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HEALTH INSURANCE IN FIJI

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ABSTRACT

The Government of Fiji is exploring options for reforming the way in which health care services are financed and delivered. This document examines the role that health insurance may play in such a reform. Health insurance in Fiji is limited to the private sector; there is currently no comprehensive social insurance mechanism designed to ensure the availability of affordable health care services. Examination of existing group plans and data collected on insurance participants can provide guidance in making policy decisions about financing future health care systems in Fiji.

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ACRONYMS, ABBREVIATIONS, AND GLOSSARY

FDF	Fiji Defense Forces
FNPF	Fiji National Provident Fund Social
GOF	Government of Fiji
HFS	Health Financing and Sustainability Project
HMO	Health Maintenance Organization
IWS	Insurance Welfare Society
MOH	Ministry of Health
NHS	National Health Service
NZ	New Zealand
OECD	Organization of Economic Cooperation and Development
PSC	Public Service Commission
RHA	Regional Health Authority
UK	United Kingdom
USAID	United States Agency for International Development
USAID/RDO/SP	USAID Regional Development Office for the South Pacific

EXECUTIVE SUMMARY

The health care delivery system in Fiji is heavily dependant upon the public sector for both the finance and delivery of basic services. That system has performed admirably when compared to other countries on traditional health status indicators. However, budgetary constraints, changing morbidity and mortality patterns, and increased public demand for services have raised questions about the system's continued ability to meet national needs. In response to these concerns, the Government of Fiji has commissioned several studies designed to explore options for reform of the way in which health care services are financed and delivered. Other studies have examined the potential for increased cost recovery at government health facilities (see Wong and Govind, 1992) and options for the privatization of certain health services (see Mercy International). The purpose of this study is to examine the role that health insurance may play in financing the provision of health services in Fiji.

There is currently no comprehensive social insurance mechanism designed to insure the availability of affordable health care services in Fiji. The Fiji National Provident Fund Social (FNPF) does manage a social insurance system to provide retirement benefits for its 158,000 members. The FNPF does not offer medical coverage for its contributors. Social insurance systems have a number of potential advantages and disadvantages over those based in the private sector. The decision to finance health services through a system based upon social insurance principals must be considered carefully.

Health insurance in Fiji is currently limited to the private sector. Two private insurers, Blue Shield (Pacific) Insurance Ltd. and Queensland (Fiji) Limited, offer basic catastrophic health insurance. These companies have been in operation since 1988 and 1989 respectively. The basic health packages offered by both companies are almost identical in both premiums and benefits. The premium for family coverage is \$190, about 2.4 percent of the average wage/salary in Fiji. Both insurers offer some form of profit sharing to their customers since rates were set with virtually no experience in the Fiji market to draw upon.

The coverage offered by both Blue Shield and Queensland covers daily hospital charges and fees for outpatient hospital services. It must be remembered, however, that in Fiji these fees appear to be nominal (covering only an estimated two percent of costs) and as a result, the insurance provided by these companies is used primarily to cover the costs of medical evacuation and treatment overseas (principally in New Zealand and Australia). There are copayments and caps on the potential benefits to be provided for any type of service.

Together, the two insurers report a combined enrollment of 22,300 subscribers or an estimated one seventh of the population of Fiji (average family size is five). Virtually all of the coverage offered by these two companies is offered through employers. Premiums are paid exclusively by employees, however, and there appear to be no examples of employer contributions to share costs. Estimates of the current market penetration rate for basic group health insurance

is 25 percent (there are an estimated 88,900 employees in the formal wage earning sector in Fiji). Therefore, there appears to be potential for significant growth in the health insurance market within the formal employment sector.

The Insurance Welfare Society (IWS) was formed in 1989 to provide a national umbrella for various groups participating in existing group health plans. The IWS has negotiated lower premiums for participating groups (premiums for participating groups fell 30-35 percent with the creation of the IWS) as well as allowing for the creation and participation of a number of non-traditional groups (especially those outside the formal employment sector). In order for the IWS to play a more important role in the sector, this study recommends that it should have a permanent staff to perform its necessary and increasing day-to-day operations while reporting to the current, voluntary board of trustees.

The largest single participating group is the Public Service Commission (PSC). Four thousand PSC employees (or 25 percent of the approximately 16,000 total PSC employees) are enrolled in the *FijiCare*^R plan offered by Queensland through the IWS. Analysis of the PSC employees who have chosen coverage indicates that 73 percent are native Fijian, 23 percent Indian, and 5 percent other. The average age of the insured is 40 years with an average yearly salary of F\$12,263. The majority of the participants (57 percent) are males. Using profit modeling techniques, all of these variables except gender were shown to be statically significant predictors of choosing health insurance.

This study recommends further analysis of the data collected on PSC insurance participants to answer the following questions before clear policy guidance can be developed:

- ▲ Are PSC adopters of health insurance representative of all health insurance adopters and all PSC employees in Fiji?
- ▲ What is the price elasticity of demand for health insurance (i.e., what is the relationship between price and the decision to adopt insurance)?
- ▲ What cultural, social and community factors might explain why native Fijians appear more willing to adopt health insurance than members of other ethnic groups?
- ▲ What effect would the sharing of premium payments between employer and employee make on the decision to adopt health insurance?
- ▲ Has the rate of adoption changed over time? What factors have affected this rate?

Several clear conclusions emerge. Specific recommendations concerning the role of health insurance in financing health services must be formulated within the context of more global discussions as to the future of the health care system in Fiji. The decision to pursue a system financed primarily through private health insurance risks sacrificing equity and universal access to market place

concerns. The future role of health insurance must be answered as part of an overall debate of the health care system that will address the following questions:

- ▲ What are the policy goals of the health care system? Should the Government of Fiji guarantee access to services for all?
- ▲ What services are to be included in such a guarantee? How will such a list of services be developed?
- ▲ How much will it cost to provide these services?
- ▲ What will be the primary means of financing these services? What are the pros and cons of potential finance mechanisms in relation to health system goals?
- ▲ Should all basic services be financed the same way, and how should finance systems be administered?
- ▲ What control systems must be put into place to monitor the chosen financial mechanisms?
- ▲ What is the relationship between the financing and production of health services?

1.0 BACKGROUND ON HEALTH FINANCING IN FIJI

The USAID Regional Development for the South Pacific (USAID/RDO/SP), along with the Ministry of Health (MOH) in Fiji, requested assistance from the Health Financing and Sustainability (HFS) Project to assess the current health financing system in Fiji with respect to cost recovery and health insurance. This report discusses the current status of private health insurance in Fiji and outlines other financing options to consider in discussions about health financing reform in Fiji focusing on the choice between private health insurance and social insurance. Health Financing in Fiji: The Role of and Potential for Cost Recovery, (Wong & Govind, 1992), discusses the current cost recovery system and presents options for its reform. These two reports, in addition to a concurrent analysis examining the potential for privatization of health services in Fiji conducted by a group of consultants from Mercy International, form a base of information for policy discussions among those charged with making decisions about health financing in Fiji.

The report by Wong and Govind provides important background information on the health sector including the macroeconomic and political context in Fiji, and trends in health expenditures. Rather than repeating information to be found in that report, readers are referred to it. Only data particularly relevant to the analysis of health insurance are presented in this report. The background information for this analysis of health insurance in Fiji was gathered during a two week field visit in January 1992. Interviews with representatives of health insurers, MOH and other Government of Fiji officials, and representatives of private and public sector employer groups were conducted during this visit and relevant data were collected. The scope of work for this activity is attached as Appendix A.

Virtually every country in the world has some organized public method of paying for health services. The method or methods employed are a function of a country's history, culture, health needs, stage of economic development, and the financial condition of the economy as well as many other factors. Whether a country spends massive amounts or meager amounts of money on health care services is not as critical as the fact that governments are involved in the financing of health care. As many governments are too painfully aware, adequate levels of financing for health services are difficult to attain and sustain. For many developing countries, government health budgets declined in real terms over the last decade. For other developing countries, particularly some in Asia, which have experienced robust economic growth, rising levels of income have led to increasing demand for health services which governments have been unable to meet. Industrialized countries are also facing problems with financing health services and most are presently engaged in some form of health financing reform. Calls for health financing reform can arise for very different reasons:

- ▲ to increase revenues for the health sector;
- ▲ to decrease costs to the health sector;
- ▲ to expand the comprehensiveness and availability of health services;

- ▲ to encourage efficiency in health services delivery; and/or
- ▲ to shift responsibility from public financing systems to private financing systems or a mixture of both.

Health financing reform is only one component of broader health systems reform. A critical distinction should be made between the provision/delivery (production, in economic terms) of health services and the financing of health care services. The simple two-by-two table below captures this distinction; national health care systems generally fit into one of the cells. Health care services can be delivered by entities in the public or private sector. Similarly, the source of financing for health services can be predominantly public or private. (Health care systems which are predominantly publicly financed can be broken down into two types: tax-based systems and social insurance-based systems. Both types of systems are discussed later in this report.) While the model below is very simplified, it serves to separate conceptually the two components of health care—financing and delivery. There are no national health systems which occupy the cell of "privately financed services publicly delivered," although certain services within national systems fit into this cell. An example is private health insurance which pays for the delivery of care in a publicly owned and operated hospital. But such an arrangement is not characteristic of any entire national health care system.

**EXHIBIT 1
ALTERNATIVE MIXES OF
HEALTH FINANCING AND HEALTH CARE PROVISION**

	Public Financing	Private Financing
Public Provision	FIJI, U.K.	
Private Provision	CANADA	U.S.

Health reform efforts around the world seek to achieve a number of policy objectives—including equity, income protection, macroeconomic efficiency, microeconomic efficiency, patient choice, and provider autonomy – with a wide array of policy instruments. The policy instruments generally are directed toward either the financing or the production side of health care. Examples of policy instruments aimed at financing issues are introducing competitive mechanisms between competing insurers, increased private insurance, and increased social insurance. Examples of instruments aimed at the production side of health care include introducing competitive mechanisms between providers, quasi-autonomous management of public hospitals, and decentralizing service delivery.

Thus Fiji is not alone in its desire to assess its current system of health financing and to identify options for change. The country faces the simultaneous dilemmas of decreasing government budget expenditures for health (in real terms), changing morbidity and mortality patterns, and increasing demand from its citizens for higher quality, more comprehensive and more specialized services. The pressure from many competing demands and declining public financing for

health services leads to concerns about how to generate additional financial resources in the health sector, how to use existing health resources more efficiently and effectively, and how to balance the public/private mix of financing and provision of health services.

Fiji has a health care system which has performed admirably when compared to other countries on traditional health status indicators and on levels of access to basic health services. Like many countries in both economic and demographic transition, however, Fiji's health care system finds itself somewhat out of synch with both the emerging health needs and demands of its population, and is unable to devote more government resources to the seemingly insatiable needs of the system. The health care system is currently funded almost exclusively through general tax revenues, and services are provided by MOH facilities and personnel, although there is a growing private sector which provides a range of health care services. Fiji's health system is truly a national health service. That this is so reflects a fundamental commitment on the part of the GOF that health services are legitimately a responsibility of government and that access to some level of health services is a "right" of citizenship. This philosophical conviction places Fiji in the mainstream of the public debate about the role of government and the nature of health care which is being played out in many countries of the world, including Fiji's largest neighbors to the south, New Zealand and Australia. Both of these countries are in the midst of major health reforms.

There are numerous models for financing health care which span the range between total public provision and financing to pluralistic systems to those which are dominated by private provision and financing. The options which Fiji might wish to consider are thus being played out on the world scene, and it behooves the MOH, the GOF, and other interested parties to monitor and learn from these experiences. Section 2.3 provides details on the health reform effort currently being implemented in New Zealand. A comprehensive survey of health reform efforts in countries comprising the Organization of Economic Cooperation and Development is almost complete and will be an excellent reference for Fiji policy makers involved in health systems reform (Saltman, 1993).

Any discussion of health financing reform will inevitably lead to a broader discussion of the goals of the health care system in a given country and the principles and values undergirding decisions about health care. These principles are often assumed, rather than being explicitly articulated, although in some cases, principles such as universal access to "free" health care, are codified in a country's constitution. Any country, including Fiji, which embarks upon a major health reform effort must be prepared to grapple with such principles as access, equity, social justice, and choice. These, and others, form the basis for many of the policy options available to governments. Without some consensus on the part of policy makers and decision makers on the fundamental principles guiding health reform, debate will be contentious and divisive, and the probability of substantive progress will be low. The rest of this report focuses on options for financing health services but against this backdrop of broader issues in health systems reform.

1.1. GENERIC FINANCING SOURCES

There are several major sources of financing for health care. Financing may be defined as the raising of resources to support or pay for the goods and services used in the health sector. One financing method alone or several in combination may be used to finance a particular transaction for one person or for a group. The mix of arrangements varies greatly. Brief descriptions are given below for the main sources of financing. A much fuller discussion of private and social insurance follows in subsequent sections of this report.

1.1.1. Government

General tax revenues are used in virtually every country of the world to finance various components of the health sector. This tax support ranges from total public financing to public financing of only certain services and/or groups in the population. Public financing is not synonymous with public provision/delivery of health care, but the two, especially in developing countries, are often linked. This is the case in Fiji. Virtually all health care practitioners are public employees, and all inpatient hospitals, with very few (2) exceptions, are publicly owned and operated. There is more diversity in ownership of ambulatory care facilities such as health centers, but again, most health centers are government owned and operated. A modest number, however, are private for-profit entities and some, run by missions or voluntary organizations, are private not-for-profit entities.

Under a tax-based health care system like Fiji's, revenues available to the system are a function of explicit decisions made by the Ministry of Finance about the allocation of general tax revenues. The Ministry of Health must compete with other government ministries for funds. When general tax revenues are growing, allocations to the MOH may grow proportionately as well. When revenues are shrinking, revenues to the MOH may remain constant but will do so at the expense of other ministries, or MOH revenues may decline as well. General tax revenues can be supplemented by taxes specifically earmarked for funding health services. For example, excise taxes on tobacco products and alcohol can be earmarked for the health care system. The U.S. is currently exploring the use of excise taxes as a way to raise additional revenues for health care.

1.1.2. Social Health Insurance

Social insurance systems are insurance funds (often called social security systems) based upon obligatory payments made by certain social classes (usually formal sector employers and employees) for a defined set of welfare and health benefits. Governments, employers, and employees contribute to the funds. Social insurance is based upon the notion of social solidarity in that benefits are not usually related to the size of the individual contribution. While total contributions to social insurance systems are determined actuarially, individual contributions are not. The Fiji National Provident Fund (FNPf) is an example of a social insurance system for pension benefits. At present, the FNPf is not involved in collecting for and

administering social health benefits. The advantages and disadvantages of social insurance-based health systems are detailed in Section 3.2 of this report.

1.1.3. Private Health Insurance

Private health insurance is a method of pooling funds voluntarily paid by individuals or groups of individuals based upon risk assessments of the subscribers. Funds and risks are generally pooled to spread the burden across a group. The price charged for private health insurance, called the premium, is often shared between an individual and the employer. Private health insurers serve as the collector of funds and reimburse providers for services covered under the provision of the health insurance plan. Even in countries with tax-based public health systems, private health insurance can, and often does, exist as a supplement to government supplied services. For some employees, private health insurance is a fringe benefit which, in effect, provides a wage supplement.

This report provides details on private health insurance in Fiji as well as a fuller discussion of the advantages and disadvantages of private health insurance in a developing country context.

1.1.4. Direct Employer-Financed and Provided Services

Some employers may opt to provide health services directly to employees through company-provided health personnel, facilities, and equipment. Services may be available only to employees or may be available to employees and their dependents. In Malawi, for example, large tea estates, which employ many thousands of workers, provide free ambulatory health care to employees and their families through a system of health centers and dispensaries. For inpatient hospital care, however, tea estate employees rely on government facilities. In another private company in Malawi, the company provides on-site health care for employees only and not for dependents.

1.1.5. Out-of-Pocket Payments by Consumers

Most households pay directly for health services of all types and such expenditures often constitute a significant proportion of total household expenditures. As noted by Wong and Govind, direct household expenditures on health care in Fiji are approximately 3 percent of total per capita household expenditures. This is quite low in comparison to many other developing countries. A recent study in Malawi estimated that the average household spends approximately 3 percent of total household income on prevention and treatment services for malaria alone (Etting & McFarland, 1993). Most out-of-pocket expenditures were for drugs and transport to health facilities.

2.0 CURRENT STATUS OF PRIVATE HEALTH INSURANCE IN FIJI

In an effort to explore all possible alternatives for financing health care, the MOH in Fiji and USAID/Suva requested an analysis of the current status of private health insurance in Fiji and an assessment of its potential for generating revenues for the health care system. The World Bank (1987), among others, has proposed four major policy reforms for financing health services in developing countries. One reform proposal encourages the development of health insurance programs to help mobilize resources for the health sector. It is important to note that health insurance has two different aspects, it is a way of raising all or part of the money to pay for health care and it is a way of securing the provision of services. This report will focus on both aspects. The next two major sections analyze the private health insurance market in Fiji from a supply and demand perspective.

2.1 PRIVATE HEALTH INSURANCE COVERAGE

The market for private health insurance in Fiji is a dynamic one and this description is, of necessity, limited to one point in time, January-February, 1992. As the market evolves, this snapshot of the market structure will be useful for baseline estimations of the growth in health insurance demand.

There are two private insurers currently selling private health insurance in Fiji—Blue Shield (Pacific) Insurance Ltd. and Queensland Insurance (Fiji) Limited. The private health insurance market in Fiji has a short but turbulent history. Blue Shield (Pacific) entered the market in early 1988 and was the sole company conducting private health insurance business in Fiji for over a year. Without prior experience in the Fiji market, the insurer set both the price of premiums and the scope of benefits in line with previous experience in other parts of the Asia/Pacific region. Early on there was some concern expressed that the premiums were quite high and that perhaps unwarranted profits were being made on the product. To obviate this somewhat, a profit sharing system was introduced as part of the basic group contract. This profit sharing scheme returns a portion of "excess" profits annually to the insured group on the basis of a formula specified in the contract.

Queensland Insurance entered the Fiji market in 1989, and there was a period of instability and volatility in the market. The Insurance Welfare Society (IWS) was formed in March, 1989, to provide a national umbrella group for various group insurance plans (life and health) formulated for both public and private groups within Fiji. One purpose of the IWS is to extract the best deal possible from the various insurance companies for its members based on its numerical negotiating strength. A second purpose is to allow for a broader definition of group than that commonly employed by insurers. For example, group members of the IWS include church groups, solidarity groups, and voluntary groups. Currently being explored is the possibility of defining traditional village units in the native Fijian communities as a group to draw many people outside the formal employment sector into the private health insurance market.

Although the IWS initially placed its health insurance business with Blue Shield (Pacific) through the broker Alexander Stenhouse, IWS has subsequently placed its business with Queensland. One immediate impact of the entry of IWS into the health insurance market was that premium prices fell by 30-35 percent suggesting that initial premium prices had been set too high. It should be noted that Queensland Insurance has a profit sharing provision similar to that of the Blue Shield plans.

The IWS is, in effect, a consumer lobbying group trying to represent the best interests of its members in negotiations with the insurance carriers. It can exert considerable clout because of the size and diversity of its membership. But there are stresses within the IWS because some group members feel they may be able to get a better deal on their own rather than through IWS. IWS is run by a board of trustees and a board of directors, but the boards feel increasingly that the complexities of the insurance business require it to have a permanent secretariat. The need for this becomes more salient if IWS is to have a more formal role in any emerging health financing system in Fiji.

2.1.1. Benefit Options

Both Blue Shield (Pacific) and Queensland offer similar basic group medical insurance plans. Both firms offer more comprehensive policies but the numbers enrolled are quite small, and they have not been marketed to the general public. The remainder of this discussion will focus on the basic group medical insurance plans. *FijiCare*^R is the plan offered by Queensland. The basic group plan offered by Blue Shield is the same as *FijiCare*^R except where noted below. (See Appendix B and C for copies of the two plans.)

(1) Local Hospital Care (Fiji Hospital and Surgical Benefits)

This schedule covers daily hospital charges in Fiji hospitals for medically necessary care. Hospital charges in Fiji are nominal and, as documented by Wong and Govind, revenues from fees of all types constitute less than 2 percent of total operating costs. Day care surgery performed in a government hospital or clinic is covered and reimbursed at the prevailing local rate and per the Australian schedule of fees for visiting physicians. Reimbursement rates for local private practitioners are set by each insurance company based on prevailing usual and customary charges in the market. Although reimbursement rates are not standard, they do not diverge greatly given that only two insurers operate in the Fiji market.

The limit of the benefit for any one disability is F\$5000 (F\$ 1 = 'US\$ 0.7 1991). A disability is defined as "a sickness or all of the injuries arising out of a single or contiguous series of accidents occurring wholly after the commencement of insurance under this policy which has been treated by a physician or a dentist." Pre-existing conditions, (i.e., those which began before the policy date), are not covered.

(2) Overseas Medical Evacuation Benefits and Overseas Treatment Benefits for Medical Treatment and/or Procedures Not Available in Fiji, as Certified by the Fiji MOH

Insurance benefits are provided for treatment not currently available in Fiji, but only if the need for the treatment is certified by the MOH in Fiji and a registered medical practitioner of the insurer's choice. Medical evacuation occurs to selected hospitals in New Zealand (NZ), and if less costly, or if the treatment is not available in NZ, to Australia. Selected hospitals are known as preferred providers.

- ▲ Treatment benefits include diagnostic services, day care services including services of surgeons, physicians, and specialists as well as intensive care, special nursing, blood and plasma, medicines, medical supplies, and surgically implanted prostheses which are certified to be medically necessary. Details of these benefits are given in the material in Appendix B and C. Treatment given in preferred hospitals has a maximum limit of NZ\$80000 (NZ\$85000 - Blue Shield) per disability, while treatment rendered in nonpreferred hospitals has a maximum of NZ\$30000 (NZ\$35000 - Blue Shield) based on per diem charges for public hospitals and reasonable and customary charges subject to a fee schedule at other NZ private hospitals.
- ▲ Evacuation benefits for the insured and a companion include economy round-trip fares to towns in which the hospital selected by the insurer is located. The maximum benefit for airfare is F\$10000 each for the insured person and a companion. Necessary board and accommodations are also provided for the companion up to F\$2500.
- ▲ The basic plans for both Blue Shield (Pacific) and Queensland have several exclusion clauses which are detailed in the material in Appendices B and C including a pre-existing condition clause for conditions existing prior to enrollment in the plan.

2.1.2. Eligibility and Coverage

Both plans are sold only to groups. *FijiCare*^R is the plan currently offered to member groups of the Insurance Welfare Society, although there is no guaranteed continuity in which plan will be offered by IWS from year to year. Other major employer groups in Fiji, both public and private, generally offer the basic group plan to employees and the market is fairly evenly divided between the two carriers. Dependents of an eligible employee group member are also covered under the plan.

2.1.3. Premium Rate

The premium rate for the basic family group policy offered by both companies is F\$190. The rate is the same for all groups, effectively making basic group health insurance community rated as opposed to experience rated. Experience rating is based on the health care utilization experience of the group to be rated. Community rating, on the other hand, is a premium set without

regard to the health care utilization experience of any one group. Rather community rating puts all groups into a common pool for rating purposes. It is difficult for community rating to survive in a highly competitive health insurance market unless mandated by law for the entire health insurance industry because the incentive for health insurers is to pluck off the group or groups with the best experience and offer a lower rate or premium to that group. The market has not yet reached such a level of competitiveness in Fiji, and thus premium rates have stayed approximately the same between the two insurers.

In Fiji, premiums may be paid entirely by the employer, shared between the employer and the employee, or paid entirely by the employee. As an example, the largest group under the IWS is the Public Service Commission (PSC). Participation in the health insurance scheme is voluntary and premiums are paid entirely by the employee.

2.1.4. Deductibles and Co-Insurance

A deductible is the initial out-of-pocket money which the insured person pays before the insurance policy pays anything at all. Neither of the two basic plans available in Fiji has a deductible. Another provision of insurance is co-insurance, (i.e., the proportion of covered medical expenses which the insured person pays that is not paid by the insurer). For example, both basic health insurance plans in Fiji have co-insurance provision for outpatient, optical and dental benefits. The insurer pays 80 percent of the usual charge and the insured pays the remaining 20 percent. Both co-insurance and deductibles are often used by insurers to reduce "unnecessary" utilization and to introduce an element of cost consciousness to the consumer of services.

2.2. ANALYSIS OF CURRENT PLANS

The basic group plan currently sold by both companies is essentially a catastrophic health insurance plan, (i.e., it lowers the financial risk of a catastrophic illness for which care is not available in Fiji). The plan supplements the benefits available to every resident of Fiji through the public sector and paid for by general tax revenues. Since the fees for health care in local Fiji hospitals are effectively zero, the plans' intent is clearly to provide for overseas care in New Zealand or Australia for those services and procedures not currently available in Fiji. Off-shore medical care represents a loss of revenue to the Fiji economy and does not constitute additional sources of revenue for health services in Fiji. The insurance, however, does secure access to services not currently available in Fiji up to the limits specified in the policy. One must know the objectives which insurance is intended to achieve in order to judge the effectiveness of private health insurance. As a revenue generator for the health system as it currently is organized, effectiveness is zero; as a way to increase access for specialized services, effectiveness is positive.

The current premium is community rated. Under actuarially based private health insurance there is an incentive for the insurer to identify individuals or groups of low risk and to offer them lower premiums. There is a similar incentive for those seeking insurance to try to secure lower premiums by becoming part of low risk groups. As the market for health insurance becomes more

segmented, the premiums increasingly become experience rated, making some groups "winners" and some "losers." This has been the experience in the U.S., particularly for small groups who have difficulty finding health insurance at a price they can afford. Because of the now widely recognized market failure in the small group insurance market, regulatory changes in the U.S. are proposed to eliminate experience rating and egregious medical underwriting.

If the goal of insurance is to contribute to national policy goals of universal access to quality care, this type of market failure causes grave concern. The perverse consequence of splintering the market for health insurance is that those who are most likely to need health insurance are the least likely to have it at a price which is affordable. Rather than spreading the risk across a community, private health insurers try to avoid risk.

Community rating explicitly recognizes the cross-subsidization of certain classes of policy holders by others in the interest of social solidarity. While splintering of groups may seem an unlikely scenario in Fiji, a relatively small market, there are already some groups, notably the Fiji Defense Forces (FDF), who have opted out of the IWS because they believe they can negotiate a better rate based on their own health experience and demographic profile. Some employers represented by the Fiji Employers Federation are also considering leaving IWS for similar reasons.

As the insurance carriers operating in Fiji gain more experience with the actual utilization of benefits by Fijians, the rate structure for premiums will undoubtedly be refined. Precise actuarial and experience data for the Fiji population will become available and it will be easier for carriers to differentially price health insurance products. In early 1992 the premium represented 2.4 percent of the average wage/salary (F\$7818) in Fiji. Since the premium is fixed regardless of income, the premium rate is financially regressive, but this regressive effect may be offset by the positive distributive effects brought about by a fixed rate regardless of age, sex, or family size.

Most employment groups in Fiji are small. Small groups in voluntary markets are expensive and volatile; marketing and administration for the insurer company are expensive. The common outcome in competitive health insurance markets is adverse selection and premium spirals which feed on each other, and there is no inevitable equilibrium that stabilizes the market. Even though the health insurance market in Fiji is modest in size, there are trends already in place which could break down the de facto community rating system currently operating to set rates and lead to the creation of many small market segments.

Another factor which could affect premium levels is the cost of health care in New Zealand and Australia. As health care reforms in those two countries proceed, costs in the health care system may change, potentially altering the choice of preferred providers. Because Fiji and New Zealand have very close ties with respect to health services, the next section presents a brief overview of current health reform initiatives in New Zealand. The information is presented as a corollary to current events in Fiji.

2.3. THE NEW ZEALAND (NZ) MODEL FOR FINANCING HEALTH CARE

In 1991, 81.7 percent of health care expenditure in NZ was publicly funded from general taxation. Private health insurance constitutes only 3.5 percent of health expenditures with another 14.5 percent of expenditures from direct household out-of-pocket expenditures. In its financing structure, NZ is like Fiji. Public expenditures on health rose during the 1980s, coinciding with a period of sustained attention to market-based initiatives throughout the economy, including public sector enterprises. NZ, like many of its industrialized country counterparts, is in the midst of substantive health reform to introduce market-based strategies in health care while maintaining a national commitment to universal access.

Four Regional Health Authorities (RHAs) will be established to manage the purchasing of and contracting for health services throughout NZ. The RHAs will act as agents for consumers and seek quality, value for money, and innovation in health care delivery through the use of contracts with service providers. Unlike current area health boards, the RHAs will not own any hospitals or other facilities, so they will, in theory, have no obligation to concentrate funding on their own hospital-based services. The RHAs will purchase services from the public, private, or voluntary sectors. Thus the two roles of purchaser and provider of health services will be separated. This separation is becoming a common theme in most health reform efforts around the world, even in publicly controlled systems like the U.K., where the notion of internal markets has been introduced. The implication for the Fiji private health insurance market which relies upon NZ private providers is that hospitals which may have to negotiate lower rates in order to compete for the business of the RHAs may increase rates to clients like the private health insurers in Fiji, who do not have bargaining power. Conversely, it is conceivable that rates could go down to health insurers in Fiji because they will receive the derived benefits of increased efficiencies in the NZ health care system.

People in NZ will be given the choice of obtaining their health care through RHAs or through other non-government health care plans. The government will explicitly define core health services (i.e., those services to which everyone should have access, on affordable terms, and without unreasonable waiting time). The way that NZ has solicited public input into defining the core services may be a useful model for Fiji to look at for its own health policy deliberations. Appendix D gives further information on the "core debate."

NZ is somewhat wary of the role of private health insurance, observing that private health insurers have a natural tendency to avoid covering high risk individuals thus shifting that financing responsibility to the public sector. The NZ government's concern about increasing the scope for private insurance is the evidence from other countries that as private insurers select out the better risks, for a given premium, the insurers are able to fund a more extensive, higher quality range of health services for the remaining low risk groups. This escalation in standards increases the costs to the government of providing health services to the higher risk groups remaining with the state in order to maintain some equity. If the government is unwilling or unable to finance the same level of services for everyone, a two-tier health system will develop, leading to an inevitable breakdown in social solidarity and an increase in cost-shifting

strategies. The reality in NZ today is that multiple service standards are beginning to emerge, where income, insurability and geographic location determine the quality and range of access to services.

This tension is part of any health care reform debate. Whatever financing arrangement is selected, these issues must be faced squarely. Since Fiji's current private health insurance system relies upon health providers in NZ where the process of health reform is well underway, it behooves policy makers in Fiji to learn from and monitor NZ's experience. Interestingly, the government of NZ initially put forward the option of a social insurance mechanism replacing tax-based funding, but has dropped consideration of this model in line with public feedback.

2.4. POTENTIAL MARKET FOR HEALTH INSURANCE

There has been growing demand for the type of health insurance sold in Fiji since a basic health insurance product was introduced by Blue Shield in 1988, although trend enrollment data were not available from the insurance carriers at the time of the consultant visit. Any further analysis of the private health insurance market should include trend data on numbers and characteristics of enrollees and the utilization experience of enrollees over time.

As of March 1992, Blue Shield (Pacific) had over 10,300 subscribers to the basic group health insurance plan at a premium level of F\$190 for family coverage and F\$100 for individual coverage. Over 550 individuals had basic individual health insurance (premium levels vary by age) and almost 400 had a comprehensive health insurance package priced between F\$250 and F\$2500 per person depending upon the level of coverage.

Queensland Insurance had, as of March 1992, approximately 12,000 policy holders of the basic group health insurance product, *FijiCare*[®], including approximately 9000 insured under the auspices of the IWS. The premium price for *FijiCare* is F\$190.

Thus, there are an estimated 22,300 policy holders of basic group health insurance in Fiji. Assuming an average household size of 5, there are approximately 11,500 persons (or 1 out of 7 Fijians) covered by basic group health insurance offered by the two current insurance carriers in the market. In 1990 there were 88,952 individuals in the formal, wage earning sector, both public and private (Current Economic Statistics, 1991, p.75). Since virtually all health insurance in Fiji is offered through employers, the market penetration rate for basic group health insurance is approximately 25 percent (22,300/88,900). Thus there appears to be ample room for growth in the health insurance market among the formal employment sector.

The Public Service Commission offers its employees (approximately 16,000 in 1991) the opportunity to purchase health insurance through a payroll deduction. The purchase of the insurance is voluntary, and the premium is paid entirely by the employee, although the administrative costs of premium collection are borne by the government. Over 4000 PSC employees have opted to purchase *FijiCare*[®], the product offered through the IWS. Therefore the market penetration

rate among PSC employees is the same as that for other employed persons in Fiji, approximately 25 percent.

2.4.1. Characteristics of Public Service Commission Insurance Adopters

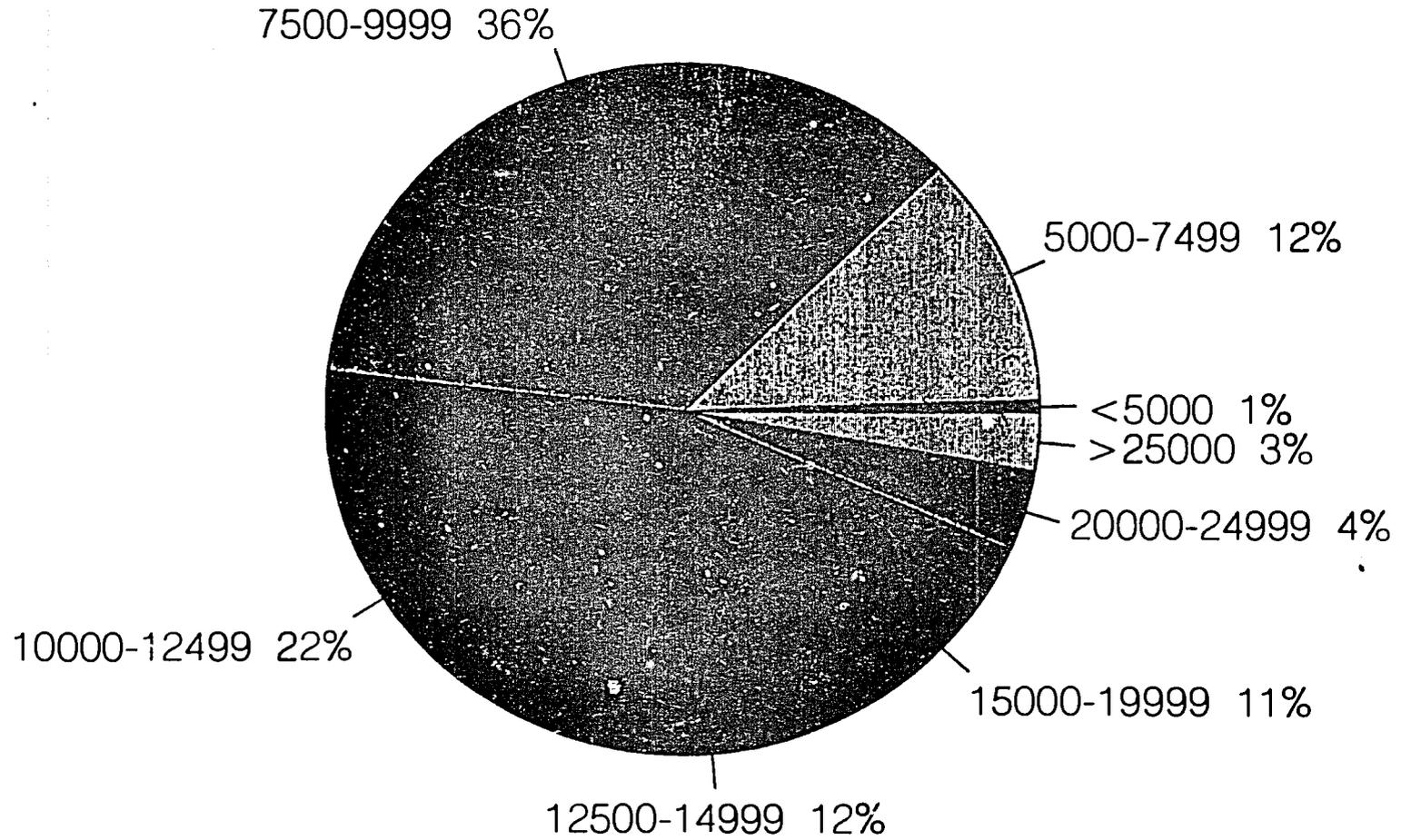
Using data provided by the PSC for employees who have opted to purchase health insurance, a profile of insurance "adopters" emerges. Seventy-two percent of those who have opted for health insurance are native Fijian, 23 percent are Indian, and 5 percent are other races. The average age is 40 years; 57 percent are males; and the average salary is F\$12,263. Exhibit 2 presents income data on the insured PSC members (i.e., the percent of those adopting health insurance by income strata). Unfortunately, data on PSC employees who have chosen not to purchase health insurance were not available to the consultant. Therefore, no direct comparison can be made between "adopters" and "non-adopters" in the PSC population.

In the absence of a direct comparison, a model was derived to predict enrollment in health insurance. The PSC data represented adopters, and a second data set was constructed from the general Fiji census statistics to represent non-adopters. A profit model was used to analyze the data. Profit models are used for analysis when the dependent variable is a discrete, categorical variable rather than a continuous variable. In this model, the dependent variable is the decision to adopt health insurance—yes or no. Statistically significant predictors of adopting health insurance are age (+), being native Fijian (+), and level of income (-). Gender was not statistically significant in the model.

The statistical findings suggest that the older one is, the more likely one is to adopt health insurance. This makes intuitive sense because the likelihood of a chronic disease such as cardiovascular disease or cancer increases with age. Specialized diagnostic and treatment services for chronic diseases are not routinely available in Fiji, and thus older Fijians, feeling more vulnerable to chronic disease, seem to be more willing than younger people to purchase health insurance. Native Fijians are more likely to adopt insurance than other races, based on the PSC data. Why this might be true is not obvious to this analyst. Further investigation of social, community, and cultural differences among racial groups might help to explain this finding. Individuals with lower incomes appear to be more likely to adopt insurance than those with higher incomes. While this may seem counter-intuitive, it may be the case that those with lower incomes are more risk averse to the possibility of a financially catastrophic health event. It may also be the case that the premium is modest enough to not be significant even for lower income individuals. Unfortunately data were not available on geographic residence or number of persons in the household, so we could not determine the effects of these important variables on the decision to adopt health insurance. Statistical results from the model are reported in Exhibit 3.

EXHIBIT 2

INSURANCE ADOPTERS IN FIJI
INCOME LEVELS



Source: PSC data, Fiji, 1992
All amounts in Fiji Dollars

EXHIBIT 3

LIKELIHOOD OF ADOPTING HEALTH INSURANCE FIJI 1992

Variable	Coefficient	t-ratio
Constant	-15.638	-19.414
SALARY	-0.32929E-04	-02.557 *
AGE	0.57808	18.012 *
SEX	-00.59728E-01	-00.665
RACE	0.95758	9.007 *
* p < 0.01		

The findings of this simple model raise many questions which will require further investigation before clear policy guidance can be given. Questions include:

- (1) Are the PSC adopters of health insurance representative of all health insurance adopters in Fiji? More generally, how representative are PSC employees of the whole Fijian population?
- (2) What is the price elasticity of demand for health insurance (i.e., what is the relationship between the premium price and the decision to purchase health insurance)?
- (3) What social, cultural, and community mores might explain why more native Fijians appear to be willing to purchase health insurance than other races?
- (4) What effect would sharing the premium between employer and employee make to the decision to adopt health insurance?
- (5) Has the rate of adoption changed over time? In what direction?

The PSC data set is a rich one for future investigation and should be thoroughly explored by policy analysis responsible for providing background information to decision makers regarding health financing reform.

2.5. ANALYSIS OF DEMAND FEATURES IN THE PRIVATE HEALTH INSURANCE MARKET

The emergence of private health insurance in Fiji has come about, in part, because there are some services, particularly specialized services, which the current tax-based, publicly financed system is unable to provide because of inadequate resources. The Mercy International consultant team explored the demand for specialized services in Fiji and the feasibility of providing selective services locally. Their report provides another perspective on this issue and should be consulted by those investigating demand for health care in Fiji.

Another ingredient in the growth of demand for health insurance is the gradually changing disease pattern of Fiji from one dominated by communicable diseases to one more characterized by chronic and "lifestyle" diseases. The existing health care system cannot change fast enough to meet the demands (and expectations) for more advanced preventive, diagnostic, and therapeutic capability. Problems of adult health, because of demographic trends, are now taking center stage from the more traditional child health interventions, which the current health system is generally well equipped to deal with. The ill health of adults imposes a major burden on health services as well as large, negative consequences on families, communities, and societies (Feachem, 1992). A country like Fiji can not afford to ignore this significant trend.

The basic health insurance product currently available in Fiji caters to the desire of a segment of the Fiji population for an outlet to more specialized care. This desire is undoubtedly a judgment about the lack of breadth and depth (comprehensiveness) of care available. It may also reflect some concern about the quality of care that is available in Fiji, particularly for outpatient services. Perceived low levels of quality—manifested in long waiting times, lack of amenities, and instability in the drug supply—drive those who can afford it to local private providers of health care. This creates incentives for health insurance products which will cover private sector outpatient fees. The lack of availability of certain services, now in much greater demand because of shifting morbidity patterns, creates even stronger incentives for health insurance to finance these services available only abroad. The lack of services creates an impetus for discussion of the development of specialized services and facilities in Fiji to substitute for seeking care abroad. The report of the Mercy International consultant team which visited Fiji at the same time as this consultant (January, 1992) presents an analysis of the feasibility of private hospitals and clinics to satisfy this potential demand.

At present, there is discussion in the MOH about bringing fees more in line with the costs of delivering health care (Wong & Govind, 1992). Such a cost recovery system, predicated upon a rational user fee structure, has significant implications for the private health insurance market. Even though the most basic health insurance product available in Fiji covers "the costs incurred in respect of confinement or day care for a disability in any government operated hospital or government medical clinic in Fiji" (Queensland Insurance [Fiji] Limited, Group Medical Insurance Policy, 1992), charges, not costs, are actually paid to the hospital. Currently charges are far below costs. If a fee structure were instituted for MOH facilities to address a goal of full or even partial cost recovery, charges would inevitably increase and mean higher claims to the health

insurers. Does the current premium for the basic health insurance product, approximately F\$190, have a margin built in to adjust for fee increases at MOH facilities, or would premiums have to be adjusted to account for fee increases? If the latter is true, then consumers must weigh the choice of the cost of health insurance against the out-of-pocket payment of fees at point of service use.

The decision to purchase health insurance is essentially a risk preference decision and will vary with individuals and households. Demand for health insurance is influenced by the price of the insurance (premium) and the individual's assessment of the probability of financial expenditures resulting from illness, the magnitude of those expenditures, the individual's income, and the degree to which he or she is risk averse. Clearly the demand for health insurance in Fiji will change as decisions are made by policy makers which influence the magnitude of expenditures which a household or individual might incur at the point of service. Insurance, in theory, makes most sense for events which are unpredictable and likely to have significant financial consequences, rather than for predictable, routine events like much preventive and primary health care. However, if the price of primary and preventive health care is set too high, there is an incentive for a household to demand health insurance for such services as well, in order to cover the costs of using the service. There are alternative ways of financing routine care which make more theoretical and practical sense than traditional insurance models. One example is the establishment of health maintenance organizations or managed care systems. These arrangements are discussed in Section 3.1.1.

3.0 COMPARATIVE HEALTH INSURANCE STRATEGIES FOR FIJI

In order for the Government of Fiji to make decisions about the type of health insurance, if any, to implement in Fiji, it is necessary to present some background on the differences between the two major types of health insurance - social insurance and private insurance. The preceding discussion on the status of current health insurance offerings in Fiji has focused on the latter because there is currently no social health insurance system in Fiji. As previously mentioned, the Fiji National Provident Fund administers a social insurance system for retirement benefits. The FNPF collects mandatory contributions from employers and employees and invests the contributions in both public and private securities and investments. In 1990, the FNPF had 158,000 members.

Health care systems can be classified into a three part topology, based upon the predominant funding source: predominantly tax-based, predominantly social insurance based, and predominantly private insurance based. What distinguishes the first two types of systems from the latter is that both tax-based and social insurance based systems have achieved a high standard of equity of financial access to care. In private insurance based systems, most notably the U.S., this standard has not been achieved, as evidenced by the 37 million people who have no health insurance at all.

Fiji's health care system is an example of the first system category - a tax-based system with centralized command and control structures. Like many of its counterparts in other parts of the world, Fiji has achieved an admirable standard of equal access to publicly financed and provided health services in spite of the geographical dispersion of the population. But additional financial resources are needed to expand and diversify the health care system. Since increased taxes are unlikely in the current economic climate, other means of raising health services revenue must be explored.

The next three sections draw the distinctions between the two major types of insurance in a general sense with reference to lessons learned from other countries, both developed and developing. In the last section of this report, the consultant will present specific recommendations and principles for the GOF to consider in its deliberations about the advantages and disadvantages of health insurance.

3.1 PRIVATE HEALTH INSURANCE

The next section is derived from numerous sources but relies most heavily on Glaser's 1991 book, *Health Insurance in Practice*.

3.1.1. General Concepts

The concept of insurance implies a person's self-centered (no pejorative connotation intended) calculations to protect himself/herself against loss. An insurance company creates pools of subscribers to spread risks, so it can market

policies, bear the actuarial risks, and earn profits. But insurance in this form is designed to avoid exceptionally risky persons, not necessarily to protect them.

Insurance is a social arrangement to reduce the risk of a serious loss through cooperation of many similarly situated persons or organizations, such as persons working for the same employer, persons in the same age group, or persons in the same geographic area. An insurance carrier pools the many comparable individuals, calculates the value of each type of potential adverse health event, calculates the proportion of members of that class suffering the event each year, and converts that proportion into a probability for each individual, a process known as actuarial assessment.

The risk borne by the insurer must be insurable according to several criteria:

- ▲ A large number of persons face comparable risks. Mathematical methods can then calculate the probability of occurrence for each class of persons and calculate an appropriate premium to keep the pool solvent with a reasonable safety margin.
- ▲ The loss can be priced exactly. The underwriter can calculate an accurate premium.
- ▲ The occurrence of the loss is a random probability.
- ▲ The loss must be reasonable. If the loss is extremely expensive, it can be covered provided that it does not occur often and the insurance/reinsurance pool is large. Trivial losses are not covered. The administration of such claims is too expensive.

Insurance is supposed to be designed and purchased for large and uncertain losses, not for small and frequent ones. Therefore, an issue when designing insurance for certain types of benefit for certain types of subscriber is whether their losses are small and frequent or large, serious, rare, and unpredictable. If they face small and predictable costs, there are better financing methods—such as personal budgeting and savings—than paid-in-full insurance. Traditional insurance mechanisms are probably not the most appropriate way to finance preventive and basic health care services, that is, small and frequent/predictable events. This is a key point to consider when assessing whether private health insurance is a means to reach broader social goals such as shifting resources away from curative to preventive services. Section 3.1.2. discusses the option of establishing managed care systems in Fiji which are conceptually designed to provide incentives for the delivery of the appropriate level of care in the most cost-effective manner.

Traditional insurance reasoning is individualistic: the subscriber (whether a person or an organization) buys a policy covering his/her own risks; the premium is calculated actuarially to cover the probability of his/her loss, and a premium table provides the option of paying higher premiums for higher monetary compensation or a wider array of benefits. The insurer reduces risks by placing comparable subscribers in the same premium class. Each member of the

class is equally likely to overpay or underpay premiums in relation to recovery for a loss. Although an insurance company would like to overcharge subscribers, it is restrained by the probability that competing companies can take away subscribers by offering actuarially accurate premiums for the same coverage. In the current health insurance market in Fiji, consisting of only two companies, these kinds of competitive tendencies have not yet appeared.

Two potential problems which can threaten the financial viability of an insurance system are moral hazard and adverse selection. Moral hazard is defined as the tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have insured. Moral hazard refers to the danger that insured individuals, having paid a premium in advance, will demand more services than they would have, had they not been covered by insurance. Moral hazard thus results in potentially increased and/or unnecessary consumption of health resources. Frequently used methods as safeguards against moral hazard include deductibles and copayments which are intended to increase the consumer's awareness of the costs of health care. Perversely, however, these types of payments may discourage insured individuals from seeking appropriate care in a timely manner because of inability to pay either the deductible or coinsurance.

Adverse selection occurs when individuals at greater risk of illness enroll in an insurance program in larger proportions than they are found in the general population. Individuals at greater risk of illness are more likely to desire insurance, since losses from illnesses are more certain events for them. Health insurers either try to screen out this individual through medical underwriting or raise premiums so high that the individual or group is effectively priced out of the market. In highly competitive insurance markets, there is an adverse selection spiral, and often the government becomes the payer of last resort for individuals "selected out" of the private health insurance market. These tend to be the sickest and poorest patients.

There are some advantages of a private, voluntary, market-oriented health insurance market which need to be understood as insurance options are considered.

- (1) Management systems may be more innovative than in public systems which are often encumbered with layers of bureaucracy. New forms of financial accounting and claims processing are quickly adopted if they are more efficient.
- (2) New benefit packages can be quickly introduced in response to demand pressures if the regulatory climate is such that this rapid response is allowed.
- (3) Inefficient insurers are not protected by a guaranteed subscription list or public subsidies.

- (4) Purchasers of insurance—employers and individuals—have a wide choice of providers and can change relatively easily.
- (5) Purchasers can decide to buy little or no health insurance and can use their money for other purposes.
- (6) Access to a more comprehensive set of services may be increased.

There are some clear disadvantages, however, of the market model for health insurance.

- (1) Poor medical risks can be left uninsured.
- (2) Benefits can be cut in order to reduce expenditures by strong purchasers and by carriers. This may be the case, for example, where employers who pay health insurance premiums are unwilling or unable to incur price hikes in premiums and so are left with cutting benefits in order to keep the premium at the lower level.
- (3) Considerable personnel and money go into marketing and administration which produces no social benefit in terms of health outcomes.
- (4) Salesmanship plays on people's anxieties and sells people as much insurance as possible. Brokers may sell more insurance than a person needs.
- (5) The health insurance market is less stable than other markets because medical markets are difficult to predict, more difficult to control, and expenses (payout in claims) can easily exceed revenue.
- (6) The subscriber may find that his customary policy is no longer offered or that his customary carrier has dropped out of the health insurance business, leaving the subscriber with no insurance.
- (7) Carriers may conceal facts and exaggerate their trends and solvency in order to attract subscribers, investors, and loans.

The U.S. has had more experience with private, market-oriented health insurance than perhaps any other country. Many would argue that this preference for private insurance over plans mandated or operated by the government is unique, at least among industrialized nations. But, even in the U.S., in response to soaring costs and large numbers of people left uninsured, the very basis of private insurance is being called into question. Proposals for reform of the private insurance market abound with emphasis on extensive regulation of the pricing, marketing, underwriting (the process of assessing risk), and design of policies, particularly those sold to small-business groups. This ferment is instructive for a country like Fiji where the private health insurance market is in its infancy and where the small size of the population makes market segmentation all the more visible and egregious.

3.1.2. Managed Care

Managed care is a term which encompasses a wide variety of organizational strategies for the delivery and financing of health care. The concept of managed care derived from the health maintenance organization (HMO) but has expanded beyond the definition of a typical HMO. In any type of managed care arrangement, the key is that the delivery of health care to the patient is actively managed by the provider in order to achieve cost-effective use of services. Another key concept is that financing and delivery of care are tied together unlike private health insurance where providers are paid for each service delivered on a fee for service basis and have no direct interest in the organization and delivery of health care.

Most managed care plans consist of a group of selected providers who agree to provide a negotiated set of benefits to a group for a prepaid premium amount. The prepayment is very often negotiated on a per capita basis. The providers are at financial risk for providing the agreed upon set of benefits for the group within the limits of the revenue available through the prepayment fee. In theory, then, the provider who actively manages the care of the patient, serving as a gatekeeper to the next level of the system, is provided with the "right" set of incentives to promote the cost-effective use of health services. Patients have incentives as well to use services within the managed care network where utilization can be reviewed and controlled by virtue of the fact that patients will pay higher fees or have higher coinsurance and deductibles if they chose to use a provider outside of the network.

Managed care networks have been most successful in areas where there is a surplus of health care providers who are in competition for patients. Competition provides an incentive for providers to accept discounted reimbursement rates in order to "capture" a group of patients. Competition among providers also prompts the creation of alliances to compete for the business of the managed care plan which specifies the type and level of services to be provided under the plan.

The notion of prepayment for a guaranteed set of health care services is not new in many developing countries. In Thailand, community funds for drugs, nutrition, sanitation, and health cards have been in place for several years. While not as sophisticated as the managed care systems in place in industrialized countries, the systems have many of the same features. For example, the health cards are financed by individual payments into a larger community health card fund. The health card guarantees the holder priority service from the nearest health center, and the holder goes on to the next level of service only by referral. The health center, in return for a negotiated fee paid by the health care fund, serves in effect as a gatekeeper for the health card holder much like a managed care primary physician serves as the gatekeeper for the participants in the managed care plan.

The potential for managed care in Fiji, whether in the form of a health maintenance organization or other organizational form, appears limited at this point in time. This is because there is not much resource slack among providers, particularly hospitals, and thus no incentive to negotiate discounted rates. Among private physicians there appears to be some surplus, and thus perhaps there is an incentive for physicians to enroll in a managed care plan which would guarantee a certain number of patients for a capitated fee to provide an agreed upon set of benefits. The small size of the Fiji health care market makes competing managed care plans unlikely.

3.2 SOCIAL SOLIDARITY AND SOCIAL INSURANCE

In most countries, with the exception of the U.S., modern health care financing is based on the philosophy and politics of social solidarity, not on the techniques of private health insurance. Statutory social insurance in health overrides methods of evaluating and underwriting insurable risks under traditional insurance. Social insurance systems stand in contrast to totally publicly financed and controlled national health systems. The latter are funded almost exclusively through general tax revenues while social insurance systems are funded by payroll taxes and other premium structures. The National Health Service (NHS) in Great Britain is the most often cited example of a total public system; Germany and The Netherlands are examples of countries whose health financing structure is built on social insurance concepts and sickness funds. Many countries in South America and some larger countries in Asia have social health insurance systems for segments of the population. Given the historical links of Fiji to Great Britain, it is perhaps not surprising that the structure of the health system in the Fiji parallels that of the U.K.

The essential features of social insurance systems are:

- (1) The statute establishing the social insurance system identifies large classes of persons who must be covered and often other large classes who can choose coverage. All insurance carriers (sickness funds or insurance companies) recognized under the law must accept all eligible applicants.
- (2) Usually the same premium—either a percentage of earnings or a fixed amount—is collected from every household regardless of risk.
- (3) All subscribers are fully entitled to all statutorily defined benefits.
- (4) Carriers of social insurance cannot ask supplements from subscribers presenting greater health risks or subscribers with larger households.
- (5) While the government exerts pressure for carriers to control costs, unavoidable deficits are usually covered by government subsidies.

Social solidarity involves the systematic redistribution of resources from the better-off to the less fortunate—both economically and in health status. The premise underpinning social insurance is altogether different from the pooling of randomly occurring risks under insurance. Healthier persons are not allowed to opt out of the general scheme, form their own class, and pay low actuarial premiums.

In most social insurance systems, a distinction is made between basic benefits and extra benefits. The latter are often provided by private health insurance companies. So it is not uncommon that a public social insurance system operates side by side with a private insurance system, each with separate roles and responsibilities. Basic benefits usually include ambulatory and inpatient care by physicians; inpatient and outpatient hospital services; drugs; and cash payments to temporarily disabled workers if the wage is suspended. In virtually all European countries, the revenue and payments for the basic benefits are administered by nonprofit carriers, usually called sickness funds, founded most often by trade unions and craft guilds. The sickness funds form the basis of enrollment of not only workers in the formal employment sectors, but also self-employed workers and agricultural workers.

Under modern social insurance, there are several alternative methods of designing payroll taxes and premiums: (1) construction of rates can be based upon a percentage of all income or by class of risk where risk is identified by age, sex, occupation, lifestyle; (2) rates can be set by law passed by the legislature or parliament, a rate regulator in government, or each sickness fund; (3) uniformity may be defined either for the whole country or by sickness fund; (4) premiums can be set with or without an earnings ceiling; (5) there may be special rules, reductions or exemptions from premiums for self-employed persons, pensioners, disabled, unemployed, and/or low-income earners; and (6) they can be designed to include or exclude family coverage.

The design of the social insurance system is obviously a very complex task and choices have to be made based upon a country's specific characteristics and needs as well as the national health policy goals which the country is attempting to achieve. Experienced and sophisticated technical assistance should be sought in the design phase and continued through implementation. Certain salient questions must be addressed in the planning and design of the system:

- ▲ Who is covered by the scheme?
- ▲ What benefits are included in the coverage?
- ▲ What is the mode of administration of the scheme?
- ▲ What is the mode of financing?
- ▲ What are the premium rates and how are they set?
- ▲ Is the scheme compulsory or voluntary?

None of these questions is easy, and there are no "magic bullets" for designing a social insurance system or, for that matter, a private health insurance system. Nonetheless, there are lessons to be learned from other parts of the world where such schemes have been implemented. Useful reviews of these systems have been published (Ron, Abel-Smith, Tamburi, 1990; Griffin, 1992; McGreevey, 1990). Any policy dialogue which occurs in Fiji should have benefit of such information or an extraordinary amount of "reinventing the wheel" is likely to take place.

One critical factor in the implementation of a system of social insurance seems to be that success is most likely when the system is implemented gradually. Experience shows that a step-by-step approach has definite advantages. Gradualism can be applied with regard to various criteria, such as the size of the enterprise, geographical area, type of benefit. Gradual implementation according to geographic area is the most frequent feature in developing countries usually starting in the urban areas and moving to rural areas. It is also common for compulsory health insurance to be applied first to selected categories of persons in the labor force. A clear preference is to start with categories of employees in the formal employment sector, leaving compulsory insurance for the self-employed for a later stage. But implementation by stages creates in effect privileged groups and possible discrimination between enterprises. Any gradualism can only be viewed as transitory, constantly under review, and superseded as soon as circumstances permit. The danger is that implementation of a comprehensive social insurance system will begin but never progress to the harder to reach segments of the population.

It can be said that social insurance for health is not just a financing mechanism but is a commitment to ensure the provision of health services, a "social program with a public commitment" (Ron, Abel-Smith, Tamburi, 1990). If compulsory health insurance contributions are imposed, then those paying the contributions have the "right" to specified health care services. This fact cannot be lost sight of during debates about social insurance as a means of increasing financing for the health sector. Imposing compulsory payments without the ability to provide prescribed health services is a breach of a social contract.

3.3. NEW ZEALAND PRINCIPLES FOR HEALTH FINANCING REFORM

Any government which embarks upon the perilous path of health reform needs to articulate principles to guide its choices among the options available for financing health care. Listed below are principles which have been elucidated in New Zealand to guide its deliberations. They are given for illustrative purposes only and not necessarily as ones for Fiji to adopt. Decision makers in Fiji must develop their own set of principles within the context of the political, economic, social and cultural milieu of Fiji.

- ▲ Health care should be financed in a way that ensures everyone affordable access to core health services.
- ▲ Health care financing should enable the government to provide greatest assistance to those least able to provide for themselves.
- ▲ Health care should be financed in a way that creates incentives for individuals and, more importantly, for health service providers who advise them, to keep down health care costs.

- ▲ Health care should be financed in a way that avoids disincentives for people to work and save.
- ▲ Health care should be financed in a way that makes explicit the costs of a person's care and who pays for it.
- ▲ The administration of health care financing should be simple and cost-effective for consumers, the government, and third parties who may be involved in collecting revenue (such as employers collecting income tax).

A comparison of the options of the three general financing models against the principles articulated above is shown in Exhibit 4. It is given as an illustration of the type of comparative analysis which should be done as part of the health policy deliberation process.

EXHIBIT 4

HEALTH CARE FINANCING OPTIONS

PRINCIPLE	GENERAL TAX-BASED SYSTEM	SOCIAL INSURANCE SYSTEM	PRIVATE INSURANCE SYSTEM
Affordable and universal access	Performs well	Performs well if the premiums are affordable	Performs poorly
Assistance for those least able	Performs poorly; healthy people generally receive too much assistance; sick people receive too little	Performs well; can target those with high costs relative to income	Performs poorly
Incentives for containing costs and encouraging desirable behavior on part of consumers and providers	Performs poorly	Performs reasonably well; premiums can be adjusted to encourage certain behaviors	Performs well with regulation
Disincentives for work and saving	Creates some disincentives for many people	Creates larger disincentives for fewer people	Creates few disincentives
Clarity of costs and who pays	Performs poorly; health costs are lost in overall government spending	Performs well; each household sees the costs of its health care coverage	Performs well
Simplicity of administration	Performs well given that tax collection systems are already in place	Performs poorly; has quite high implementation and ongoing administrative costs	Performs poorly

4.0 RECOMMENDATIONS

It is perilous to make recommendations about the specific direction which the GOF should take regarding health financing until policy decisions have been made about the generally agreed upon social goals which the GOF wants to achieve in its health care system. Additional information on the mechanics and operations of various health financing options is probably not warranted until this more philosophical discussion has taken place. When that dialogue does occur, as it must, among all the significant players in both the public and private sector, and some general consensus is achieved, then the process can move to a more technical level.

When the more technical level of the process is reached, there will be a need to have a clearly identified operations center for directing the inevitable amount of very complex and detailed analysis that should precede the adoption of any change in health financing policy. Where this operations center is located is a decision for the GOF, but it should occupy a significant position in the policy arena, so that there can be no doubt that the government is serious about the task of health financing reform. Fiji will undoubtedly need technical assistance from many sources and should consider long term, resident technical assistance from those who are skilled in the design and implementation of health financing systems. It will be a lengthy process and will involve contentious debate and hard decisions, but will ultimately reward the people of Fiji with a health financing structure which is based on shared goals and realistic strategies for achieving them.

The solace for Fiji, as it pursues these deliberations, is knowing that many other countries, developed and developing, face similar quandaries regarding the demand for more health resources at a time when most are faced with the need to contain government expenditures. There are models which have been proposed and implemented in other countries which can provide some information to inform the process of health reform in Fiji. But in the end the decision about the shape of the health care system is the responsibility of the government and people of Fiji to make.

In addition to the preceding general comments, there are certain recommendations which follow from the discussion in this report.

- (1) The data from the Public Service Commission should be examined more fully to identify characteristics of PSC employees who have chosen to purchase private health insurance and those who have not. Both quantitative and qualitative data analysis should be undertaken. Qualitative analysis might take the form of focus groups to identify perceptions about the current health insurance products available in Fiji as well as desirable elements of any new product.

- (2) The Insurance Welfare Society (IWS) is an important player in the health insurance market in Fiji and should be encouraged to play a substantive role in ongoing and future discussions about the shape of health reform. It should have a permanent staff for day-to-day operations in addition to the voluntary board of trustees.
- (3) The development of private health insurance products in Fiji should be monitored closely by the MOH in concert with the Insurance Commissioner.
- (4) A series of policy workshops should take place with participation by all relevant parties, including representatives of the public and private sector, to establish a workplan and timetable for health financing reform in Fiji. Representatives should be senior managers and decision makers in their respective organizations.
- (5) A working group should be formed from participants in the policy workshops to detail the health financing options available to Fiji. A permanent full-time technical advisor should be assigned to the working group funded by all relevant parties, including the MOH, the IWS, the health insurance industry, the Fiji National Provident Fund, private practitioners, donor agencies such as USAID, and others. The technical advisor should be placed where he/she will have a visible role in policy development and where the commitment of the GOF to health financing reform is obvious.
- (6) Decision makers from Fiji should participate in international and regional meetings/seminars/workshops about health financing strategies.
- (7) Representatives from Fiji should consult with the government of NZ about health reform efforts and undertake a series of visits to the technical experts designing the health financing system in NZ.

It is premature for this consultant to make a specific recommendation regarding the type of health financing system which is most suitable for Fiji, but lessons learned from other countries suggest that private health insurance as the primary mechanism for financing the health care system sacrifices equity and universal access to market place concerns. In private health insurance, health care is viewed as a commodity and not as a public good. Many countries of the world would vigorously defend the classification of certain health services as a public good and express that notion as a cornerstone of public policy. Fiji should rigorously explore the advantages and disadvantages of social insurance versus a tax-based system as the two most salient options for a strong health financing foundation rather than embarking on the path of developing a private health insurance market.

Regardless of the path which Fiji takes, there is a fundamental logic in moving through the policy making process, and it is this logic which should form the framework for all future activities related to health financing reform.

- ▲ What are the policy goals of the health service system? For example, should the GOF guarantee access to health services for the citizens of Fiji?
- ▲ What health services are included in this guarantee? What criteria should be used to include services in the list of "core" services?
- ▲ How much will it cost to provide this set of services?
- ▲ What are the primary sources of financing for health care? What are the pros and cons of each source in terms of Fiji's defined health system goals?
- ▲ Should all core services be financed in the same way? Do intrinsic characteristics of the service determine the source of financing?
- ▲ How should the financing system be administered?
- ▲ What management and financial controls should be in place to monitor the financing system?
- ▲ What is the relationship between financing and production of health services?

To answer each one of these questions will require information and analysis which can only be done if there is political will to undertake the process of health financing reform. Without that political will, the process is doomed to fail before it begins.

APPENDIX A
STATEMENT OF WORK

STATEMENT OF WORK - FIJI

Like many developing countries, Fiji recognizes the need for reform of its financing mechanisms for the health sector. As public spending to the sector has decreased during the past years, it has become increasingly evident that the mix of revenue to the sector from available sources (public, private, and third party) must be adjusted to reflect current needs. The MOH in Fiji is committed to such reforms through the initiation/revision of cost recovery mechanisms for urban hospital services, development/expansion of health insurance coverage, and increased privatization of certain services.

The MOH currently wishes to increase the percentage of costs recovered through patient fees. Finance policy must be modified to allow public sector health facilities to retain the revenues generated through fee collection in order to improve the quality (and perhaps quantity) of services delivered.

In order to assist the MOH in the reform of cost recovery mechanisms in use, USAID/Suva requests the assistance of consultants to perform an assessment of the current system, develop a feasible plan for its reform, and organize two workshops: one for MOH officials that will build Ministry consensus around the proposed changes, and another whose purpose is to develop consensus for the proposed changes in other Ministries, especially the Ministry of Finance.

In order to do this, USAID/Suva requests that the consultant(s) perform the following tasks:

- (1) estimate current costs of most frequently used in-patient and out-patient services at hospitals;
- (2) assess current fee structures for services at hospitals;
- (3) assess current revenues generated by hospitals by service;
- (4) assess current means testing and other mechanisms for protecting access to services by the poor;
- (5) assess current insurance mechanisms, their current coverage and contribution to current hospital revenues and;
- (6) assess the potential for alternate third party payment mechanisms including HMOs and the "social security/provident fund."

The consultant(s) will present the findings in a report(s) to be submitted to USAID/Suva and the Government of Fiji. In addition to the above, the report(s) shall contain:

- (1) recommendations for the revision of fee schedules and fee collection mechanisms in use at hospitals in Fiji;
- (2) recommendations for the revisions of finance policy to allow hospitals to retain and manage revenues generated by fee collection;

- (3) guidelines for use by hospitals for the use of revenues to improve service delivery; and
- (4) recommendations on the type of health insurance programs to be encouraged in Fiji.

The consultant(s) will present the results of the assessments and report(s) described above to MOH officials in a workshop. Workshop participants will provide feedback on report contents and develop a MOH work plan for activities in this area. The workshop report will provide the basis for the development of a report to the Cabinet with recommendations for change in current policy and operations. A second workshop will be held, if necessary, to further refine the report and build support among other Ministries for the proposed reforms.

The consultant(s) will coordinate activities with other consultants performing feasibility studies on the privatization of certain hospital services.

It is anticipated that the activities described above will require the services of a health policy analyst/planner and a health economist/financial expert for a total of 86 person days each for field studies and an additional 60 person days (30 person days for each of two workshops) to prepare and conduct the workshops. Twelve (12) person days are allocated for home office backstopping. Thus 158 person days are estimated needed to complete activities funded under this PIO/T. Of this, 49 person days needed to complete the work outlined in this PIO/T will be funded through the Health Financing and Sustainability Project, per agreement (43 person days in the field and 6 person days for home office backstopping) and a 109 person days will be funded through a buy-in reflected in this PIO/T. Activities to be performed by each of the consultants will be planned over four visits (two study/assessment and two workshop) over a six to nine month period. A tentative action plan for the visits is included below. Scheduling of each visit will be done in collaboration with the proposed consultants, USAID/Suva, and appropriate MOH officials.

Visit 1: Assessment

- Assess cost recovery performance, obstacles, and possibilities (including rapid assessment of means testing and ability to pay mechanisms).
- Assess insurance performance, obstacles, and possibilities (including coverage and services offered).
- Assess GOF budgetary trends for last five years (including real and absolute expenditures, personnel costs, resource allocation between urban and rural services and resource allocation between hospital and non-hospital services, if possible).
- Set up data collection methods.

- Perform initial analyses.
- Hire local consultants to obtain data needed for full assessment.

Visit 2: Analysis

- Complete data collection (if necessary).
- Complete analysis of cost, pricing, and insurance studies.
- Prepare and discuss draft report.

Visit 3: Workshops

- Conduct two workshops.
- Define and prepare follow-up steps as outlined by workshop participants.

APPENDIX B
BLUE SHIELD GROUP MEDICAL POLICY



Blue Shield (Pacific) Insurance Ltd

2ND FLOOR, CIVIC HOUSE, P.O. BOX 15137, SUVA.
TEL: 311733/FAX 679 300318/CABLE "BLUESHIELD"

POLICY NO. ...

WHEREAS the Proposer named in SCHEDULE 1 herein has applied to Blue Shield (Pacific) Insurance Limited (hereinafter called "the Company") for the insurance herein described and has paid or has agreed to pay the premium in SCHEDULE 2 for such insurance.

NOW THIS POLICY WITNESSETH that **DURING THE PERIOD OF INSURANCE**

stated in SCHEDULE 1 or during any subsequent period for which the company has extended or renewed the provisions of this policy, any person (s) named in SCHEDULE 3 as (a) persons (s) insured (hereinafter individually named and whose agent the Proposer shall be deemed to be for all purpose relating to the insurances defined in this policy) shall contract sickness or injury necessitating expense by the Proposer or the Person (s) Insured in respect of treatment or services as described in SCHEDULE 4 and undertaken by or on the recommendation of physician or surgeon, the Company will subject to the terms, exceptions, limitations and definitions contained in or endorsed on this policy indemnify the Proposer as Principal or as Agent for the Person (s) Insured as the case may be in respect of eligible expenses. **PROVIDED** that any and every proposal and/or declaration and/or statement made by or with the authority of the Proposer and the Person (s) Insured or either of them relating to this insurance is agreed to be the basis of this contract and is deemed to be incorporated herein.

SCHEDULE 1: THE ASSURED

Name

Group Medical Policy

Address

Period of Insurance

Renewal Date

Date of Proposal

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SCHEDULE 2: THE PREMIUM

Annual Premium

Date Premium Payable

Amount Payable

FS

Signed at on the day of 19

for and on behalf of
BLUE SHIELD (PACIFIC) INSURANCE LTD.

Examined

Authorised Signature

IMPORTANT NOTICE — That Company declines any responsibility for any premium payments other than those (a) paid to Registered Broker, (b) paid in cash at the Company's office, (c) in the form of non — negotiable cheques made out to Blue Shield (Pacific) Insurance Ltd or (d) through bank transfers.

SCHEDULE 4 : SCHEDULE OF INSURED BENEFITS

1. FIJI IN-HOSPITAL AND SURGICAL BENEFIT (PACMED) - Provided an Assured named as person assured for this benefit in Schedule 3 of this Policy has been charged for a Confinement or for provision of Day Care in any Government operated Hospital or Medical Clinic in Fiji, the Company will, subject to the terms, conditions and exclusions of this Policy, meet the costs incurred to the limits described hereunder -

Daily Hospital Charge (for Shared Accommodation or as may be certified Medical Necessary	As Charged
Hospital Charges for Surgery, Anaesthesia & Theatre	As Charged
Hospital Charges for Consultations with Specialists	As Charged
Hospital Charges for X-Rays and Diagnostic Procedures	As Charged
Hospital Charges for Pharmaceuticals or Supplies	As Charged
Hospital Charges for Blood or Plasma	As Charged
Hospital Charges for medically necessary prostheses to a limit per Disability	F\$ 1,000.00
Hospital Care for Daycare (as defined in this Policy)	As Charged
Local Travelling Expenses in respect of confinement or Daycare for a treatment or procedure certified to be not available from the government hospital or clinic where Assured is domiciled	As Charged
Daycare Surgery a) performed in a Government Hospital or Clinic	As Charged
b) in a Private Hospital or Clinic by a visiting Specialist) subject to certification that the required procedure is) not available through the Public Health Services)	As Per Australian Commonwealth Schedule of Fees for Services
Local Consultants)	As per Public Health Scheduled Rates.
All other medical requirements)	As per Public Health Scheduled Rates.
 LIMIT OF BENEFIT FOR ANY ONE DISABILITY	 F\$ 5,000.00

2. OVERSEAS MEDICAL EVACUATION BENEFITS (MEDIVAC): Subject to specific certification by a Specialist appropriately qualified in respect of a covered Disability suffered by an Assured or if such Specialist not be available, by the Ministry of Health in Fiji that the medical treatment or procedure needed by an Assured is not available in Fiji, the Company shall at its own option -

- a) secure the appropriate evacuation overseas and the provision of the benefits described hereunder in a Preferred Hospital, or
- b) reimburse the eligible costs of treatment in other than a Preferred Hospital.

THE BENEFITS :

I: TREATMENT BENEFITS including Diagnostic Services, Day Care Services, and Hospital Confinement Services including services of Surgeons, Physicians and Specialists as well as Intensive Care, Special Nursing, Blood & Plasma, Medicines, Medical Supplies and Prostheses which are certified to be medically necessary will be provided in appropriate Preferred Hospitals in New Zealand or Australia as the Company shall determine according to the medical needs of the Assured and the availability of the required treatment. An assured who shall elect to be treated at a hospital other than the Preferred Hospital nominated by the Company shall be entitled to the benefits prescribed for such hospitals hereunder.

(LIMIT OF BENEFIT

FOR TREATMENTS UNDERTAKEN IN -

- 1) In a Preferred Hospital, for any Disability, without requirement of paying
Limit per Disability inclusive Evacuation Benefits NZ\$ 85,000.00
or
- 2) In any Public Hospital where the Daily Charge is inclusive of all professional fees and necessities of treatment Per Day .. NZ\$ 550.00
Limit per Disability inclusive Evacuation Benefits NZ\$ 35,000.00
or
- 3) In any other Hospital, reimbursement of reasonable and customary charges at the rate as would be payable in a hospital in New Zealand but not to exceed the inner limits inscribed hereunder in respect of any item of benefit :

Hospital Daily Care - Shared Accommodation	NZ\$	264.00
Same Day Surgical Procedures	Maximum	NZ\$ 264.00
Same Day Non-Surgical Procedures	Maximum	NZ\$ 105.00
Professional Fees: Surgeons, Anesthetists, Physicians, Radiologists, etc		As Per Australian Commonwealth Schedule of Fees and Services
Special Nursing when in excess of 3 hours per day	Per Day	NZ\$ 278.00
	Per Disability	NZ\$ 1,588.00
Theatre Fees	Maximum	NZ\$ 1,324.00
Prescription Pharmaceuticals for treatment in a Private Hospital	Per Disability	NZ\$ 2,648.00
Prostheses - (non cosmetic) - necessitated by an operation performed within the preceding 12 months	Per Disability	NZ\$ 2,648.00
Intensive Care as supplement to Daily Care Charge - Limit 14 days/disability	Per Day	NZ\$ 278.00
Major Surgical Items, payment towards cost of	Per Disability	NZ\$ 2,648.00
COMBINED LIMIT for Pharmaceuticals, Prostheses & Major Surgical Items	Per Disability	NZ\$ 3,972.00
Day Care (as defined in this Policy)	Per Procedure	As Charged
LIMIT OF MEDICAL BENEFITS FOR ANY ONE DISABILITY INCLUSIVE EVACUATION EXPENSES		NZ\$ 35,000.00

II. EVACUATION BENEFITS - Medical Evacuation Benefits as scheduled hereunder shall be provided for each time a medical evacuation has been approved for an Assured in respect of any one disability for so long as the Overall Limit of Benefit for the said has not been exceeded.

FOR THE ASSURED :

- 1) Return Economy Airfares (or stretcher fares as may be Medically Required) to the airport nearest the Preferred Hospital selected by the Company is located or the actual cost of fares to any other place but not to exceed the cost of the former.
- 2) Cost of medical supplies or rental of medical appliances required for the care of the Assured on the journey from Fiji to the Preferred Hospital or from the Preferred Hospital to Fiji.
- 3) Cost of transportation by ambulance or taxi from the airport of destination to the Preferred Hospital selected by the Company and likewise cost of return to said airport following discharge from the said hospital.
- 4) Cost of board and accommodation other than when confined in the hospital during the period of necessary treatment as hereunder -

a) When provided by the Preferred Hospital	Per Day	As Charged	
b) When in a hotel, motel or boarding house - As Charged but not to exceed	Per Day	NZ\$	55.00
c) Any other accommodation	Per Day	NZ\$	20.00

FOR A MEDICAL ATTENDANT APPROVED TO ACCOMPANY THE ASSURED :

- 1) Return Economy Airfares to the airport nearest the Preferred Hospital selected by the Company is located or the actual cost of fares to any other place but not to exceed the cost of the former.
- 2) Any additional cost of transportation by ambulance or taxi from the airport of destination to the Preferred Hospital selected by the Company.
- 3) Cost of taxi from the hospital to the hotel, motel or other accommodation selected by the said medical attendant and from such place of accommodation to the airport of departure for Fiji.
- 4) Cost of board and accommodation from the time of delivery of the Assured to the hospital until the time of the first reasonably available return aircraft to Fiji.

a) When provided by the Preferred Hospital	Per Day	As Charged	
b) When in a hotel, motel or boarding house - As Charged but not to exceed	Per Day	NZ\$	150.00
c) When in Any other accommodation	Per Day	NZ\$	30.00

- 5) Fees customarily charged by the medical attendant for the period commencing at the time of departure from Fiji until the time of return to the first airport of arrival in Fiji provided that fees payable for any part of a day shall be equal to the fees payable for a full day.

FOR ANY OTHER PERSON APPROVED TO ACCOMPANY THE ASSURED :

- 1) Return Economy Airfares to the airport nearest the Preferred Hospital selected by the Company is located or the actual cost of fares to any other place but not to exceed the cost of the former.
- 2) Any additional cost of transportation by ambulance or taxi from the airport of destination to the Preferred Hospital selected by the Company.
- 3) Cost of taxi from the hospital to the hotel, motel or other accommodation selected by the said medical attendant and from such place of accommodation to the airport of departure for Fiji.
- 4) Cost of board and accommodation from the time of arrival of the Assured to the hospital until the time of the first reasonably available return aircraft to Fiji.

a) When provided by the Preferred Hospital	Per Day	As Charged	
b) When in a hotel, motel or boarding house - As Charged but not to exceed	Per Day	NZ\$	70.00
c) When in Any other accommodation	Per Day	NZ\$	20.00

III. REPATRIATION OF BODY & FUNERAL BENEFITS - in the event of the death of an Assured while overseas under the provisions of this Benefit the Company will provide reimbursement for costs of embalming, coffin and transportationto a Maximum of NZ\$ 3,000.00

LIMITS FOR EVACUATION BENEFITS FOR EACH EVACUATION -

- | | |
|---|---------------|
| a) The Assured - | As Required |
| b) Accompanying Medical Attendant | As Required |
| c) Accompanying relative or companion (inclusive cost of fares) | NZ\$ 2,500.00 |

THE OVERALL LIMIT OF COST FOR EVACUATIONS IS INCLUSIVE IN THE MAXIMUM OF BENEFIT PER DISABILITY

IV. OVERSEAS HOSPITAL CONFINEMENTS WITHOUT PROPER REFERRAL:

In the event an Assured shall have availed himself of treatment for a covered disability as a bed patient in any overseas hospital without the certifications and referrals required for the provision of this benefit and it is ascertained that the required treatment would -

- | | |
|---|-----------------------------|
| a) not have been available in Fiji, the maximum reimbursable shall be the amount which would have been payable for an equal course of treatment in a Preferred Hospital in New Zealand | to a Maximum of NZ\$ 35,000 |
| b) have been available in Fiji, and the Assured is covered for hospital benefits in Fiji under this Policy, the maximum reimbursable shall be the amount as would have been charged in a Hospital Operated by the Government in Fiji. | to a Maximum of F\$ 5,000 |

3. OUTPATIENT REIMBURSEMENT PLAN:

Pays 80% of costs of :

	Eligible Benefits
Physicians Visit per visit	F\$ 6
Consultation with a Specialist upon written referral from a Physician	F\$ 20 each visit
Prescribed Medicines, per year	F\$100
Diagnostic, X-ray and Laboratory per year	F\$ 75
OVERALL LIMIT PER YEAR	F\$250

Subject to the following conditions:

1. Pre-existing Conditions will not be payable
2. Incurable or chronic disease diagnosed during the first year of cover will be payable only up to the end of the policy year.
3. Prescribed Medicines is defined as medicines which have been prescribed by a physician for the cure or relief of a covered Disability which may not be legally purchased without a physician's prescription.

Tonic, Vitamins, diet and home medicines are not payable.

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4. OPTICAL BENEFITS:

Reimburse 80% of costs to the limits hereunder:-

	Maximum Payable Payable
Consultations with an Optometrist, per visit	F\$ 4
Contact Lens) Not to exceed one per pair	80
Lens - for spectacles) pair in this per pair	50
Spectacle frame) section in any one year	30

Lens and spectacles are payable subject to specific certification by an optometrist that the items are medical necessary.

5. DENTAL BENEFITS

Pays 85% of costs to the limits hereunder:-

	Maximum Payable Payable
Removable of Plaque	F\$ 9
Prophylaxis (scale & clean)	15
Flouride Application	15
Fissure Sealing	15
ANNUAL LIMIT	75
Fillings: Amalgam - one surface	18
two surfaces	23
three + surfaces	27
Composite Resin - one surface	20
two surfaces	24
three + surfaces	26
Enamel Bonded Composite Resin - one surface	25
two surfaces	28
ANNUAL LIMIT - Filling & Extractions	200
Diagnostic Services - Initial examination	21
Subsequent examination	16
X-rays - single view	10
each additional view	4
full mouth	38
ANNUAL LIMIT - Diagnostics	75

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6. MATERNITY BENEFITS

The Company will provide, subject to the terms of this Policy, the Benefit described hereunder to the Insureds named in Schedule 3 - "Schedule of Lives Insured" who are recorded as insured for this Benefit in the Column headed "Maternity" upon the termination of the pregnancy by reason of vaginal delivery, caesarian delivery or miscarriage

THE BENEFIT in respect of any one pregnancy.....Fiji \$ 250

7. TRAVELLERS INSURANCE BENEFITS

The Company will provide, subject to the terms of this Policy, indemnification by repair, replacement or monetary payment, losses of employed members of the staff of the Sopac Technical Secretariat provided they be incurred during the course of travelling on their official duties in countries other than in the island of Fiji:

MEDICAL & OTHER EXPENSES: "FRANGIPANI" COVER UP TO F\$30,000

1. Medical treatment, hospitalisation, surgery, ambulance and paramedic services, diagnostic tests, visits to registered doctors and medicines prescribed by such doctors.
2. Pregnancy complications requiring treatment up to the 39th week of pregnancy but excluding premature and surgical deliveries.
3. "Get You Home" expenses such as additional costs of economy class travel, accommodation costs, essential medical evacuation costs including charges for a qualified nurse required by a registered doctor to accompany the Insured Person.
4. Costs of burial or transport of body or ashes if death shall occur during the period of insurance up to a maximum benefit of F\$1,250 per Insured Person.

Provided always that all such expenditure shall be of a reasonable and customary nature.

The Insurance does not cover:-

- a) Any illness or physical condition existing prior to the date of issue of this insurance.
 - b) Care or treatment for which payment is not required or which is payable by any other insurance or indemnity covering the Insured Person.
 - c) Dental care and treatment, except as necessitated by external accidental injuries to sound natural teeth occurring during the period of insurance.
 - d) Charges in respect of special or private nursing except in the event of medical evacuation being necessary, cosmetic surgery, eyeglasses and refraction or hearing-aids, and prescriptions therefore except as necessitated by injuries occurring during the period of insurance.
5. Hospital room benefit is limited to US\$250 per day but this amount is doubled when such charges inclusive of all medical treatment services and tripled when the hospital charges per day include all professional fees and medical services.
 6. The first F\$30 of each and every claim per person per disability injury is not insured.

SPECIFIC EXCLUSIONS APPLYING TO MEDICAL AND OTHER EXPENSES COVER:-

- (a) Congenital conditions of all kinds including congenital hernias and neo-natal hernias.
- (b) Psychotic, mental or nervous disorders (including any neuroses and their physiological or psycho-somatic manifestations)
- (c) Any and all conditions arising from surgical, mechanical or chemical methods of birth control and any and all conditions or treatment pertaining to infertility.
- (d) Communications or transportation expenses other than medically necessary telecommunications and local ambulance/transportation services.
- (e) Treatment or service not undertaken in the recommendation of a legally registered physician; routine physical examination or health check-ups not accidental to the treatment of diagnosis of suspected sickness or injury sustained during the journey covered by this insurance and occurring or arising during the period of insurance.
- (f) Injury or disease arising out of duties of employ, employment or profession unless such duties or activities are declared to and accepted by the Insurers and the required additional premium has been paid.

PERSONAL ACCIDENT: "FRANGIPANI" COVER F\$20,000

The benefit described in this section shall be payable for death or losses occurring within one year of the accident which occasions such death or loss, provided such accident occurs wholly within the period of insurance. The FULL sum insured per person is payable for permanent total disablement, total and permanent loss of sight in one or both eyes, loss by severance or permanent and total loss of use of one or more limbs, or death.

The maximum amount payable for any and all events arising under this section shall not exceed the maximum of the sum insured per Insured Person. In the event of the death of an Insured Person giving rise to a claim under this section the beneficiary shall be that person's next of kin or estate if there is no next of kin unless a selected beneficiary has been stated on the insurance certificate at the time of this issue.

8. PERSONAL ACCIDENT BENEFIT

THE BENEFIT : Subject to the provisions of this Rider, the Company shall pay Personal Accident Benefits to the Policy Owner or as otherwise required under the terms of the Policy, if during the Period of Assurance, an Assured shall while within the Territorial Limits inscribed herein, sustain a loss as a result of an Accident for which a benefit is payable in terms of this Rider. The amount payable independent of any other benefit payable under provisions of this Policy or any other Rider attached thereto and shall be the amount set inscribed in the Schedule of Benefits hereunder.

DEFINITIONS :

ACCIDENT means an event occurring entirely beyond an Assured's control and shall include Exposure or an event of violent, external and visible force causing bodily injury which solely and independently of any other cause shall within twelve (12) calendar months result in death, total and permanent disablement or dismemberment.

EXCLUDED ACTIVITIES means activities for which either no benefits or reduced benefits (as per Clause "Reduced Benefits" in Conditions hereunder), are payable under this Rider and include -

- a) Professional sports or practising therefor
- b) flying or other aerial activity other than flying in a multi-engined aircraft operated by a recognised airline or charter operator as a passenger.
- c) climbing or mountaineering necessitating the use of ropes, pitons or guides
- d) participating in motor rallies
- e) racing other than foot racing, swimming or yacht racing in territorial waters.
- f) diving to a water-depth greater than 30 metres

EXPOSURE means death, total and permanent disablement or dismemberment of an Assured caused by exposure directly resulting from a mishap to the Assured or to a vehicle, aircraft or vessel in which he was travelling.

LIMB means a hand, an arm, a foot or a leg.

LOSS OF USE OF A LIMB means any of -

- a) the severance of a leg at or above the ankle.
- b) the severance of a hand at or above the wrist.
- c) the total loss of use of a hand or a leg.

PERMANENT TOTAL DISABLEMENT means total disablement of an Assured from attending to his usual occupation which disablement after continuing for 104 weeks shall then permanently and totally disable the Assured from following any gainful occupation.

CONDITIONS SPECIFIC FOR THIS RIDER

The following Conditions are supplementary to the Conditions stated in the Policy and shall modify or amplify same only where specific reference is made to a like Condition in the Policy.

ABANDONMENT : If the Company shall disclaim liability for any claim hereunder and such claim shall not within twelve calendar months from the date of such disclaimer have been referred to arbitration under the provisions herein contained then the claim shall for all purposes be deemed to have been abandoned and shall not be recoverable thereafter.

AGE LIMITS : The limits for which a person may be assured under the terms of this Rider shall be -

Description	Death, Dismemberment, Total & Permanent Disablement
GROUP MEMBERS	
Aged less than 16 years	Nil
Aged more than 16, less than 65 years	\$ 500,000
Aged more than 65 years	Nil
DEPENDENTS	
Aged less than 8 years	Nil
Aged more than 8, less than 16 years	\$ 20,000
Aged more than 16, less than 65 years	\$ 200,000
Aged more than 65 years	Nil

ARBITRATION : All differences or disputes arising out of this Rider which cannot be resolved between the Policy Owner and the Company shall be referred to the decision of an Arbitrator to be appointed in writing by the parties in difference or if they cannot agree upon a single Arbitrator to the decision of two Arbitrators one to be appointed in writing by each of the parties.

In the event that the Arbitrators do not agree then an Umpire shall be appointed in writing by the Arbitrators and before entering upon the reference. The making of an award by the Arbitrators shall be a condition precedent to any right of action against the Company.

AUTOMATIC TERMINATION : This Rider shall automatically terminate -

- if the Policy terminates,
- on the Policy Anniversary nearest an Assured's 65th birthday.
- on the payment of the full Sum Assured under this Rider.

CANCELLATION : Upon written request by the Policy Owner, this Rider may be cancelled on any premium or installment premium due date.

CHANGE OF OCCUPATION OR ADDRESS : In the event of any alteration in the occupation or the address of an Assured, the Policy Owner shall give immediate written notice to the Company and shall pay any additional premium required by the Company.

CLAIMS PROCEDURE : Written notice shall be given to the Company as soon as reasonably possible (but not later than 45 days after the event) of the occurrence of any event which may give rise to a claim under this Policy. Failure to provide notice to the Company within 45 days shall not invalidate a claim if it be shown that the notice was provided as soon as it was reasonably possible.

All certificates information and evidence required by the Company shall be supplied free of cost to the Company and in the form prescribed by the Company

An Assured in respect of whom a claim is being made under this Rider shall as often as required submit to medical examination on behalf of and at the expense of the Company. In the event of the death of an Assured, the Company shall be entitled to require a post mortem examination at their own expense.

CONSIDERATION : This Rider is issued in consideration of the Application for this Rider and the payment of the premium therefor. The initial premium for this Rider is included in the total premium stated in the Policy Schedules and is payable under the same conditions except that such premium shall cease to be payable whenever this Rider shall terminate.

The Annual renewal premium for this Rider shall be the amount shown alongside the name of this Rider in Schedule 1 of the Policy. The Company may amend the Premium Rate at any time after 30 days written notice to the Policy Owner at his usual place of residence provided that any such amendment shall become effective from the next anniversary of the Policy Date.

LIMITATION OF LIABILITY : -

- a) The Company shall not be liable for any claim arising from accidental bodily injury aggravated as a result of proper medical care and treatment not being sought or followed.
- b) In no case shall the Company be liable for any claim for losses incurred later than twelve months after an accident which is alleged to be the cause of such loss.
- c) Notwithstanding anything to the contrary in this Policy or in this Rider the Sum Assured in respect of any Assured under this Rider shall be reduced by the amount of any Benefit already paid under this Rider.

NON-PARTICIPATION : This Rider does not participate in the profits or surplus of the Company.

REDUCED BENEFITS : The benefit payable under this Rider is reduced by the percentages shown hereunder if a claim shall become payable as a result of the Assured engaging in any of the following activities:-

By 25% for martial arts, boxing, wrestling, association football, scuba diving, boating, yachting, water ski-ing horse-riding, hunting, squash and wind-surfing.

By 50% for motor-cycling as a driver or passenger, winter sports, competition racing, show-jumping, cross-country racing, horse-racing, ice-skating, rugby football and trekking.

By 75% for ice or water ski-jumping, ice hockey, rock-climbing requiring use of ropes or pitons, pot-holing, polo (on horseback), hang-gliding, parachuting and steeplechasing.

RENEWALS : Any renewal of this Policy shall be at the option of the Company and the Policy Owner shall, at the time of each Renewal, give written notice to the Company of any material fact affecting the risks covered under this Rider which has come to his notice prior to the date of renewal including any disease, physical or mental defect and/or infirmity affecting an Assured.

TERRITORIAL LIMITS : This Rider covers Accidental bodily injury in any part of the World.

WAR CLAUSE : The Company reserves the right to increase the premiums payable for this Policy in the event of any invasion or an outbreak of war (whether declared or not) which involves the country of residence of any of the Assureds and the Company shall have no liability for any claim arising directly or indirectly from invasion or war if the Policyholder has failed to pay the required increase in premium. Any increase in premium shall be effective from date invasion or war has commenced.

SCHEDULE OF BENEFITS - PERSONAL ACCIDENT BENEFIT RIDER : SCALE 1.

The Company will pay the percentage of the Sum Assured as per the table hereunder as appropriate in respect of an event for which a claim becomes payable -

MAXIMUM BENEFIT - The Aggregate Total of all percentages payable in respect of any one Assured shall not exceed 100% of the Scheduled Benefit.

	Scheduled Benefit
Total permanent loss of sight in both eyes	100%) of 16,000
Total permanent loss of two or more limbs	100%)
Total permanent disablement from any other cause	100%)
Total permanent loss of 1 arm	80%)
Total permanent loss of 1 leg	75%)
Total permanent loss of 1 eye with serious diminution of sight in the other	75%)
Total permanent loss of 1 lower arm or 5 fingers of 1 hand	70%)
Total permanent loss of 1 foot or lower part of leg	60%)
Total permanent loss of hearing in both ears	50%)
Total permanent loss of sight in 1 eye	50%)
Total permanent loss of lens in 1 eye	30%)
Total permanent loss of 1 thumb	30%)
Total permanent loss of 1 forefinger	20%)
Total permanent loss of 1 joint of a thumb	15%)
Total permanent loss of 2 joints of 1 forefinger	12.5%)
Total permanent loss of 1 little finger	12%)
Total permanent loss of 1 big toe	10%)
Total permanent loss of hearing in 1 ear	10%)
Total permanent loss of 2 joints of 1 little finger	8.5%)
Total permanent loss of 1 middle or 1 ring finger	8%)
Total permanent loss of 2 joints of 1 middle or 1 ring finger	6.5%)
Total permanent loss of 1 joint of a finger	5%)
Total permanent loss of a toe other than a big toe	5%)
Temporary Incapacity - 2/3 weekly earning per week commencing upon the date when shall cease. Maximum per week	\$41

NOTE - Permanent and total loss of use of a limb shall be treated as loss of the limb.

EXCLUSIONS : No benefit is payable under this Rider in respect of death or bodily injury sustained by an Assured as a result of or contributed to by -

- a) engaging in any of the Excluded Activities other than as may be inscribed in the Condition named "Reduced Benefits" above.
- b) intentional self injury or suicide
- c) partaking of any drug unless taken in accordance with the directions and prescription of a registered medical practitioner
- d) pregnancy or childbirth
- e) intoxication
- f) any physical or mental defect or infirmity affecting the Assured and of which the Assured was aware at the date of this Rider or at last renewal thereof unless such had been declared in writing to the Company and acknowledged by the Company.
- g) radioactive contamination, whether arising directly or indirectly.
- h) involvement in any criminal activities other than as a proven victim or bystander.

SPECIMEN COPY

THE PREFERRED PROVIDER OUT-PATIENT PLAN

The Preferred Provider Out-patient Plan is not an insured plan but an arrangement between specified clinics and employee groups. Blue Shield acts only as co-ordinator and manager for the plan and ensures the best interests of insured groups who enter into such an arrangement. The dependents of employees in a participating group are also eligible to enjoy the plan.

DESCRIPTION:

- 1) Blue Shield offers a list of names of clinics in most of the major towns in Fiji which are operated by one or more well renowned and experienced doctors.
- 2) At such time an employee group elects to enjoy in such a plan, they select the clinic at which they wish to be attended. Where more than one clinic is available in a town, the whole of a group may elect to use the services in one clinic only, or part of the group may elect to use one clinic while other members of the group may elect to use the services in another clinic.
- 3) Once the members of a group have elected to use the services at a specified clinic their names are registered at such clinic and they will be recognised there as a covered member as long as their plan continues.

THE BENEFITS

- 4) Employees registered at a clinic may attend only such clinic for their out-patient medical needs at any time during the normal working hours for the clinic. There is no limit to the number of visits.
- 5) Benefits include, subject to a service fee of \$ 1.00 per consultation.
 - i) Free Consultations with a physician.
 - ii) Free medicines, dressings and injections.

EMERGENCIES, OUT OF TOWN BENEFITS & BENEFITS OUTSIDE OF CLINIC HOURS.

- 6) In the event an employee requires urgent medical services (a) outside of normal clinic hours at his designated clinic or needs medical attention when attending his designated clinic is not practical, he may seek service in any clinic or hospital operated by the Government of Fiji and any costs incurred for the required treatments will be fully refundable by Blue Shield Insurance.

7) EXCLUSIONS:

The plan does not cover -
Treatment for pre-existing conditions of chronic nature.
Routine immunisations.
Vitamins, tonics, weight reducing pills, iron pills and over-the-counter (Non-Rx) medicines.

8) PREMIUMS

The premium per person covered is \$ 60 annually subject to review every 31 December. Premiums at initiation of a group cover are payable on the 25th. day of the calendar month preceding the date on which cover is to commence. Premiums may be paid in half-yearly installments subject to a surcharge of 3% or quarterly or monthly installments subject to a surcharge of 6%.

9) STARTING AND ENDING DATES:

Cover on any group will commence on the 1st. day of each calendar month and will continue for so long as the premium are paid.

10) TERMINATION:

Cover will cease on the last day of the month for which premium has been paid unless the premium for the following period has been paid to Blue Shield Insurance.

11) FAILURE OF A CLINIC TO PROVIDE SERVICES WITHIN THE TERMS OF THIS AGREEMENT

In the event a selected clinic fails to provide the services agreed in this agreement during the specified hours, an employee is entitled to seek service at any other clinic and have a full reimbursement of costs therefor from Blue Shield Insurance.

SCHEDULE 5: DEFINITIONS - HEALTH BENEFITS

- "ACCIDENT"** means an event of violent, accidental, visible and external force which independent of any other cause has inflicted bodily injury necessitating treatment by a Physician.
- "ACUTE CONDITION"** means an impairment of health caused by disease or injury which may be cured or alleviated by a medically recommended course of treatment.
- "CHILD"** means any person who is more than fourteen (14) days old, unmarried, wholly dependent upon an Insured and under the age of eighteen (18) (or under the age of twenty three (23) if continuing studies as a full time student in a recognised educational institution).
- "COMPANY"** means Blue Shield (Pacific) Insurance Ltd. with its Head Office in Suva, Fiji.
- "CONFINEMENT"** means a period of confinement in a Hospital for which an occupation charge has been made by the Hospital.
- "CONGENITAL CONDITION"** means medical abnormalities existing at the time of as well as abnormalities becoming apparent later but developing as result of a factor latent or inherent at birth.
- "DAY CARE"** means Treatments provided in a Hospital or in a specially equipped clinic or treatment centre which -
- Utilize apparatus designed for installation in Hospitals to provide specialised and uncommon services such as radiotherapy, kidney dialysis and major physiotherapy.
 - Do not require the patient to be confined in a Hospital, and
 - Are provided by a Specialist or under the direct supervision of a Specialist.
- "DEDUCTIBLE"** means the amount of an Eligible Expense which must be borne as an expense by the Insured before any benefit becomes payable under the terms of this Policy.
- "DEPENDENT"** means the spouse of an Insured Person and his Children.
- "DISABILITY"** means a Sickness or all of the injuries arising out of a single or contiguous series of Accidents occurring wholly after the commencement of insurance under this Policy which has been treated by a Physician or a Dentist.
- "ELIGIBLE EXPENSES"** means the costs of:
- Medically Necessary surgical or medical Treatments but not to exceed the Usual and Customary costs of same when such were incurred in securing the cure or the relief of a Disability of such nature as to require the personal attention or day to day personal supervision by a Physician or
 - Such other special benefits as may be described in the Policy.
- "ELIMINATION PERIOD"** means a period dating from the date an Insured is covered under this Policy during which time the Insured is not eligible for medical benefits except as may be necessitated by an Accident.
- "EMPLOYMENT RISK CLASSIFICATIONS*":** The employment Risk Classifications referred to in this Policy are as hereunder:-
- | | | |
|-----------|----------------------------------|--|
| Class I | Very Light Occupational Hazards: | Professional and Mercantile Classes, not superintending nor engaging in manual labour, that is persons generally engaged in professional, administrative, managerial and clerical positions. |
| Class II | Light Occupational Hazards | : Superintending but not engaging in manual labour but engaging in Wholesale or Retail trade and those involved in frequent travelling. |
| Class III | and Above | : All hazardous occupations. |

- "GENERAL PRACTITIONER"** means a Physician in General Practice who is registered as such in the geographical area in which he provides the services of a physician but shall not include a person related to the insured within the third degree of consanguinity or relationship by marriage nor shall it include a person normally domiciled in the same residence as an Insured in reference to any claim being made under this Policy.
- "GROUP"** means the whole of a specifically composed group of persons (existing for reasons other than to procure group medical insurance) or a logical sub-division of such group
- "HOSPITAL"** means an establishment duly registered as a hospital in the geographical area of its operations which has facilities for major surgery, diagnosis and treatment of Sickness and Injury, is under twenty four hours a day supervision of Physicians and Registered Nurses, and is not primarily a clinic, home for alcoholics or drug addicts, home for the aged or the handicapped or a nursing, rest or convalescent home.
- TYPE A HOSPITALS** are Hospitals in which the Daily Charge covers only accommodation, Board and General Nursing Care.
- TYPE B HOSPITALS** are Hospitals in which the Daily Charge covers all hospital supplies and services excepting fees of Physicians and Specialists.
- TYPE C HOSPITALS** are Hospitals in which the Daily Charge is inclusive of all services including fees of Physicians and Specialists.
- PREFERRED HOSPITAL** means a Hospital which has agreed with the Company to provide privileged services to insureds who have a Credit Service Agreement covered under this Policy including controlled fees for Accommodation and Food, Professional Fees and Hospital Supplies and Services with a provision that Insureds being treated for a covered disability are guaranteed that costs for all Acute Conditions will be within the Scheduled Limits of Benefit and the whole of such be billed directly to the Company.
- "INJURY"** means damage to bodily tissue caused solely by Accident.
- "INSURED PERSON or INSURED"** means a person whose name has been indorsed on Schedule 3 of this Policy as an Insured.
- "MEDICALLY NECESSARY"** means medical supplies or service which is -
- i) Consistent with the diagnosis and customary medical treatment for the condition.
 - ii) In accordance with the standards of good medical practice.
 - iii) Not for the convenience of the Insured or the Physician.
 - iv) Performed in the least costly Setting required for the treatment.
- "ORO-DENTAL SURGERY"** means a complicated and difficult oral operation necessarily performed by a Specialist under general anaesthesia in a specially equipped clinic or in the operating theatre of a Hospital.
- "PHYSICIAN"** means a person who is licensed to practise as a doctor of medicine in the geographical area in which he provides such service but shall not include a person related to the insured within the third degree of consanguinity or relationship by marriage nor shall it include a person normally domiciled in the same residence as an Insured in reference to any claim being made under this Policy.
- "POLICYHOLDER"** means the person in whose name the Policy has been issued by the Company.
- "POLICY DATE"** means the Policy commencement date indorsed on Schedule 1 of the Policy.
- "POLICY YEAR"** means a year commencing on the Policy Date or any anniversary thereof on which the Policy has been renewed.
- "PREMIUM"** means the annual Premium indorsed in Schedule 2 of the Policy.

- "PRE-EXISTING CONDITION"** means a Disability which commenced before the Policy Date.
- "PREFERRED PROVIDER"** means a Hospital, a Physician, a Pharmacy, Practitioner of Medical ancillary service or a Medical Laboratory which has made agreement with the Company to provide supplies and or services at preferential prices.
- "PRESCRIBED MEDICINES"** means medicines which have been prescribed by a physician for the cure or relief of a covered Disability which may not be legally purchased without a physician's prescription.
- "PROPOSER"** means the person or the trustee(s) appointed by such person who have signed the application which was the basis on which this Policy was issued and has signified the truth of the statements made therein.
- "PUBLIC HOSPITAL"** means a Hospital operated entirely by the public service of a country.
- "REGISTERED NURSE"** means a person qualified to provide nursing care to sick and injured persons and enrolled as such on registers of the health authorities in the country in which the services are provided.
- "RENEWAL POLICY or RENEWAL"** means a Policy which has been renewed on an anniversary of the Policy Date without any loss of continuity since the Policy Date of the original Policy.
- "SICKNESS"** means a pathological departure from the normal healthy state which necessitates treatment by a physician.
- "SPECIALIST"** means a medical or a dental practitioner registered and licensed as such in the geographical area of his practice who is classified by the appropriate health authorities as a person with superior and special expertise in specified fields of medicine or dentistry. In the United Kingdom and the European Economic Community countries, the word means a person who holds or has held a consultant appointment in a recognised Hospital or otherwise is accredited as a Specialist for the purposes of the European Economic Community Medical Directives.
- "SURGICAL SCHEDULE"** means the Schedule of Relative Unit Values for Surgical Operations published by the California Medical Association in 1974 as currently modified and adapted by the Company for the geographical area where a surgical operation is performed and in relation to Policies issued in the Oceanic area of the Pacific and Asia shall mean no more than 15% higher than indexed in the most recent Commonwealth Schedule of Fees issued by the Commonwealth of Australia.
- "TREATMENT"** means surgical or medical procedures required for the cure or the relief of a Sickness or Injury covered under the Policy for so long as such shall require the continuing administration or supervision of by a Physician on a day to day basis.
- "USUAL and CUSTOMARY" or "U & C"** means the Usual and Customary fee or charge as would have been made by the greater majority of persons or establishments as the case may be for services or supplies of equivalent quality with due consideration for expertise, experience, geographical location and special economic and social factors as may apply.

SCHEDULE 6: CONDITIONS

ABANDONMENT: If the Insurers shall disclaim liability to the Insured Person/Certificate Holder for any claim hereunder and such claim shall not within twelve calendar months from the date of such disclaimer have been referred to arbitration under the conditions herein contained then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

ADDITIONS & DELETIONS: The Policyholder shall advise the Company of the particulars of additional persons to be covered within the Group or persons to be deleted from the Group and shall credit or debit the Policyholder for the premium by the month proportionate to the period of time under cover provided that the minimum chargeable premium in respect of any one person in respect of part of a month shall be the premium for one complete calendar month.

ALTERATIONS: Alterations in the terms of the Policy or on any Endorsements thereto will not be valid unless same have been signed or initialed by an authorised representative of the Company.

ARBITRATION: (MEDICAL SERVICES - NECESSITY OR COSTS) Any difference arising between the Company and an Insured or a Provider in respect of a medical service or the charge made for a medical service shall be referred within one calendar month of having been required to do so by either of the parties to an arbitrator who shall be a Specialist (or a Senior Physician if a Specialist not be available). If the parties cannot agree on a single arbitrator then two arbitrators shall be appointed, within one month of such failure to agree on a single arbitrator, one by each party provided each one be a Specialist and in the event of disagreement between the arbitrators an umpire shall be selected by the arbitrators who shall be a senior Specialist or such other person as shall be considered by them as proper to be umpire and the Umpire's decision made in session with the Arbitrators shall be final and binding on the parties in difference.

(OTHER DIFFERENCES) All other differences arising out of this insurance shall be referred to the decision of an Arbitrator to be appointed in writing by the parties in difference or if they cannot agree upon a single Arbitrator to the decision of two Arbitrators one to be appointed in writing by each of the parties within one calendar month after having been required in writing so to do by either of the parties. In the instance that such two Arbitrators do not agree they shall in writing appoint an Umpire whose decision made in session with the Arbitrators shall be final and binding on the parties in difference.

BENEFITS APPLICABLE TO EACH DISABILITY: Unless specifically stated otherwise in the Schedules, the benefits paid to any Insured for a specific Disability and related causes will not reduce the amount available to him for any other Disability. Provided that no Renewal has been effected, Eligibility for Benefits will cease at 4 pm Fiji Mean Time on the last day of the Policy Period.

CANCELLATION:

- a) By the Policyholder: The Policyholder may cancel his Policy at any time by notifying the Company of his intent in the form of a registered letter addressed to the Company at its Head Office in Suva, Fiji and he shall be entitled to a refund of Premium less the amount due to the Company computed at its Short Period Rates for the period of the current Policy Year prior to the date of cancellation.
- b) By the Company: The Company may not cancel the Policy at any time after the completion of two continuous years of insurance except for non payment of premium or non compliance with Policy Conditions. Any cancellation by the Company during the first two years shall be without prejudice to any claims of an Insured which have been made or are pending prior to the date of such cancellation and the Policyholder shall be entitled to a refund by the Company to the proportionate part of Premium corresponding to the part of the Policy Year following the date of any such cancellation.

CERTIFICATION, INFORMATION and EVIDENCE: All certificates, information and evidence required by the Company shall be provided to the Company at the expense of the Insured. An Insured shall at the Company's request and expense submit to a medical examination whenever such be deemed necessary.

CLAIMS: Notice of any claim must be given to the Company within thirty-one days of such being incurred. Claims submitted after such period shall not be considered invalid if it can be reasonably shown that earlier submission was not a possibility. All claims shall be made together with proof satisfactory to the Company at the claimant's own expense of the death, illness, disability, injury or loss for which a claim is made hereunder together with all relevant bills, receipts, tickets, coupons, contracts or agreements relevant to the claim including when pertinent, a full physician's report stipulating the diagnosis of the condition treated and the date the disability commenced in the physician's opinion and the physician's summary of the course of treatment including medicines prescribed and services rendered.

CONDITIONS PRECEDENT TO ANY LIABILITY OF THE COMPANY: Any liability of the Company to an Insured shall be wholly dependent upon:

- a) The Company having been furnished with all the required statements and declarations to be provided by the Insured (by a parent or duly appointed guardian if the Insured is a minor) on the Enrollment Form provided by the Company and the truth of all such statements and declarations.
- b) The truth of all statements and declarations made in respect to any claim made against the Company by an Insured (or by a parent or duly appointed guardian if the Insured be a minor).
- c) The due observance and fulfillment of the Terms, Provisions and Conditions of this Policy and Endorsements to it insofar as they relate to anything to be done or complied with by the Insured.

COVER FOR INFANTS: Should a Child be born to an Insured while the Policy is in force and if the Company be notified of the event such Child will be covered under the Policy for medical conditions which originate subsequent to the fourteenth day after birth or subsequent to the notification of the birth to the Company whichever shall occur the later. Additional premium will not be chargeable in respect of the Child for the current Policy Year.

DEVALUATION & INFLATION: If at any time -

- a) the currency of Fiji is devalued more than eight (8) percent or the rate of inflation exceeds eight (8) percent during the course of the Policy Year, or the Company shall have the right at any time after it has provided the Policyholder with not less than 30 days notice of its intention so to do, increase the premium on Medical Evacuation Plans and Outpatient Benefit Plans by an amount not exceeding sixty five (65) percent of the rate of devaluation or inflation during the Policy Year, and/or,
- b) if the cost of hospital services in Fiji are increased more than eight (8) percent the Company shall have the right at any time after it has provided the Policyholder with not less than 30 days notice of its intention so to do, increase the premium on Fiji Hospital & Surgical Plans by an amount not exceeding sixty five (65) percent of the rate of increased of services during the Policy Year, provided that any such increase shall apply only to that part of the Policy Year not yet expired on the date the increase is applied.

EVIDENCE: All certificates, accounts, receipts, information and evidence required by the Insurers shall be furnished in such form as the Company may require.

GENDER: When appropriate to the text any reference to the male gender shall apply equally to the female gender.

GRACE PERIOD: Provided the premium for this Policy is paid on an annual basis, the Company will advise the Policyholder immediately a premium falls due and will not treat the policy as being lapsed until 30 days have elapsed after the date on which the premium fell due. When premium is paid by another mode, an advice of the overdue premium will not be forwarded, but a like period of time will be allowed before the policy is deemed to have elapsed.

GROUPS: A group is the entire number of persons who are categorised as having interests common to all of the said persons such as employees of one employer or members of a club or association with defined special interests but excluding clubs or associations which have been formed primarily for the purpose of securing the privileges of Group Insurance. For the purpose of this Policy the terms Employer shall apply equally to Club and Association Managements and the term Employees shall apply equally to Club and Association Members.

- A. GROUPS - EMPLOYEES:** An Employee Group is one where -
- i) There are not less than 30 employees in the Group.
 - ii) The Group consists of all the employees who conform with certain criteria set by the employer such as salary level, work classification or period of service as may have been determined by the employer and agreed by the Company.
 - iii) If the employer pays all of the premium (NON CONTRIBUTORY GROUPS), then 100% of the employees who satisfy enrollment criteria must be included.
 - iv) If the employee pays all or part of the premiums (CONTRIBUTORY GROUPS), then not less than 75% of employees who satisfy the criteria must be included.
 - v) All of the employees in the group (or Sub-group where applicable) are covered for the same level of benefit.

ELIGIBILITY - NON CONTRIBUTORY GROUPS: If at the time the policy commences an employee is-

- 1) actively at work, his cover will commence upon commencement of the policy.
- 2) not actively at work, his cover will commence on the first day he returns to full-time employment.

ELIGIBILITY - CONTRIBUTORY PLANS: If at the time the policy commences an employee is-

- 1) actively at work and-
 - a) applies to be enrolled within 14 days of becoming eligible to join the group, his cover will commence on the date of policy commencement or the date his application is received by the Company, whichever date is the later.
 - b) applies to be enrolled later than 14 days after becoming eligible to join the group, his cover will commence on the next following first day of the month subject to satisfactory evidence of his insurability being presented to the Company.
- 2) not actively at work and applies to be enrolled prior to the 14th day after his return to full time employment, his cover will commence on the date he returns to full time employment or on the date his application is received whichever shall be the later.

SUB-GROUPS: An employer may divide a group into sub-groups according to clearly apparent different criteria and any such one or more of the sub-groups which satisfy the requirements of clause (i) through (iv) of "GROUPS- EMPLOYEE" above, shall be treated as if it were an Employee Group.

- B. GROUPS - EMPLOYEE'S DEPENDENTS:** Groups of employee dependents shall consist of spouses (legal or de facto), and Children and shall conform to the following -
- i) **NON-CONTRIBUTORY GROUPS:** If the employer pays all of the premium on dependents, then all dependents of the employees in the group must be included.
 - ii) **CONTRIBUTORY GROUPS:** If the employee pays all or part of the premium on his dependents, then not less than 75% of the employees must elect to pay premium on their dependents.
 - iii) **HUSBAND & WIFE EMPLOYEES:** When a husband and spouse are both in the same employee group, both will be classified as employees and any children will be entered as the dependents of one of them.
 - iv) **DEPENDENT'S BENEFITS:** It is allowable for dependents to be on a different plan from the employees, but in either event all dependents of a group of employees must be covered under the same plan.

- v) **DEPENDENT'S ELIGIBILITY - NON CONTRIBUTORY GROUPS:** Subject to the above, provided the dependent of an insured employee-
- a) is not confined in a hospital or has not been discharged from a hospital within 30 days prior to the date the employee commences cover under the policy, the cover on the dependent will commence at the same time.
 - b) is confined in a hospital or has been discharged from a hospital within 30 days prior to the date the employee commences cover under the policy, the cover on the dependent will commence after the expiration of 30 days following the date of the most recent discharge from hospital.

- vi) **DEPENDENT'S ELIGIBILITY - CONTRIBUTORY GROUPS:** Subject to the above, a dependent of an employee insured under this Policy shall be eligible for enrollment-
- a) at the time the employee has been covered under the policy, provided he is not confined in a hospital nor has been discharged from a hospital within the preceding 30 days.
 - b) thirty (30) days after his most recent discharge from hospital if he has been confined in a hospital on the day the cover commenced on the insured employee, or has been discharged from a hospital within 30 days prior to the day the cover commenced on the insured employee.

- vii) **DEPENDENTS' TERMINATION OF COVER:** Cover on dependents in a Group Policy shall cease at the same time as cover shall cease on the employee.

GROUPS LESSER THAN 30 EMPLOYEES: Groups of a number less than 30 persons may be insured (together with their dependents) at modified group rates as will provided by the Company upon receipt of relevant particulars.

GROUPS CONTRIBUTORY - LESS THAN 75% OF TOTAL GROUP: Contributory Groups (or sub-groups), with a participation of less than 75% of the total may be insured (together with their dependents) at modified group rates as will provided by the Company upon receipt of relevant particulars.

MINIMUM and MAXIMUM AGES: No person may be included for cover under a Policy unless he has attained an age of more than fourteen days and unless he be less than sixty years old at the Policy Date of the original Policy unless such person has been advised to the Company and cover for same has been signified by the inclusion of the name of such person on Schedule 3 - "Schedule of Lives Insured" with appropriate notation of the benefits for which he is being insured.

NOTICES TO THE COMPANY: All notices which the Company requires the Policyholder or any Insured Person to provide must be in writing and addressed to the Company at its Head Office in Suva, Fiji.

OTHER INSURANCE: All Insured Persons insured by any other policy providing reimbursement for expenses arising out of Accident or Sickness shall inform the Company of such and provide the Company with a copy of such policy.

POLICY, SCHEDULES & ENDORSEMENTS AS ONE CONTRACT: If a special meaning is attached to any word or expression in the Policy, the Schedules or in any Endorsements it will continue to bear such meaning throughout the Policy.

RECOVERIES: At any time the Insured has been indemnified under this Policy for a loss which may be recoverable from a third party, the Insured shall upon demand subrogate his right of recovery for the said losses to the Company who may at their own expense take proceedings in the name of the Insured to recover compensation from any Third Party provided any amount so recovered, but not to exceed the amount of the Company's expenses for the indemnity and the costs of recovery from the third party, shall belong to the Company.

SHORT PERIOD RATES: The Short Period Rates of the Company are:

For a period not exceeding 1 week	1/8 of the annual Premium
For a period not exceeding 1 month	1/4 of the annual Premium
For a period not exceeding 2 months	3/8 of the annual Premium
For a period not exceeding 3 months	1/2 of the annual Premium
For a period not exceeding 4 months	5/8 of the annual Premium
For a period not exceeding 6 months	3/4 of the annual Premium
For a period not exceeding 8 months	7/8 of the annual Premium
For periods exceeding 8 months	FULL annual Premium.

TERMINATION: The benefits under this Policy will terminate at such time as -

- a) The scheduled benefit has been exhausted.
- b) At midnight, Suva time, on the last day this Policy remains in force; Provided that if the Insured be confined in a Hospital at the time the Policy would terminate, his cover will be extended for as long as the confinement remains medically necessary or the scheduled benefits have been exhausted, whichever shall occur the first.

TRANSFERS: If the Insured(s) shall have transferred cover for medical benefits from another carrier to this company without any interruption of continuity of cover and the Company has been provided with proof of same, then any medical benefits which would have been available to him under the previous cover for a disability which was in course of being treated, will be available under the provisions of this Policy to limits of -

- a) such amount of benefit as would have been available to him under his previous cover, or
- b) the maximum of benefits scheduled in this Policy, whichever shall be the lesser.

SCHEDULE 7: EXCLUSIONS

The Company will not pay for expenses arising out of:

1. Care or treatment for which payment is not required or to the extent which is payable by any other form of insurance or indemnity recoverable by the Insured.
2. Congenital Conditions and Pre-existing Disabilities unless such have been specifically declared to the Company and cover for same has not been specifically excluded.
3. Dental treatment other than may be specifically endorsed as a benefit herein except for Oro-surgical operations and injuries to sound natural teeth arising out of an Accident.
4. Cosmetic surgery, eye glasses and refraction or hearing aids and prescriptions thereof unless necessitated by Injuries wholly occurring during the period of insurance.
5. Treatments other than those provided by a Physician or under the direct supervision of a Physician for the cure or relief of a covered Disability.
6. Routine physical examinations, health check-ups or tests not incident to treatment or diagnosis of a covered Disability or any treatment which not Medically Necessary.
7. Treatments undertaken in nature cure clinics, health hydros or similar establishments or in nursing homes attached to such establishments except as specifically provided for in the Policy.
8. Childbirth and prenatal or postnatal care except as may be indorsed as a benefit on the Schedules herein.
9. Pregnancy, miscarriage or abortion unless necessarily requiring confinement in a Hospital and treatment by a Specialist for:
 - a) Hyperemesis Gravidarum, Eclampsia, Pre-eclampsia, Ectopic Pregnancy or Hyatidiform Mole.
 - b) Other severe complications induced by Injury or concurrent Sickness.
10. Professional Fees charged by a member of the Insured's immediate family or by a person normally resident in the household of the Insured.
11. Residential charges in a Hospital or Nursing Home during any period when confinement is not necessarily required for treatment of a covered Disability by a Specialist.
12. Injury, Sickness or Disease arising out of duties of employment or profession in an Occupational Class higher than Class II.
13. Disabilities directly or indirectly caused or contributed to by war, civil war or invasion or through participation in the activities of any military organisation.
14. Disabilities incurred in the pursuit of any illegal act or deliberate exposure to exceptional danger except in an effort to save human life.
15. Disabilities resulting from the pursuit of dangerous avocations or sports including mountaineering requiring use of ropes or pitons, flying except as a fare paying passenger on a duly licensed commercial aircraft, parachuting, parasailing, steeplechasing, diving requiring use of breathing apparatus, winter sports, professional football, boxing or wrestling and competition racing in a vehicle of any kind.
16. Self inflicted injury, attempted suicide or excessive consumption of alcohol or drugs other than those prescribed by a physician for the relief or cure of a covered Disability.
17. Psychotic, mental or nervous disorders (including any neuroses and their physiological or psychosomatic manifestations).
18. Surgical, mechanical or chemical process of contraception or treatment pertaining to infertility.
19. Long term custodial or maintenance services for the permanently disabled.
20. Venereal Disease or their sequelae.
21. Acquired Immune Deficiency Syndrome (AIDS) and associated diseases.

APPENDIX C

QUEENSLAND INSURANCE GROUP MEDICAL POLICY



QUEENSLAND INSURANCE (FIJI) LIMITED

Queensland Insurance Centre
Victoria Parade, Suva, Fiji. P.O. Box 101.
Telephone: 315455 Telex No. 2414 Fax: (679) 300285

GROUP MEDICAL INSURANCE POLICY
POLICY NO. 77811

COPY

WHEREAS Queensland Insurance (Fiji) Limited (hereinafter known as the Insurer) has agreed to insure certain benefits required by the INSURANCE WELFARE SOCIETY

AND

The INSURANCE WELFARE SOCIETY (hereinafter known as the "Policy Holder"), has made an application on behalf of their member employees and their dependants for insurance benefits and has agreed that eligibility for the benefits provided under this Policy shall be subject to the Declarations made to the Insurer by the said Policy Holder, their member employees and dependants.

THIS POLICY WITNESSETH THAT subject to the Schedules, Conditions, Endorsements, the Proposal and the Declarations which are deemed part of this Policy contract and the payment of the Premiums herein specified,

THE INSURER SHALL upon receiving written notice in the prescribed manner together with evidence satisfactory to the Insurer of -

- (1) the happening of an event in respect of which a Benefit is payable,
- (2) when required by the insurer, proof of the date of birth of an Assured in respect of whom a claim is made, and
- (3) the identity of the person(s) claiming payment,

provide the Benefit to the Policy Holder, the Assured or his executors, administrators or as may be otherwise stated in the Schedules, provided that the claim is notified and the first expense incurred during the period of insurance.

PERIOD OF INSURANCE: 17.13 HRS 01st July 1991 to 0.00 HRS 01st July 1992

AND IN WITNESS WHEREOF this Policy has been signed on behalf of the Insurer in Suva, Republic of Fiji this
for and on behalf of the Insurer

Queensland Insurance (Fiji) Limited

SCHEDULE 1:

COPY

BENEFITS OPTIONS

Benefits as described hereunder and in detail in Sub-Schedules 3A, 3B, and 3C .

PLAN CODE	THE BENEFITS	LIMITS OF BENEFITS
A	LOCAL HOSPITAL-Local Hospital Care	F\$ 5,000 Per Disability
B	MEDIVAC - Medical Evacuation to New Zealand or Australia	
	a) In a Preferred Hospital	NZ\$80,000 Per Disability
	b) In any other hospital	NZ\$30,000 Per Disability

SUB-SCHEDULE 1A - LOCAL HOSPITAL: **COPY**

SCHEDULE OF INSURED BENEFITS

FIJI HOSPITAL AND SURGICAL BENEFIT - The Insurer will meet the costs incurred in respect of confinement or Day Care for a Disability in any Government operated Hospital or Government Medical Clinic in Fiji to the limits described hereunder -

a) Daily Hospital Charge inclusive of all costs As Charged

Hospital Charges for medically necessary and surgically implanted prostheses necessitated by an operation performed within the preceding 12 months \$1,000 per Disability

Hospital Care for Day Care As Charged

b) **DAY CARE SURGERY** - subject to the eligibility of the Assured for Medical Evacuation and Overseas Treatment.

Services Provided by visiting Overseas Consultants As per Australian Medical Benefit or Southern Cross Schedule of Fees

Service Provided by Consultants resident in Fiji Usual and Customary

All other Medical Requirements for treatment Usual & Customary

LIMIT OF BENEFIT FOR ANY ONE DISABILITY F\$5,000

SUB-SCHEDULE 1B (MEDIVAC - N.Z.) INSURED BENEFITS

- 1) **OVERSEAS MEDICAL EVACUATION BENEFITS:** Subject to specific certification by the Ministry of Health in Fiji and a Registered Medical practitioner of the Insurer's choice that a medical treatment or procedure needed by an Assured is not available in Fiji, the Insurer shall provide or reimburse the costs of the following benefits:-

NEW ZEALAND MEDICAL TREATMENT BENEFITS - including Diagnostic Services, Day Care Services, Hospital Confinement Services including services of Surgeons, Physicians and Specialists as well as Intensive Care, Special Nursing, Blood & Plasma, Medicines, Medical Supplies and Surgically Implanted Prostheses which are certified to be medically necessary -

(in the event that the condition cannot be adequately treated, diagnosed or the cost of the treatment required is less costly than the medical evacuation will be to Australia, the same benefit limits will apply, but they will be expressed in the Australian Dollar equivalent)

(LIMIT OF
BENEFIT)

- A) In a Preferred Hospital, for any Disability without requirement of paying NZ\$80,000
PER DISABILITY

or

- B) In any Public Hospital where the Daily Charge is inclusive of all professional fees and necessities of treatment Per Day NZ\$450.00
Limit per Disability NZ\$30,000

or

- C) In any other Hospital, reimbursement of reasonable and customary charges at the rate as would be payable in a hospital in New Zealand but not to exceed the inner limits inscribed hereunder in respect of any item of benefit - (inclusive of GST AT 12.5%)

Hospital Daily Care - Shared Accommodation		NZ\$275.00
Private Room		NZ\$285.00
Same Day Surgical Procedures	Maximum	NZ\$265.00

COPY

Same Day Non-Surgical Procedures	Maximum	NZ\$105.00
Professional Fees: Surgeons, Anesthetists, Physicians, Radiologists, etc		As per Medical Benefit Schedule
Special Nursing in excess of 3 hours per day		NZ\$278.00
per disability	•	NZ\$1,588.00
Theatre Fees - Maximum per Disability		NZ\$1,400.00
Prescriptions Pharmaceuticals for treatment:		
	Per Disability	NZ\$2,800.00
Prostheses - (non cosmetic) - necessitated by an operation performed within the preceding 12 month and surgically implanted	Per Disability	NZ\$2,800.00
Intensive Care as supplement Daily Care Charge - Limit 14 days/disability Per Day		NZ\$ 278.00
Major Surgical Items, payment towards cost of	Per Disability	NZ\$2,648.00
COMBINED LIMIT for Pharmaceuticals, Prostheses & Major Surgical Items Per Disability		NZ\$4,200.00
Day Care Per Procedure		As Charged
Board & Accommodation in hotel/motel during period of Daycare	Per Day	NZ\$ 60.00
LIMIT OF MEDICAL BENEFITS FOR ANY ONE DISABILITY		NZ\$30,000

COPY

MEDICAL EVACUATION BENEFITS - for so long as such are certified to be medically necessary including costs of Economy Return Fares of the Assured (on stretcher if so required), necessary medical appliances or supplies for journey, local ambulance, air ambulance, or ambulance launch, Economy Return Fares for a medical attendant and/or a family member, the medical attendant's fees and accomodation until return to Fiji, and daily room and board allowances for accompanying family member as hereunder -

ASSURED

Return Economy Airfares (or stretcher fares as may be medically required) for the Assured to the town in which the Hospital selected by the Insurer is located or the actual cost of fares to any other place but not to exceed the cost of the formerAs Charged
Maximum \$10,000

Overseas Telephone - Cost of two 3 minutes calls to Fiji

COMPANION

Return Economy Airfares for the accompanying Medical Attendant and/or family member to the town in which the Hospital selected by the Insurer is locatedAs Charged
Maximum F\$10,000

Ambulance, air ambulance, launch ambulance or taxi transportation from a Fiji Hospital to Airport and overseas airport to the hospital and return for so long as such are certified to be medically necessary and not including expenses other than for evacuation overseas.

Fees charged by an accompanying Medical Attendant for services to the Assured.

Necessary Board and Accomodation costs of the Medical Attendant until the time of the earliest available return flight to Fiji.

Cost of two 3 minutes telephone calls to Fiji.

Board & Accommodation allowance for accompanying family member for so long as the continued attendance of such shall be certified to be medically necessary by the attending physician

Per Day NZ\$60.00

OVERALL LIMIT OF MEDICAL EVACUATION BENEFITS FOR COMPANION AND MEDICAL PRACTITIONER EXCLUDING AIRFARES F\$2,500

COPY

REPATRIATION OF BODY & FUNERAL BENEFITS - in the event of the death of an Assured whilst overseas under the provisions of this Benefit the Insurer will provide for the purpose of embalming, coffin and transportation an additional

F\$1,500

OVERSEAS HOSPITAL CONFINEMENTS WITHOUT PROPER REFERRAL

In the event an Assured shall have availed himself of treatment for a disability as a bed patient in any overseas hospital without the certifications and referrals required for the provision of this benefit and it be ascertained that the required treatment would-

a) not have been available in Fiji, the maximum reimbursable shall be the amount which would have been payable for an equal course of treatment in a Preferred Hospital in New Zealand

NZ \$25,000

b) have been available in Fiji, the maximum reimbursable shall be the amount as would have been charged in a Hospital operated by the Government of Fiji

F\$5,000

SCHEDULE 2:

DEFINITIONS

- ASSURED** Employees of the Member Groups of the INSURANCE WELFARE SOCIETY to whom a Certificate of Insurance has been issued, whose names have been provided to the Insurer by the INSURANCE WELFARE SOCIETY as persons to be insured together with completed forms of declaration in respect of each of such employee and their dependants to be included for cover.
- ACCIDENT** means an event occurring entirely beyond the Assured's control and shall include Exposure or an event of violent, external and visible force causing bodily injury which solely and independently of any other cause shall within twelve (12) calendar months of the event necessitate medical treatment.
- CHILD** means an unmarried person who is not older than 18 years, (nor older than 24 years if registered as a full time student in a recognised educational institution), and wholly financially dependent on an Assured.
- CONFINEMENT** means a period of confinement in a Hospital for which an occupation charge has been made
- CONGENITAL CONDITIONS** means medical deformities/abnormalities existing at the time of birth.
- DAY CARE** means Treatments provided in a Hospital or in a specially equipped clinic or treatment center which
- a) Utilizes apparatus designed for installation in Hospitals to provide specialized and uncommon treatments such as radiotherapy, kidney dialysis and major physiotherapy.
 - b) Does not require the patient to be confined in a Hospital, and
 - c) Are provided by a specialist or under the direct supervision of a Specialist.
- DAY CARE SURGERY** procedures performed by visiting Overseas Consultants or by Specialists in private practice

resident in Fiji provided the treatment or procedure performed has been certified by the Ministry of Health to be unavailable from Public Health facilities in Fiji.

DEPENDANT means the spouse of a married Assured and his natural or wholly financially dependent children and in the case of an unmarried Assured, one nominated next of kin or his financially dependent children.

DISABILITY means a Sickness or all of the injuries arising out of a single or contiguous series of Accidents including life threatening congenital, and pre-existing conditions where covered, occurring after the commencement of Insurance under this Policy.

MEDICAL PRACTITIONER means a Physician in General Practice who is registered as such in the geographical area in which he provides the services of a physician but shall not include a person related to or living with anyone making a claim under this Policy.

HOSPITAL means an establishment duly registered as a hospital in the geographical area of its operations which has facilities for major surgery, diagnosis and treatments is under supervision of Physicians and Registered Nurses twenty four hours a day, and is not primarily a clinic, home for alcoholics or drug addicts, home for the aged or the handicapped or a nursing, rest or convalescent home.

INSURER means Queensland Insurance (Fiji) Limited, Head Office in Suva, Republic of Fiji.

MEDICALLY NECESSARY means medical supplies or service which is -

- a) Consistent with the diagnosis and customary medical treatment for the condition.
- b) In accordance with the standards of good medical practice.
- c) Not for the convenience of the Assured or the Medical Practitioner.
- d) Performed in the least costly Setting required for the treatment.

COPY

ORO-DENTAL SURGERY	means a complicated and difficult oral operation necessarily performed by a specialist under general anaesthesia in a specially equipped clinic or in the operating theatre of a hospital.
PRE-EXISTING CONDITIONS	means a sickness or a disablement of an Assured which had been in existence prior to the commencement of cover under this Policy.
PREFERRED PROVIDER	means a Hospital which has agreed with the Insurer to provide privileged services for controlled fees for accommodation and food, professional fees and hospital supplies and services .
PRESCRIBED MEDICINES	means medicines which have been prescribed a physician for the cure or relief of a covered Disability which may not be legally purchased without a prescription "RX classified"
PUBLIC HOSPITAL	means a Hospital operated entirely by the public service of a country.
REGISTERED NURSE	means a person qualified to provide nursing care to sick and injured persons and enrolled as such on registers of the health authorities in the country in which the services are provided.
SICKNESS	means a pathological departure from the normal healthy state which necessitates medical treatment.
SPECIALIST	means a medical or a dental practitioner registered and licensed as such in the geographical area of his practice and who is registerable as a Specialist by the Fiji Medical Council and the Fiji Dental Council respectively.
TREATMENT	means surgical or medical procedures required for the cure or the relief of a Disability.
TREATMENT DURATION OF	means when in respect of an approved Evacuation overseas for Hospital confinement Day care or Diagnostic Procedures, the period from the day of departure overseas until:- (a) the day of discharge from the Hospital, (b) the day on which the attending Specialist

COPY

certifies that Day Care is completed or
(c) the day on which the required diagnostic
procedures are certified as completed by the
attending Specialist, whichever shall be the
later.

USUAL AND CUSTOMARY OR U & C

means the usual and Customary fee or charge
as would have been made by the greater majority
of persons or establishments as the case may
be for services or supplies of equivalent
quality with due consideration for expertise,
experience, geographical location and
special economic and social factors as may
apply.

COPY

SCHEDULE 3

CONDITIONS

ALTERATIONS:

Alterations in the terms of the Policy or on any Endorsements thereto will not be valid unless same have been signed or initialed by an authorised representative of the Insurer.

CANCELLATION/RENEWAL

The Insurer must give 30 days Notice to the Insurance Welfare Society of its intention not to renew this policy. The Insurance Welfare Society must also give 30 days notice to the Insurer of its intention not to renew this policy.

CERTIFICATION, INFORMATION AND EVIDENCE:

- 1) all certificates, information and evidence required by the Insurer in respect of any claim which may be payable under this Policy shall be provided to the Insurer at the expense of the claimant.
- 2) an Assured to whom a claim under this Policy may be payable, shall at the Insurers request and expense submit to a medical examination whenever such be deemed necessary.
- 3) when a claim shall be in respect of the death of an Assured, the Insurer shall be permitted to have a post mortem examination conducted at their own expense, if they so require.

GENDER:

Where the context so admits, any reference to the male gender shall apply equally to the female gender.

GEOGRAPHICAL LIMITS:

Cover is restricted to the Republic of Fiji, however this restriction shall not apply to temporary residence overseas not exceeding 6 months.

NOTICES

Any notice to be given under the provisions of this Policy will be sent to the last known address of the Policy Holder.

PREMIUMS:

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- 1) Premiums are payable fortnightly in arrears for the members of the Public Service Commission, monthly in arrears for the Public Service Commission Unestablished staff and monthly or quarterly in advance for the rest of the member groups of the Insurance Welfare Society.
- 2) Coverage will cease if after 30 days from the commencement of the new Premium Period, all or part of the premium remains unpaid.

TERMINATION - INDIVIDUAL ASSURED:

The benefits under this Policy in respect of an Assured will terminate at midnight, Fiji time, on the last day of the Policy Year in which the Assured shall have attained his sixty fourth (64th) birthday. Assured wishing to continue with the Group policy must obtain the approval of the Insurer.

COPY

GENERAL CONDITIONS

ARBITRATION

(MEDICAL SERVICES - NECESSITY OR COST) : Any difference arising between the Insurer and an Assured or a Provider in respect of a medical service or the charge made for a medical service shall be referred within one calendar month of having been required to do so by either of the parties in difference to an arbitrator who shall be a Specialist (or a Senior Physician if a Specialist not be available). If the parties cannot agree on a single arbitrator then two arbitrators shall be appointed within one month of such failure to agree on a single arbitrator, one by each party, provided each one be a Specialist and in the event of disagreement between the arbitrators an umpire shall be selected by the arbitrators who shall be a senior Specialist or such other person as shall be considered by them as proper to be Umpire and Umpire's decision made in session with the Arbitrators shall be final and binding on the parties in difference. In the event the arbitrators cannot agree on the appointment of an umpire, the umpire shall be a person appointed by the Ministry of Health in Fiji.

(OTHER DIFFERENCES) All other differences arising out of this Insurance shall be referred to the decision of an Arbitrator to be appointed in writing by the parties in difference or if they cannot agree upon a single Arbitrator to the decision of two Arbitrators one to be appointed in writing by each of the parties within one calendar month after having been required in writing so to do by either of the parties. In the instance that such two Arbitrators do not agree they shall appoint an umpire in writing whose decision made in session with the Arbitrators shall be final and binding on the parties in difference. In the event the arbitrators cannot agree on the appointment of an umpire, the umpire shall be a person appointed by the Insurance Commissioner of Fiji.

BENEFITS APPLICABLE TO EACH DISABILITY:

Unless specifically stated otherwise in the Schedules, the benefits paid to any Assured for a specific Disability and related causes will not reduce the amount available to him for any other Disability.

CLAIMS:

Notice of any claim must be given to the Insurer within thirty-one days of such being incurred. Claims submitted after such period shall not be considered invalid if it can be shown that submission was made as soon as reasonably feasible. All claims shall be made together with proof satisfactory to the Insurer at the claimant's own expense of the death, illness, disability, injury or loss for which a claim is made hereunder together with all relevant bills, receipts, tickets, coupons, contracts or agreements relevant to the

COPY

CONDITIONS PRECEDENT TO ANY LIABILITY OF THE INSURER:

Any liability of the Insurer to an Assured shall be wholly dependent upon -

- a) The truth of all statements and declarations made in respect to any claim made against the Insurer by an Assured (or by a parent or duly appointed guardian if the Assured be a minor).
- b) The due observance and fulfillment of the Terms, Provisions and Conditions of this Policy and Endorsements to it insofar as they relate to anything to be done or complied with by the Assured.

OTHER ASSURANCE:

In the event of making a claim, any Assured insured by any other policy providing reimbursement for expenses arising out of Accident or Sickness shall inform the Insurer and provide them with a Copy of the policy.

RECOVERIES:

At any time the Assured has been indemnified under this Policy for a loss which may be recoverable from a third party, the Assured shall upon demand subrogate his right of recovery for the said losses to the Insurer who may at their own expenses take proceedings in the name of the Assured to recover compensation from any Third Party provided that, any amount so recovered, but not to exceed the amount of the Assured expenses for the indemnity and the costs of recovery from the third party, shall belong to the Insurer.

COPY

SCHEDULE 6

EXCLUSIONS

EXCLUSIONS - The Insurer will not pay for any disability or expense arising out of

- 1) Care or treatment which is payable by any other form of Insurance or indemnity recoverable by the Assured.
- 2) Congenital deformities and abnormalities except when they are certified to be of life threatening nature which can be alleviated by standard Medical Procedures.
- 3) Dental treatment except for Oro-surgical operations and injuries to sound natural teeth arising out of an Accident.
- 4) Treatments undertaken in nature cure clinics, health hydros or similar establishments or in nursing homes attached to such establishments.
- 5) Pregnancy, miscarriage or abortion unless necessarily requiring confinement in a Hospital and treatment by a Specialist for -
 - a) Hyperemesis Gravidarum, Eclampsia, Pre-clampsia, Ectopic Pregnancy or Hyatidiform Mole, or
 - b) Other severe complications induced by injury or concurrent sickness.
- 6) Residential charges in any Hospital or Nursing Home during any period except when confinement is necessarily required for treatment of a covered Disability by a Specialist.
- 7) Any Disability incurred in the pursuit of any illegal act.
- 8) Self inflicted injury, attempted suicide or excessive consumption of alcohol or drugs other than those prescribed by a physician for the relief of a disability.
- 9) Psychotic, mental or nervous disorders.
- 10) Surgical, mechanical or chemical process of contraception or treatment pertaining to infertility.
- 11) Long term custodial or maintenance care for the incurable.
- 12) Any condition which is directly or indirectly attributable to or consequent upon Acquired Immune Dificiency syndrome "AIDS" or "AIDS" Related complex (ARC), howsoever this Syndrom has been acquired or maybe named.

COPY

- 13) Venereal or sexually transmitted diseases.
- 14) Elective surgery; cosmetic or plastic surgery except to the extent that such treatment is necessary for the cure or alleviation of a Disability
- 15) Non medical services or charges such as radio, television and the like except as may be specifically endorsed as a benefit.
- 16) Pre-existing Medical Conditions for:-
 - A) All individuals joining a member group of the Insurance Welfare Society after 1st July 1991, unless:-
 - i) they are members of a Compulsory group.
 - ii) they are new employees of a Voluntary group provided they join the Scheme within thirty (30) days of appointment.
 - B) Members of existing Voluntary groups of the Insurance Welfare Society if period of participation in the Scheme is less than three (3) months prior to 1st July 1991.
- 19) War, Invasion, Act of Foreign Enemy, Hostilities or Warlike Operations (whether War be declared or not), Mutiny, Civil Commotion assuming the proportions of or amounting to a Popular Rising, Military Uprising, Insurrection, Rebellion, Revolution or Military or Usurped Power, or any act of any person or persons acting on behalf of or in connection with any organisation, the objects of which include the overthrowing or influencing of any de jure or defacto government by terrorism or by any violent means.

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SCHEDULE 7

PROFIT SHARING

THE PREMIUM RETURNABLE shall be paid at the end of the policy period as follows:-

80% of ((70% of premium) minus claims)

1. DEFINITIONS:

CLAIMS shall mean the Sum of Claims during a Policy Year together with adequate Reserves for Claims Pending and Claims Incurred But Not yet Received reduced by the amount of any Reserves carried over from the preceding year.

2) PROVISIONS FOR PAYMENT:

Profit Share shall be paid at the end of the policy year provided that:-

- a) If the Insurer cancels the policy mid-term, pro-rata Profit Share applies.
- b) If the Insurance Welfare Society cancels the policy mid-term, no Profit Share will be paid.
- c) If the Insurer refuses to renew the policy, Profit Share will be paid in full.
- d) If the Insurance Welfare society elects not to renew the policy at the end of the policy year, Profit Share will be paid in full.

APPENDIX D:
THE NEW ZEALAND CORE DEBATE

The Core Debate

Stage One: How we define the core

Contents

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1 - The Core Service Debate

What it is and why you should read this document

Your health is important - not just to you as an individual, but to New Zealand.

As a country we place great value on health and we have many reasons to be proud of what has been achieved by our health system. It's also one of the biggest industries in the country, making up seven percent of New Zealand's gdp and employing more than 60,000 people around the country, so there's a lot at stake with it.

But it's time to confront some difficult issues. Our health system isn't performing as well as it used to.

The fact is that it has been under pressure for some time. The costs of health services keep on going up as better drugs are discovered and new technology is developed. Plus our population is ageing, and that means we will need to spend more on the health of older people.

If New Zealand's economy had continued to grow over the last 20 years the problems we're facing wouldn't be so serious. But it hasn't been and we can't afford to spend any more on health. There isn't enough money available to do all the things we want to do now, let alone pay for newer and better things in the future.

We have no choice but to start taking a good, hard look at what we, as a community, want from our health service. We have to make decisions about what we value and what our priorities are.

And that's where this debate about core services fits in. The core sets down, at a national level, those health services that Regional Health Authorities and health care plans must ensure access to. We have to work out which health services we think everyone should have access to, on affordable terms and without unreasonable waiting times. This is not going to be easy. It's likely to take a number of years, but it will be a process of refinement and done in stages.

The first stage, before we even think about what we want to go on the list, is to think about **how** we are going to define the core. The choice we make here will depend on where we think detailed decisions should be made and by whom - at central government level, regional level, or the level of clinician and patient. We will also need to consider questions of access to core services - such as user-charges, waiting times and distance from services.

Two broad issues that need to be considered are:

- **the needs and preferences of the community as a whole must be balanced with the needs and preferences we have as individual users of health services - there is a trade-off between a well-defined core and consumer choice**
- **we need to strike a balance between public consultation, individual choice and expert input into the decision-making process**

The Government is committed to a process of public consultation over this and future issues regarding core services. This booklet explains some of the different options for how we define core services, it sets out some of the things you might like to think about at this stage and it outlines what is required from a submission.

Remember, you don't have to decide on the core itself just yet. A process of consultation about what services, conditions or treatments should be included in the core will be undertaken by the National Advisory Committee on Core Health Services, to be appointed early in the new year by the Minister of Health.

2 - *The background*

On Budget night this year the Minister of Health Simon Upton announced a major reform of our health system.

The key elements of the reforms are:

- Four Regional Health Authorities (RHAs) will be established to buy all health services for the people who live in their area. This will include both primary care, provided by general practitioners and others in the community, and hospital-based care.
- RHAs will not own any hospitals, laboratories or other facilities themselves, but will be able to buy services from any provider in the public, private or voluntary sectors.
- Most big public hospitals and related services will be turned into Crown Health Enterprises (CHEs) and, while still publicly owned, will be run on more business-like lines.
- Many smaller communities will be given the opportunity to take over their local hospitals and run them as community trusts.
- People will have the choice of obtaining their health care through RHAs or through alternative health care plans. Everybody will be covered by either an RHA or a health care plan. It won't be possible for people to 'opt-out' of the health system.
- Public health services will be funded separately from other 'personal' health services.
- The health services for which Government funding is available and to which everyone has access will be defined more clearly. These services will become New Zealand's core health services.

How we go about working out what our core health services list will look like is what this document is all about. Once we have a clear idea on this, we will then need to decide what should be in the core.

Having a list of core health services can serve a number of objectives, so we must ask ourselves what we want our core to do:

- **Universal Access:** a core could ensure that no-one misses out on those services which we all consider essential.
- **Value for money:** a core could ensure that we get maximum possible benefit for whatever amount we decide to spend on health.
- **Expenditure control:** a core could be used to limit how much money the Government is obliged to spend on health.
- **Quality and appropriateness:** a core could make sure we get the best quality and most appropriate care.
- **Uniformity:** a core could make the list of health services available more explicit and uniform nationally.
- **Clear responsibility:** a core could make decisions about where we spend our health dollars more open to public scrutiny, both at the national and regional level.

There are many options for the type of core list we could have and there may be other objectives the core could be used to achieve. Which of these objectives we want the core to serve will influence the type of core we choose. It may also be that we decide that the core is not the best way of pursuing some of these objectives.

Choosing to achieve one objective through the core may require a trade-off with another. For example, the present system of general practice subsidies achieves the objective of reasonably universal access in terms of price, with the Government subsidising visits for those deemed unable to pay the full cost themselves. This system is not good, however, at achieving the objective of expenditure control. If we want to achieve both objectives, we may choose to do one through the core and another through some other mechanism.

3 - *What happens now?*

New Zealand does, in fact, have a core now.

There are things that the Government does not provide money for and which may be quite costly to buy privately. Other services are, by implication, in the core.

The things not publicly funded now include most adult dental work, liposuction, chiropody and optometry.

But while everything that is fully or partly funded could be said to be part of the core, we apply a dizzying array of mechanisms, with decisions made at all sorts of levels, to try and serve some of the objectives outlined in the previous section.

For example, pharmaceuticals are part of the core. The Government provides money to subsidise the medicines and drugs that we need - at varying levels depending on age, employment status and income. But it is difficult for the Government to control how much it spends in this area, even though not all pharmaceuticals are subsidised, because decisions about what to prescribe are made by each individual doctor.

Certain operations are not performed in New Zealand, such as liver transplants, but the Government makes some money available to help people travel overseas for these operations. This is a fixed sum of money each year and it has to be divided up amongst all the people needing these operations. Until recently the decision about who gets help was made by the Minister of Health based on advice from the Department of Health. These decisions are now made by area health boards. To make up the funding shortfall, many communities start local fund-raising efforts to help people travel overseas for these kinds of operations.

With our hospital-based health services, area health boards are given a fixed sum of money and expected to provide a comprehensive range of secondary-care services. If you have a car accident, or some other accident needing emergency care, you will get prompt, high quality treatment no matter where you are in New Zealand. But it is up to each individual board to make decisions about how to prioritise services. If you need a hip replacement you may wait 18 months in one place and three years somewhere else. A surgical team may be able to do many more operations than it is currently, but can't because of funding constraints - the board won't get any more money for doing more operations - leaving facilities under-used. Decisions about which patients need which services, and who has greater priority, are often left to individual clinicians.

4 - *The options*

Broadly speaking, there are two main ways we could go about defining our core services list at the national level.

At one end of the spectrum is a detailed, priority-ranked list where most of the decisions about what is in the core are made collectively at the national level. At the other end is a general list, which would specify core health services in terms of broad categories of health services and leave more detailed decisions about priorities and how to use scarce health resources to the local level (either the RHA, health care plan or devolved further to clinicians and patients).

There is a whole range of alternatives between these two options. We could have a national general list with decisions at the RHA level made according to some nationally determined criteria, or a national general list with a regionally determined detailed list of services which the RHA or health care plan would offer.

The option we choose for defining core health services affects the way in which decisions about using resources for health care are made and by whom. Many people have a stake in the way health care choices are made: all of us as individuals; all of us as members of particular groups or communities; politicians; people with special skills such as economists, epidemiologists, general practitioners, nurses, dentists, hospital specialists, statisticians and managers; and many more. The more detailed the list at the national level, the less chance there is for regional variations and individual choices by clinicians and patients.

It is worth noting that no list could ever be so detailed that all variations and individual circumstances were taken account of, thus removing the need for some decision-making at the doctor-patient level.

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Detailed priority ranked (DPR) list

This kind of core list consists of an explicit, priority-ranked list of health services. The idea behind this type of core is to gain the maximum benefit for every dollar of health expenditure.

With a detailed priority ranked list the decisions about the appropriate treatments are highly centralised and the method by which these decisions are made is explicit.

The only place in the world where this has been tried is in the State of Oregon, in the United States. In this example there are 709 health condition and treatment pairings on the list, ranked in order of priority. First on the list is medical therapy for pneumonia, followed by medical therapy for tuberculosis. Obstetrical care for pregnancy is number 21 and medical therapy including dialysis for chronic renal failure is number 310. The last pairing on the list is life support for anomalies and reduction deformities of the brain.

In Oregon the priority was determined by a process of combining social values and other data. There are many things to take into account when determining the social values of a service, including the value to society, the value to an individual at risk of needing the service, and whether it could be considered essential to a basic health care package. Additional information is then required, such as the cost and quality of life benefit of a treatment, to determine a priority ranking for each service.

Using a detailed priority ranked list, it is relatively simple to match the size of the health budget with those services deemed to be part of the core because a line can be drawn at any point on a DPR list. We might say that all those things down to number 560 must be on the core, therefore our health funding must be set at a certain level. Or we might say that we have this amount of money, therefore we can fund everything down to a certain point on the list.

In Oregon, for instance, providing funding for everything down to number 310 would cost \$US98.51 per person per month. It would cost \$US145.05 per person per month to fund everything on the list.

But while it is simple to draw the line, doing so can require some difficult political decisions to be made.

As well as determining what's on our core list, a service's position on a priority-ranked list could also be used to help define other dimensions of access, such as waiting times.

For example, if you get appendicitis you'll get rushed to hospital for immediate surgery because you'll die if it's not dealt with urgently. But if you need a hip replacement it's reasonable that you may have to wait a certain time. For this reason surgical removal of appendix would be higher on the list than hip replacements.

So a DPR list has the potential to achieve the objectives of value for money, expenditure control and universal access. But valuing health services raises difficult ethical and empirical issues. How do we decide whether heart transplants are more important than incubators for premature babies? Should collective decision-making be used to decide whether someone should have a particular treatment, particularly if their doctor feels that another treatment would be more appropriate?

The process of ranking health services in such detail is highly complex and one which would require a lot of input from people with expert skills. This could mean that non-medical people and community groups feel less involved in the decision-making process, unless they are consulted on an on-going basis.

A DPR list also has the potential to be condition-treatment focused and it can be difficult to build in services which don't fall into these categories, such as ambulance services.

General list

The essential feature of a general list is that it identifies groups of services in the core. These categories are specified in broad terms and not ranked. The Government devolves many decisions to RHA and health care plan level - they may then devolve more decision-making to the individual clinician/patient level.

This means that a general list gives patients and their doctors more discretion than they would have with a more detailed list. It allows medical practitioners to respond more flexibly to rapidly changing technology, and it gives Regional Health Authorities or health care plans more room to move within each category

General lists could either be positive - every category that's on it has to be covered; negative - every category other than those on the list has to be covered; or some combination of the two

A general core could be a list of services, conditions, treatments, or a combination of these. The following list of categories of health services can be used to illustrate the possibilities of a general list. This is not a comprehensive list of all possible health services, nor is it in any kind of order.

- *Preventive Dental Care, adults and children: cleaning and fluoride applications.*
- *Maternity Care, including most disorders of the newborn: antenatal care during pregnancy; delivery of baby.*
- *Potentially Fatal Conditions, treatment prevents death without full recovery: surgical treatment for head injury with prolonged loss of consciousness; medical therapy for bacterial meningitis; surgical treatment of an open break of a joint.*
- *Preventive Care for Children: immunisations proven to be effective; medical therapy for streptococcal sore throat to prevent rheumatic fever; hearing and vision screening.*
- *Potentially Fatal Conditions, treatment prevents death with full recovery: surgical removal of appendix for appendicitis; repair of deep, open wound in body; medical therapy for childhood bacterial pneumonia.*
- *Fatal or Nonfatal Conditions, treatment causes minimal or no improvement in quality of life: removal of unexposed tattoos; surgical repair of fingertip loss that does not include fingernail.*

- ***Comfort Care, therapy to provide relief for conditions in which death is imminent: end-stage cancer; therapy for the frail elderly.***
- ***On-going Nonfatal Conditions, one-off treatment improves quality of life: hip replacement; cataract surgery; medical therapy for rheumatic fever; operation for enlarged prostate.***
- ***Infertility Services: surgery for tubal disease; test-tube fertilisation.***

This isn't the only way to categorise health services, but it does illustrate how it could be done. Once we had decided on our categories we would look at each one and say yes, that should be on our core list, or no, that's not part of the core.

For example, we might decide that preventive dental care for adults and children is a useful service, but it shouldn't be part of the core. (At the moment in New Zealand the Government funds preventive dental care for children, but not for adults.)

We might decide at national level that regional health authorities or health care plans should offer services within the category for one-off treatments for non-fatal conditions which improve quality of life, but it would be left to RHAs or health care plans to decide the mix and style of services they provide within this category - one RHA may provide day surgery facilities for many of these services, while another may continue to have over-night hospital stays.

Preventive care for children may be a core category. In one area special travelling health teams may be set up for early detection of things like glue ear and the need for glasses, while another region may rely on general practitioner check-ups.

Another type of a general list could be to categorise services according to service delivery groups.

For instance, six of these groups could be mental health, pediatrics, medical, surgical, primary care and geriatrics. Within each service group there would need to be a statement about the level of services.

This statement could be a negative list of services which won't be provided, a positive list, or a combination of the two. For example, in the surgical group, we might say cosmetic surgery and heart transplants are not included, but that hip replacements, appendix removal and major reconstructive surgery are.

Alternatively, our statement about the level of services could be guidelines saying which categories of surgery are a priority and under what conditions.

For example we might specify the conditions under which we do surgery for a terminally ill cancer patient to reduce pain and suffering. This would improve their quality of life, but possibly only for a short period of time.

Under our medical service group we might say that services not included, or given a low priority, were the use of cholesterol-lowering drugs for borderline high-cholesterol cases and drug treatment for borderline hypertension. But we might give high priority to anti-biotic treatment for bacterial pneumonia and drug treatment of heart disorders.

The different service groups may be priority ranked. For instance we might say that primary care services, such as help for lifestyle changes in the case of borderline hypertension, had higher priority than surgical or medical treatments for this condition.

Using a general list makes expenditure control more difficult. If our general list divides health services into broad categories, then in theory we could keep doing everything within any category until the money ran out and then nothing more, or we could keep doing everything regardless of how much money was spent. In reality neither option is possible. Health services can't just stop when the money runs out, nor do we have the money to just keep on spending what we like. A general list is also likely to lead to less uniformity of access to, and availability of, services.

So another option could be to have a general list accompanied by a national set of requirements covering other dimensions of access.

For example we might have a requirement covering waiting times. This might say that all life-threatening conditions must be treated immediately, but that a wait of up to eight months for a hip replacement is reasonable.

Another set of requirements may cover geographical access. Clearly, not everyone can live within one kilometre of a base hospital, so the core requirements may specify treatment at the nearest available hospital. This may mean that in an area far from a base hospital, a broken hip might be repaired by a local general surgeon rather than by an orthopedic surgeon.

Another possible option would be to have a national general list accompanied by a more detailed priority ranked list at Regional Health Authority or health care plan level. This would leave more scope for variations between each region and between health care plans and there would be less certainty of entitlement, but it would serve the objective of accountability.

5 - Things to consider

There are obviously lots of things to take into account before we decide how we want to go about defining our core. Once we have decided on that, there are yet more things to think about when evaluating what should be on the core list.

But defining core health services for New Zealand is a dynamic process. No-one is asking for a final list first-time round. Initially, we can expect a list that looks pretty much like what we have now. It will change over time because medical technologies, our needs as a society and our values are always changing. The core will never be finished and 'set in concrete'.

Many of the questions and concepts surrounding the idea of core health services are complicated. Some require specialist skills, like working out a cost-benefit analysis of different health treatments. Very few people are in a position to make a considered judgement on all of these questions. But there are many areas where all of us can have an input, for instance finding out what it is that we as a society value. It is vital that as many people as possible tell the Government what they think about core services.

To recap, the two broad issues that need to be considered are:

- **the needs and preferences of the community as a whole must be balanced with the needs and preferences we have as individual users of health services - there is a trade-off between a well-defined core and consumer choice**
- **we need to strike a balance between public consultation, individual choice and expert input into the decision-making process**

Some of the questions we need to ask ourselves are:

- What mix between a general and a detailed priority ranked list do we want? In deciding this we have to think about where we want decisions made, at the national, regional or individual level.
- Who should decide what services or treatments or health needs are in the core - individuals, community groups, politicians, medical people, economists, accountants, health managers?
- How should this decision-making process work? Public meetings, written submissions, telephone surveys, etc..?
- Should the health services within the core be priority-ranked and, if so, how?
- Who should make decisions regarding the up-dating of the core list? A group similar to that involved in making up the initial list, a group which represents a cross-section of New Zealand society, a small working group of experts?
- How should these decisions on up-dating the core be made? Using the same process that was used to work out the core list, or with decision-making powers vested in a smaller group?
- What things should be taken into account when valuing health services - including value to society and value to the individual - and deciding what should be on the core? Expected incremental improvement in health status, cost, likelihood of success (of an operation or treatment), likely duration of benefit, fault or moral responsibility of the patient, numbers who may potentially benefit?
- Once the core is decided, how should it be enforced? For instance, if you think you have been denied access to something which should be part of the core, who should decide whether you're right or not?

6 - How to make a submission

Before you start it might be helpful to discuss the issues raised here with family members, friends and workmates. Perhaps your ratepayers association, your plunket group, or the people you work with could get together, talk through the issues, and then make a submission.

The key things we need to know are:

1. Who you are (either you as an individual or you as the group which is making the submission).
2. Where you are from.
3. Which of the objectives on p.6 you think the core should be used to achieve.
4. Which method of defining the core you think we should use to achieve those objectives:
 - a detailed priority ranked list;
 - a general list (positive, negative or combination);
 - a general list with national requirements;
 - a general list with more detailed regional priority ranking;
 - or some other combination of these options.
5. Why you made this choice. This section can be as long or as short as you like.

Address your submission to:

Submissions
Your Health and the Public Health
PO Box 55
Wellington

It must reach us no later than 5 pm on January 7, 1992.

Your submission doesn't have to be typed, but it should be clear and readable.

Official Information Act

Under the Official Information Act (OIA) members of the public can ask to see any of the submissions received (and any other papers or documents used). If submissions are released under the OIA personal details, such as your personal medical history if you have used it to illustrate your point of view, would be deleted. Your name and address, however, would be made public.

7 - Where to from here?

Submissions for this first stage of the core debate close on January 7, 1992.

A report on the submissions will be prepared for the Minister of Health. The Government will then make a decision about which is the preferred way of going about putting the core itself together.

Early in the new year the Minister will appoint a National Advisory Committee on Core Health Services. This committee will then embark on a process of consultation about what services, conditions or treatments should be included in the core.

Once Regional Health Authorities are operational it is intended that a core list be used as the basis for determining the health services to which they are required to ensure access.

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