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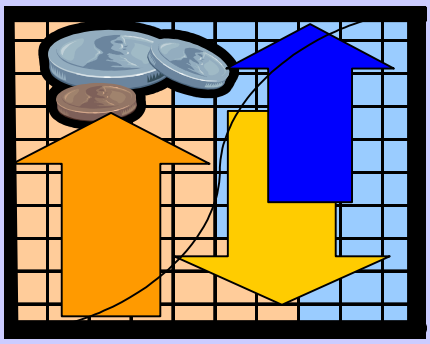

PRIVATE HEALTH INSURANCE: IMPLICATIONS FOR DEVELOPING COUNTRIES

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PRIVATE HEALTH INSURANCE:

IMPLICATIONS

FOR

DEVELOPING COUNTRIES

by

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Abstract

Private health insurance plays a large and increasing role around the world. This paper reviews international experiences and shows that private health insurance is significant in countries with widely different income levels and health system structures. It contrasts private health insurance across regions and highlights countries with particularly high rates of private expenditures. It argues that policy makers need to confront the role that private health insurance will play in their health systems and regulate the sector appropriately so that it serves public goals of universal coverage and equity.

Keywords: Health Insurance, Health Policy, Private Sector, Economic Development, and Public Policy.

Background and Context

Is there a Role for Private Health Insurance in the Health Policy of Developing Countries?

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

Unlike taxation and social security, which are commonly viewed as promoting equity, private insurance often conjures up visions of unequal access, large numbers of uninsured people, and elitist health care for the rich. Experience indicates that unregulated or poorly designed private health insurance systems can indeed exacerbate inequalities, provide coverage only for the young and healthy, and lead to cost escalation.(2)

However, when appropriately managed, private health insurance can play a positive role in improving access and equity in developing countries for several reasons. First, out-of-pocket spending on health services is the most common form of health financing in developing countries and represents a significant financial burden for households.(3) To the extent that private insurance gives households an opportunity to avoid large out-of-pocket expenditures, it can provide access to financial protection that is otherwise lacking.

Secondly, many developing countries have public expenditures for health of less than $10 per capita per year, with large informal sectors.[2] (4) Their ability to generate tax revenues or fund social insurance systems to provide broad financial protection for health care is limited. Private coverage, when appropriately regulated, may be one way to move towards prepayment and risk pooling until publicly funded coverage can expand sufficiently. It also allows policy makers to target limited public resources towards the most vulnerable groups, while those who can afford it, can contribute to their medical costs.

Thirdly, history shows that the social insurance systems of several OECD countries evolved from voluntary private health insurance schemes based on professional guilds or communities. (5) These historical lessons in building institutional capacity and the changing role of private coverage as public financing is strengthened, may be useful in informing policy debates in developing countries as they consider moving towards public insurance systems.

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[1] This paper does not deal directly with the extensive literature on commuity health insurance although community health insruance plans are included in the National Health Accounts data presented. For more information on community health schemes, please see Carrin, G. et al entitled,"Community based health insurance schemes in Developing Countries: Facts, Problems and Perspectives, and other references cited.

[2] The Commission on Macroeconomics and Health recommends USD 34 per capita annually to provide a package of essential health interventions.

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

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

Methods

Although most countries have some type of private health insurance market (6), data on private insurance expenditures, populations covered, premiums charged and impact on the health care system, are very limited. This study uses data on private insurance available through National Health Accounts (see Appendix #1) which have several limitations: NHA data are not available for all countries and may underestimate the role of private insurance, particularly in developing countries where the private market tends to be unregulated; trend data for most developing countries is not reliable because reporting on private coverage is relatively recent. Also, since little systematic data have been collected on insurance markets in developing countries, evidence tends to be empirical and anecdotal. Despite these limitations, the increasing role of private insurance suggests that this topic needs greater attention. We hope that this paper will underscore the need to collect more extensive and reliable data in this area.

What is Private Health Insurance?

Private health insurance has historically been characterised as voluntary, for-profit commercial coverage. However, in looking at private coverage around the world, it is evident that a wide variety of arrangements are described under the umbrella of private insurance and that the boundaries between public insurance[3] and private insurance are becoming increasingly blurred (7). The *OECD Adhoc Group on Private Insurance* uses the difference in how insurance is funded as the key criterion to distinguish between private and public insurance. (8) Ultimately, all money comes from household income, but in public insurance programs this money is channelled through the State, via a general or social insurance tax collector, whereas in private insurance the money is paid directly to the risk pooling entity (figure 1).

It is useful to recognise the spectrum of arrangements that range from purely private, for-profit commercial insurance to purely publicly funded and publicly managed insurance. Figure 2 suggests a spectrum between these two extremes, classified along three key dimensions:

- Whether insurance is mandatory or voluntary.

[3] The term ***public insurance*** is used here to encompass the full range of schemes that are variously described as "social insurance" or "national insurance".

- Whether contributions are risk rated (minimal risk transfer), community rated (transfer of risk between healthy and sick) or income based (transfer of risk between healthy and sick; and higher income and lower income).

- Whether management of the scheme is commercial for-profit, private non-profit, or public/quasi-public.

This spectrum is not meant to be construed as a causal or developmental model but rather highlights the variety of different arrangements that exist. Although private insurance and public insurance are often discussed in terms of the extremes, the most common arrangements are actually found in the centre.

As the spectrum shows, in general, private insurance tends to be voluntary, while public insurance tends to be mandatory, but this is not always the case. For example, in Uruguay and Switzerland purchase of private cover is mandatory similar to public insurance systems,[4] whereas in Mexico, the recently approved public insurance scheme (*Seguro Popular*) is voluntary. (10) Another example of this variety is found in the United States where insurance coverage is voluntary, yet several states mandate employers over a certain size to provide health coverage for their employees (7).

In the dimension of contributions, private insurance premiums tend to be risk rated or community rated, while public insurance contributions tend to be income related, but again exceptions exist. In management of insurance schemes, the variations are more pronounced. In Australia and Ireland, for example, the largest "private" insurance companies are publicly owned and in many social insurance systems, private entities manage publicly financed sickness funds.

In addition to the three dimensions above, private insurance can be classified by the different roles it plays in the health financing system.[5] When it provides *Principal Coverage*, private insurance is the primary form of prepayment for some portion of the population. For example, in the United States, private health insurance provides the main coverage for the non-poor who are under 65 years of age; while in the Netherlands, households above a certain income threshold are not allowed to participate in the public sickness funds, and in most cases, purchase private coverage (5). Principal insurance usually pays for a broad package of health services; often mirroring those financed in a public system.

In *Supplementary Coverage*, private insurance complements coverage provided by a publicly funded system and covers a limited set of interventions that address the particular gaps in a country's public coverage. For example, insurance policies may cover residual health care costs (such as co-payments in France); services not included in the basic publicly funded package (such as outpatient drugs or dental care in

[4] Some authors consider Switzerland to have a social insurance scheme while others, such a s the OECD Adhoc Group on Private Insurance characterises its scheme as private insurance.

5 The OECD Adhoc Group on Private Insurance identifies four categories of private health insurance: Primary, Duplicate, Complementary, and Supplementary. For our purposes, we have chosen to emphasize the difference between systems in which private health insurance provides "principal coverage" (corresponding to the OECD's category of "primary health insurance") and those in which it provides "supplementary coverage" (corresponding to the OECD taskforce's other three categories). (8)

Slovenia); or allow easier access to services and payment for private providers (such as in Australia and the U.K. where private policies enable faster access to specialists and elective hospital care).

International Situation

Variations by Income Level

Based on available data, thirty-nine countries in the world have private health insurance exceeding 5% of total health expenditures. Although private insurance markets are most well developed in wealthier countries, almost half (46%) of these countries are in the low and lower-middle income categories. (Table #1).

Private insurance tends to play a different role depending on a country's wealth and institutional development. In many lower- and middle-income countries, private insurance may be the only form of risk pooling available and it usually provides principal coverage to those in the formal sector, with private policies frequently subsidised by employers. Historically, this is not unlike the situation in Western Europe in the nineteenth century when the only significant forms of insurance were provided by mutual associations, employers, guilds or unions - on a voluntary basis. For example, 10% of Sweden's workforce was covered by voluntary private insurance schemes called "Friendly Societies" in 1885.(11) In Germany, Bismarck established the first national social insurance system by knitting together voluntary pre-existing occupationally and industrially based sickness funds. (12)

By contrast, in most OECD countries today, with the exception of the U.S., private insurance provides supplementary coverage to predominantly publicly funded systems. In France, for example, 85% of the population purchases private policies to pay for co-payments; while in the Netherlands over 90% of the population purchases either principal or supplementary insurance plans (figure 3). In the OECD, when private insurance provides principal coverage, it generally faces significant restrictions. The European Union's directive on health insurance states that health insurance should only be subject to normal financial regulations except where a “general good” could be demonstrated. (14). When private health insurance is the only form of risk pooling for the population, the public interest can be clearly demonstrated, and the insurance regulations of many countries reflect this. (7)
Among wealthy countries, Australia and Ireland are unique in explicitly encouraging private health insurance as a strategy to complement public financing. Historically, both countries used private insurance to provide principal coverage for significant segments of their population and it is now used to relieve pressures on the public system. As a result of targeted interventions, about 45% of the population in each of these countries purchase private insurance. Despite the fact that private coverage is now supplementary, both countries have strong regulatory structures to manage the market and require private insurers to community rate premiums and meet guaranteed issue and renewal requirements. [6] (15)

Variations by Region

[6] Guaranteed issue and renewal requirements ensure that everyone has an opportunity to be offered coverage regardless of health status, and that those who become sick are not terminated.

Latin America has the most countries with private insurance coverage. Over the past two decades, Latin American countries have undertaken many reforms of their health care systems, and private insurance has sometimes been an explicit strategy to attract private funds into the health sector. Several countries have encouraged investment from foreign insurers and managed care companies, by opening their health insurance markets, however, most countries have failed to enact adequate regulatory controls to preserve equity and ensure consumer protection. (16) Recently there have been efforts to remedy this by placing requirements on insurers for solvency, equitable rating methods, and standard benefit packages. Despite this, enforcement of regulations remains weak and presents a challenge in many parts of Latin America.(16)

Private health insurance markets also exist in *Africa* with South Africa, Namibia and Zimbabwe funding a significant percentage of their health care costs through private insurance. Botswana, Cote d'Ivoire, Kenya, Madagascar and Mali, have large markets as well. Community health insurance schemes are also fairly extensive in some countries, such as the *mutuelles* in Senegal. (17,18) Other forms of voluntary coverage have emerged as the result of market forces and laissez faire government policies towards the private sector. As a result, regulation of insurers tends to be weak and private insurance may lead to greater inequity and cost-escalation if it expands significantly.

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

Asia presents a particular challenge and an opportunity for private coverage. It is the region in which out-of-pocket expenditures account for the highest share of total health spending and where private insurance could play a role in moving towards greater prepayment and risk pooling. However, private health insurance markets have developed in some countries without an adequate regulatory framework and these countries run the risk of exacerbating inequalities in access to health care. Several successful and well-documented community health schemes also exist in this region. (20). Although NHA data are not available on expenditures of private insurance in India, it is estimated that 3·3% of the population is covered, making it the largest market in the region (33 million).(21) China has explored private insurance in urban areas and has also opened its market to foreign companies. A few Pacific Island countries (e.g. Fiji, Samoa and Papua New Guinea) have had foreign insurers enter their markets to provide coverage for services in the islands and enable access to care in Australia and New Zealand.(22). Both the Philippines and Indonesia have made forays into private health insurance with varying levels of success. In the early 1990s, Indonesia introduced private health insurance schemes based on Health Maintenance Organization (HMO) principles (23). The Philippines has created a quasi-public agency called the Philippines Insurance Corporation, which sells individual private health insurance policies in addition to managing the country's growing social insurance program. (24)

Several countries in *Eastern Europe* are considering policies to encourage private insurers to sell supplementary health insurance coverage. (25). Slovenia has one of the most well developed private insurance systems, funding 14·6 % of total health care expenditures in 2001; while Albania's market funded 12% of its health expenditures in that year. In Central Asia, Turkmenistan has a private insurance market which accounts for 7% of its total expenditures for health (NHA 2001).

Countries with the Highest Private Insurance Expenditures

In 2000, seven countries stood out as funding over 20% of total health expenditures through private coverage (figure 4). Interestingly, these ranged from Zimbabwe, a low-income country that spent $171 annually per capita on health care, to the United States, which spent the highest amount on health care in the world ($4499 per capita) (3). Each of these countries use private insurance to provide principal coverage for some segment of its population. Three of these are adjoining countries in Sub-Saharan Africa: Namibia, South Africa and Zimbabwe, while three are in South America: Uruguay, Chile, Brazil. while three are in South America: Uruguay, Chile, and Brazil. All of these countries experienced significant European immigration.(26) The countries of the Americas won their independence much earlier, and consequently developed health insurance institutions over a longer period of time and in parallel to similar developments in Western Europe. By contrast, health insurance schemes in the African countries were established under colonial governments, and have only had a few decades of independent development.

In the three African countries, private insurance covers a relatively small share of the populations, despite representing a large share of total expenditures. For example, in Zimbabwe, in 2000, an estimated 6% of the population purchased private cover which accounted for 26% of total health expenditures. Seventeen percent of those in the paid formal sector were covered by private insurance schemes. (2) Despite Zimbabwe's plans in 1997 to launch a comprehensive social insurance scheme, the share of private insurance expenditures rose sharply between 1998 -2000 (from10% to 26%). (NHA) In 2001, perhaps due to economic turmoil, this share fell to 19%. In Namibia, private coverage also protects largely the employed sector. (27) South Africa has a history of over 100 years of private insurance based largely on mutual insurers called medical schemes or medical aid societies. Wealthier people benefit most from this insurance, with 80% of those in the two highest income quintiles being covered compared to only 2% of those in the lowest income quintile (28). In 2000, private insurance covered about 7 million people (17% of the population), again, largely employees in the formal sector and their families. (28) In this group of African countries, only South Africa has a strong regulatory structure governing the private market. In 1998, the country strengthened its regulatory framework through the quasi-governmental Commission for Medical Schemes and in 2002, the government proposed a major reform aimed at achieving universal health coverage which envisions gradual evolution of the private insurance market into a mandatory social insurance system. (28)

Unlike the Sub-Saharan countries, the three Latin American countries have much larger private health insurance markets. Uruguay is unique in having a mandatory, private insurance system that covers over 60% of the population. This system is complemented by publicly funded programs for the elderly and poor. (29) Uruguay has a long history of health insurance regulation aimed at making insurers serve public

policy goals; for example, from their inception, concerns that medical factors should play a primary role in treatment decisions led to the requirement that physicians participate in running insurance companies. Later, regulations were introduced covering many of the basic operations of insurers. In Chile, the role of private insurance in health financing is explicit and allows those who can afford it to 'opt-out' of the publicly funded health system and buy private cover. (30) By contrast, Brazil's private health insurance market grew despite public policies aimed at establishing a universal publicly financed health system. In both Chile and Brazil, private insurers emerged with relatively light regulation, but since the late 1990s, as a result of market failures, the governments of both countries have been trying to impose more stringent regulations on the operations of insurers. (29)

The United States is the only rich country to rely on voluntary private insurance to provide coverage to most of its people. Over 70% of the population obtain health coverage through private insurers, with almost 64% of this through employment-based insurance plans. (31) However, U.S. *public* expenditures on health are on par with *total* health expenditures for most OECD countries and cover the elderly, disabled and poor, through public insurance programs such as Medicare and Medicaid, as well as a system of public hospitals and community clinics. (32) The U.S. private insurance market is heavily regulated. Many U.S. states mandate community rating or do not permit fully risk rated premiums, and specify tight rate bands for premiums in hopes that this will allow small groups and individuals to obtain affordable coverage. (7) Seventy-five percent of U.S. states have guaranteed issue and renewal requirements in the small group market and almost half have set up insurance pools for high-risk populations funded through assessments on insurers. (7)

These seven countries differ significantly in their income levels, the percentage of people covered through private insurance and the extent of effective regulation of the private market. However, they have several similarities worth noting: in each country private insurance provides principal coverage targeted largely at the formal, employed workforce and their families. And in each country, vulnerable populations are covered through publicly funded programs.

Implications for Policy Makers in Developing Countries

As this paper shows, private health insurance is more widespread than public debates may lead us to believe. Many developing countries have private health insurance markets which are serving their middle class; and may also afford some degree of financial protection for the poor (particularly those that are more commonly characterised as community health insurance schemes). Many developed countries use supplementary private insurance to fill gaps in their publicly funded systems and pay for increasing health services demand.

As developing country policy makers consider whether they will allow private insurance to emerge or, if it already exists, how they can better manage the market, a few lessons are important from the experiences of developed countries.

First, no high-income country uses private coverage as the primary method for insuring poor or high-risk populations. Even in the U.S., which has the largest private insurance market in the world, the poor and aged are covered through large publicly funded

programs. Instead private insurance provides an opportunity for the employed and those who can afford it, to contribute directly to the costs of health care, and serves as a mechanism to capture private funds to finance growing demands on the health care system.

Second, government stewardship of health insurance markets is critical to their effective functioning. Developed countries that rely on private insurance to cover large segments of their population, or in which private insurance plays a prominent role, intervene often quite significantly, in the market to ensure adequate consumer protection and equity. Through policies, incentives and regulations they essentially "conscript private insurance to serve the public goal of equitable access" (7). While it is recognized that the institutions necessary for stewardship are often weak in developing countries, it can be argued that the challenge of regulating health insurance markets is no more complex than operating an efficient, high quality, public system of hospitals and clinics. Indeed, establishing a function for oversight of private insurers may conform more closely to the comparative advantages of government.

Finally, as the experiences of Germany, the Netherlands and Sweden show, as countries move towards universal coverage, the role of private health insurance can change. (5, 11) When public funding is low, private insurance can serve as a transitional mechanism, building capacity and providing financial protection for certain segments of the population, allowing limited tax revenues to be directed to public goods and vulnerable groups (5). The institutional capacity, information systems, and skills involved in regulating private health insurance may later be useful in managing publicly funded schemes as they expand.

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

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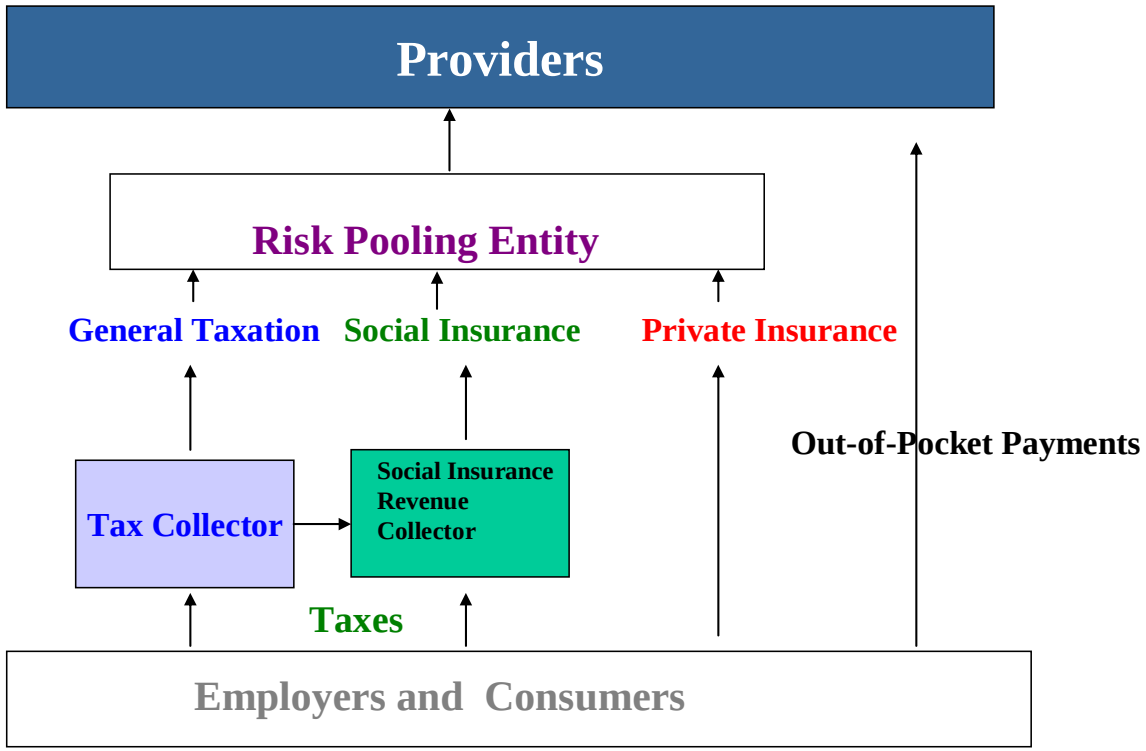
Table 1
Countries with Private Insurance Expenditures over 5% of Total Health Expenditures in 2001: By Income

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

Source: National Health Accounts Team, EIP/GPE/FAR, WHO;
Income Categories: The World Bank Group, 2004 www.worldbank.org

Figure 1: Financing Mechanisms



Adapted from Mossialos, E., Dixon, A. Funding health care in Europe: weighing the options. European Union. 272-300. 2000

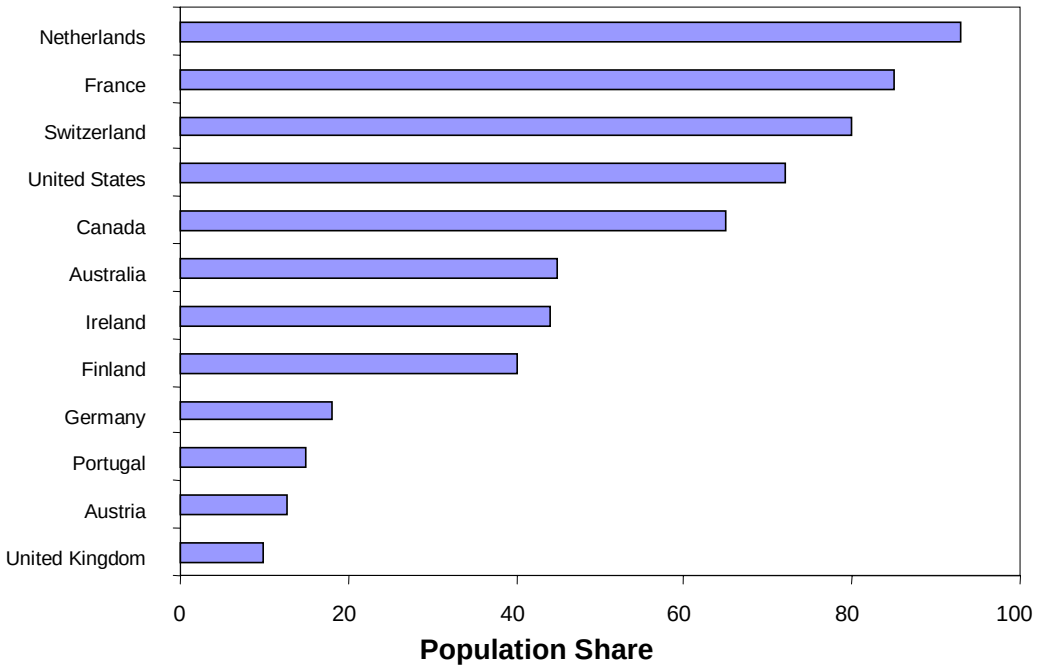
Figure 2. Variety of Insurance Arrangements

Privately funded **Publicly funded** (through some type of taxation)

Voluntary/Mandatory	Voluntary	Voluntary	Voluntary	Voluntary	Mandatory	Mandatory	Mandatory	Mandatory
Risk Rated/Income Related Contributions	Risk-rated	Risk-rated	Communtiy Rated	Communtiy Rated	Communtiy Rated	Communtiy Rated	Income Related	Income Related
Private For-Profit/Public Management	For-Profit Commercial (e.g. Aetna)	Non-Profit (e.g. BUPA in U.K.)	Non-Profit Community (e.g. SEWA in India)	Public (e.g. Medibank in Australia	Non-Profit (e.g. CHCI in Uruguay)	Private For-Profit (e.g. Switzerland)	Private Non-Profit (e.g. Netherlands)	Public

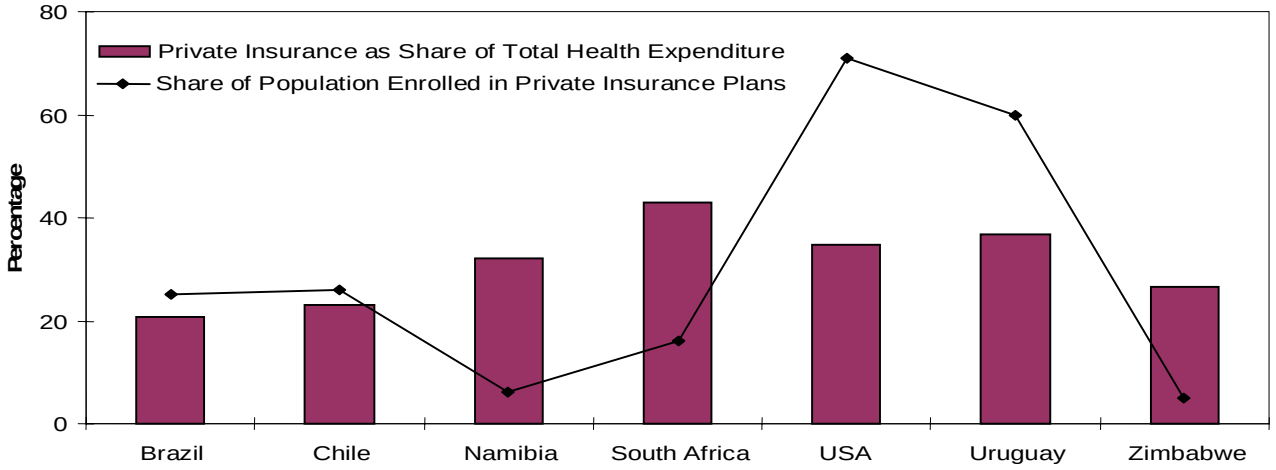
Private Insurance ⟷ ***Public Insurance***

Figure 3. Share of Population With Private Health Insurance (%)
Selected OECD Countries: 2000



Source: OECD, 2000.

Figure 4. Countries with Highest Private Health Insurance Expenditures: 2000



Sources: National Health Accounts Team, EIP/GPE/FAR, WHO: 2000 data; Zigora; Chollet; and Namibia Department of Health.

Country	Total Health Expenditures as a Percentage of GDP	Private Health Expenditures as a Percent of Total Health Expenditures	Private Insurance as a Percentage of Total Health Expenditures	Private Insurance as a Percent of Private Health Expenditures	Out-of-Pocket Payments as a Percent of Private Health Expenditures	Out-of-Pocket Payments as a Percent of Total Health Expenditures
Afghanistan	5.2	47.4	0	0	100	47.4
Albania	3.7	35.4	12	33.9	65.3	23.1
Algeria	4.1	25	1.3	5.1	89.9	22.4
Andorra	5.7	29	n/a	n/a	92.6	26.9
Angola	4.4	36.9	0	0	100	36.9
Antigua and Barbuda	5.6	39.1	n/a	n/a	100	39.1
Argentina	9.5	46.6	14.5	31.1	62.4	29.1
Armenia	7.8	58.8	0	0	100	58.8
Australia	9.2	32.1	7.8	24.2	59.6	19.1
Austria	8	30.7	7.1	23.3	61.3	18.8
Azerbaijan	1.6	33.1	0.8	2.3	97.7	32.3
Bahamas	5.7	43	n/a	n/a	100	43
Bahrain	4.1	31	8.4	27.2	69.3	21.5
Bangladesh	3.5	55.8	0	0	93.2	52
Barbados	6.5	33.7	7.9	23.4	76.6	25.8
Belarus	5.6	13.3	0	0.3	99.7	13.3
Belgium	8.9	28.3	1.9	6.8	58.8	16.7
Belize	5.2	54.9	0	0	100	54.9
Benin	4.4	53.1	n/a	n/a	99.9	53
Bhutan	3.9	9.4	0	0	100	9.4
Bolivia	5.3	33.7	2.6	7.7	85.7	28.8
Bosnia and Herzegovina	7.5	63.2	0	0	100	63.2
Botswana	6.6	33.8	6.9	20.5	35.3	11.9
Brazil	7.6	58.4	20.9	35.9	64.1	37.5
Brunei Darussalam	3.1	20.6	0	0	100	20.6

Bulgaria	4.8	17.9	0	0	98	17.6
Burkina Faso	3	39.9	n/a	n/a	97.4	38.9
Burundi	3.6	41	0	0	100	41
Cambodia	11.8	85.1	0	0	84.6	72.1
Cameroon	3.3	62.9	n/a	n/a	81.6	51.3
Canada	9.5	29.2	11.5	39.3	52.3	15.3
Cape Verde	4.5	16.1	n/a	n/a	100	16.1
Central African Republic	4.5	48.8	0	0	95.4	46.6
Chad	2.6	24	n/a	n/a	80.9	19.4
Chile	7	56	22.6	40.3	59.6	33.4
China	5.5	62.8	0.2	0.4	95.4	59.9
Colombia	5.5	34.3	11.9	34.8	65.2	22.4
Comoros	3.1	40	0	0	100	40
Congo	2.1	36.2	n/a	n/a	100	36.2
Cook Islands	4.7	32.4	0	0	100	32.4
Costa Rica	7.2	31.5	0.5	1.5	92.1	29
Côte d'Ivoire	6.2	84	8.6	10.3	89.7	75.4
Croatia	9	18.2	0	0	100	18.2
Cuba	7.2	13.8	0	0	76.8	10.6
Cyprus	8.1	52.3	1	2	98	51.3
Czech Republic	7.4	8.6	0	0	100	8.6
Democratic People's Republic of Korea	2.5	26.6	0	0	100	26.6
Democratic Republic of the Congo	3.5	55.6	0	0	100	55.6
Denmark	8.4	17.6	1.6	9.2	90.8	16
Djibouti	7	41.2	0	0	55.2	22.7
Dominica	6	28.7	0	0	100	28.7
Dominican Republic	6.1	63.9	0.2	0.4	88.4	56.5
Ecuador	4.5	49.7	4.7	9.5	73.8	36.7
Egypt	3.9	51.1	0.3	0.5	92.2	47.1
El Salvador	8	53.3	2.6	4.9	94.9	50.6

Equatorial Guinea	2	39.6	0	0	52.3	20.7
Eritrea	5.7	34.9	0	0	100	34.9
Estonia	5.5	22.2	1.1	4.8	84.7	18.8
Ethiopia	3.6	59.5	0	0	84.7	50.3
Fiji	4	32.9	0	0	100	32.9
Finland	7	24.4	2	8.3	82.7	20.2
France	9.6	24	12.7	53.1	42.6	10.2
Gabon	3.6	52.1	0	0	100	52.1
Gambia	6.4	50.6	0	0	90	45.6
Georgia	3.6	62.2	0.2	0.3	99.7	62.1
Germany	10.8	25.1	8.4	33.5	42.4	10.6
Ghana	4.7	40.4	0	0	100	40.4
Greece	9.4	44	2	4.4	73.9	32.5
Grenada	5.3	28.1	0	0	100	28.1
Guatemala	4.8	51.7	2.7	5.3	85.7	44.3
Guinea	3.5	45.9	0	0	100	45.9
Guinea-Bissau	5.9	46.2	0	0	100	46.2
Guyana	5.3	20.1	0	0	100	20.1
Haiti	5	46.6	n/a	n/a	45.3	21.1
Honduras	6.1	46.9	3.5	7.5	88.9	41.7
Hungary	6.8	25	0.3	1.3	85.5	21.4
Iceland	9.2	17.1	0	0	100	17.1
India	5.1	82.1	n/a	n/a	100	82.1
Indonesia	2.4	74.9	6.1	8.2	91.8	68.8
Iran, Islamic Republic of	6.3	56.5	1.5	2.6	94.2	53.2
Iraq	3.2	68.2	0	0	100	68.2
Ireland	6.5	24	6.8	28.4	55.2	13.3
Israel	8.7	30.8	0	0	100	30.8
Italy	8.4	24.7	0.9	3.6	82.1	20.3
Jamaica	6.8	57.9	13	22.5	73.4	42.5
Japan	8	22.1	0.3	1.4	74.9	16.6
Jordan	9.5	53	4	7.4	73.9	39.2

Kazakhstan	3.1	39.6	0	0	100	39.6
Kenya	7.8	78.6	7.5	9.5	67.6	53.1
Kiribati	8.6	1.2	0	0	100	1.2
Kuwait	3.9	21.2	0	0	100	21.2
Kyrgyzstan	4	51.3	0	0	100	51.3
Lao People's Democratic Republic	3.1	44.5	n/a	n/a	80	35.6
Latvia	6.4	47.5	0.2	0.3	99.7	47.3
Lebanon	12.2	71.9	11.8	16.5	81.2	58.4
Lesotho	5.5	21.1	0	0	100	21.1
Liberia	4.3	24.1	0	0	84.2	20.3
Libyan Arab Jamahiriya	2.9	44	0	0	100	44
Lithuania	6	29.5	0	0	91.7	27.1
Luxembourg	6	10.1	1.5	14.6	74.6	7.6
Madagascar	2	34.1	5.1	15	85	29
Malawi	7.8	65	1	1.6	43.7	28.4
Malaysia	3.8	46.3	3.3	7.2	92.8	43
Maldives	6.7	16.5	0	0	100	16.5
Mali	4.3	61.4	11.5	18.7	72.4	44.4
Malta	8.8	31.5	0	0	100	31.5
Marshall Islands	9.8	35.3	0	0	100	35.3
Mauritania	3.6	27.6	0	0	100	27.6
Mauritius	3.4	40.5	0	0	100	40.5
Mexico	6.1	55.7	2.7	4.9	92.4	51.5
Micronesia, Federated States of	7.8	28	0	0	35.7	10
Monaco	7.6	43.9	0	0	100	43.9
Mongolia	6.4	27.7	0	0	73.4	20.3
Morocco	5.1	60.7	13.8	22.7	74.1	45
Mozambique	5.9	32.6	0.2	0.5	39.3	12.8
Myanmar	2.1	82.2	0	0	99.6	81.9
Namibia	7	32.2	25.1	77.9	17.9	5.8

Nauru	7.5	11.3	0	0	100	11.3
Nepal	5.2	70.3	0	0	93.3	65.6
Netherlands	8.9	36.7	15.5	42.4	24.1	8.8
New Zealand	8.3	23.2	6.2	26.5	72	16.7
Nicaragua	7.8	51.5	2.1	4	93.1	47.9
Niger	3.7	60.9	1.8	2.9	85.4	52
Nigeria	3.4	76.8	0	0	100	76.8
Niue	7.7	3	0	0	100	3
Norway	8	14.5	0	0	96.8	14
Oman	3	19.3	0	0	42.9	8.3
Pakistan	3.9	75.6	0	0	100	75.6
Palau	9.2	8	0	0	100	8
Panama	7	31	5.8	18.7	81.2	25.2
Papua New Guinea	4.4	11	1	9.4	83.3	9.1
Paraguay	8	61.7	17.5	28.4	71.6	44.2
Peru	4.7	45	7.2	16.1	81.7	36.8
Philippines	3.3	54.8	10.8	19.8	78.2	42.8
Poland	6.1	28.1	2.1	7.6	92.4	26
Portugal	9.2	31	1.3	4.3	58.5	18.1
Qatar	3.1	26.5	0	0	33.7	8.9
Republic of Korea	6	55.6	9.5	17.2	74.3	41.3
Republic of Moldova	5.7	50.3	n/a	n/a	100	50.3
Romania	6.5	20.8	1.6	7.9	92.1	19.1
Russian Federation	5.4	31.8	1.4	4.5	84.4	26.9
Rwanda	5.5	44.5	0.1	0.3	66.1	29.4
Saint Kitts and Nevis	4.8	33.7	n/a	n/a	100	33.7
Saint Lucia	4.5	35.4	n/a	n/a	100	35.4
Saint Vincent and the Grenadines	6.1	36.5	n/a	n/a	100	36.5
Samoa	5.8	17.8	0	0	87.5	15.6
San Marino	6.8	22	n/a	n/a	100	22
Sao Tome and Principe	2.3	32.3	0	0	100	32.3

Saudi Arabia	4.6	25.4	9.4	36.8	38	9.7
Senegal	4.8	41.2	3.5	8.4	91.6	37.7
Serbia-Montenegro	8.2	20.8	0	0	100	20.8
Seychelles	6	31.8	0	0	75	23.9
Sierra Leone	4.3	39	0	0	100	39
Singapore	3.9	66.5	0	0	97	64.4
Slovakia	5.7	10.7	0	0	100	10.7
Slovenia	8.4	25.1	14.6	58.3	41.7	10.4
Solomon Islands	5	6.5	0	0	49.2	3.2
Somalia	2.6	55.4	0	0	100	55.4
South Africa	8.6	58.6	42.4	72.2	22.1	12.9
Spain	7.5	28.6	4	14.1	82.8	23.7
Sri Lanka	3.6	51.1	0.6	1.1	95	48.6
Sudan	3.5	81.3	0	0	99.3	80.7
Suriname	9.4	39.8	0.3	0.7	57	22.7
Swaziland	3.3	31.5	0	0	100	31.5
Sweden	8.7	14.8	0	0	100	14.8
Switzerland	11	42.9	10.2	23.8	73.9	31.7
Syrian Arab Republic	5.4	56.1	0	0	100	56.1
Tajikistan	3.4	71.1	0	0	100	71.1
Thailand	3.7	42.9	4.1	9.6	85	36.5
The former Yugoslav Republic of Macedonia	6.8	15.1	0	0	100	15.1
Timor-Leste	9.8	40.5	0	0	20.8	8.4
Togo	2.8	51.4	n/a	n/a	100	51.4
Tonga	5.5	38.4	0	0	100	38.4
Trinidad and Tobago	4	56.7	4	7.1	86.5	49
Tunisia	6.4	24.3	5.4	22.4	77.6	18.9
Turkey	5	29	0.3	1.2	98.8	28.7
Turkmenistan	4.1	26.7	7	26.3	73.7	19.7
Tuvalu	5.4	46.6	0	0	100	46.6

Uganda	5.9	42.5	0.2	0.5	53.4	22.7
Ukraine	4.3	32.2	0	0	100	32.2
United Arab Emirates	3.5	24.2	4.6	19.1	65.6	15.9
United Kingdom	7.6	17.8	3.1	17.2	55.3	9.9
United Republic of Tanzania	4.4	53.3	2.4	4.4	83.1	44.3
United States of America	13.9	55.6	35.6	64.1	26.5	14.8
Uruguay	10.9	53.7	37.3	69.6	30.4	16.3
Uzbekistan	3.6	25.5	0	0	100	25.5
Vanuatu	3.8	40.8	0	0	100	40.8
Venezuela, Bolivarian Republic of	6	37.9	1.8	4.6	95.4	36.1
Viet Nam	5.1	71.5	3	4.2	87.6	62.6
Yemen	4.5	65.9	0	0	88.7	58.5
Zambia	5.7	46.9	0	0	71.8	33.7
Zimbabwe	6.2	54.7	19	34.8	52.2	28.5

Source: National Health Accounts Team, EIP/GPE/FAR, WHO: 2001