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# Social Policy Highlight 06


## Extending health protection: Meeting the challenge

The absence of affordable health care contributes to millions of people falling into poverty each year. This being so, how to better finance health protection for all is a policy issue on the rise. Nowhere is this challenge more pronounced than in developing countries, and it is with regards to these countries that the need for the sharing of good practice remains greatest. To this end, this *Highlight* underlines current thinking on the extension of health protection.

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Health protection has become one of the hottest issues on social policy agendas. Considering international commitments to realize global improvements in health levels, not least to help combat poverty, this is not surprising. Another issue is the increased risk of 'new' global health pandemics such as SARS or avian flu, while 'old' communicable diseases like cholera, yellow fever and tuberculosis continue their creeping return. But regardless, affordable health care remains inaccessible to the majority of the world's population. As one measure of the challenge, it is estimated that 100 million people a year fall into poverty because of inadequate access to affordable medical treatment.[1]

Beyond the human cost, the economic cost of underdeveloped health systems is also considerable: For example, by 2020, in African countries with the highest levels of HIV/AIDS prevalence, national income growth targets may fall short by 20 per cent.[2] But despite a growing awareness of the importance of improving health, many practical challenges remain with regards to extending access to health protection.

This issue:

- Looks at the challenge of extending health coverage
- Outlines different health protection financing models
- Highlights measures to extend coverage and deliver services


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Key policy issues for developing countries relate to identifying the minimum package of health care benefits that should be provided to populations, choosing the financing model(s) to be used, and ensuring the necessary institutional infrastructure and human resources to enable benefits to be efficiently and effectively delivered.

## National development and health care spending

The amount spent on health and the manner in which it is financed is often influenced by a country's level of development. In general, the richer a country the more it will spend. On average, high-income countries spend about 10 per cent of GDP on health, middle-income countries spend 6 per cent, while low-income countries spend less than 5 per cent. Significantly, most low-income countries spend less than US$34 per capita on health, the World Health Organization's recommended minimum annual spending target for essential interventions.[2]

A related issue is achieving a more equitable distribution of resources. In many developing countries, a great deal of the available funds is often allocated to specialist facilities in large cities. This being so, the primary health care priorities of the majority often remain under-financed.

And international aid offers no panacea either: available donor finance is often tied to programmes for specific diseases, such as Tuberculosis, Malaria, and HIV/AIDS. Therefore, the possibility of financing treatment for other medical conditions is excluded.

Consequently, for lower-income countries, out of-pocket payments play a major role and may represent 60 per cent of total health spending. This contrasts with a figure of around 20 per cent in high-income countries.[2]

### Financing health protection

Country approaches to financing health commonly seek to spread health costs across population groups through risk pooling. Typically, four dominant models of financing[3] are used:

**National health systems** – predominantly financed by general tax revenues, with services largely delivered through public institutions.

**Social health insurance schemes** – normally financed by payroll taxes, they may operate as a unitary national organization or as several organizations and may involve both public- and private-sector participation in service delivery.

**Health insurance plans** – private health insurance financed normally by voluntary individual risk-rated premiums, with services delivered through contracted providers.

**Civil society-based health insurance** – organized by communities or small groups of individuals as a means to pool risks and financed by voluntary contributions and sometimes supported by public subsidies.

It is widely agreed that out-of-pocket spending on health disadvantages lower-income groups. It may even lead individuals to not seek or to discontinue treatment, thus possibly aggravating a medical condition that may then require more complicated or expensive treatment. And the resulting incapacity that may arise may also lead to a loss of earning capacity.

Inevitably for many developing countries, with limited tax-raising opportunities and with international aid not always sufficiently targeted on the priority needs of recipients, finding the required finance is difficult.

When faced with wider challenges related to tax collection, labour markets and health service infrastructure, developing countries tend to use a combination of the above models. Although international aid may supplement health spending significantly, the combined use of these different financing approaches and institutional structures nonetheless present difficulties for realizing coherent and integrated policy.

## Extending coverage in developing countries

Tax-financed national health systems providing universal access to the same package of benefits are sometimes viewed as the most socially equitable. But to function well, they require adequate and sustainable fiscal resources, which are rarely guaranteed in lower-income countries. When coverage cannot be realized for the lack of sufficient tax revenues, contributory approaches must be considered.

Social health insurance schemes are viewed as being most equitable when national coverage is relatively extensive, thereby making it practical for higher earners to subsidise lower earners. Yet, coverage under social health insurance schemes in many countries remains low, and contribution evasion is a problem. This may be because the scheme lacks the necessary flexibility to meet the specific health needs and different contributory capacities of diverse population groups.

Intuitively, for low-income groups, one way to extend contributions-financed coverage could be through government subsidies. The question that follows is how to identify and then maintain administrative records of the eligible poor? And this question becomes more complex when the often weak administrative capacities of states and the prevalence of informal economy employment across the developing world must also be considered.

Of course, not all informal economy workers are the working poor. This suggests that different approaches might be used to extend health coverage to different groups of informal economy workers – between those who should have the financial capacity to make contributions and those who do not.

While some argue in favour of promoting individual risk-rated premiums for the non-poor[3], other possible approaches include civil society-based health insurance schemes. Another is to reinforce social health insurance administrations at the local level, sometimes through partnering agents in the community, to better collect contributions and reach out to target groups.

## Parallel developments

Across many developing countries, the trend is toward the parallel introduction of social health insurance for formal-sector workers and voluntary community-based health insurance for those marginal to the formal economy. Although community-based schemes may offer a way to extend coverage, these are not without risk.

Commonly, the limited size of the insurance pool makes community-based schemes vulnerable to the cumulative cost risk of repeated or catastrophic insured events. One response being investigated by the ISSA and its partners is to build coherent linkages between statutory and community-based schemes, wherein member schemes mutually support or re-insure one another.[4]

## Delivering services

Developing countries face a double health burden of infectious diseases coupled with rising non-communicable diseases. Although behavioural patterns play a role, the underlying social determinants of health still need to be tackled. Furthermore, gaining adequate access to pharmaceuticals is another key challenge.

Beyond overarching developing country financial constraints, first steps to meeting this double burden and to delivering better health services require defining an essential basket of benefits and developing a national drug list. But developments in these respects remain at risk from the continuing migration to more developed countries of many developing country health professionals. This particular challenge cannot be overestimated.

## Looking forward

The objectives of the Millennium Development Goals (MDGs) include reducing infant mortality, improving maternal health, combating disease, and improving access to medical drugs. Yet, to realize the MDGs by 2015, a significant increase in health financing is required, and this may not be immediately nor easily attainable. In the meantime, good practice suggests that greater attention be paid in all countries to identifying:

– the minimum basket of necessary health care benefits for all
– the appropriate financing model(s) to share risk
– the necessary institutional and regulatory structures, and
– the means to overcome all challenges to building integrated, coherent, and sustainable health systems.

## Notes


1 **Ministère des Affaires étrangères**, France 2007. ***Proceedings of the International Conference on social health protection in developing countries***, 15–16 March, 2007, Paris. Available at http://www.diplomatie.gouv.fr/en/france-priorities_1/health-and-food_1102/international-conference-on-health-insurance-coverage-in-developing countries_5492/index.html.

2 **Schieber, G.; Fleisher, L.; Gottret, P.** 2006. *Getting real on health financing*, ***Finance & Development***, Vol. 43, No. 4. Available at http://www.imf.org/external/ft/fandd/2006/127schieber.htm.

3 **Baeza C.; Packard, T.G.** 2007. *Extending the risk pool for health in developing countries: The challenge of moving to general tax funding*, ***International Social Security Review***, Vol. 60, No.2–3, pp. 83–97.

4 **Coheur, A; Jacquier, C; Schmitt-Diabaté, V; Schremmer, J.** 2007. *Linkages between statutory social security schemes and community-based social protection mechanisms: A promising new approach*, paper presented at Technical Commission on Mutual Benefit Societies, World Social Security Forum, Moscow. Available at http://www.issa.int/wssf07



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