinsurance as established under the scheme's Rules and Regulations;¹² and
- other benefits authorized under the scheme's Rules and Regulations.

The individual MSAs of the employed/self-employed would be funded by the balance of contributions on their behalf to the National Medical Savings Fund after subtracting their PHI subscription and their prorated share of administrative costs. In addition to the contributing employed/self-employed, the MSAs would also cover (at the minimum) the MSA holder's spouse and dependent children. However, additional individuals could be designated as MSA beneficiaries by MSA holders, and additional

9 The labor force in 2008 was estimated to number 10,899. Employment was dominated by the private sector (6,471 or 59.4%) and the public sector (3,736 or 34.3%). The informal sector employed 240 (2.2%), while 452 (4.1%) were unemployed (Source: calculations based on Palau SSA database).

10 The payment of PHI subscriptions of the unemployed is discussed in the Act's Rules and Regulations. The treatment of the unemployed (4.1% of the labor force, according to the 2005 Census) is complicated by the fact that no government support is currently provided to them. However, Section 1 of the National Healthcare Financing Act stipulates that "Safety nets will be provided to ensure that no person is denied access into the healthcare system or turned away for lack of money."

11 According to the Act, coinsurance for on-island inpatient care would be subject to a ceiling of \$200 to \$400 per episode, depending on household income.

12 According to the Act, coinsurance for off-island referrals would be limited to a ceiling of \$1,000 to \$4,000, depending on household income.

Fund contributions would finance PHI for catastrophic costs, individual MSAs for outpatient care, and administrative costs. The government would fund PHI costs for the non-working elderly and the disabled.

Principal PHI benefits would include inpatient care at BNH and approved off-island care and associated medical evacuation.

MSA funds would be used to pay for outpatient care and certain private health insurance costs of the MSA account holder and his/her spouse and children.

MSAs would be computer-based accounts, with actual funds remaining in the National Medical Savings Fund for investment under the authority of the Social Security Board.

Under the National Healthcare Financing Act, SSA would be responsible for day-to-day operation of the Fund and PHI under the oversight of the National Healthcare Financing Governing Committee.

Only general features of the proposed health care financing scheme were included in the legislation. Details would be contained in the Rules and Regulations that would be finalized after the bill was signed into law.

tax-deductible contributions could be made to MSAs without limit. MSA funds would be used to pay for the following expenses:

- all nonexcluded health care expenses provided to covered individuals, including user fees at BNH and fees for services provided by accredited private clinics,¹³ and any deductibles, coinsurance, and copayments required by PHI or private health insurers;
- private health insurance premiums;¹⁴ and
- other payments or withdrawals authorized by the scheme's administration.

The individual MSAs would be virtual accounts (i.e., credited to individuals in a computer database). The actual funds would remain in the National Medical Savings Fund to be invested under the authority of the Social Security Board. Annual investment income would be credited to the individual MSAs in proportion to their average annual balances. Upon the death of an MSA holder, any remaining funds in the MSA would be deposited into an MSA(s) of the holder's heir(s). Permanently exiting foreign workers would receive any funds remaining in their MSAs after a 6-month waiting period.

The National Healthcare Financing Act did not contain a provision establishing a new bureaucracy for managing the proposed health care financing scheme, but instead put SSA in charge of day-to-day management of the Fund and PHI under the oversight of a National Healthcare Financing Governing Committee.¹⁵ That committee would comprise one representative each from the Ministry of Finance, MOH, SSA, the Governors Association, and the Chamber of Commerce. The Governing Committee would have authority over the entire scheme, except for Fund investments, which would be under the authority of the Social Security Board, and subject to the same investment restrictions as the Social Security Trust Fund. The Social Security Administrator would be responsible for day-to-day operation of both the Fund and PHI, including preparation of annual reports and an annual budget for administration. The Social Security Administrator would be empowered to draft (i) Rules and Regulations governing administrative procedures, collections, payments from MSAs, and benefits under PHI; and (ii) a memorandum of understanding for signature by the Ministry of Finance, MOH, and SSA governing the procedures to be followed in reimbursing MOH for services provided to the insured.

SSA would be authorized to enter into agreements with providers other than BNH. This would include agreements for inpatient care, off-island referral care, and medical evacuation, as long as the reimbursement would not exceed the amount that would be paid to BNH for the same services, and as long as any off-island referral—including medical evacuation—were approved by the MOH Medical Referral Committee using the same standards applied to off-island referrals made by BNH.

¹³ MSA funds cannot be used for kidney dialysis, which will continue to be fully financed by the government.

¹⁴ Private health insurance is available to employees of relatively large enterprises. Despite the fact that premiums are quite high in relation to benefits, about 10% of the population is currently covered by private health insurance.

¹⁵ Responsibility for collecting the more than \$12 million in outstanding accounts receivable at BNH would be transferred to SSA from the Ministry of Health.

The legislation presented only the general features of the proposed health care financing scheme. The details were to be provided for under the Rules and Regulations, which were adopted in February 2011.

Actuarial Analysis of the Proposed Health Care Reform Legislation

An actuarial analysis of the proposed reform was prepared by the TA team actuary using estimates of the costs of covered health services at BNH that were prepared with assistance from the TA team (Box 2) (Hennicot 2009a). The primary objective of the actuarial analysis was to determine whether or not the health care financing scheme proposed under the legislation would be financially sustainable.

The base year for the actuarial projections was fiscal year (FY) 2008. The costs for each type of benefit were estimated by separately projecting the number of patient encounters (measured in terms of patient discharges or outpatient visits) and their unit costs. The resulting estimated unit costs for the base year are presented in Table 4.

An actuarial analysis of the health care financing scheme proposed under the legislation was prepared by the TA team to determine the scheme's financial sustainability.

Box 2: Estimation of Service Delivery Costs at Belau National Hospital

During the first Phase 2 technical assistance (TA) mission in January 2009, the Minister of Health requested assistance from the TA team in estimating service delivery costs for curative care at Belau National Hospital (BNH). He and others believed that the standard fees charged by the hospital did not accurately reflect the actual costs of service delivery. Most of the work involved in estimating these actual costs was performed at BNH during August 2009. Fortunately, many operations (including financial operations) are computerized at BNH, and most of the information needed to prepare the cost estimates was readily available from the hospital's various databases. The main exceptions were data on the division of physician working time between the various cost centers—for which estimates had to be prepared by individual physicians—and on medical equipment—for which limited information was available regarding its physical location within the hospital. Despite these problems, reliable cost estimates were obtained for the various curative care services provided at BNH. These estimates indicated significant discrepancies between actual costs and standard fee revenue (revenue based on the standard fees charged for services before sliding fees are applied, and not reflecting actual collection ratios). In particular, the estimates indicated that some of the standard fees (excluding drugs, supplies, and ancillary services) were too high. The percentage amounts by which the fees for each of the following services exceeded their estimated costs are indicated in parentheses: inpatient care in the medicine and pediatrics wards (20%), curative outpatient care (94%), kidney dialysis (167%), emergency room care (58%), and laboratory services (228%). In the case of some of BNH's cost centers, fees fell short of the estimates by the percentage amounts indicated: obstetrics ward (36%), behavioral health wing (73%), dental clinic (46%), radiology facility (13%), pharmacy (64%), supplies (88%), physical therapy (33%), and overseas referrals (46%). Some of these discrepancies reflect conscious Ministry of Health (MOH) policies that heavily subsidize medicine, medical supplies, behavioral health inpatient care, and off-island referrals. However, in cases in which standard fees diverged from the estimated costs for reasons other than deliberate policy, it was expected that MOH would adjust the fees upward or downward to correct for this divergence (assuming that the relative fees within each cost center were correct). In addition, the TA team recommended that MOH reconsider its policy of heavily subsidizing medicines and supplies, and allow the charges for these items to reflect their actual costs, this of course being prior to applying the sliding fee scale to these items as it does to services.

Table 4: Estimated Unit Costs and Service Utilization Rates at Belau National Hospital, FY2008

Type of Cost	Total Cost ^a (\$)	Cases (visits/ discharges)	Unit Cost (\$)	Reference Population Size	Annual Cases Per Capita
Outpatient care ^{a b}	2,290,607	24,827	92.3	20,701	1.199
Emergency care ^a	637,108	5,376	118.5	20,701	0.260
Dialysis ^a	715,354	3,524	203.0	20,701	0.170
Inpatient care ^a	3,562,720	2,759	1,291.3	20,701	0.133
Off-island referrals ^a	734,214	75	9,789.5	20,701	0.0036
Total (MOH)	7,940,002
Private providers (Palau) ^c	391,610	19,580	20	20,701	0.946

... = data not available, MOH = Ministry of Health.

a Knowles 2009. MOH costs exclude fixed capital costs—e.g., the cost of the Belau National Hospital (BNH) building; these costs were assumed to be covered by the government.

b Includes dental care.

c Azzam 2008 a. The cost of private outpatient care is low because drugs and ancillary services dispensed by BNH are often provided to private patients.

Source: Hennicot 2009a and Knowles 2009.

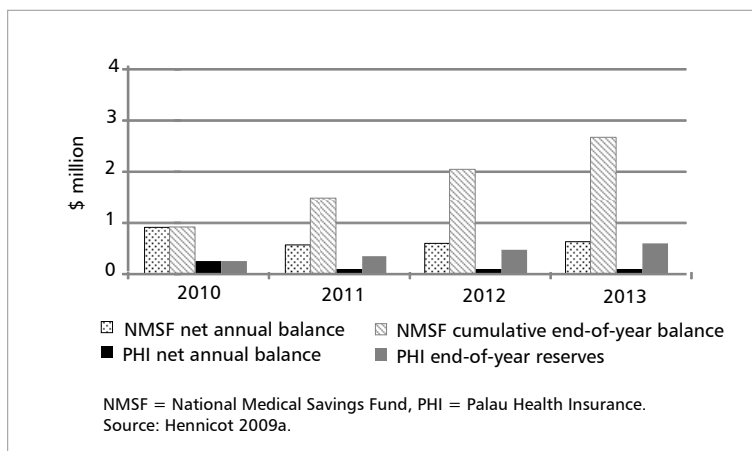
Two sets of projections were prepared for the actuarial analysis, one based on the status quo, the other based on the provisions of the proposed legislation.

Two sets of projections were prepared in the course of the actuarial analysis: (i) those based on the status quo, in which it was assumed that all provisions applying under current laws and regulations would remain in effect throughout the period relating to the projections, and (ii) those based on the provisions of the proposed health care reform legislation. For the latter set of projections, it was assumed that contributions to the National Medical Savings Fund would begin in the first quarter of 2010, and that benefits would also begin in the first quarter of the same year. This was done to allow the financial results to be presented on an annual basis. Figure 1 presents the projected net annual balance (including investment income) of both the National Medical Savings Fund and PHI under the following assumptions:

- The increase in utilization rates under the status quo scenario was assumed to reflect the trends observed in past years, i.e., (i) a rapid increase for kidney dialysis, (ii) a slow but gradual increase for outpatient and off-island care, and (iii) a decrease for inpatient and emergency care (though this was conservatively assumed to remain constant at the rate that occurred in FY 2008). Utilization rates under the health care reform scenario were assumed to change at the same rates as under the status quo scenario, except that the utilization rate for off-island referrals was assumed to increase by 22.5% in both 2010 and 2011 (i.e., by a total of 50.0% over the first two years of PHI operation).¹⁶

¹⁶ It is believed that the current high share of the cost of off-island referrals charged to patients (55% of medical care costs) restricts utilization, effectively limiting access to those who can afford to pay. It is expected that the sharp reduction in patient charges for off-island referrals under the reform will make this type of care accessible to a wider population, resulting in a marked increase in demand and service utilization during the first 2 years of operation after enactment of the reform legislation.

Figure 1: Actuarial Projections for the National Medical Savings Fund and Palau Health Insurance, 2010–2013



- Unit costs were assumed to increase by 2.0% annually in real terms, and to be unaffected by changes in utilization rates.
- User fee collection rates (i.e., revenues collected as a percentage of billed charges) were assumed to remain at their FY 2008 levels under the status quo scenario. However, due to aging of Palau's population, and in conjunction with current MOH fee policies (those aged 55 and above are billed only 5.0% of service fees), cost recovery rates for all types of services were assumed to decrease slowly over the period under analysis.
- User fee collection rates for outpatient and emergency care were assumed to increase to 100% under the health care reform scenario beginning in 2010, reflecting the mandatory establishment of MSAs and new provisions for write-offs of accounts receivable.¹⁷ For inpatient care and off-island referrals, cost recovery rates were estimated on the basis of the proposed coinsurance rate (20.0%) and the proposed ceilings on out-of-pocket payments. The effective cost recovery rates were estimated to be 10.0% for inpatient care and 11.5% for off-island referrals. For medical evacuations, the cost recovery rate was conservatively assumed to be 7.5%.
- Real wages were assumed to increase by 1.0% annually.
- Contribution collection rates were assumed to be 100.0% for government agencies, 95.0% for private and semipublic employers/employees, and 90.0% for the self-employed.¹⁸
- The share of private household medical expenditure (comprising user fees, coinsurance payments, and premiums for complementary private health insurance coverage) to be paid out of MSAs was assumed to be 50.0% in 2010, increasing to 75.0% in 2011, and remaining at that level in all subsequent years.

¹⁷ It was expected that the Rules and Regulations would include a provision for recovering unpaid BNH bills directly from MSAs after the proposed reform legislation went into effect.

¹⁸ While these contribution collection rates may appear high, they are based on the actual rates experienced in Palau's Social Security System. The Social Security Regulations provide the Administrator with considerable power of enforcement, including fines and imprisonment for knowingly false statements and reports, and payment of interest on unpaid balances, attorneys' fees, and court costs for late payments. These powers have been exercised vigorously in recent years.

- The rate of return on National Medical Savings Fund investments was assumed to be constant at 2.5% per annum in real terms.

The salary share of the cost of inpatient and off-island medical care covered by PHI would continue to be financed through the government budget (i.e., the cost of government salaries would not be included in PHI reimbursements to BNH). Based on the BNH cost estimates, the salary share of inpatient care costs (excluding the annual depreciation cost of the building) was estimated at 50%, while the salary share of off-island referrals costs was estimated to be 20%.

Projected Fiscal Impact of the Health Care Reform Legislation

The negative fiscal impact of the health care reform legislation would comprise expenditure of the government on employer contributions for its own employees (2.5% of their salaries), plus the cost of PHI contributions for nonworking persons aged 60 and above and for the nonworking disabled. The positive fiscal impact would comprise the reduction in government direct budget support made possible by reimbursements from MSAs and from PHI. Unsurprisingly, the net fiscal impact was projected to be positive, because the provisions of the health care reform legislation would generate substantial additional revenue from employment taxes, i.e., from the contributions of employees and employers in the private sector and the state enterprise sector, and the contributions of government employees and the self-employed. The health care costs of the nonworking elderly and disabled were already heavily subsidized by the government, with the result that the reform provisions would have little fiscal impact in this area. In addition, the use of prepaid MSA funds to finance user fees was expected to increase the collection ratio of user fees for outpatient care at BNH. However, there would be a delay between the time the government began making contributions and when the funds would begin to flow back to BNH in the form of MSA and PHI reimbursements.

The projections of the fiscal impact of the health care reform legislation (Figure 2) assumed that its provisions would be implemented during the first quarter of 2010. Employee contributions would thus begin in the first quarter, and employer contributions would begin at the end of the first month of the third quarter (during the first quarter, the employee contributions would be held by employers). Benefit payments were assumed to begin in the third quarter, implying that MSA and PHI reimbursements would begin to flow to BNH during the third quarter. Due to the lag between contributions and benefits, the positive net fiscal impact was projected to be \$46,568 in 2010, but \$714,019 in 2011.

Enactment of the Health Care Reform Legislation

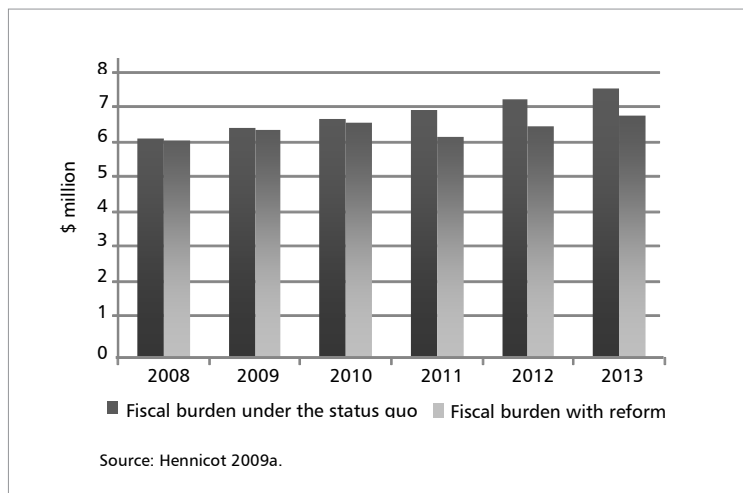
The proposed National Healthcare Coverage and Savings Act (Senate Bill No. 8-48¹⁹) was reintroduced in the Senate of the Eighth Congress on 18 March 2009 with the National Healthcare Financing Act as a proposed amendment. The bill passed the Senate on 14 October 2009 and the House on 21 January 2010, and was signed into law by the President on 7 May 2010.

¹⁹ Proposed amendments to the National Healthcare Financing Act, Senate Bill No. 8-48, SD1, Eighth Olbil Era Kelulau (OEK), First Special Session, March 2009 (2 September 2009).

The salary share of inpatient and off-island medical care costs covered by PHI would continue to be financed through the government budget.

The net fiscal impact was projected to be positive, because the provisions of the health care reform legislation would generate substantial additional revenue from employment taxes.

Figure 2: Projected Fiscal Impact of Health Care Reform Legislation in Palau, 2008–2013



The National Healthcare Financing Act defines only the general features of the new health care financing scheme. Details of the scheme were to be provided under the Rules and Regulations, which were to be finalized following enactment of the legislation. A first draft of the Rules and Regulations was prepared with the assistance of the TA team (Hennicot 2009b). The finalized Rules and Regulations—adopted in February 2011—contain General Provisions (mostly based on existing Social Security bylaws), as well as detailed guidelines for implementing (i) contributions to the National Medical Savings Fund, (ii) the MSAs, (iii) PHI, and (iv) other provisions (i.e., complaints and appeals, collection of contributions and delinquency, offenses and penalties, and ethics and secrecy).

Withholding under the new health care financing scheme was expected to begin on 1 October 2010, with the first quarterly contributions being paid to SSA in January–February 2011. MSA funds and coverage by PHI began on 1 April 2011.

Extent to which the Reform Legislation Addresses Outstanding Problems in Health Care Financing

The National Healthcare Financing Act addresses, at least partly, most of Palau's health financing problems outlined previously. MSAs were given an incentive to curb health care costs by strengthening individual responsibility for them, since individuals would now be spending their own money on health care. A primary motive for creating MSAs was to encourage payment of user fees through prepayment. User fees had not previously been an effective measure for controlling costs, however, because they often were not paid. The previous system of user fees was also less equitable because payment was required to be made at the time services were received, this requirement potentially negatively impacting access to needed services. Under the provisions of the National Healthcare Financing Act, funds in MSAs belonging to individual households will accumulate over time, with

Because of a lag between contributions and benefits, the projected positive net fiscal impact would be small in the first year, but much larger in the second.

The legislation was enacted by Congress in January 2010 and signed by the President in May 2010. The Rules and Regulations, drafted with the help of the TA team, were adopted in February 2011.

The reform legislation at least partly addresses most of Palau's health care financing problems. The legislation gives MSAs an incentive to curb costs and encourage equitable access to services.

Coinsurance requirements aim to offset some of the potentially negative incentives created by some provisions of the legislation.

Financial sustainability of the new health care scheme is promoted by diversification of financing sources.

The risk of catastrophic health care expenses is eliminated and access to expensive care is improved. Foreign worker access to health care is likewise improved.

Some aspects of private sector participation in the health care sector may widen.

risk likewise being pooled at the household level over time. Incentives for individuals to engage in good health practices are provided through discounts on PHI subscriptions in exchange for complying with recommended preventive measures. By separating provider and payer functions, the reform measures created the potential for movement toward a more cost-effective mix of on-island and off-island services. However, achieving this goal may require modification of the current fee-for-service method of reimbursement.

On the other hand, PHI provides an incentive for patients to use inpatient rather than outpatient services, since only inpatient care is covered by PHI. It may also result in an increase in demand for both on-island inpatient care and off-island care by reducing the share of costs paid by patients (moral hazard). These incentives could increase health care costs. The 20% coinsurance provision for on-island inpatient care and for all off-island care is intended to offset these incentives. If 20% coinsurance proves inadequate, the percentage can be raised by revising the Rules and Regulations (no change in the legislation would be necessary). Moreover, BNH is the only provider of inpatient care in Palau, while utilization of off-island care will be controlled by the MOH Medical Referral Committee. There is little incentive for MOH to take advantage of the MSAs or PHI, because it has a strong stake in their financial sustainability, unlike circumstances under some larger health care systems, in which some providers may gain at the expense of other providers.

The health care reform legislation promotes financial sustainability by diversifying the sources of health care financing to include payroll taxes as well as general tax revenues, household out-of-pocket expenditures, and foreign assistance. As a result, additional fiscal space is expected to be created in the government budget, which could eventually be used to reduce the dependency of Palau's health sector on United States financing.

The reduction of household out-of-pocket financing of health care is expected to improve equity in the provision of health services. The legislation eliminates the risk of catastrophic health care expenses, and improves access to relatively expensive inpatient and off-island health care. The access of foreign workers to health care is also expected to improve through their participation, on an equal basis, in both the MSA and PHI schemes. Foreign workers will also be able to repatriate balances in their MSAs when they leave Palau permanently. Universal coverage of PHI ensures that benefits are received by Palauans and non-Palauans alike. MSAs are sometimes criticized as being inequitable, because only the employed have MSAs, and the amount of funds accumulated in MSAs is linked to workers' earnings. However, spouses and dependent children are allowed access to MSA funds, and additional individuals can be given access to MSAs by MSA holders. The sliding fee scale and ceilings on copayments linked to household income mean that lower income households will need less money in their MSAs than will higher income households.²⁰

The reformed health care system reserves space for the private sector. Compulsory participation in PHI will probably reduce demand for private health insurance that covers the same benefits. However, it will potentially

²⁰ Palauan stakeholders wanted to retain a role for community solidarity in the health system because they considered this an important feature of Palau culture worth preserving. Community solidarity is thus expressed in the reform measures by the financing of needed health care for those with limited means.

widen the market for supplementary and complementary private health insurance coverage (e.g., for outpatient care), because the risk to insurers of catastrophic losses will be reduced, and because MSA funds can be used to finance private health insurance premiums.²¹ Reimbursement of private health care providers by both MSAs and PHI at rates comparable to those charged by BNH is also permitted under the new system.

Alternative Approaches Considered

Palau's health reform was developed after careful consideration of alternative approaches, including

- continuing with the existing national health system model,
- universal private health insurance coverage,
- social health insurance with a comprehensive benefit package,
- a privatized social health insurance fund, and
- a health insurance scheme managed by MOH.

The existing national health system was underfunded. There may have been some scope for cost cutting by allowing BNH more flexibility in the management of its budget, further developing primary care, or rationalizing the mix of on-island and off-island services—including wider use of telemedicine. However, the scope for raising user fees was limited by the hazard of impairing access to health care services and increasing the risk of catastrophic health care expenses.

One alternative to the existing system considered was mandatory enrollment in a private health insurance plan—as in Switzerland—presumably with the size of premiums and other conditions being regulated. However, private health insurance is expensive in Palau (competition is limited, and premiums are based on the cost of off-island health care). Further, there would be regulatory challenges in that attempts by insurers to attract relatively healthy individuals and discourage relatively unhealthy ones would need to be prevented.

Another alternative considered was mandatory social health insurance with a comprehensive benefit package (instead of relying on MSAs to finance outpatient care). Such a scheme would be more challenging to administer than the new health care scheme because of the large number of claims that would need to be processed and paid, particularly in the case of fee-for-service reimbursement. The potential cost control and health-promoting benefits of MSAs would be forgone, as well as the potential for the young to accumulate MSA balances. However, the National Healthcare Financing Act leaves open the possibility of moving to this type of coverage in the future by stating that the National Healthcare Financing Governing Committee will “continue to explore other possible options for improving the scope and fiscal sustainability of the National Medical Savings Fund and Palau Health Insurance...”

Yet another option considered was to have health care reimbursement managed by a private insurer. This possibility is also likely to be explored in

Both the status quo and other options were considered as alternatives to the reform legislation.

Alternatives to the proposed legislation were carefully assessed.

²¹ Private health insurance premiums are high in Palau, reflecting the high risk of catastrophic losses due to adverse selection. With catastrophic losses covered by PHI, private health insurers should be able to lower premiums for complementary and supplementary benefits, possibly widening the market for private health insurance.

the future, depending on the experience with SSA management. However, the alternative of an MOH-managed health insurance scheme was not seriously considered. In fact, MOH had previously attempted to operate a voluntary health insurance scheme. Without mandatory enrollment in an MOH-managed scheme, compliance would probably be low, because MOH has neither the legal mandate nor the means (e.g., information on employer payrolls) to enforce compliance. An MOH-managed scheme would also sacrifice the potential benefits of separating the payer from the provider. Further, it might be argued that operating a health insurance scheme is an inappropriate activity for a government agency with the mandate (and presumed expertise) to protect the health of the population.

Lessons Learned in Palau and their Applicability to Other Pacific Island Countries

Lessons Learned

Palau's experience in reforming its health care system provides some important lessons for other countries. Perhaps foremost among these is that it demonstrated the value of having a small group of dedicated national leaders to guide the effort. The rapid progress made in developing a sustainable health care financing scheme was due mostly to the talents and dedication of the technical assistance (TA) Steering Committee, whose members had a clear vision of what they wanted and were pragmatic in transforming their vision into a workable scheme. Early on, members of the TA Steering Committee reached agreement on the preferred features of the reform and signaled their desire to move quickly in developing the draft legislation for implementing their vision. The version of the legislation that was enacted varied little from their vision.

The Palau experience also demonstrates the value of expert advice. Although the process of reforming Palau's health care system was led by the TA Steering Committee, the TA team provided critical inputs. For example, preliminary financial projections prepared by the team clearly indicated that it was inadvisable to impose a ceiling on contributions, as originally proposed by the TA Steering Committee. The TA Steering Committee readily agreed to remove the ceiling after evaluating the projections. The TA team's recommendation to allow the medical savings account (MSA) funds to be used to pay for private health insurance premiums—because many employers were already sponsoring private health insurance plans for their employees—was readily accepted by the TA Steering Committee. The TA team's consistent advice against a voluntary scheme because of the problems of managing adverse selection was also accepted by the Steering Committee. Additionally, the availability of supporting materials and testimony from the external (and thus presumably disinterested) experts comprising the TA team was of value, as well as the assistance provided during the period that the proposed legislation was under consideration.

Another important lesson learned was the clear need for an effective body for governing the scheme. The TA Steering Committee and the TA

An important lesson learned was the value of the reform effort being led by a small group of dedicated national leaders.

The value of external expert advice was clearly demonstrated.

An effective representative body for governing the health care system was found to be essential.

team devoted considerable time to this issue and concluded that the Social Security Administration was not sufficiently representative as a body for governing the scheme. It was thus decided that a separate governing board for the scheme needed to be formed. The National Healthcare Financing Governing Committee includes representatives of the ministries of finance and health, SSA, the Governors Association, and the Chamber of Commerce. However, responsibility for day-to-day management of the scheme was assigned to the Social Security Administrator. Mandatory audits and annual reporting were additional requirements included in the draft bill, as was a mandatory actuarial assessment before contribution rates could be modified.

Applicability to Other Pacific Island Countries

The Palau health care reform legislation includes two main components: social health insurance and MSAs. Social health insurance is relevant as a health financing option in many Pacific island countries (PICs). The primary existing sources of health care financing in PICs—government budgets and foreign assistance—appear to have reached the limits of their use. Demand for health care, on the other hand, is expected to grow rapidly due to the increasing prevalence of noncommunicable diseases, especially diabetes, hypertension, heart disease, cancer, and motor-vehicle-related injuries. Demand for overseas treatment is also growing in most PICs. Government subsidies for overseas treatment are small relative to demand, necessitating rationing, which is not always based on the need for treatment and subsidization. Although the risk of overseas treatment is clearly an insurable risk (low frequency and high loss), adverse selection is an obstacle for further development of private health insurance, as evidenced by limited access (groups only) and high premiums. Private insurance against the risk of overseas treatment costs is currently an option only for employees of large enterprises.

Social health insurance is not a practicable option for all PICs. However, certain preconditions contribute to the likely success of social health insurance schemes. These include (i) existence of good-quality health services with fairly uniform access, (ii) a large share of employment in the formal sector, (iii) presence of administrative capacity for operating a social health insurance scheme, and (iv) a strong commitment on the part of the population to social solidarity. While these preconditions all exist in Palau, this does not hold true for every PIC. The quality of health services varies greatly among PICs, and physical access to health care is limited in cases in which the population is widely dispersed among numerous, distant islands (e.g., in Kiribati). Data on employment and labor markets are quite limited in PICs. However, for several PICs, estimates have recently become available for paid employment as a percentage of total employment and for the unemployment rate (i.e., the number of unemployed as a percentage of the labor force). Table 5 compares estimates of employment and unemployment available in selected PICs with those available in selected Asian countries. Although estimates are available for only half of the PICs listed in Tables 1 and 2, PIC labor force indicators (with the exception of the unusually high unemployment rate in the Marshall Islands in 1999) are broadly similar to those in the selected Asian countries.²²

Social health insurance is a relevant option for many PICs in view of the limits of existing financing sources and the rapid growth in demand for health care.

²² Six of the eight selected Asian countries have social health insurance schemes. The exceptions are Malaysia and Sri Lanka.

Social security systems are either nonexistent or limited to provident funds (often managed offshore) in most PICs. In the absence of an effective social security system, it is unclear how a social health insurance scheme would be administered. One possibility would be to base a social health insurance scheme in the ministry of health. However, this would require building up capacity in an area far removed from the normal functions of health ministries. Even if such capacity could be developed, a legally enforceable system for collecting revenues would be required. One alternative might be to implement the scheme for public servants first in cases in which the population is sufficiently large. With this experience in administration and enforcement, the scheme could then be expanded to cover the private and informal sectors.

Social health insurance is not a practicable option for PICs in which preconditions that would contribute to its likely success do not exist.

Table 5: Wage and Salary Employment and Unemployment Rates in Selected Pacific Island Countries and Asian Countries for the Most Recent Year for which Data are Available

Country	Year ^a	Wage and Salary Workers as % of Total Employment	Unemployment Rate (%)
Pacific Island countries			
Fiji	2005	58.6	4.6
Marshall Islands	1999	71.3	30.9
Palau	2005	94.5	4.1
Papua New Guinea	2000	...	2.8
Samoa	2001	48.7	...
Tonga	1996	42.2	5.2 ^a
Tuvalu	2002	96.2	6.5
Selected Asian countries			
People's Republic of China	2008	...	4.2
Indonesia	2008	32.6	8.4
Malaysia	2008	74.6	3.3
Mongolia	2003	39.3	2.8 ^b
Philippines	2008	52.4	7.4
Sri Lanka	2008	56.0	5.2
Thailand	2008	43.2	1.2
Viet Nam	2004	25.6	2.1

... = data not available.

^a 2002.

^b 2008.

Sources: International Labour Organization; Palau 2005.

The absence or limitations of social security systems in most PICs make it unclear how a social health insurance scheme would be administered.

The underdeveloped use of health care user fees effectively bars use of the social health insurance option in many PICs.

Palau's health care reform may be a relevant model for PICs in which certain preconditions are fulfilled. Additional groundwork may be required before other PICs could apply the Palau model successfully.

In many PICs, significant user fees for health care services are not charged, and private health care is not well developed.²³ Little or no demand for health insurance that covers on-island health care would thus be a likely outcome in many PICs. This would effectively prevent the use of social health insurance as an alternative source of financing for domestic health care. The absence of significant user fees also suggests that the financial management capacity of many government hospitals is quite limited.

In PICs in which significant user fees are being charged, MSAs would appear to be a relevant option.²⁴ In principle, MSAs provide a way for the young to accumulate savings for financing the increased health care costs of middle age and beyond. MSAs may also be a vehicle for providing people with an incentive to maintain good health in order to preserve their accumulated MSA balances. However, no systematic evidence is as yet available that supports this hypothesis (Hanvoravongchai 2002).

It may be concluded that reform of the Palau health care system—including both its social health insurance and MSA components—presents a relevant model for some PICs. The government health systems of such PICs would already be charging significant user fees, and the government would possess the administrative capacity for managing a social health insurance scheme (e.g., through an effective social security system that includes pensions). For other PICs, additional groundwork would be required before the Palau model is relevant. A first step might be introduction of user fees in government hospitals. Equity issues could be addressed by using a sliding scale for user fees as in Palau. Limits on out-of-pocket expenditure could also be imposed to ensure equity of access.

Examples include yearly expenditure limits for those suffering from chronic diseases, and per-episode expenditure limits for persons suffering from acute illnesses or injuries. Such features would help build up hospital financial management capacity and contribute to developing an awareness that health care is not free.

²³ A striking feature of most PICs is the active involvement of church missions in the provision of education, but not in the provision of health care. This is in contrast to Africa, where many of the same church missions are important providers of health care (often receiving subsidies from the government). The main reason for the absence of church-mission providers of health services in most PICs is probably the same as the reason for the small size of the private health sector generally in PICs, i.e., the generous tax financing provided exclusively to government health facilities.

²⁴ The preconditions for MSAs are mostly the same as those for social health insurance, the exception being a commitment to social solidarity (because MSAs do not involve cross-subsidies). It would be feasible to manage MSA funds offshore, as is sometimes done with provident funds. However, the reimbursement of health providers would presumably have to be managed domestically.

References

Asian Development Bank (ADB). 2008. *Technical Assistance to the Republic of Palau for Development of a Sustainable Health Financing Scheme*. Manila.

Azzam, Osmat. 2008a. *Financial Viability of the National Health Saving Plan*. Consultant's report. Manila (TA7079–PAL).

_____. 2008b. *Palau National Health Account 2007*. Consultant's report. Manila (TA7079–PAL).

Gottret, Pablo and George Schieber. 2006. *Health Financing Revisited: A Practitioner's Guide*. Washington, DC: World Bank.

Government of the Republic of Palau. 2009. *National Health Care Financing Act*. Senate Bill No. 8-48, SD1, Eighth Olbiil Era Kelulau, First Special Session, March. Koror.

Hanvoravongchai, Piya. 2002. *Medical Savings Accounts: Lessons Learned from Limited International Experience*. Geneva: World Health Organization.

Hennicot, Jean-Claude. 2009a. *Actuarial Assessment of Proposed Health Financing Schemes: Republic of Palau*. Consultant's report. Manila (TA7079–PAL).

_____. 2009b. *National Health Care Financing Act: Draft Rules and Regulations*. Consultant's report. Manila (TA7079–PAL).

International Labour Organisation. LABORSTA: Labour Statistics Database.

Knowles, James C. 2009. *Estimation of Costs at Belau National Hospital*. Consultant's report. Manila (TA7079–PAL).

Knowles, James C. and Jean-Claude Hennicot. 2009. *Development of a Sustainable Health Financing Scheme*. Consultant's final report. Manila (TA7079–PAL).

Office of Planning and Statistics, Palau. 2005. *Census of Population and Housing of the Republic of Palau. Volume 1. Basic Tables*.

United States Bureau of the Census. International Database. Washington, DC.

Wagstaff, Adam. 2007. *Social Health Insurance Reexamined*. Policy Research Working Paper 4111. Washington, DC: World Bank.

_____. 2009. *Social Health Insurance vs. Tax-Financed Health Systems—Evidence from the OECD*. Policy Research Working Paper 4821. Washington, DC: World Bank.

World Health Organization Statistical Information System. <http://www.who.int/whosis/en/>

Sustainable Health Care Financing in the Republic of Palau

The government and the people of the Republic of Palau have been working with the Asian Development Bank (ADB) since 2005. Since Palau is one of ADB's newest members, ADB conducted an extensive analysis of the constraints to development before agreeing on the country partnership strategy with the government in 2009. The strategy focuses on improving public sector effectiveness to meet the government's fiscal strategy, supporting private sector development, reforming the water and sanitation sector, and addressing the impact of climate change. In support of this strategy, Palau has received two loans amounting \$16.0 million and five technical assistance projects for a total of \$3.3 million.

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