Levels and trends of indicators related to universal financial risk protection, including both proximate and distant determinants

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First Global Symposium on Health Systems Research

Montreux, 16-19 November, 2010

IHP

INSTITUTE FOR HEALTH POLICY

Defining "universal health coverage"

- Not sufficient to define in terms of nominal or legal access or "scheme coverage"
  - "Free" or "universal" access often not a reality
- Not sufficient to define in terms of health care treatment/outcomes or of reducing financial barriers
  - Curing sickness is not the only or even most important health policy goal
  - Risk protection/solidarity key motivating principle
    - Germany 1860s - Solidarity principle/Risk protection
    - Japan/Sri Lanka 1930s - Risk protection
    - UK 1940s - Solidarity principle

Operational definition of universal health coverage should embody:

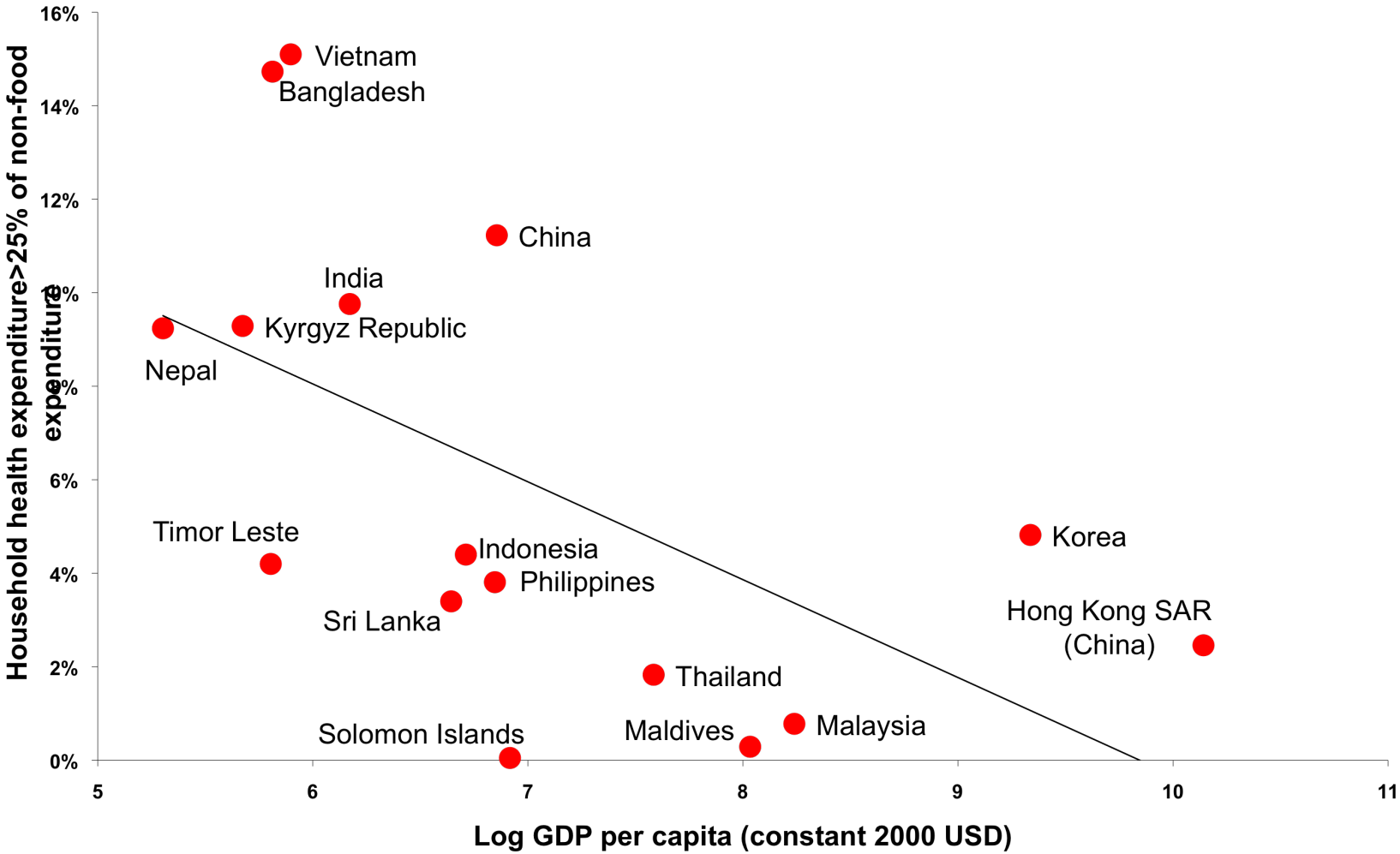
Access to services

- Arrangements for the financing and provision of health services such that there is:
  - (i) at the minimum equality in actual use of health services by socioeconomic status/income, *and*
  - (ii) *equity in use in relation to need in case of higher income economies*

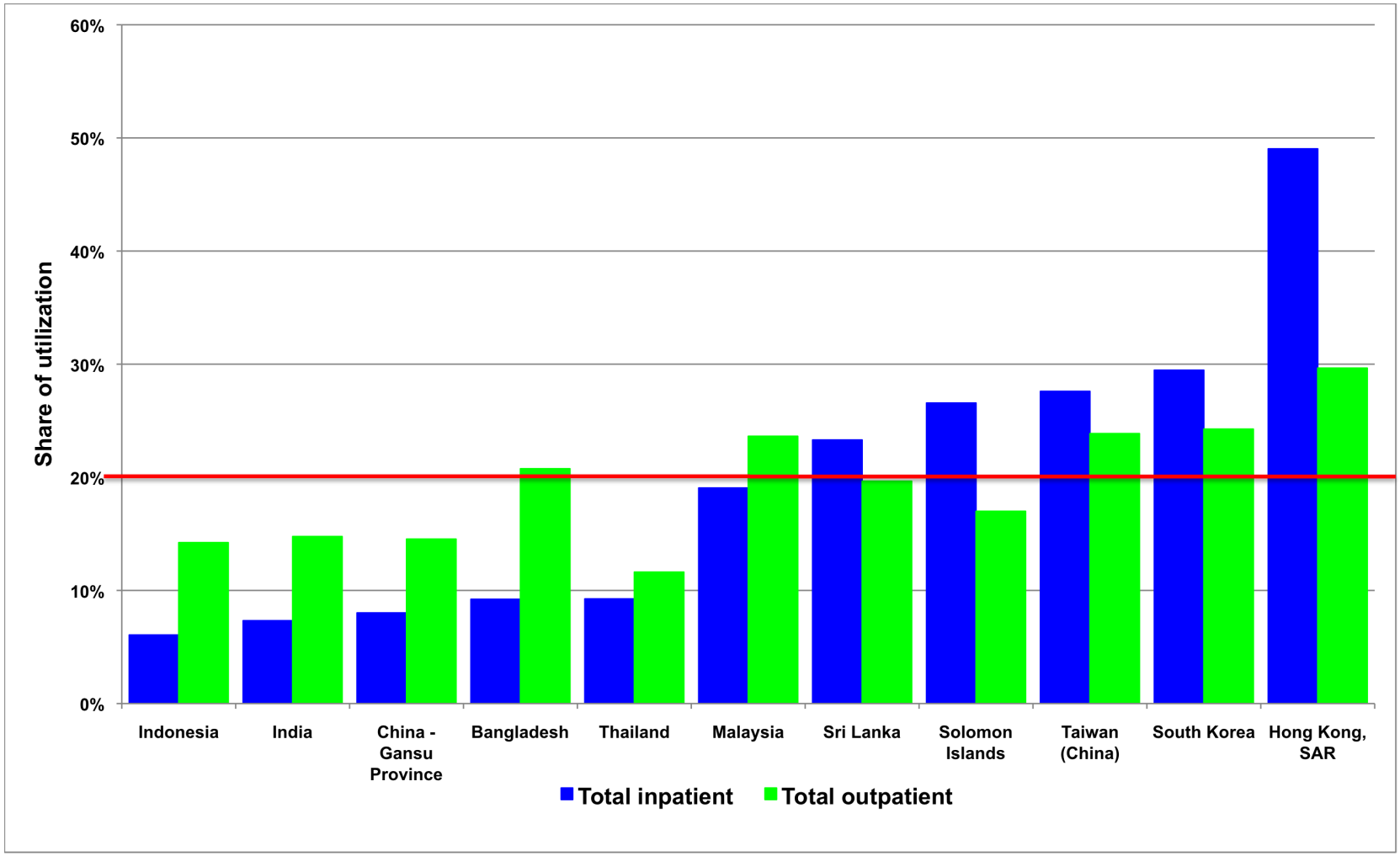
Risk protection

- Arrangements for the financing and provision of health services such that households do not make impoverishing payments in order to obtain a socially-acceptable minimum level of services

Protection against catastrophic expenditures feasible at low incomes



Equal service use by the poor achievable at low incomes



What financing mechanisms have worked in achieving universal health coverage?

Available financing mechanisms

Natural state

- Out-of-pocket payment

Risk-pooling/pre-payment approaches

- Tax-funded, integrated health services
- Social health insurance
- Community health insurance
- Private or voluntary insurance

Financing mechanisms that have not worked

- Public sector user charges <u>with exemptions for the poor</u>
  - Proven impossible to cheaply/reliably target the poor & has failed to reduce inequalities in access, e.g., Ghana, Uganda, Thailand, China, Indonesia
- Voluntary community health insurance
  - No success in scaling-up (>10% of population), with limited protection because of low incomes
  - Works least well in the poorest communities with lowest levels of social capital, e.g., China, India, Vietnam
- Contributory social health insurance <u>w/o tax subsidies</u>
  - Difficult to extend coverage to poor, informal workers, owing to poor capacity to pay and difficulties in collection, e.g., Japan, Korea, China, Mongolia
- Private health insurance
  - Never able to cover informal sector workers, the poor

What has worked: public financing

- Incomplete consensus exists around need for primary reliance on public financing/pre-payment schemes
  - General revenue financing
  - *and/or* Social health insurance

- Where consensus breaks down
  - Continued advocacy of social health insurance or of tax financing in all settings
    - Failure to recognize that general revenue financing can represent implicit insurance mechanism
    - Failure to recognize public sector failures
  - Lower income settings where public financing is constrained

EXHIBIT 5
Regression Results: Estimated Effects Of Various Factors On Household Catastrophic Health Spending

			Middle income					
	Low income		All		Prepayment more than 50% of health spending		High income	
Factor	Coefficient	*p* value	Coefficient	*p* value	Coefficient	*p* value	Coefficient	*p* value
GDP per capita	0.15	0.55	−0.87	0.05	−1.26	0.03	−1.16	0.41
Gini coefficient	2.05	0.02	3.01	0.01	3.78	0.00	3.13	0.08
Fraction of population under age 5	0.11	0.67	0.50	0.09	0.64	0.06	0.66	0.35
Fraction of population above age 60	0.47	0.37	1.47	0.00	1.85	0.00	0.27	0.64
Total health spending share in GDP	0.66	0.08	0.82	0.06	0.88	0.09	1.39	0.31
Prepayment share in total health spending	−1.34	0.00	−2.53	0.00	−5.21	0.01	−7.54	0.00
SHI	0.04	0.92	−1.30	0.00	−0.36	0.55	−0.89	0.22
Mix	−0.32	0.65	0.15	0.64	0.13	0.79	0.29	0.56
_cons	−0.18	0.95	12.35	0.02	16.71	0.01	13.48	0.37
No. of obs.	36		49		35		31	
No. of clusters	28		39		30		27	
R^2	0.55		0.70		0.74		0.69	

SOURCE: Authors' analysis of survey data.
NOTES: Variables are defined in the text. GDP is gross domestic product. SHI is social health insurance.

Xu, Ke, David B. Evans, Guido Carrin, Ana Mylena Aguilar-Rivera, Philip Musgrove, and Timothy Evans. 2007. *Protecting Households From Catastrophic Health Spending*. Health Affairs 26 (4):972-983.

Critical problems in public financing strategies for UHC

Financing strategies that have worked: usual consensus

1. Tax-financing

2. Social health insurance *with* general revenue subsidies

(+ international assistance)

Financing strategies that have worked: reality

1. Tax-financing *with* funding sufficient to finance most services

2. Tax-financing with funding sufficient to finance half of needed services *and* parallel, privately-financed private provision

3. Social health insurance *with* general revenue subsidies

1. Tax-financing *with* funding sufficient to finance most services

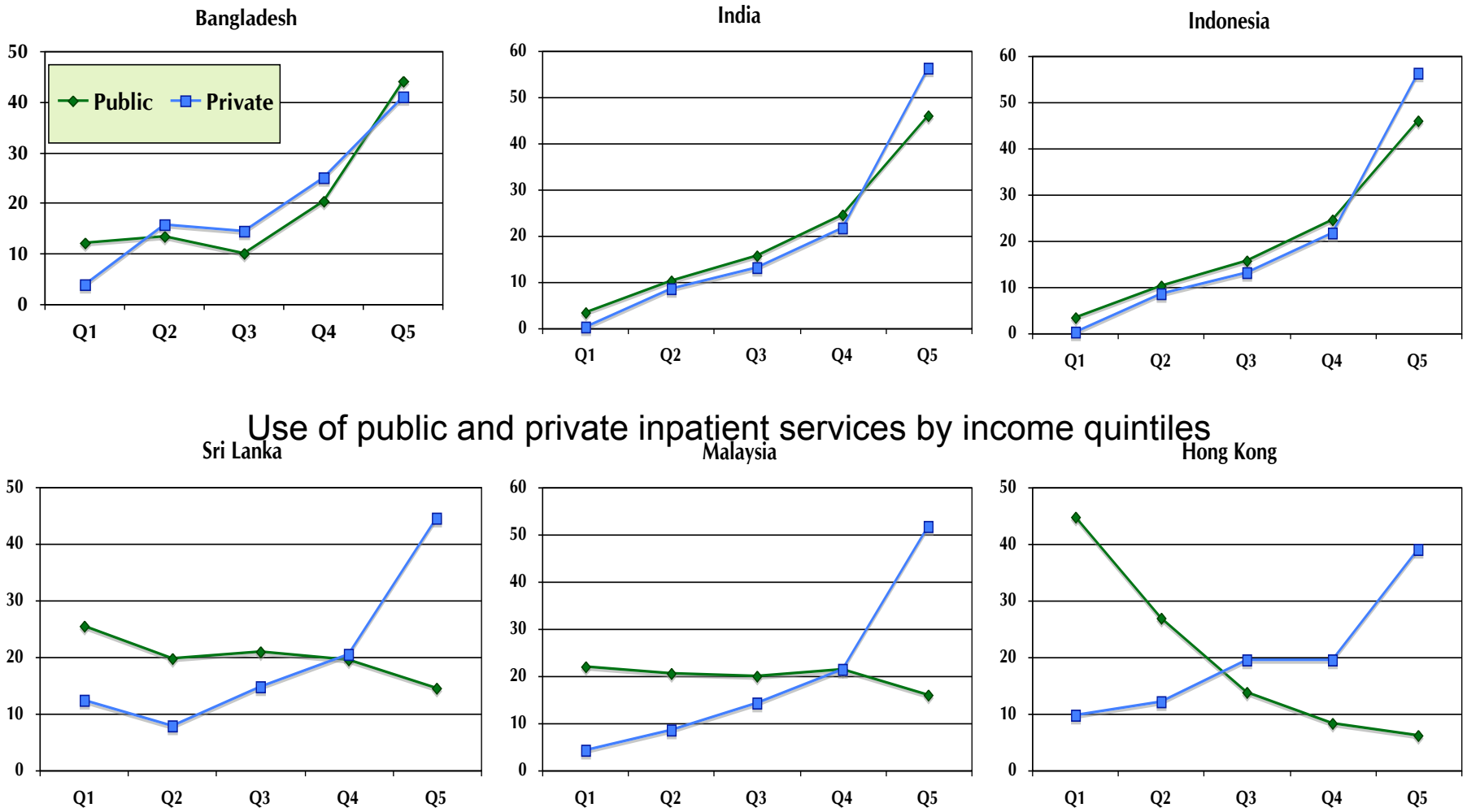
- Traditional UK NHS/Beveridge model
  - » Depends on level of tax-financing being sufficient to pay for most healthcare services (>80%)
  - » Equity and system stability dependent on domination by public financing
  - » Costs 4-8% of GDP in public expenditures

- Most poor countries lack sufficient budgetary resources to replicate UK NHS/Beveridge model
  - » Can afford only 1-2% of GDP in tax subsidies (w/o ODA)
  - » So only able to provide 40-60% of overall needs through public services
  - » Typical outcome is that limited public services are captured mostly by rich, leaving poor without services
  - » Purchaser-provider split as in UK internal market not feasible in low governance/capacity settings

2. Tax-financing with parallel, privately-financed private provision

- Where budgetary resources are insufficient to finance most healthcare services
  - Usual situation in poorer economies, and sometimes in high-income economies (e.g., Hong Kong, pre-1990s Ireland)
  - Tax-financing prioritized to:
    - » Hospital services (insurance function)
    - » Public and preventive health (public goods, externalities)
    - » Outpatient services for poorer population
  - Non-poor persuaded to opt out to privately finance services
- Success dependent on:
  - Effective targeting of publicly financed outpatient services to poor
- Examples:
  - Jamaica, Namibia, Cameroon, Sri Lanka, Malaysia, Hong Kong

Ability to segregate utilization by income between public and private sectors critical to achieving UHC in low expenditure settings

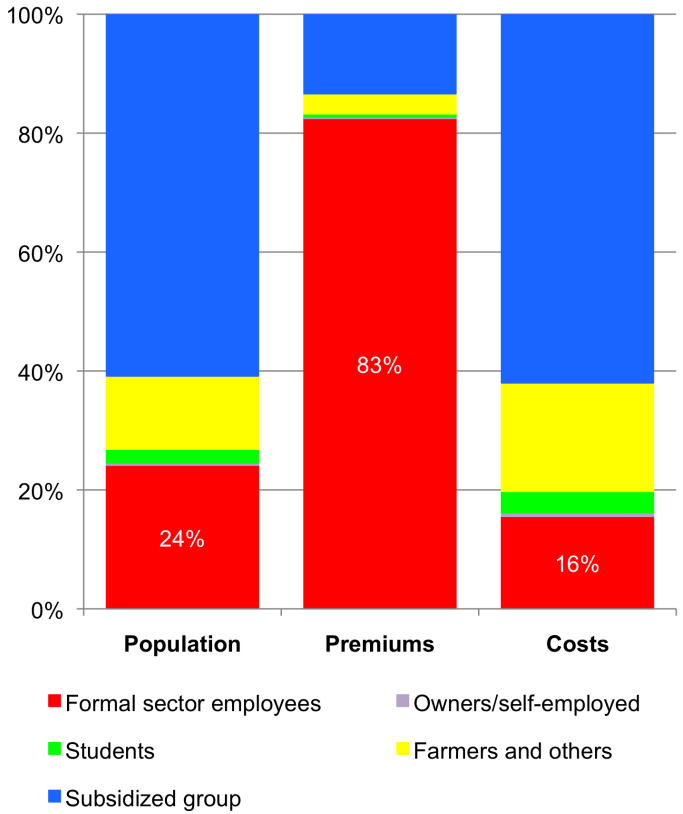


3. Social health insurance with general revenue subsidies

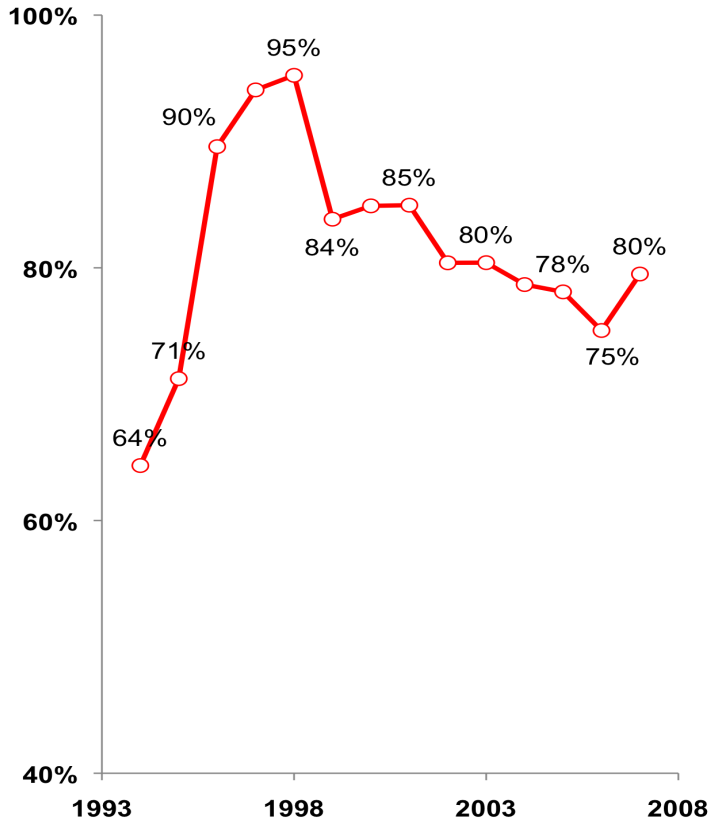
- Contributory SHI not effective in achieving UHC – needs substantial subsidies:
  - General revenue tax-subsidies
  - Cross-subsidization within risk pool from formal sector
  - Costa Rica, Korea, Mongolia: Social insurance linked to employment could not expand beyond formal sector without government tax subsidies for poor and informal workers
- History indicates not feasible in LICs
  - Premium collection from informal sector/poor expensive and low-yielding, requiring large subsidy to contribution ratio. Larger the ratio, the less implementable or politically sustainable
  - To be affordable, government must be able to control prices paid and prevent excess charging, implying significant capacity

Cross-subsidies and trends in insurance coverage, Mongolia

Size, premiums and benefits of covered groups



Trends in insurance coverage of population (%)



Critical questions

- Need for more meaningful measures of health coverage
- How can tax-financing be combined with private spending and provision in low government expenditure settings in a pro-poor manner?
- How do some countries ensure that tax-financed services are pro-poor?
- SHI - how much cross-subsidization and tax subsidies can be sustained?
- SHI – how can new SHI systems control prices in low capacity settings?