UNIVERSAL HEALTH COVERAGE

WHY HEALTH INSURANCE SCHEMES ARE LEAVING THE POOR BEHIND

Matti Kohonen

10th April 2014

OXFAM

GROWING MOMENTUM FOR UHC

- Momentum is building – diverse range of actors uniting in support of UHC
- But many different things being done in the name of UHC
- Therefore imperative to articulate what we mean by UHC

OXFAM

UHC DEFINITIONS

- *"Universal Health Coverage will be achieved when all people have access to quality health services (prevention, promotion, treatment, rehabilitation and palliative) without fear of falling into poverty"* (WHO World Health Report 2010)
- Requires progress on three fronts: range of services available, the proportion of the costs of those services that are covered, and the proportion of the population that is covered – the 'UHC Cube'.
- For Oxfam:
  - UHC should be framed by values of universality, social solidarity and equity.
  - Everyone should have the same financial protection and access to same range of quality health services *according to need and not ability to pay.*
  - UHC is about the right to health. This means moving away from a 'contributory' basis for entitlement
  - 'Progressive realisation' should not mean starting with the easiest to reach

OXFAM

NO SINGLE UHC ‘RECIPE’ BUT FOUR KEY INGREDIENTS

- Promote equitable access by removing financial barriers, especially direct payments
- Pre-payment must be compulsory
- Large risk pools are essential
- Governments need to cover the health costs of people who cannot afford to contribute

OXFAM

1) REMOVING DIRECT PAYMENTS

- *"The most inequitable method for financing health care services"* (WHO World Health Report 2008)
- Worldwide every year 100 million people are pushed into poverty by direct health care costs
- Revenue previously raised through user fees should be replaced with more efficient and equitable prepayment mechanisms
- A number of countries have abolished user fees for some or all of their citizens as a first step towards UHC.

OXFAM

2) MAXIMISE COMPULSORY PRE-PAYMENT

- No country has achieved anything close to UHC using voluntary insurance as its primary financing mechanism.
- “It is impossible to achieve universal coverage through insurance schemes when enrolment is voluntary”
- If prepayment for those who can afford it is not compulsory, the rich and healthy will opt out and there will be insufficient funding to cover the needs of the poor and the sick

- Mcintyre graph

OXFAM

3) ESTABLISH LARGE RISK POOLS

- Should secure maximum re-distribution in the form of income cross-subsidies – from rich to poor – and risk cross-sibsidies – from the healthy to the ill.
- Can only be achieved through large risk pools
- National risk pools most likely to support UHC
- Small risk pools cannot spread risk sufficiently

OXFAM

4) COVER HEALTH COSTS OF PEOPLE WHO CANNOT AFFORD TO CONTRIBUTE

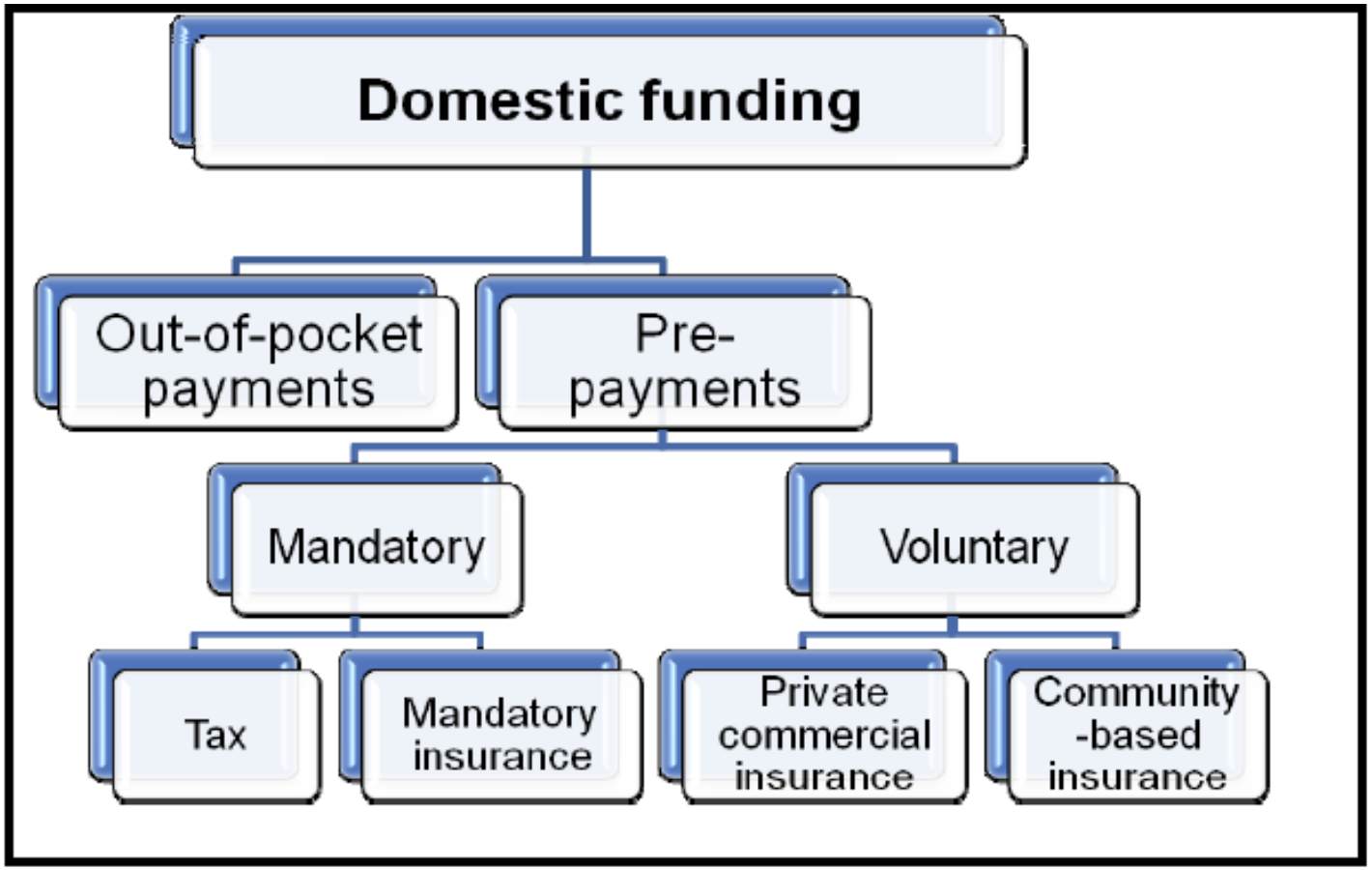
- Countries must raise sufficient public funds to cover the health care costs of people who cannot afford to contribute
- Common in rich countries with insurance schemes – governments inject money into the system to ensure coverage for people who cannot pay
- In countries with high levels of poverty, general government revenues are especially important.

OXFAM

DOMESTIC HEALTH FINANCING

OXFAM

CATEGORISATION OF DOMESTIC HEALTH FUNDING MECHANISMS



Source: McIntyre (2012)

OXFAM

PRIVATE HEALTH INSURANCE

OXFAM

PRIVATE HEALTH INSURANCE

- Limited role in developing countries – only 11 of 154 low/middle income countries fund more than 10% health care through PHI
- Can increase financial protection and access to health services to those able to pay, BUT high premiums mean only those on higher incomes can join
- Does not support risk-sharing. Policies designed to attract people with low health risks (‘cream skimming’)
- Requires strong regulation – a challenge in high-income countries like the USA

OXFAM

COMMUNITY-BASED HEALTH INSURANCE (MUTUELLES)

OXFAM

COMMUNITY-BASED HEALTH INSURANCE (CBHI) / MUTUELLES

CAN play a role where more widespread prepayment and pooling arrangements do not exist, BUT potential to be scaled-up is limited:

- Enrolment rates are generally low. Strong evidence that most schemes fail to cover the poorest groups.
- Premiums usually charged at a flat rate – therefore regressive
- Tend to generate little revenue and are not financially viable in the long-run
- Have small risk pools
- Offers limited financing protection - insufficient funds to cover large health costs so tend to cover either limited number of primary services or expensive hospital care

OXFAM

SOCIAL HEALTH INSURANCE

OXFAM

SOCIAL HEALTH INSURANCE

- Originated in Europe as work-related programmes. Coverage gradually expanded to non-working population.
- Most schemes do not cover entire population from outset and initially restricted to formal sector employees
- Workers in formal sector pay contribution through payroll and employers usually contribute
- Workers in informal sector pay a premium to join (usually flat rate)
- Members are entitled to a defined package of health benefits

OXFAM

SOCIAL HEALTH INSURANCE

- Great potential in theory – mandatory pre-payment and pools revenue
- Worked to achieve UHC in high-income countries
- BUT attempts to replicate in low- and middle-income countries proved unsuccessful
- Typically characterised by large scale exclusion – bigger the informal sector the bigger the coverage gap

SOCIAL HEALTH INSURANCE

- Premiums act as a major financial barrier. Exemptions are difficult to implement.
- Premiums charged at a flat rate - regressive
- Not everyone can afford to join and membership is impossible to enforce. In low- and middle- income countries SHI schemes therefore become de facto voluntary
- ‘Formal sector first’ approach often results in two-tiered system
- Premiums from the informal sector raise little revenue – expensive and complicated to collect.
- As major employers governments face huge bills to cover employer contributions

OXFAM

TWO APPROACHES THAT WORK

OXFAM

TWO APPROACHES THAT WORK

Countries that have made most progress towards UHC fall into two broad camps:

1. Countries which fund UHC from tax revenue (e.g. Sri Lanka, Brazil, Malaysia)
2. Countries which collect insurance contributions only from those in formal employment and use general government revenue to cover the rest of the population (e.g. Thailand, Mexico)

OXFAM

SCALING UP TAX FINANCING TO ACHIEVE UHC

- Oxfam estimates that improving tax collection in 52 developing countries could raise an additional 31% in tax revenues.
- Scope to increase personal income tax for high earners and company tax rates. Average top income tax in OECD countries is 40%, compared to less than 25% in developing countries.
- Developing countries forego $139bn each year through corporate tax exemptions
- Property taxes, taxes on luxury goods, ‘sin taxes’ can raise funds for UHC
- Innovative financing mechanisms – e.g. small levies on financial transactions
- Non-tax income from extractive industry royalties

OXFAM

GLOBAL SOLIDARITY

- Urgent action on global tax evasion and avoidance. Tax dodging by multinational companies costs developing countries more than $160bn annually.
- In short/medium term achieving UHC will require significant development assistance. More long-term and predictable aid is vital.

OXFAM

CONCLUSION

OXFAM

CONCLUSION

- Growing momentum for UHC is welcome, exciting and challenging
- UHC should be framed by the values of universality, social solidarity and equity.
- UHC is not a ‘one size fits all journey’ but policy makers should prioritise WHO’s four key principles
- Public financing is the key to ensuring access to quality care for all but the crucial question of how to generate more tax revenue has been overlooked

OXFAM