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HEALTH CARE FOR THE WORLD'S POOREST

Is Voluntary (Private) Health Insurance an Option?

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About 80 percent of the world population currently lives in countries that are either developed or developing. The other 20 percent lives in countries that are stagnant or falling behind. As a result, by the 2015 target date for the Millennium Development Goals, about one billion people will still live in severe poverty. Some of these people will live in countries that are stuck in one or more development traps; others will live in poor, remote, and backward areas of countries experiencing economic growth, on average. While it will be difficult, if not impossible, to reduce income poverty under those circumstances, other aspects of poverty—particularly bad health and premature death—can be reduced.

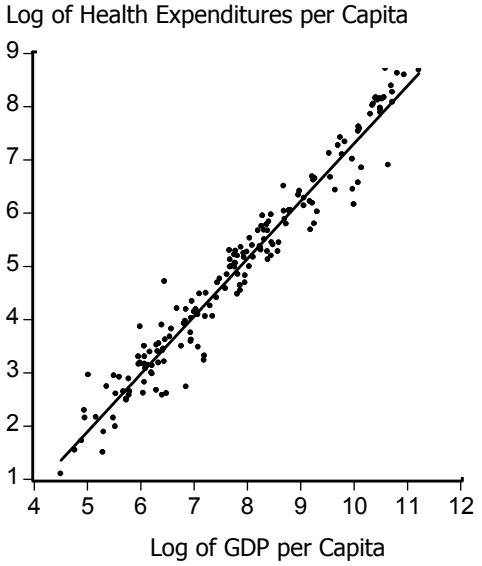
This brief focuses on options for increasing the chances that the billion at the bottom of the global income distribution will have access to affordable health care. The discussion draws on some long-standing regularities in health economics and new developments in the design and implementation of low-cost health insurance for low-income people in developing countries. It shows why private finance for health care will continue to play a major role, especially in poor countries, and argues that increased coverage of voluntary, private health insurance can be a suitable way of securing high-quality health care for the poor.

The First Law of Health Economics

The tight relationship between per capita health expenditures and gross domestic product (GDP) is illustrated in Figure 1. The cross-country regression is based on 176 observations for 2004. Other than for the countries of the Organisation for Economic Co-operation and Development, which show a slightly higher income elasticity, tests for regional effects are all negative. The fit of this simple regression is very tight (the R-squared is 0.954), which leaves little room for issues such as fee-for-service versus capitation systems, global budget caps (for hospitals), public versus private financing, and—most importantly for the purpose of this discussion—foreign aid and debt relief to have an additional impact on the overall financial resources available for health care within a country. (Health expenditures per capita increase 0.07 percent for every 1 percent increase in foreign aid; the standard error is 0.042.)

Why is per capita health expenditure so closely related to GDP per capita? One would expect that, in countries where governments give high priority to health care, overall spending would be relatively high, given GDP per capita—unless, of course, private financing for health care is being reduced as a result. This crowding-out phenomenon can also be at work when foreign aid for health care is increased, thus allowing governments, or the private sector, to spend less of their own resources. Whatever the mechanism, when GDP per capita is known, health expenditures per capita can be predicted with more than 95 percent accuracy.

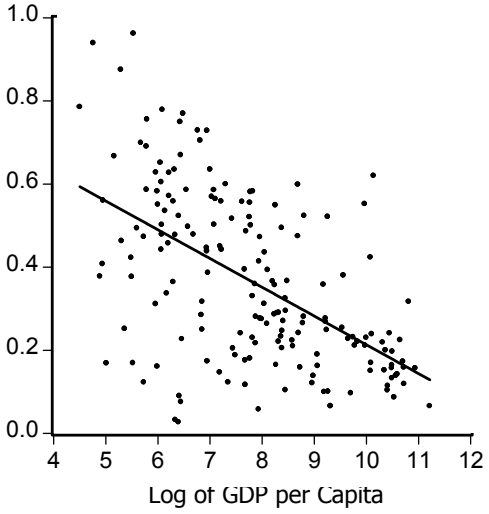
Figure 1. The First Law of Health Economics



Source: World Health Organization, Statistical Information System <http://www.who.int/whosis/en/index.html> (accessed 2004).

A second common observation is that in low-income countries, private, not-insured, out-of-pocket expenditures on health care make up a larger share of total financial resources than in richer countries (Figure 2). In many low-income countries the share exceeds 50 percent; in India and China it is over 75 percent. However, the R-squared for this regression is only 0.311, leaving plenty of scope for policy measures to reduce the out-of-pocket share, especially through the implementation of health insurance. Risk sharing for health care is critical to efforts to alleviate poverty. A recent study shows that about 150 million people per year suffer catastrophic financial shocks due to uninsured health care expenditures.

Figure 2. The Share of Out-of-Pocket Expenditures Decreases with Development



Source: World Health Organization, Statistical Information System <http://www.who.int/whosis/en/index.html> (accessed 2004).

These two observations prompt the conclusions that in low-income countries total future resources for health care will be small, and a large share will consist of private, out-of-pocket expenditures. Conventional efforts to increase health resources will not change this. The main challenges are to increase overall resources without crowding out existing private resources and to increase risk sharing for poor households.

Poor Pockets in Growing Countries

By 2015, a large number of the world's poor will live in poor, remote areas of what will by then be middle-income countries. For these countries, the problem will not be a question of sufficient resources for health care but of how those resources are being distributed. Equality in health has been high on the international policy agenda for decades, but it proves to be an illusive goal. Virtually without exception, country studies show that the poor have less access to all types of health care and benefit less from publicly provided services than do higher income groups. Thus, health status is universally lower for the poor than for the rich. The quest for health equality is often used as a major argument for heavy government involvement in health care. After more than 25 years of policy failure in this area, evidence suggests it is time to rethink reliance on the government as sole financier/provider of health care.

Colombia provides a good example on how progress can be made to achieve access for all. It introduced a comprehensive health insurance scheme in the early 1980s consisting of two regimes: a contributory regime focusing on workers with monthly incomes of about US$170 or higher and a subsidized regime for the poor. The contributory regime is financed through mandatory payroll taxes and the subsidized regime from a mixture of fiscal revenues and cross-subsidies from payroll taxes. A controversial but necessary aspect of the dual insurance scheme is that benefits are more limited in the subsidized regime, reducing the requirement of equality. Paradoxically, the overall effect of the introduction of the new system has been more equality in insurance coverage, access to health care, and health outcomes.

Further, even for the fully subsidized regime, the government has not solely relied on the public sector; instead, participants choose from among a mixture of public or private, for-profit or not-for-profit health insurance companies. In turn, the insurance companies contract health services from a network of public, private, or own clinics and hospitals. This supply aspect is often overlooked when discussing the feasibility of providing access to health services for the poor through low-cost health insurance. In many developing countries governments promise free health care for all but fail in the delivery. As part of the public sector, health staff often go unpaid for months, clinics lack drugs and equipment, and hospitals become dilapidated from lack of maintenance. The insurer–provider contracts provide for a steady and reliable income flow for clinics and hospitals, which facilitates sufficient staffing and much-needed investment in health care infrastructure. The Colombian experience suggests that health insurance coverage for all can be achieved in middle-income countries provided that a number of lessons are taken to heart: first, the goal of ex ante equality is an impediment to providing access for all. The global evidence on that is overwhelming. Second, higher levels of ex post equality can be achieved if coverage levels for the poor take the realistic view that resources are limited. And finally, by relying on insurer–provider contracts—where the providers can be public or private—incentives can be put in place to provide reliable access for all income levels.

Financing Health Care in Poor Countries

Financing health care in poor countries that have limited or no growth prospects remains challenging. But here too health insurance can play a major role. As shown above, the share of private payment for health care is large in poor countries. Given the overall limitations of resources, policies to increase access should be designed so as not to crowd out those private resources. Prepaid, low-cost voluntary health insurance provides such a mechanism. It harnesses the existing resources, provides a steady income flow for the providers, and protects participants from financial shocks as a result of illness. Recent experience in a number of African countries suggests a way forward.

The Dutch nongovernmental organization (NGO) PharmAccess develops low-income health insurance products for a variety of low-income workers. The NGO started with workplace programs in large international companies, providing comprehensive health insurance for the workers, including counseling and treatment related to HIV and AIDS and treatment of tuberculosis

and malaria. As in the case of Colombia, PharmAccess develops contracts between insurers and providers to guarantee easily accessible and high-quality care. This approach is currently being implemented in more than 30 African countries. The major challenge now is not only to provide insurance coverage to workers at large and often international companies, but also to increase coverage for workers in small and local companies and for the self-employed. Pilot projects of this kind are being developed and implemented in Namibia, Nigeria, and Tanzania. The schemes provide an easy mechanism for donor support to subsidize the insurance premiums, without risking the crowding out of existing public or private resources. Group insurances are developed for farmer cooperations, participants of microfinance schemes, market women, fishermen cooperations, small information and communications technology enterprises, organized coffee growers, and other target groups. In all cases the benefit levels are tailored to the needs (and means) of the target groups. With the aid of a generous grant from the Dutch government, insurance premiums are subsidized for the first few years to entice low-income households to participate in these new schemes. The steady income flow from these prepaid schemes allows providers to invest in improvements of health care infrastructure.

Of course, the success of this approach depends on the effective and sustained demand for these voluntary (private) prepaid insurance schemes. Long-term experience with such schemes is still limited, but a growing literature on the willingness to pay for health insurance suggests that the market for such schemes is large, also among the poor.

The Willingness to Pay for Health Insurance

In the absence of real world experience, economists gauge the willingness to pay (WTP) for health insurance in low-income countries by means of contingent valuation (CV) methods. The number of studies in this area is rapidly growing and provides a consistent picture. One study by Barnighausen et al. examines WTP among informal-sector workers in Wuhan, China, finding that these workers are willing to pay the equivalent of about US$4 per member per month. This amount is higher than the estimated cost of insurance based on past health expenditures. Another study by Dror et al. uses unidirectional bidding in a CV survey to obtain estimates of willingness to pay for health insurance in India, finding that the poor are willing to pay a higher percentage of their income on health insurance premiums than higher income groups. The median WTP for health insurance is the equivalent of about US$15, and 25 percent of the respondents are willing to pay the equivalent of US$20 or more. Asgary et al. examine willingness to pay for health insurance in rural Iran, finding that households are willing to pay US$2.77 per month on average. Asfaw and von Braun estimate that, on average, the willingness to pay for a community-based health insurance scheme in Ethiopia is the equivalent of about US$0.60 per month, pointing out on page 249 that, while this amount seems small, "if universal coverage of insurance is assumed, it is possible to generate around 631 million Birr (US$75 million) per annum from 1.57 million urban and 9.5 million rural households of the country. This amount is much higher than the maximum amount of money used as a recurrent budget by the health sector of the country."

A recent study for Namibia reports the results presented in Table 1. Using the CV method, the authors estimate that households in the poorest quintile are willing to pay the equivalent of about US$18.50, or 5 percent of their income, on health insurance. Remarkably, this is almost exactly the expected amount of their current expenditure level. Higher income households are willing to pay more for insurance, again reflecting their expected outlays (for the highest income group, the WTP is much lower than their expected expenditures, probably due to the limited coverage of the hypothetical insurance package that was offered).

Table 1. Mean Willingness to Pay for Health Insurance and Expected Health Expenditures

Quintile	Expected Health Expenditures per Capita per Year N$	Mean WTP per Capita per Year N$	WTP as a Percentage of Mean per Capita Consumption per Year %
1	130	132	4.97
2	162	180	3.07
3	215	204	1.96
4	324	264	1.31
5	902	312	0.47
Total	283	252	1.20

Source: Calculated by author based on Republic of Namibia Okambilimbili Survey, 2006, and A. Asfaw, E. Gustafsson-Wright, and J. van der Gaag, "Willingness to Pay for Health Insurance: An Analysis of the Potential Market for Health Insurance in Namibia," (Brookings Institution, Washington, DC, 2007).

Experience with Community Health Insurance Programs

Voluntary health insurance schemes have long been around in developing countries. Unfortunately, the experiences with such schemes are mixed and hard analyses into the causes of these mixed results are scarce. Based on an extensive survey of the literature, Preker et al. conclude that there is good evidence that community financing arrangements lead to better access to drugs, primary care, and even hospital care, but they also find that many schemes have difficulties in raising sufficient resources. Implementation problems are also mentioned in a report from the Ministry of Health in Tanzania that discusses experiences with community health insurance schemes in Tanzania, Zanzibar, Uganda, and Ghana. In particular, the need to introduce user fees (to entice participation in the insurance

scheme) and to design a system of exemptions (for instance, for pregnant women) and waivers (for the very poor) proved to be major obstacles for the successful implementation of such schemes. Wagstaff et al. find that the introduction of a heavily subsidized voluntary health insurance scheme in rural China did increase outpatient and inpatient utilization by 20 to 30 percent but had no impact on out-of-pocket spending or utilization among the poor.

It is worth noting that none of these studies analyzes or even describes the link of the insurance schemes with health care providers. The current evidence suggests that for such schemes to be successful, more experience is necessary with alternative forms of implementation, including effective insurance provider contracts.

The sustainability question for these types of schemes is not different from the sustainability question regarding budget support for public systems. For low-income countries, additional resources to provide free or highly subsidized public health care will be necessary for years to come. The same is likely to be true for prepaid health insurance schemes for low-income households. The main difference is that the prepaid schemes leverage the already available private resources and thereby empower low-income households to demand easily accessible quality care. Furthermore, the prepaid schemes can contract out services with both public and private providers, thus contributing to the development of a more integrated overall health care system.

Conclusion

In poor, nongrowing countries, and in poor pockets of countries that are developing, resources for health care will be scarce and a large proportion of those resources will be private. Donor aid for the first group of countries, and central government aid for the poor in the second group, should be designed in such a way that the private resources stay in the health system, rather than being crowded out. Private, voluntary health insurance may provide a mechanism to achieve this. It will also provide a reliable income flow for health care providers and protect the poor against the negative financial shock of having to face large health care expenditures. Potentially, the demand for suitably designed low-cost private health insurance is large, even among the poor. The main challenge is to design insurer–provider contracts that guarantee reliable and easy access to high-quality care. Experience with such contractual arrangements is scarce. The way forward should include experimentation with alternative contractual arrangements among (public and private) insurers and (public and private) providers, accompanied by serious evaluation efforts to learn from mistakes and accumulate best practices.

For Further Reading: A. Asfaw and J. von Braun, "Innovations in Health Care Financing: New Evidence on the Prospect of Community Health Insurance Schemes in Rural Areas of Ethiopia," *International Journal of Health Care Finance and Economics* (Vol. 5, 2005); A. Asgary, K. Willis, A. Taghvaei, and M. Rafeian, "Estimating Rural Households' Willingness to Pay for Health Insurance," *European Journal of Health Economics* (Vol. 5, 2004); T. Barnighausen, Y. Liu. X. Zang, R. Sauerborn, *Willingness to Pay for Social Health Insurance among Informal Workers in Wuhan, China: A Contingent Valuation Study* (London: Bio Med Central Health Services Research, 2007); D. M. Dror, R. Radermacher, R. Koren, "Willingness to Pay for Health Insurance among Rural and Poor Persons: Field Evidence from Seven Micro Health Insurance Units in India," *Health Policy* (Vol. 82, 2007); "Health Financing Workshop," Ministry of Health and Social Welfare (Dodoma: United Republic of Tanzania, May 2005); A. Preker, G. Carrin, D. Dror, M. Jakab, W. Hsiao, and D. Arhin-Tenkorang, "Effectiveness of Community Health Financing in Meeting the Cost of Illness," *Bulletin of the World Health Organization* (Vol. 80, 2002); J. van der Gaag, Towards a New Paradigm for Health Sector Reform (Washington, DC: Brookings Institution, in progress); A. Wagstaff, M. Lindelow, G. Jun, X. Ling, and Q. Juncheng, "Extending Health Insurance to the Rural Population: An Impact Evaluation of China's New Cooperative Medical Scheme," World Bank Policy Review Working Paper 4150 (Washington, DC, 2007).

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