Equity in health care financing: international lessons and implications for paths to UHC

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Aims

- Common understanding of key terms
- Policy context
- Measuring health system equity
- Interpreting the evidence for policy
- Challenges
Policy context

- Increase in inequalities in access to adequate care
- Increased interest in putting policies in place to ensure progress towards universal coverage
- Considerable debate over the design of a health system that provides universal coverage
- Little is known about health system equity in many LMICs both in terms of:
  - the distribution of health care benefits and
  - financing burden across socio-economic groups
Universal Health Coverage

Achieving universal access to needed health services, at acceptable quality, without risk of financial impoverishment

– Most of the wealthiest countries in the world now have some forms of UC (except the USA)

– Several middle income countries also do – e.g. Brazil, Mexico, Thailand

– Lower income countries on the path towards it – e.g. Philippines, Vietnam, Rwanda, Ghana.

– Others making progress – e.g. India, South Africa, China
THE THREE DIMENSIONS OF COVERAGE
( WHO, 2010)
EXAMPLE: Republic of Korea

- 1977-89 entire population ‘covered’ under national Health Insurance System.

- **Height** (Cost sharing)
  - requirements for outpatient care (30-55% of fees) and for inpatient care (20% of fees).
  - ‘Special’ payments to get preferred doctors,
  - In summary, out of pocket payments accounted for about 65% of personal spending on health services in mid 90s.

- **Depth** (Services covered)
  - upper limit on number of days covered by insurance
  - many expensive services excluded from coverage.

*Despite having achieved ‘universal coverage’ with the national health insurance Scheme, citizens do not all have equal access to health care and financial protection against high costs of severe illness or long-term chronic illness!*

Source: Kutzin 2000
Policy relevance

• Pursuit of universal health care coverage needs to be informed by an understanding of how equitable a health system is. This means:
  – Financing is equitable if contributions are in line with ability to pay (FIA).
  – Health service use is equitable if benefits are distributed according to need for health care (BIA).
Distribution of financing burden

• Financial Incidence Analysis (FIA) used to address 2 questions:
  – which socio-economic groups bear what burden of funding health services?
  – which health financing strategies place greater burden on the poor (regressive) and which are progressive?
• Data requirements
  – estimates of the share of household expenditure paid in taxes and other forms of health care financing
  – some measure of ability to pay (e.g. Adult Equivalent Consumption Expenditure, Income quintiles, etc.)
• Analysis
  – Compare the distribution of health care payments as a share of household consumption expenditure across households and socio economic groups
Sources of health financing (WHO, NHA 2010)
Financial incidence

- *Regressive* (lower income groups contribute higher % of income than higher income groups)
- *Progressive* (groups with higher income contribute higher % of their income compared to lower income groups)
Financial Incidence Analysis

- Kakwani Index – Compares distribution of burden of payment with distribution of ability to pay/income
- $K < 0$ implies regressive contributions (poorer households contribute a greater share of their income than richer households)
- $K > 0$ implies progressive contributions (richer households contribute a greater share of their income than poorer households)
Example: Tanzania

Measuring progressivity of health care financing sources

<table>
<thead>
<tr>
<th>Funding source</th>
<th>Concentration index</th>
<th>Kakwani Index (standard error)</th>
<th>Weight (% share of total funding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal income tax</td>
<td>0.95***</td>
<td>0.53 (0.113)</td>
<td>7%</td>
</tr>
<tr>
<td>Corporate income tax</td>
<td>0.84***</td>
<td>0.42 (0.376)</td>
<td>5%</td>
</tr>
<tr>
<td>Total income taxes</td>
<td>0.90***</td>
<td>0.48 (0.128)</td>
<td>12%</td>
</tr>
<tr>
<td>VAT</td>
<td>0.46***</td>
<td>0.03 (0.018)</td>
<td>21%</td>
</tr>
<tr>
<td>Excise taxes</td>
<td>0.55***</td>
<td>0.13 (0.080)</td>
<td>6%</td>
</tr>
<tr>
<td>Import duty</td>
<td>0.57***</td>
<td>0.14 (0.056)</td>
<td>4%</td>
</tr>
<tr>
<td>Total consumption taxes</td>
<td>0.49***</td>
<td>0.07 (0.031)</td>
<td>31%</td>
</tr>
<tr>
<td>Total taxes</td>
<td>0.60***</td>
<td>0.18 (0.092)</td>
<td>43%</td>
</tr>
<tr>
<td>OOP</td>
<td>0.34***</td>
<td>−0.08 (0.036)</td>
<td>53%</td>
</tr>
<tr>
<td>NHIF</td>
<td>0.84***</td>
<td>0.42 (0.087)</td>
<td>3%</td>
</tr>
<tr>
<td>CHF</td>
<td>−0.07</td>
<td>−0.49 (0.053)</td>
<td>1%</td>
</tr>
<tr>
<td>Total insurance</td>
<td>0.70***</td>
<td>0.28 (0.081)</td>
<td>4%</td>
</tr>
<tr>
<td>Total health</td>
<td>0.47***</td>
<td>0.05</td>
<td>100%</td>
</tr>
</tbody>
</table>
Progressivity in health care financing in SSA: Kakwani Indices for financing sources in Ghana, South Africa and Tanzania

Figure 1: Kakwani Indices for financing sources in Ghana, South Africa, and Tanzania
A negative index shows a regressive financing mechanism and a positive index a progressive mechanism.
Moving towards progressive financing (1)

- OPPs always regressive (unless the poor opt out of care altogether)
- CBHI – new evidence of regressivity in Tanzania (low coverage, flat rate premium)
- Minimize role of voluntary health insurance
- Critical role of public sources:
  - Structure of tax system – some taxes more regressive
  - Features of progressive social health insurance:
    - No cap on contributions, broaden base for contributions, limit opt-out economic stagnation and have large informal (& rural) sectors, scarce admin resources
Moving towards more progressive financing (2)

- **Higher level public facilities** tend to be pro-rich. Programmes targeting public subsidies at lower level facilities will benefit the poorest, whereas investments in higher level and referral facilities will be of greater benefit to the rich (South Africa, Ghana, Nigeria, Tanzania, Thailand).

- **Faith-based providers** are of benefit to the poor for inpatient care (Tanzania). Also offer flexible pricing policies to poorer households. Government policies of subsidizing faith-based hospitals to act as district hospitals in some areas is, therefore, of benefit to the poor (Tanzania).

- **Public–private partnerships** are being increasingly promoted in the health sector (IMF etc.). Greater subsidies might be offered to faith-based facilities for inpatient care in rural areas (Tanzania, Ghana).

- **Private for-profit providers** essentially benefit the richest portion of the population. Implies that public subsidies such as tax exemptions allocated to these providers benefit the rich (Tanzania, South Africa, Ghana).
Benefit Incidence Analysis (BIA) is used to address 2 questions:
- who (in terms of socio-economic groups) receive what benefit from using health services; AND
- is this distribution of benefits appropriate, i.e. are benefits distributed in line with needs?

Data requirements
- household survey dataset (information on health service utilization and some measure of socio-economic status)
- unit costs of different types of health service

Analysis
- When utilization rates are combined with unit costs for different health services, the distribution of benefits from using services, expressed in monetary terms, can be estimated and compared with the distribution of the need for health care.
Example: Distribution of benefits from outpatient facilities in South Africa

![Bar chart showing the distribution of benefits across quintiles]

**Figure 2** Percentage share of public outpatient benefits. 
*Source:* Analysis of SACBIA dataset

Illustrates the share of benefits across quintiles  
*Source:* McIntyre & Ataguba, 2011
Example: Concentration curves

CC shows cumulative share of benefits accruing to a cumulative proportion of individuals.

C-Index gives a picture of the extent of pro-poorness (or pro-richness) of the overall distribution of benefits.

Public clinic: Pro poor (concentration index of -0.116)

Hospital: Pro rich (Concentration index of 0.360)

Source: McIntyre & Ataguba 2011)
Incorporating ‘need’ into BIA

• Most studies look at whether or not each quintile’s percentage share of benefits is greater or less than their share of the population (i.e. 20% in each quintile)
• Assumes that the level of need is same across quintiles or greater amongst the poor – but to what extent?
Example (source McIntyre & Ataguba 2011)

- Comparing distribution of benefits against measure of need
Evidence (1)

- Despite higher burden of illness in low SES, overall distribution of benefits favours the rich (South Africa, Ghana, Tanzania, Nigeria)
- Access to needed appropriate services was the biggest problem in terms of UHC
- Public services generally favour the rich and this accentuates the pro-rich orientation of private for profit services
Evidence (2)

Factors influencing benefit incidence (i.e. affecting poor more severely):

- Affordability constraints to accessing public services (health care & transport)
- Problems with service availability (drug stock-outs, no functioning diagnostics, lack of skilled staff)
- Service acceptability problems (poor staff attitudes, lack of confidence in skills of staff)
Challenges

- BIA & FIA - Analyses constrained by limitations in the availability of data
  - Existing household budget surveys do not collect detailed information on health care utilization rates, out-of-pocket payments, etc.
  - Difficult to obtain reliable unit costs for BIA. Often no comprehensive national study of health sector costs.
- BIA - due to the under-reporting of self-reported illness amongst lower income groups in developing countries often need to use a measure of self-assessed health as a proxy for need. Biases?
Policy relevance

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Thank you