

Health insurance for the poor: Myth or reality?



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Overview

A growing evidence base suggests that health insurance in poor areas can improve people's access to health care. But the poorest in these areas do not seem to benefit much. Health insurance programs, generally, have not helped in reaching out to the poorest or improving their health care use. And whether insurance improves health outcomes among the poor remains to be established.

Key words: health insurance, community-based health insurance, health care utilization, catastrophic spending

Mind the development gaps

Extending good health care to the poorest people is vital if health outcomes are to be improved. Although it is poor people who suffer from ill-health more often, they are denied good health care as it is not available or expensive. Extending or accessing good health care costs money.

In 2006, governments paid for 58 per cent of global health expenditure, whilst the rest was private payments. In many developing countries where governments have lesser money to finance health care, individuals have to spend large amounts to receive good health care. For example in India - a country of one billion featuring among the top 10 for communicable disease - spends 5.2 per cent of its GDP on healthcare. But of this amount, the largest part - 4.3 per cent - is from the private sector. Government spends only an amount equal to 0.9 per cent of GDP on public health. In low income countries, out-of-pocket payments constitute almost 85 per cent of the private expenditure (WHO, 2009).

If poor people have to pay for care when they need it, they may avoid seeking care, become heavily indebted and/or become poorer. Health insurance is one way reducing of out-of-pocket payments and improving poor people's access to health care. Health insurance could be provided either through formal government programs or informal community-based schemes, including, amongst others, micro-insurance schemes, community health funds and mutual health organisations and so on. To make them more equitable, insurance schemes sometimes offer subsidies to a targeted section of poor people, or may be tailored for specific services, such as primary care.

But several questions remain. Does health insurance really protect poor people financially? When insured, do they seek more and better health care? And most importantly, does subscribing to any of these schemes actually improve their health?

Lessons learned

Health insurance helps to reduce catastrophic expenses, but not all schemes reach out to the poorest people: The evidence on national health insurance programs shows that although the effects may vary across countries, in general insurance schemes help to reduce people's expenses. For example, Mexico's national health insurance program *Seguro Popular* helped reduce substantially the likelihood of extraordinary health expenses amongst insured households (Galárraga *et al.*, 2008).

A recent experimental study estimated this reduction to be nearly 23 per cent over the period the program was assessed (King et al, 2009). Similar experiences were seen with Colombia's Universal Health Insurance System – which includes two different schemes: the contributory regime for the better off and the subsidized regime for the poorest people. This system greatly reduced catastrophic expenses for all (Giedion and Uribe, 2009). In China however, a government subsidised voluntary health insurance scheme – the New Cooperative Medical Scheme – did not have any effect on average out-of-pocket payments of people (Wagstaff *et al.*, 2007).

A systematic review of studies on community based health insurance found strong evidence that subscribing to an insurance scheme protects people financially. But it also found that this protection could be limited. Most studies find that the poorest groups, in the areas that the schemes serve, tend to be left out of them (Ekman, 2004). In rural Senegal, the poorest third of the population were much less likely to become members of one such community health insurance scheme. Amongst those who subscribed to it, out-of-pocket payments reduced significantly even though the costs of joining the scheme were a concern (Jutting, 2004).

Whilst community health insurance can exclude poor people, this is not so of provider based schemes do not do so. The systematic review of CBHI schemes also compared them to those run by health care providers, such as hospitals and national schemes. Whilst provider schemes reduced people's expenses to a lesser extent than community health insurance' schemes, they were better at reaching out to the poorest people (Ekman 2004).

Use of health care improves when people are insured, but again poor people do not benefit always: In poor areas, members of health insurance programmes are much more likely to use health services when they need care. Colombia's subsidised national health insurance programme increased the likelihood of health service use by nearly 5 per cent, particularly amongst women, elderly and urban residents (Trujillo et al., 2005). Insured women were more likely to deliver babies with the help of skilled health care personnel and sought more care during pregnancy. The subsidised programme also increased the likelihood of poor children being completely immunised by 8 per cent (Giedion et al., 2007). China's New Cooperative Medical Scheme helped people to gain better access to tertiary health care. It increased outpatient visits by 20 per cent, though not amongst the poorest fifth of people (Wagstaff et al., 2007).

More recent studies of community health insurance schemes looking at their effect on health care use find similar results. In Burkina Faso, a randomised trial found that 40 per cent of those who reported illness in the insured group used formal health care services, as compared to the 10 per cent in the uninsured group (Gnawali et al., 2008). Similarly, in Senegal health care use increased and health care expenses were lower amongst those using community-health insurance, than those who were uninsured (Jutting, 2004). However, both studies note that the benefits were concentrated amongst the better off.

Better health for insured people: There are very few studies which have assessed whether health insurance improves the health of people (Ekman, 2004). A review of 127 documents on 258 community based schemes globally noted that 'none attempted to evaluate the impact on the health status of its

members' (ILO, 2002: 28). Most studies focus on the financial aspects of the schemes and hardly any on their impact on service use or financial protection of poor households.

Little evidence is available to prove whether insurance improves health outcomes or not. One study which evaluated Vietnam's health insurance programme showed it helped to improve children's health, increased health care use and helped poor people to spend their money on other household needs instead. Overall, the nutritional status of young children under 4 years of age have improved as seen in increases in height and weight (an increase of 2.35cm and 0.75 kg respectively), but not amongst those in the poorest families. The programme also had a positive impact on adult body-mass index - a measure of body fat based on height and weight that applies to both adult men and women. Though one in five of the poorest families did not show any improvements (Wagstaff and Pradhan, 2005).

Closing the evaluation gap

Although there is evidence that health insurance programmes have a positive impact in poor areas, their effect on improving the situation of very poorest families cannot be established. Generally, insurance programmes, which have a component of subsidy, seem to help the poorest. However, the evidence on this is still unclear. In some cases formal health insurance with subsidies have worked but not in others. And as mentioned previously evidence on whether the health of poor people improves as a result, is seriously lacking.

Rigorous impact studies are needed to investigate the impact of formal and informal (community-based) health insurance on immediate and long-term health outcomes. Studies that examine community-based health insurance are particularly needed as there are many such schemes operating worldwide.

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Credits

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