PAYING FOR HEALTH CARE: THE IMPORTANCE OF FINANCIAL PROTECTION

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OVERVIEW OF LECTURE

- Patterns of paying for health care in low and middle income countries
- Role of household payments for health care and their consequences for the household economy and for poverty
- Relative merits of various financial protection policies
  - removal of user fees
  - community based insurance
  - social health insurance
  - general tax funding
- How the rich world can support countries to improve financial protection for health

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SOME FACTS: GOVERNMENT AND PRIVATE HEALTH EXPENDITURE (%)

Income Group	Total health expenditure as share of GDP	Government share of total health expenditure	Private share of total health expenditure
Low-income	4.9	38.9	61.1
Lower-middle income	4.4	39.0	61.1
Upper-middle income	6.1	54.8	45.1
High-income	12.5	61.9	38.0
Global	9.4	59.1	40.8

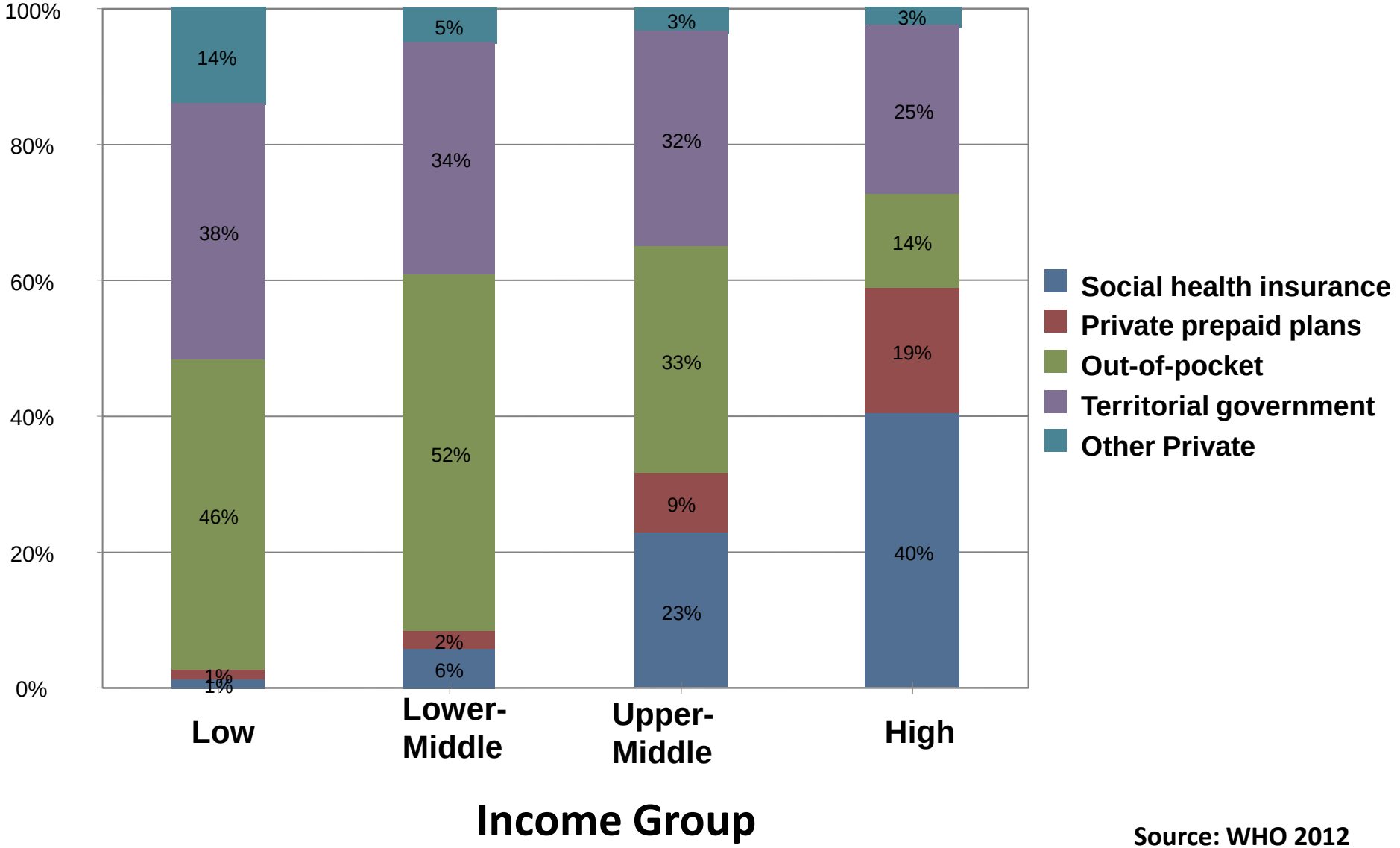
Source: WHO Global Health Expenditure Atlas. Geneva: WHO. Available at: http://www.who.int/nha/atlas.pdf accessed 05/01/12

SOME FACTS: SPECIFIC SOURCES OF HEALTH EXPENDITURE (%)

Income Group	External resources as share of total health expenditure	Social health insurance as share of government health expenditure	Out-of-pocket expenditure as share of private health expenditure
Low-income	25.7	3.6	78.4
Lower-middle income	2.4	15.0	87.8
Upper-middle income	0.2	45.7	75.1
High-income	0.0	65.2	37.0
Global	0.4	59.5	50.2

Source: WHO Global Health Expenditure Atlas. Geneva: WHO. Available at: http://www.who.int/nha/atlas.pdf accessed 05/01/12

SHARES BY FINANCING AGENT



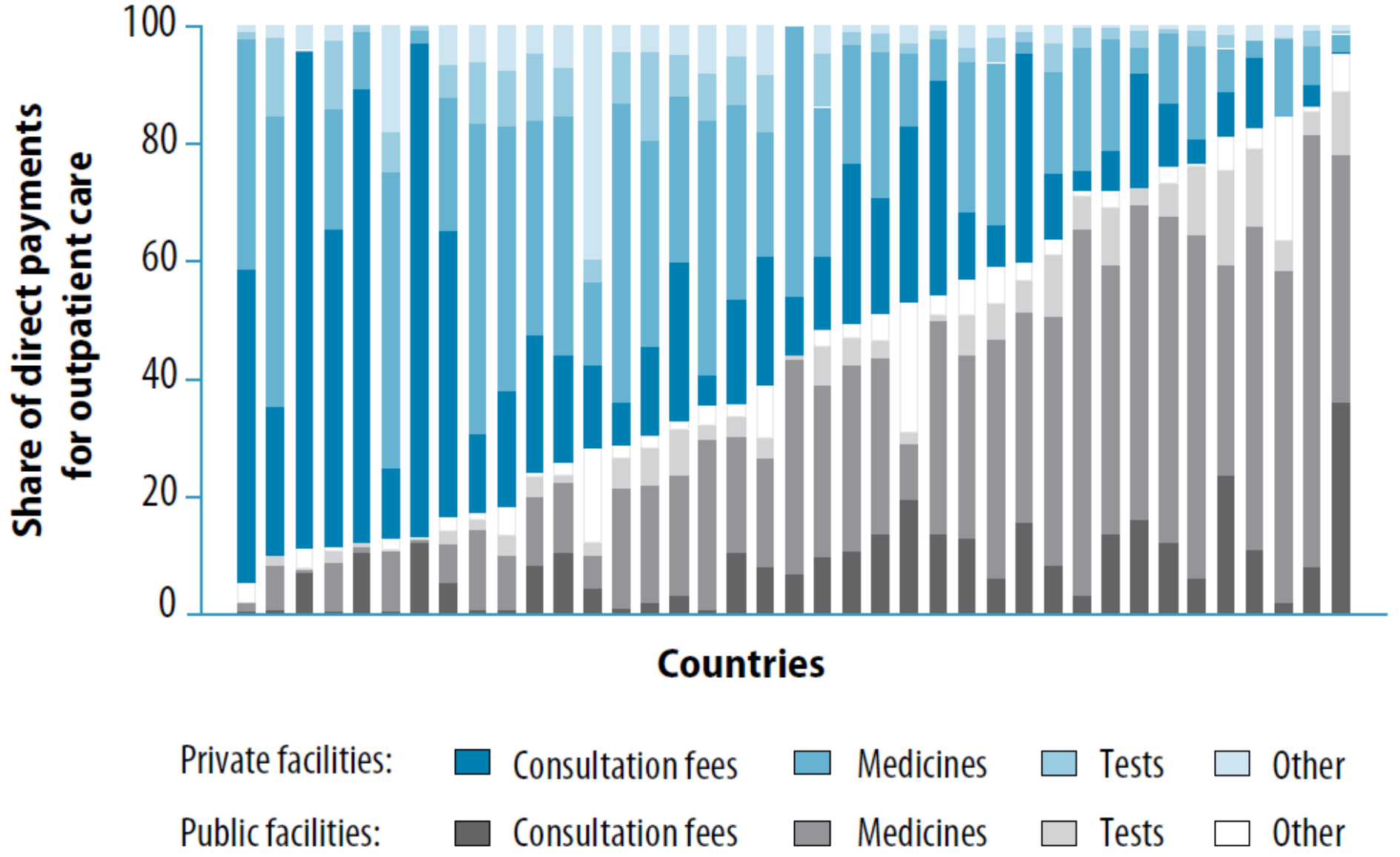
Source: WHO 2012

SOME FACTS: PER CAPITA AMOUNTS (US$)

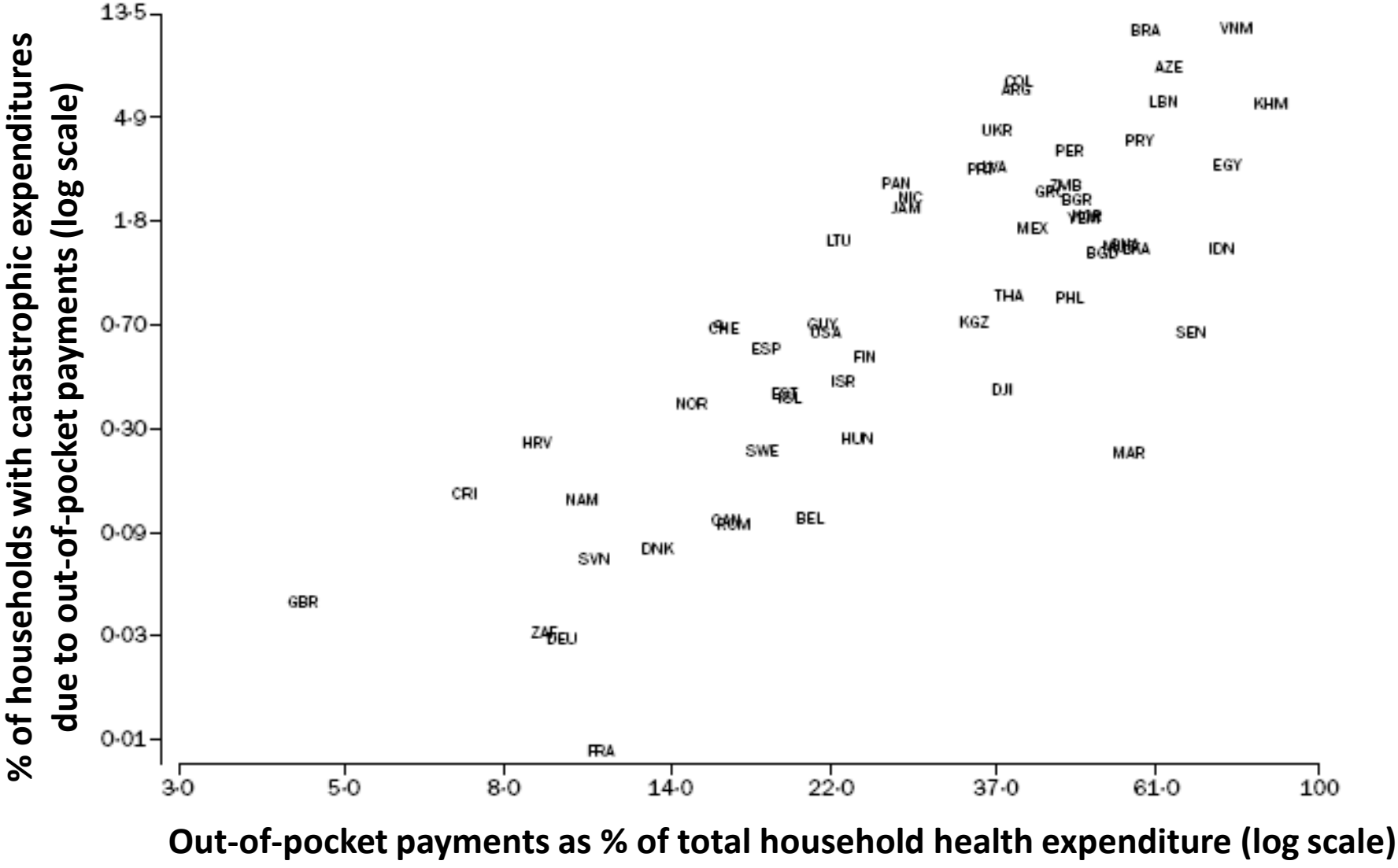
Income Group	Total health expenditure per capita	Government health expenditure per capita	Out-of-pocket expenditure per capita
Low-income	25	10	12
Lower-middle income	62	25	32
Upper-middle income	326	177	112
High-income	4692	2946	646
Global	900	549	176

Source: WHO Global Health Expenditure Atlas. Geneva: WHO. Available at: http://www.who.int/nha/atlas.pdf accessed 05/01/12

Fig. 3.3. **Direct payments made at public and private facilities in 39 countries** (World Health Report 2010)



RELATIONSHIP OF OUT OF POCKET EXPENDITURES TO CATASTROPHIC LEVELS OF HEALTH EXPENDITURE (65 countries, Xu et al Lancet)



SIGNIFICANCE OF OUT-OF-POCKET PAYMENT: HOSPITAL ADMISSIONS OF CHILDREN IN TANZANIA (Saksena et al 2011)

Expenditure quintile	Hospital expenditure per admission as % of household expenditure in previous month	
	Mean	Median
1 (poorest)	81.1	34.0
2	38.2	25.8
3	23.5	14.3
4	21.3	15.2
5 (richest)	12.4	7.2
All	35.4	16.0

SIGNIFICANCE OF OUT-OF-POCKET PAYMENT: RURAL SOUTH AFRICA (Goudge et al 2009)

- Poor rural area in South Africa with free public primary care and hospital fee exemptions for poor
- Survey of 280 households (1446 individuals)
- 70% of households had one or more members with health problem
- On average, households paying for health care spent 4.5% of monthly household expenditure
- 20% of households spent more than 10%
- 15% of households spent more than 15%

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SIGNIFICANCE OF OUT-OF-POCKET PAYMENT: KIDNEY FAILURE IN THAILAND (Prakonsai et al 2009)

- 'Before this I had about 40,000-60,000 Baht (US$ 994-1242) but it has all gone. I planned to keep it for food and housing when I get old. I sold my cattle; I sold rice; I sold everything I had. My dialysis cost me everything' (poorer patient)

- I saw a lot of poor patients who came from rural areas. At the beginning they could afford to pay for the treatments because they sold their land and cattle. But when they sold everything and their money ran out, I have not seen them coming back to get treatments from the hospital (richer patient)

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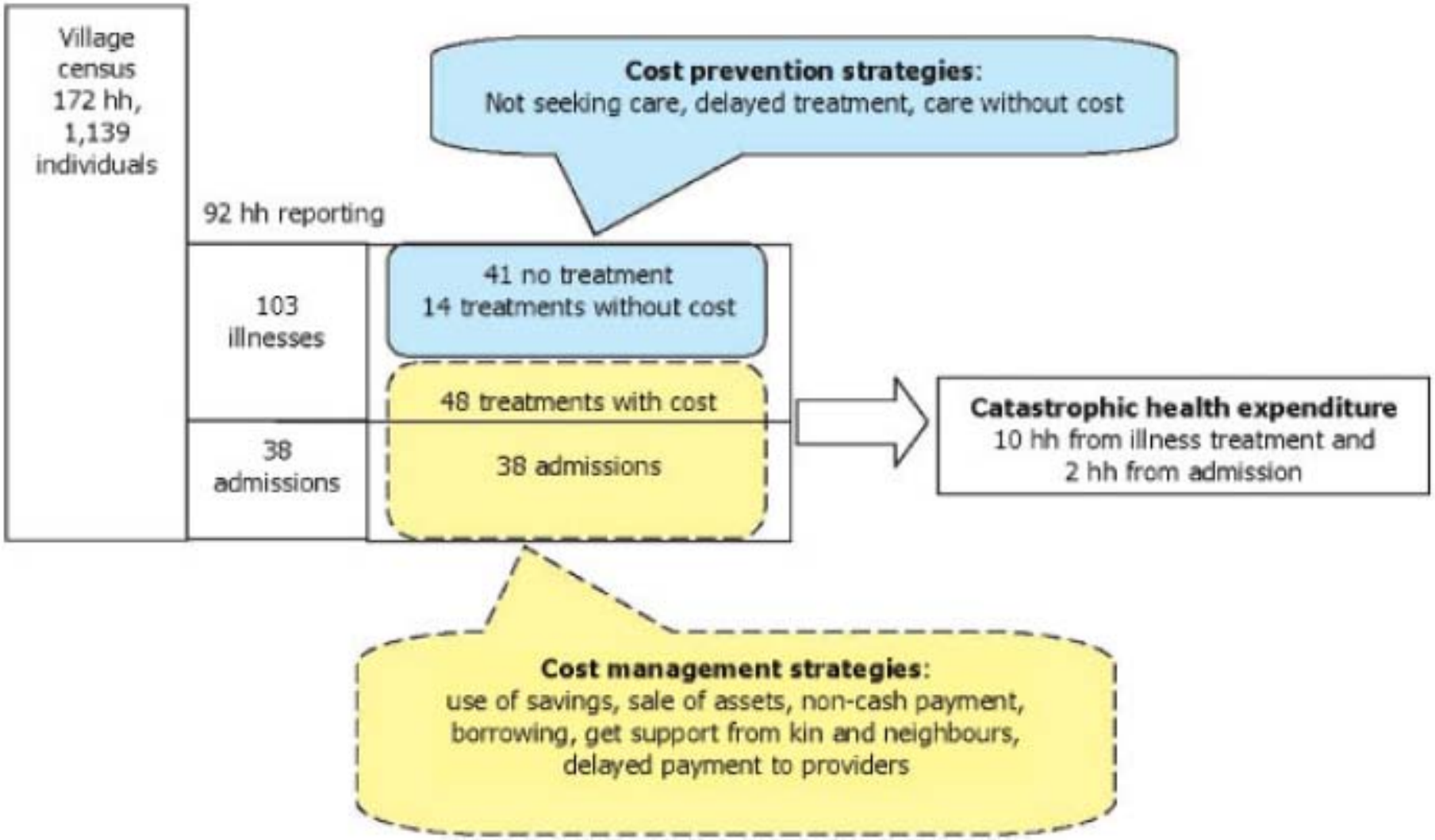
COPING STRATEGIES: LAO VILLAGE (Patcharanarumol et al 2009)



PREFERENCE FOR PRIVATE PROVIDERS IN LAO

- *Private providers more flexible*: 'The private practitioner or clinic is easy to reach and easy to talk with. Before giving treatments they will ask us whether we have enough money or not. The opposite is true in public hospitals. They will give treatments first and then give us a bill. We have to accept how much the bill is....'
- *Public facilities not polite*: 'Health staff came to see the patient on the ward and he asked us every day about repaying money for treatment...I felt extremely embarrassed in front of the other patients and relatives'
- *Lack of awareness of entitlements:* 'Someone has to pay for treatment costs. Who would pay if we did not pay? The government has no money to support free case so there is no exemption'

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IMPLICATIONS FOR INTERGENERATIONAL TRANSMISSION OF POVERTY (Krishna 2012)

- Two brothers in poor Rajasthan village studied 1977-2010
- Lala remained poor; Manohar escaped poverty
- Lala had chronic asthma
  - High and continuing health care costs
  - Limited physical ability to work as farm labourer
- Manohar had robust health
  - Apprenticed as barber
  - Set up own shop

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STRATEGIES TO INCREASE FINANCIAL PROTECTION

- Remove user fees in public facilities
- Encourage community (voluntary) health insurance
- Introduce or expand social health insurance
- Increase share of general tax revenue going to health care
- Target external assistance better
- Support development of financial protection arrangements

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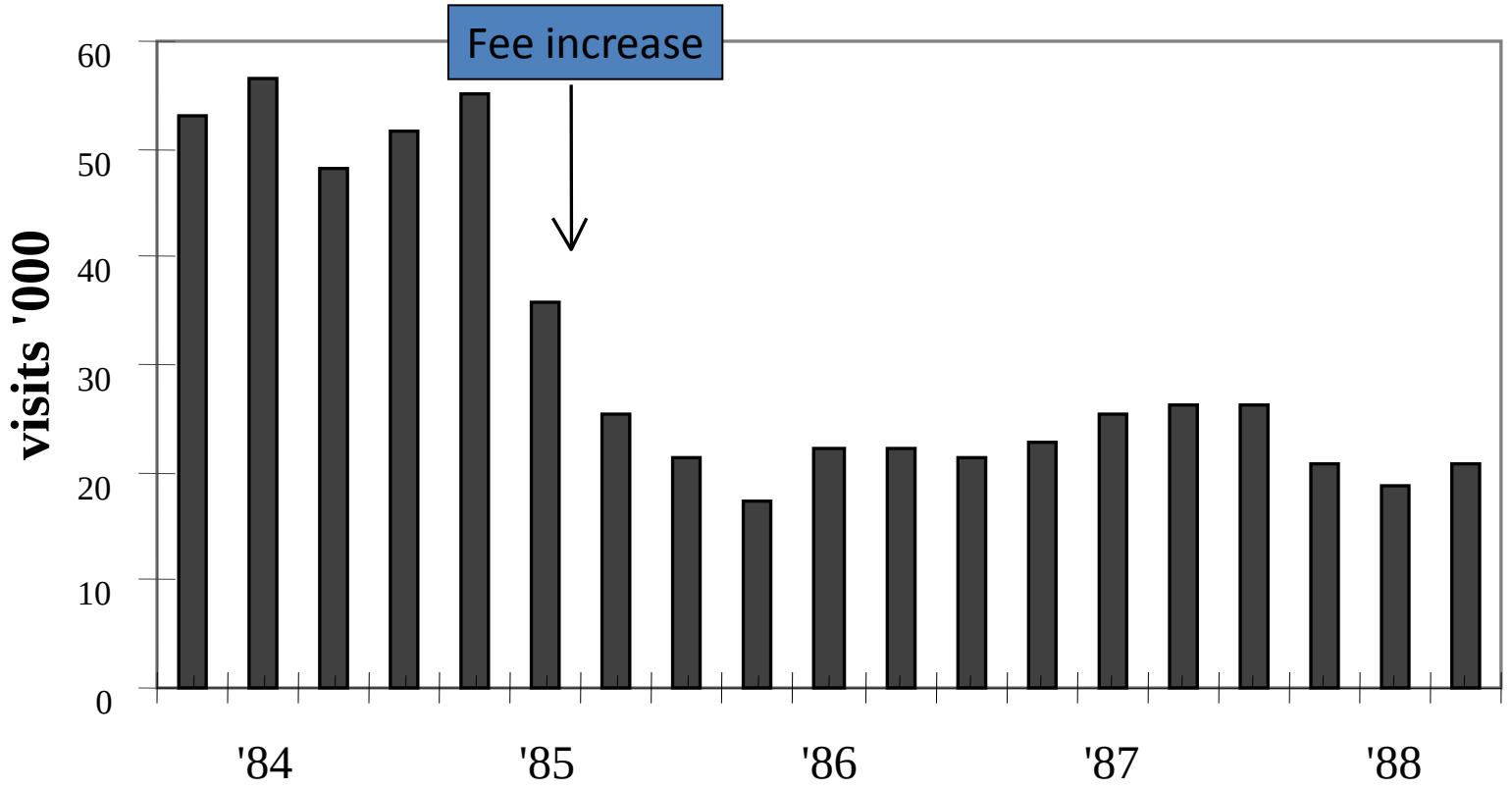
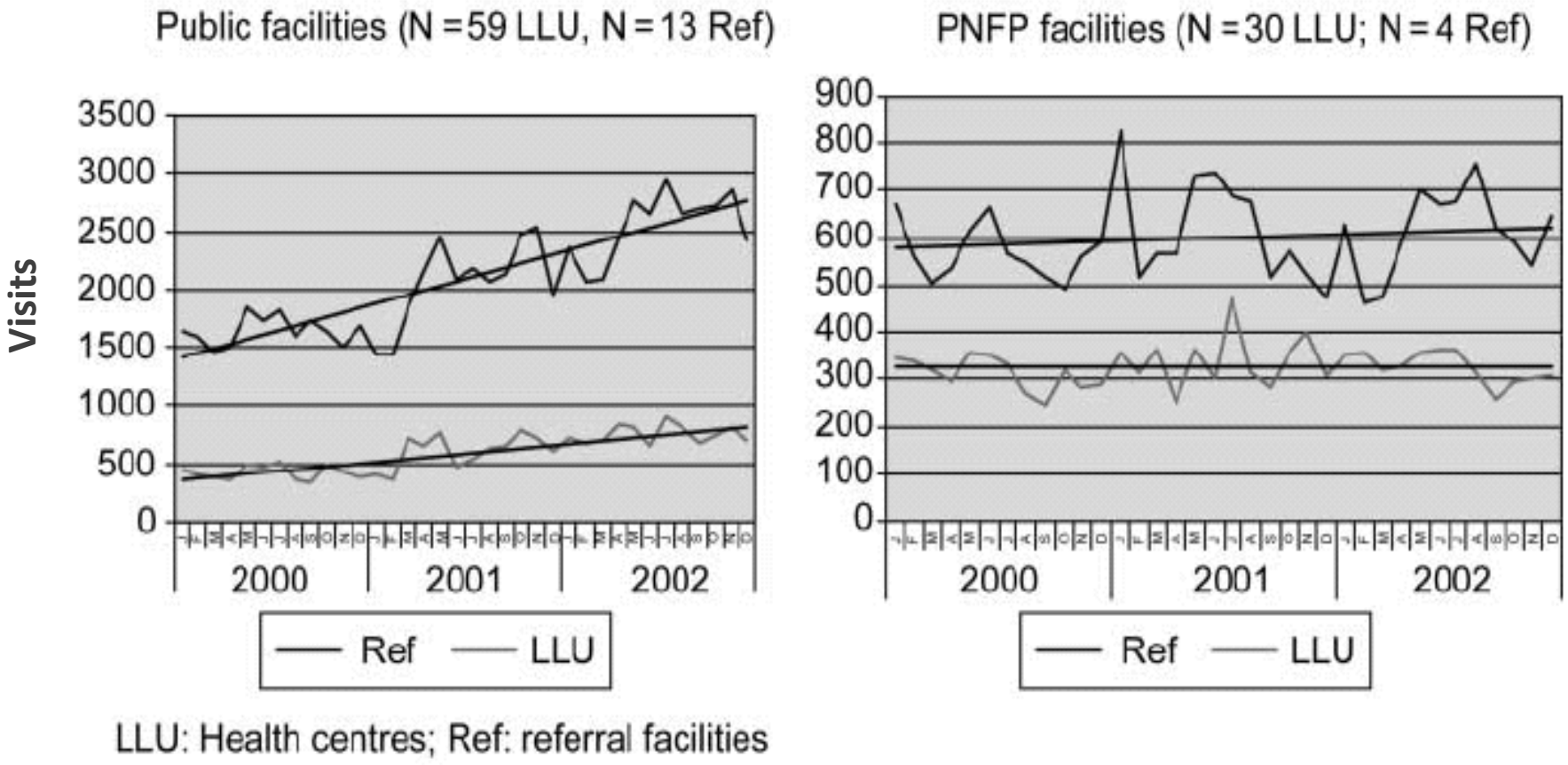
IMPACT OF USER FEES IN VOLTA REGION, GHANA

(Waddington and Enyimayew 1990)



RESPONSE TO USER FEE REMOVAL IN UGANDA

(Nabyonga et al 2005)



LLU: Health centres; Ref: referral facilities

PRE-REQUISITES FOR USER FEE REMOVAL TO BE EFFECTIVE

- Provide additional funding to enable health facilities to cope with loss of income and increase in number of patients
- Ensure regular supply of drugs
- Support staff to respond to patient needs

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COMMUNITY BASED HEALTH INSURANCE

- Various names and types – mutuelles, voluntary health insurance, medical aid schemes, micro insurance
- Organised at community level – by community structures or by not for profit organisations
- Run on not-for-profit basis
- Involve risk pooling across households
- Many small schemes but a few large ones – eg Rwanda, SEWA in India

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SELF-EMPLOYED WOMEN'S ASSOCIATION (SEWA)

- Started Ahmedabad, in 1972
- An organisation (trade union) of poor, self-employed women workers
- Around 1m members of SEWA Union
- Offers integrated life insurance, medical insurance and asset insurance to SEWA Union members and their husbands and children
- 32,000 members in 2009; paying Rs60 per person (c 1 Euro)

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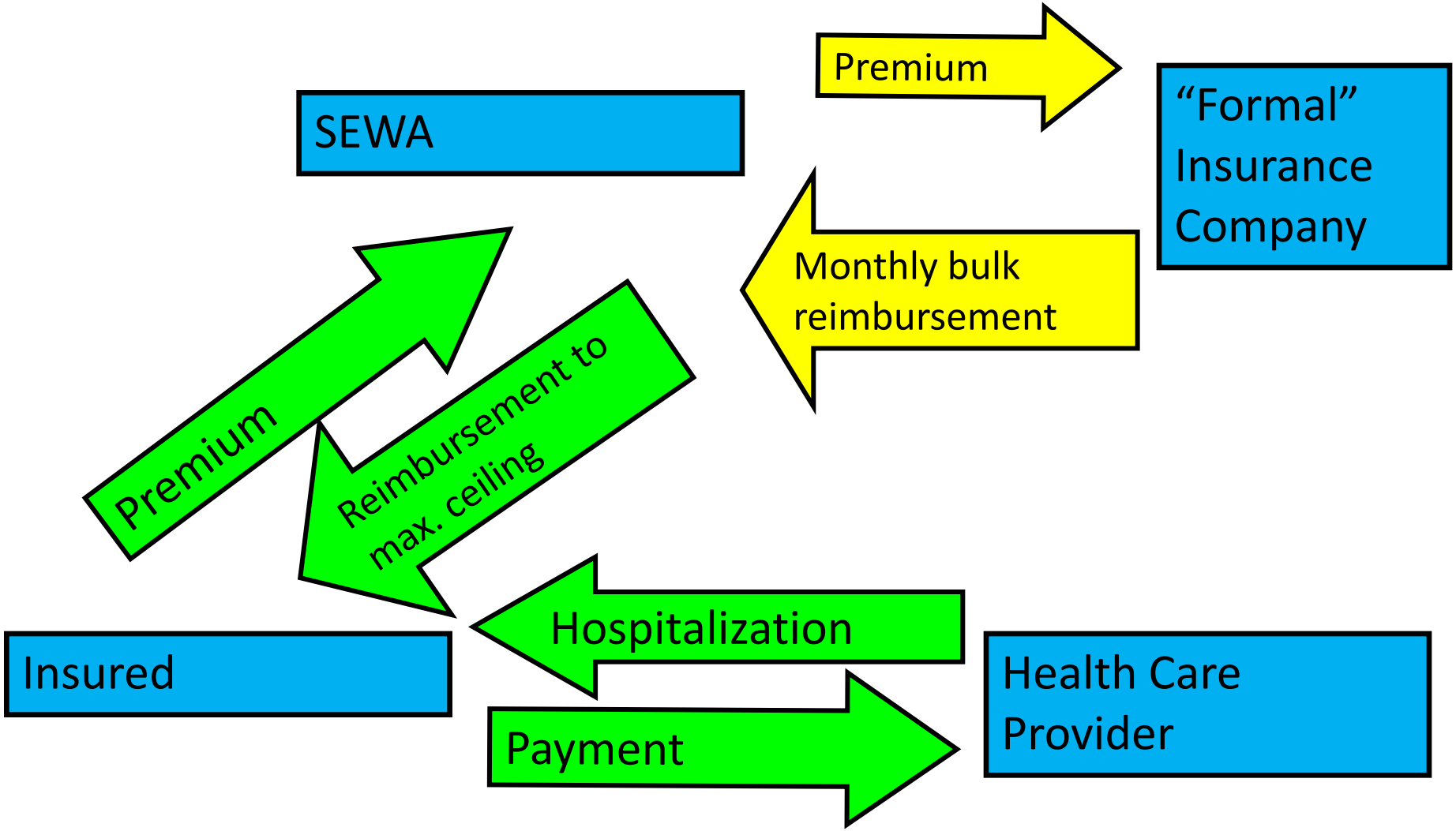
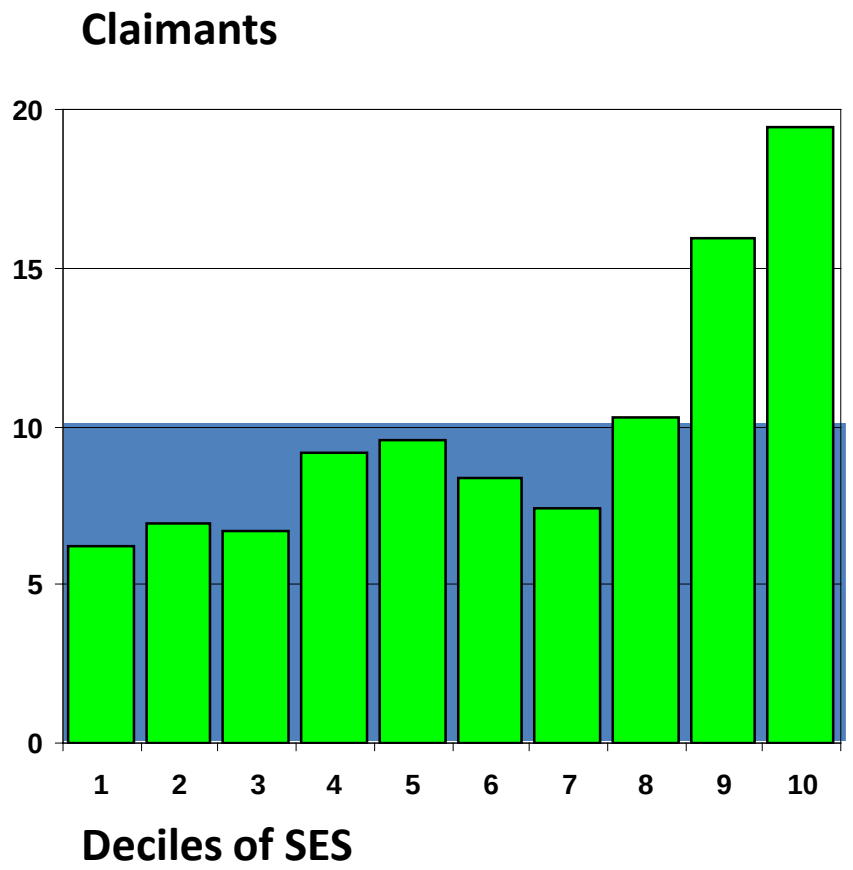
SEWA INSURANCE SCHEME



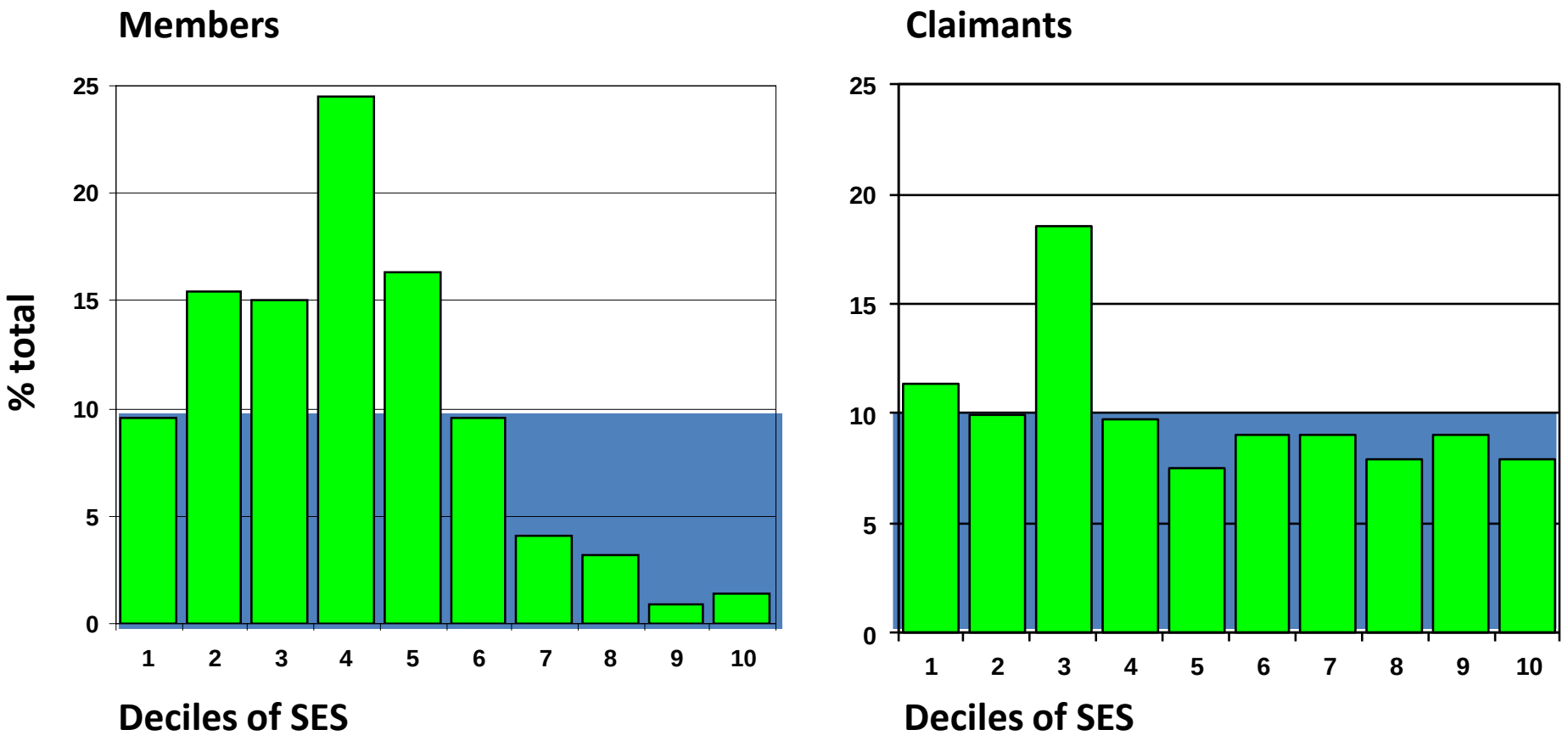
DISTRIBUTION OF MEMBERS AND CLAIMANTS BY SOCIOECONOMIC STATUS, 2003

RURAL



DISTRIBUTION OF MEMBERS AND CLAIMANTS BY SOCIOECONOMIC STATUS, 2003

URBAN



IMPROVING THE FUNCTIONING OF SEWA

- Tested ways of increasing take up of insurance benefits (education of mothers; removing up front payment)
- Utilization increased with improved members' knowledge of scheme, greater contact with local representative, trust
- But everyone increased their level of use – no greater increase amongst poorest
- Community-based interventions very difficult to target to the poorest
- Barriers to take-up not only financial
- Need to address multiple barriers to access to services – knowledge, cost, responsiveness of health care workers, availability of drugs etc

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MANDATORY FINANCING APPROACHES

- Social health insurance, general tax funding
- Difficulties in leveraging them for health:
  - Limited capacity to tax
  - Small share of workers in formal sector
- But some countries making progress:
  - Ghana: national health insurance with compulsory social health insurance for formal sector workers and network of voluntary district based mutual insurance for rural people; exemptions for poorest; heavy reliance on general tax to finance
  - Rwanda : strongly promoted community insurance with pooling at district and central levels; external aid subsidises premiums for poorest
  - Thailand: universal coverage introduced in 2001 with three schemes:
    - Civil servants non contributory scheme
    - Social health insurance for formal sector
    - General tax funded scheme for rest of population

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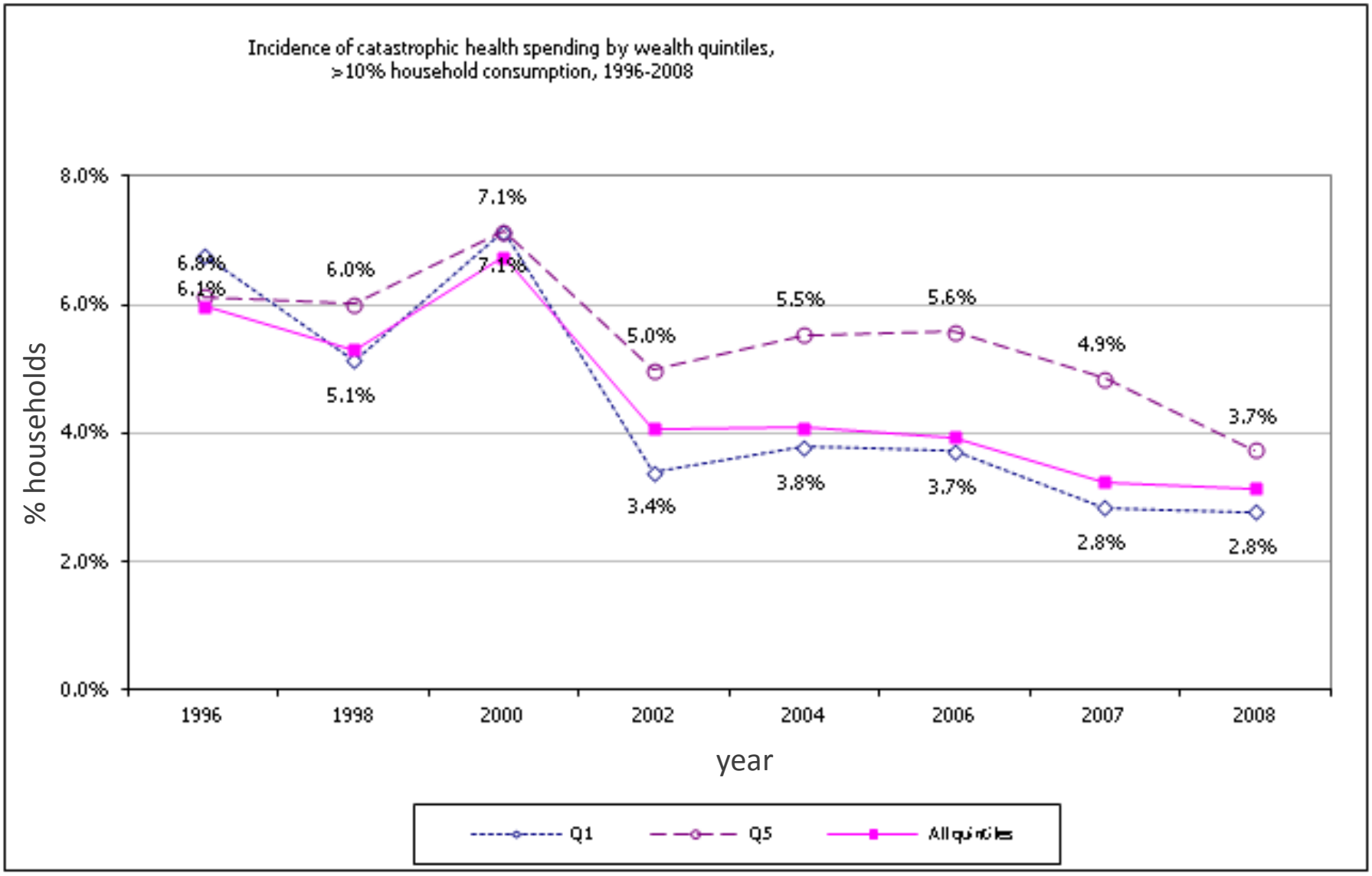
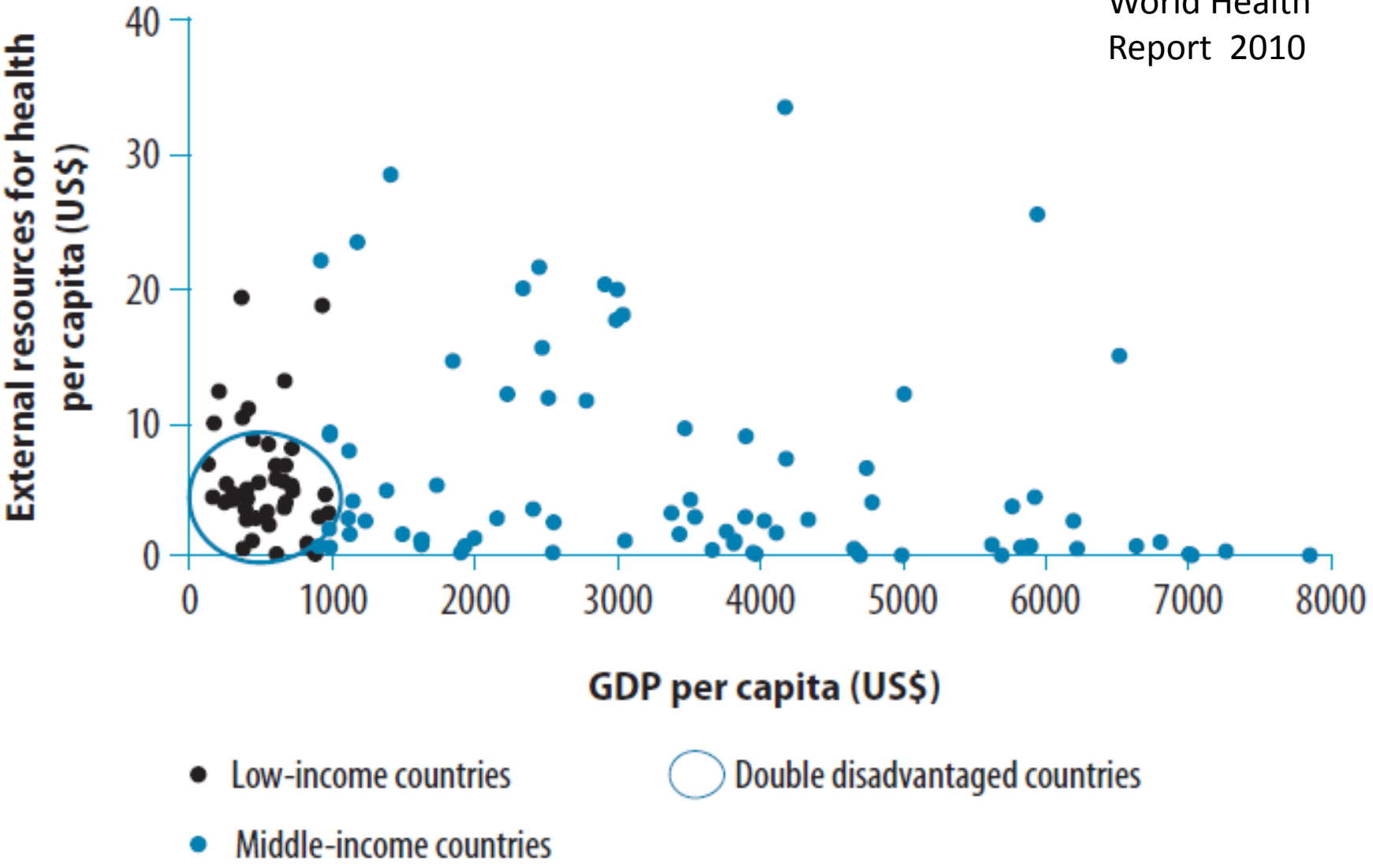
THAILAND: CATASTROPHIC HEALTH EXPENDITURE PRIOR TO UNIVERSAL COVERAGE (1996-2000) AND AFTER (2002-2008)



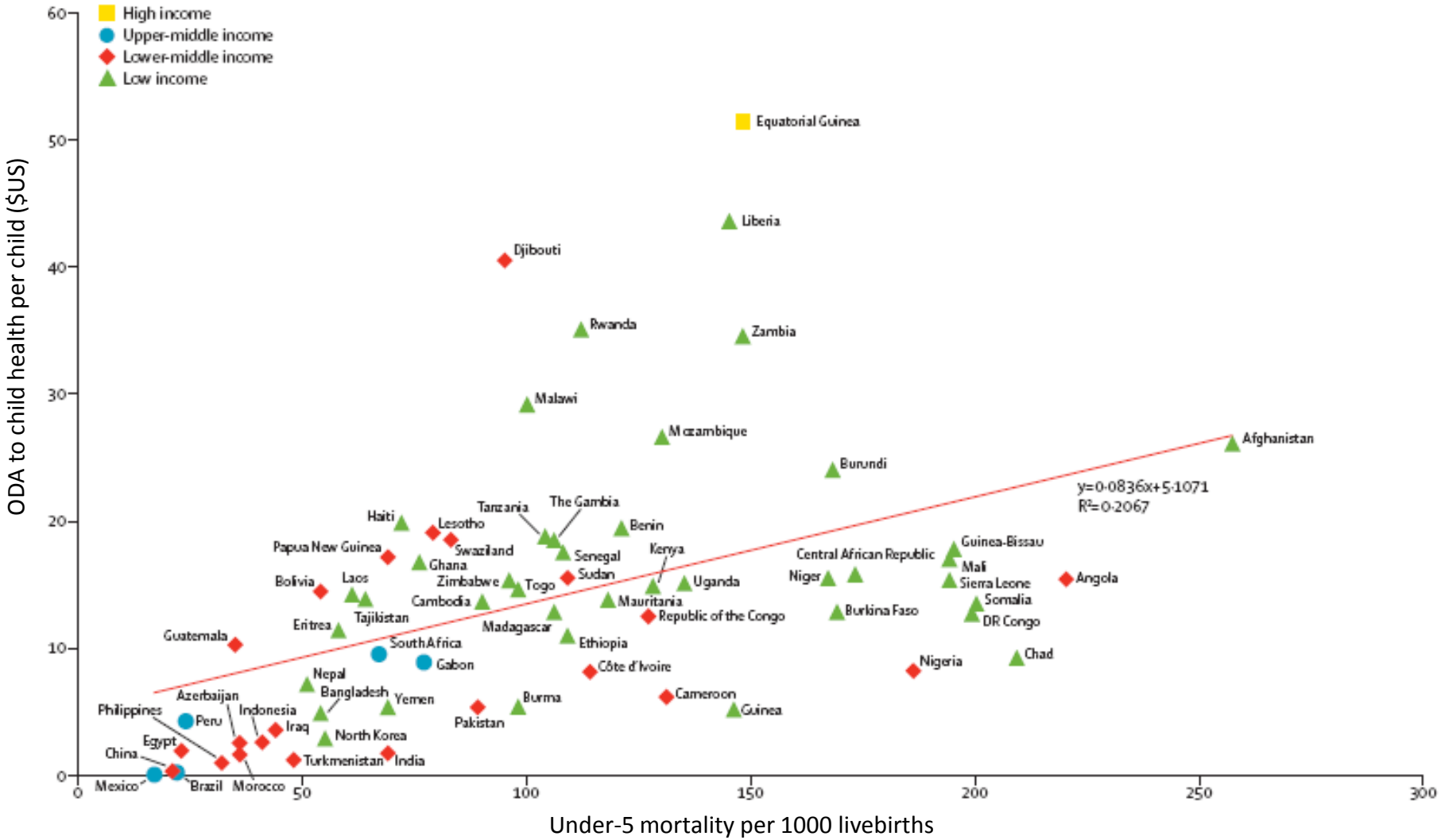
Source: Household surveys

Fig. 2.3. **Development assistance for health per capita by country income level, low- and middle-income countries, 2007[a]**

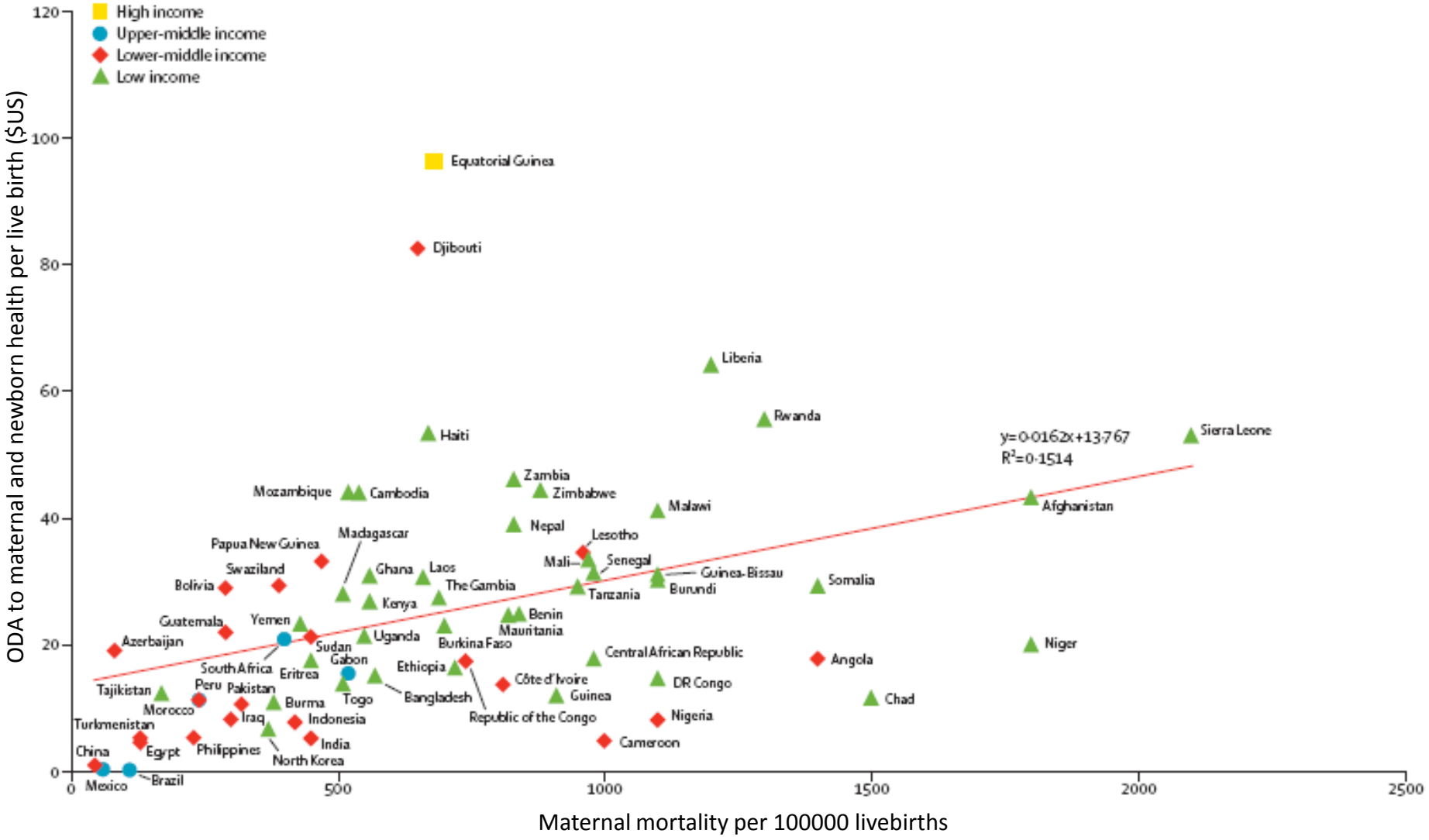
World Health Report 2010



EXTERNAL AID FOR CHILD HEALTH AND CHILD MORTALITY IN PRIORITY COUNTRIES



EXTERNAL AID FOR MATERNAL HEALTH AND MATERNAL MORTALITY IN PRIORITY COUNTRIES



SUPPORTING HEALTH SYSTEM FUNCTIONS

- External aid has prioritised spending on health interventions for key diseases
- Important but interventions are delivered by a health system needing buildings, staff, transport, supervision, management etc
- Supporting development of health system financing needs to be supported along with service delivery – important for
  - Effectiveness and sustainability of services
  - Reduction of poverty
- But important to support countries to develop financing systems that suit their circumstances

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