Chapter 26

Health Care for the World's Poorest: Is Voluntary (Private) Health Insurance an Option?

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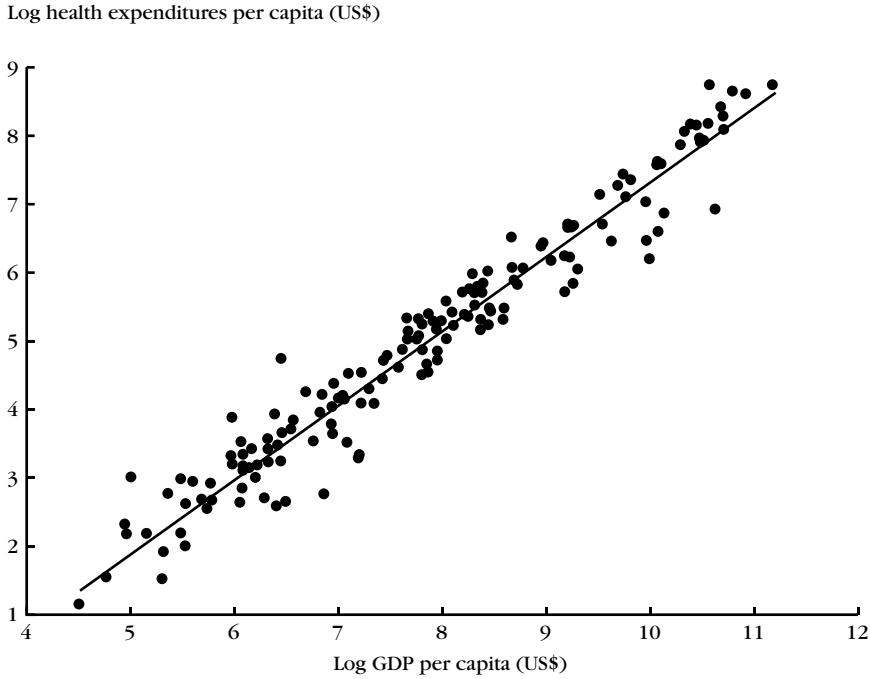
About 80 percent of the world's population currently lives in countries that are either developed or developing. The other 20 percent lives in countries that are stagnant or falling behind. As a result, by the 2015 target date for meeting the Millennium Development Goals, about 1 billion people will 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. Although 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 chapter 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 by 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 26.1. The cross-country regression is based

Figure 26.1 The first law of health economics



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

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 all yield negative results. The fit of this simple regression is very tight (*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 important 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.)

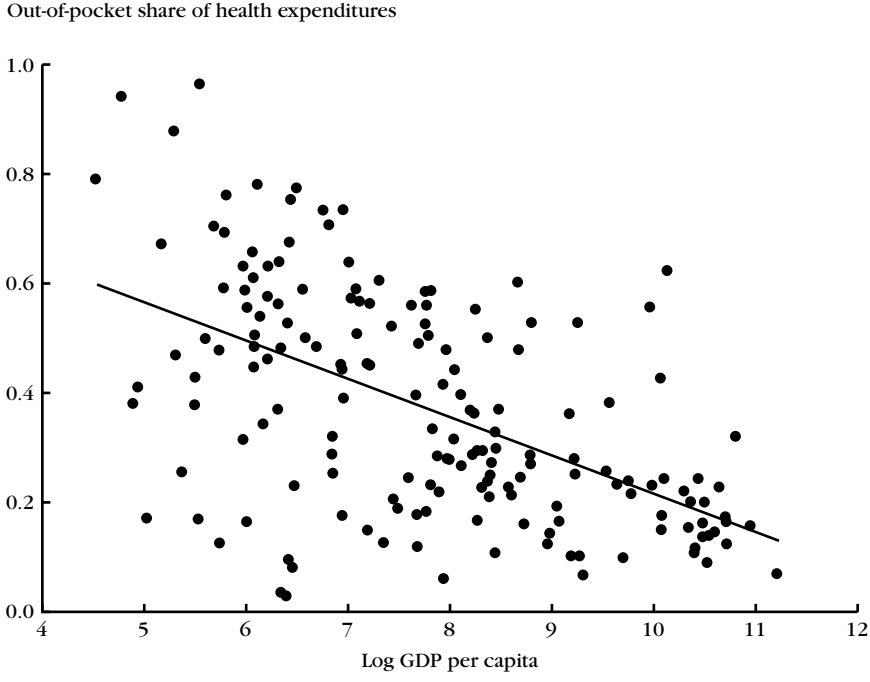
Why is per capita health expenditure so closely related to GDP per capita? One would expect that in countries where governments give high priority to health care, the overall rate of spending would be relatively high given GDP per capita—unless, of course, private financing for health care is being reduced 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 fewer 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.

A second common observation is that in low-income countries, private, uninsured, out-of-pocket expenditures on health care make up a larger share of total financial resources than in richer countries (Figure 26.2). In many low-income countries the share exceeds 50 percent; in India and China it is over 75 percent. However, *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.

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

Figure 26.2 Decreases in the share of out-of-pocket expenditures with development



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

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 has proven an elusive 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 that it is time to rethink reliance on government as the sole financier or provider of health care.

Colombia provides a good example of 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$170.00 or higher and a subsidized regime for the poor. The contributory regime is financed through mandatory payroll taxes, 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 relied solely on the public sector; instead, participants choose from among a mixture of public and private, for-profit and not-for-profit health insurance companies. In turn, the insurance companies contract health services from a network of public, private, or owned 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 pro-

vided 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 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—with the providers either 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 health insurance can play a major role here, too. As shown earlier, 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 experiences 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 for 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. These schemes provide an easy mechanism for donor support to be used to subsidize the insurance premiums without risking the crowding out of existing public or private resources. Group insurance packages are developed for farmer cooperatives, participants in microfinance schemes, market women, fishermen cooperatives, 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 the 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, even 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. (involving a survey conducted between September 1999 and January 2000) examined WTP among informal-sector workers in Wuhan, China, and found that these workers were willing to pay the equivalent of about US$4.00 per member per month. This amount is higher than the estimated cost of insurance based on past health expenditures. Another study conducted in 2005 by Dror, Radermacher, and R. Koren used unidirectional bidding in a CV survey to obtain estimates of WTP for health insurance in India, finding that the poor were willing to pay a higher percentage of their income on health insurance premiums than were higher-income groups. The median WTP for health insurance was the equivalent of about US$15.00, and 25 percent of the respondents were willing to pay the equivalent of US$20.00 or more. Asgary et al. examined WTP for health insurance in rural Iran, finding that households were willing to pay US$2.77 per month on average. Asfaw and von Braun have estimated that on average, the WTP for a community-based health insurance scheme in Ethiopia was the equivalent of about US$0.60 per month, pointing out that although 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" (249).

A recent study for Namibia reported the results presented in Table 26.1. Using the CV method, the authors estimated that households in the poorest quintile were 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 amount of their current expected expenditure level. Higher-income households were willing to pay more for insurance, again reflecting their expected outlays (for the highest-income group, the WTP much lower than their expected expenditures, probably due to the limited coverage of the hypothetical insurance package that was offered).

Table 26.1 Mean willingness to pay (WTP) for health insurance and expected health expenditures

Quintile	Expected health expenditures per capita per year (Namibian dollars at 2006 prices)	Mean WTP per capita per year (Namibian dollars at 2006 prices)	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

Sources: Calculated by the author based on the 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* (Washington, DC: Brookings Institution, 2007).

Experience with Community Health Insurance Programs

Voluntary health insurance schemes have long been around in developing countries. Unfortunately, the experiences with such schemes have been mixed, and hard analyses of the causes of these mixed results are scarce. Based on an extensive survey of the literature, Preker et al. concluded that there is good evidence that community financing arrangements lead to better access to drugs, primary care, and even hospital care, but they also found 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 Ghana, Tanzania, Uganda, and Zanzibar. 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 major obstacles for the successful implementation of such schemes. Wagstaff et al. found 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 analyzed or even described 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 to 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 goal. 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 information on best practices.

For Further Reading

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