Advancing Health Systems Podcast Series, Episode 3 - Full Transcript

Health Insurance

Abdo Yazbeck: There's a lot of uncertainty in health spending. Empirically we found, whether it's in China or in the U.S., 10 percent of the population in a typical year will end up consuming 60 percent of health spending. We don't know who the 10 percent are, and we don't know how much money they will need. So insurance becomes an important way of pooling resources from everybody so that when people need care, then it can be paid for them.

Jeanna Holtz: Instead of one individual paying for a health event, when that happens, insurance is a mechanism that replaces that with small, regular, prepaid amounts that pool money together and that can be used for a group of people when an individual within the group has an illness. It's also a way of enabling those who can afford to pay more to contribute at higher levels. The underlying premise should be that health is a human right, and that people should be able to access the health care that they need without financial hardship. Insurance is one mechanism to enable that to happen.

Kirby Crider (Host): Welcome back, listeners, to the show Advancing Health System in Low- and Middle-income Countries. This podcast mini-series is part of the HFG project, the Health Finance and Governance project. You could learn more about that project in episode zero, but just know that the goal of the project is to strengthen health systems, especially in low- and middle-income countries around the world. My name is Kirby Crider, and I'll be your host, yet again. I work on the HFG project. And I've said this in the past, but I just want to reiterate that I am delighted, honored, and I feel like it's a privilege to be here talking to you. We've been watching play counts and the previous episodes keep growing, and there's people listening from all over the world, which is really cool to see.

If you're someone who's interested in achieving universal health coverage, you can appreciate that one of the biggest barriers to access is high out-of-pocket spending. This is something we talked about in our first episode on domestic resource mobilization, where we discussed that the high cost of health care is a leading cause of bankruptcy. Health insurance, the topic of this episode, is one approach countries are implementing to address this issue.

Insurance schemes seek to pool financial risk, reducing the overall financial burden on individuals, improving access to those critical health care services that we want and need. In this episode we're going to hear from experts about different models that are being implemented around the world; some challenges to setting up a health insurance scheme in a low- or middle-income country, because they are different than in higher income countries; and we'll learn a bit, too, about what approaches some countries are using to make these schemes financially sustainable.

I spoke with Abdo Yazbeck, who you heard of the beginning of this episode, along with Jeanna Holtz, who I'll introduce later. Abdo is a senior economic advisor on the HFG project and works for Abt Associates. He described four major insurance models that exist around the world and gave us a historical perspective.

Abdo Yazbeck: The first one that almost everybody is familiar with is the Bismarck Model, or what's now being called social health insurance. That's a situation where money is earmarked from labor tax. So anybody who works, a percentage of their salary and a percentage of what the employer pays goes into a fund that's used for health care services. That's called social health insurance, or the Bismarck Model. For example, the most obvious countries are Germany or France. It's well-developed countries. It's also all over Latin America and increasingly in Eastern Europe, and now starting to show itself in Asia as well, and even some African countries are interested in it.

The second model is more of the British or Canadian model, and it's called the Beveridge Model, named after Lord Beveridge. This came after World War II, where the British wanted to make sure society, which was poor and impoverished because of the war, had basic services and health was one of the more important services. There's not a standard insurance but everybody is covered, so they are insured in a way and they don't pay into it. There's no labor tax, it's overall government revenue that pays for it. In this model, usually the government is in charge of funding it, and in many cases, even delivering services. So those are the two largest, dominant models; the public financing model and the labor tax financing model.

Kirby Crider: So, Abdo has described two health insurance models at this point. The first one is the Bismarck Model, and it involves funds collected for health insurance from payroll taxes. The second is the Beveridge Model, in which funds come from general tax revenue. In both cases, essentially everyone is covered. When I spoke with Abdo, he also described a third model, which is the one some high-income countries have tried, in which they establish a market of mandatory private or commercial health insurance and combine that with some form of government subsidy. You might recognize many features of this in the U.S. health care system.

Abdo Yazbeck: The U.S.-based insurance system, which has elements of the Beveridge, in which there is a labor relationship. In the United States, insurance is an employer responsibility, and so most of us get our insurance because we work in a certain place and part of our salaries are taken out; part of the employer payment gets into an insurance, but it's labor linked. So what happens with that is that those who are outside labor, then, they need a different way to be covered. It's not necessarily the most efficient or equitable health system because it leaves a lot of people outside, and so government has to jump in.

The fourth model, which is dominant in low-income countries, is zero insurance. You pay when you ask for service or when you need the services. It's a fee-for-service, it's an out-of-pocket spending. It means the 10 percent of the population who need 60 percent of health spending, at any point in time, will face amazingly high medical bills, which they may not be able to use. So you end up with two outcomes, and both are terrible. You either borrow money to pay, you impoverish yourself, or you can't even borrow enough, so you don't get care at all. Both are terrible outcomes. So, the fourth model, which is really the default model, which is no insurance, no pooling, no public funding, it's basically we pay when we need it and it's a terrible way of organizing health care financing.

Kirby Crider: So, the fourth model (that's not really a model), is a big reason why many low- and middle-income countries are seeking out new health insurance models. I found it really interesting to be able to put a name to the different models that I've witnessed here in the U.S. and seen overseas as well. One thing I took away from the conversation with Abo is that different countries have tended towards these different models, and different combinations of these models, for a variety of different reasons. Some of

them are economic, some might be political, and some are likely cultural, too. So, we've got the historical and the global perspective, but let's consider low- and middle-income countries specifically, the subject of this podcast. Something that makes low- and middle-income countries different than higher income countries is the presence and the ubiquity of the informal worker.

Adam Koon is a health researcher on the HFG project. I spoke with him about a recent study he worked on looking at the informal workforce in low- and middle-income countries.

Adam Koon: Informality, you might ask why that matters or why you should care if somebody is informal if they're not paying taxes. It's very difficult to then direct that money into some sort of national health insurance; they're not in the system administratively. But also, if people are not in the workforce, it is very difficult to know where they are, who they are, and what their family size is. They can oftentimes be invisible. So, some of the people that work but are informal are farmers, market vendors, day laborers for construction, transport workers -- taxis or rickshaws -- as well as people that do other types of hidden work. What we found, which was striking, is that in the EPCMD countries--

Kirby Crider: These EPCMD countries that Adam refers to are 25 countries that are prioritized for assistance by USAID because they represent more than two-thirds of maternal and child deaths around the world.

Adam Koon: --roughly 70 percent of the labor force is informal. This is much higher than in the general pool of low- and middle-income countries. In some countries, like Madagascar, over 95 percent of the population is informal. Even some upper-middle-income EPCMD countries, like Indonesia, still have a considerably large informal sector. So this begs the question of how useful that characterization is.

Kirby Crider: It's important to think about informal workers in the context of low- and middle-income countries. You can't automatically tax informal workers because they're not receiving the kind of traditional paycheck that we might think of here in the U.S. But as we'll see in our two country examples, low- and middle-income countries around the world are implementing health insurance schemes. The question is, how are they doing it?

I'd like to start by sharing with you what's been happening in Ghana. Ghana's National Health Insurance Scheme, or NHIS, is considered one of the most ambitious plans in Africa for achieving universal health coverage. It started in 2003, and it has successfully expanded to cover about 40 percent of the population by 2014, and it's expanded even further since then. Here's Jeanna Holtz. She's a senior health economist at Abt Associates working on the HFG project. You heard her at the beginning of this episode, right after Abdo's comments. Jeanna will introduce us to the case study of Ghana.

Jeanna Holtz: Ghana is a great example of a country that seized the political moment to introduce a national health insurance scheme. Ghana previously had sort of a history of people paying out-of-pocket for their services, and they call that Cash and Carry. It was very unpopular because it created hardship for people, and it particularly was hard for people who were poor.

Kirby Crider: To learn a little bit more about Ghana's National Health Insurance Scheme, I talked to Nathan Blanchet. He's also a senior health economist and he works for Results for Development, as part of the HFG project.

Nathan Blanchet: The enactment of the NHIS was very much a result and heavily influenced by this competition between two major parties, the NPP and the NDC. The NPP ran on a campaign, in the 2000 election, of abolishing this this user fee-based, or this Cash and Carry, program that was so controversial. They said they would abolish it and they won that election. That was the first time in Ghana's most recent history, the early '90s, that there was a changeover in power. So, that party came in and I think there was a lot of pressure for them to deliver on that campaign promise before the next election in 2004. Ghana has since undergone two more peaceful democratic turnovers of power.

Kirby Crider: So how did Ghana do this? There was clearly the political will when this new party came into power and ran on national health insurance and abolishing this very unpopular system. But there were also some other things that they did that were very important. Here's Nathan again.

Nathan Blanchet: They got new sources of funding. They added two and a half percentage points to their value-added tax -- like a sales tax -- that would go into a dedicated fund for the health insurance scheme. They also got some contributions from their formal sector workers through their social security program. Those two sources have made up about 90 percent or more of the revenues for the scheme.

The second thing was that they created what we health economists call a risk pool, meaning that everyone in the country, every Ghanaian who enrolled in this scheme, is essentially in the same pool covered by the same funds, and their risks are able to be shared. They also made their insurance scheme quite comprehensive in its benefits. It is intended to cover 95 percent of the disease burden, and you can use it anywhere, so it's been portable. So, those were some of the things that Ghana did and, most would agree, really got right as some important foundations. It did help end Cash and Carry, and helped increase utilization of health care, including among the poor. They also have had many challenges, and that's part of what partners, like the HFG project, have been working with Ghanaians on.

Their scheme was enacted very quickly, designed very quickly, and it was extremely ambitious. Over the past 15 years, they have faced some pretty serious financial sustainability problems and also some problems with the efficiency of their operations. The major challenge with financial sustainability was that there was never a real careful balancing between the revenues coming in from the taxes that I mentioned, and the expenses going out. There were really no controls put in place. There was limited ability to monitor what providers were submitting claims for, there were no co-payments or anything like that to serve a bit as a check on use of services, and utilization has climbed and has outstripped the revenues coming in.

Well, they are now in the process of doing various reviews and assessments to revise their benefits package. They have realized that they really want to orient that benefits package more toward primary health care services so that they can reach more people with more cost-effective services. They also have realized that there's just a great deal of new capacities and new functions that need to be run in the insurance setting, and the national health insurance authority has been growing its abilities to do that. One of the biggest things they have worked on is using evidence better.

Kirby Crider: Let's move across the continent to eastern Africa, to Ethiopia. In 1998, Ethiopia developed a national health care financing strategy. The strategy aimed to improve and diversify resource mobilization for health care to ensure equitable and efficient resource allocation and use, and to secure financial protection for its citizens. So, working off of this strategy, over the last 20 years Ethiopia has

made impressive progress in strengthening many aspects of its health system, and the country has made remarkable progress in reducing infant and under-five mortality rates in recent years.

One of the challenges has been with health financing. In 2010 and 2011, per capita health spending was only about 21 U.S. dollars per year, and about one-third of that was covered by out-of-pocket expenditures, which is very high. These high out-of-pocket costs meant that people often did not seek care for themselves or their families, or when they did seek care, it was financially catastrophic or totally impoverishing. In response to these problems, Ethiopia has adopted and is now rapidly taking to scale what's called community-based health insurance, or CBHI. Here's Hailu Zelelew. He's the HFG country manager for Ethiopia and he has more on this.

Hailu Zelelew: Between 2011 and 2013, USAID helped the country to pilot community-based health insurance. It was piloted in certain districts, which is out of close to over 900 districts. Under HFG, we supported the government Ethiopian health insurance agency to evaluate the pilot program. The pilot showed important development, in terms of providing financial protection and health service utilization amongst the CBHI members versus the general population. So, because of that, the government was convinced that it needs to scale up community-based health insurance, and we helped in developing the scale-up strategy in 2015 and, since then, it has been scaled up.

Kirby Crider: So, with this model, community members organize and contribute into a system that pools risk and improves service coverage for everyone. But you might be asking yourself, does this generate enough resources to cover costs? And, what about the poorest people? How are they covered? What about the people that can't pay into the scheme?

Hailu Zelelew: So, government is providing financial support to cover around 10 percent of poor households to be enrolled into a community-based health insurance scheme. So they are members, like any other segment of the population who are enrolled in the community-based health insurance, and they benefit from the program in terms of financial protection. They don't have any different I.D. card from other members, they can't be labeled as poor households, because nobody knows that the government paid for them. They are recognized as community-based health insurance members.

You can’t implement this kind of program at scale unless you have strong government buy-in, leadership and commitment, and that commitment includes the financial commitment. The other lesson I would bring is the necessary institutional arrangement and capacity. Government established a brand new health insurance agency, it’s called Ethiopian Health Insurance Agency. That agency has over 1,000 staff, and it has around 29-30 branch offices throughout the country. It’s leading community-based health insurance as well.

Kirby Crider: A key to Ethiopia’s success is that the government subsidizes CBHI for the poorest 10 percent of households to make sure they're included in the scheme, and it doesn't differentiate between those receiving subsidies and those who paid for it themselves. And it's made a significant investment in the Ethiopian Health Insurance Agency to effectively manage the program.

How's it doing? As of today, approximately 500 districts now are implementing CBHI, which provides access to health services for 19.3 million people. Throughout this episode, I hope you've seen that it's really not about a one size fits all or the one best system. Whether it's the Beveridge Model or the Bismarck Model, it's rather about continuing to adjust strategies and being able to, and willing to, adjust

strategies in order to achieve health objectives. It's also about ensuring financial sustainability. Here's Abdo Yazbeck one more time.

Abdo Yazbeck: All these systems, it's not about getting them right. It's about getting a system to keep tinkering because stuff will happen, changes will happen, the population or politics will happen. So you need to build a robust system to keep adjusting. Bring in more voices so you're protected from it becoming a political issue, because the reality is democracy changes the players, and if you keep changing systems with the players at the root, it's a challenge for a sector like health. If you ignore the others and you tie it too much to one political party, that's what the country chooses to do, you create a high risk of the next government throwing it all out and starting all over.

Kirby Crider: Before we end the episode, I'd like to play one last clip from Catherine Connor, who's the deputy director of the HFG project.

Catherine Connor: Most of the countries we have worked in have taken a very deliberate, intentional approach to learn and adapt as they implement an expansion of health insurance. If you look at Europe, how long did it take England, Germany, France to develop and operate the health coverage that they have today? It took them more than 100 years. In relative terms, what we're seeing happen in Africa and Asia is much faster, frankly; much, much faster. Ghana introduced their health insurance and it got about 75 percent coverage within 10 years.

The importance of a project like ours is that our client, USAID, as an international donor, they want to see a day when their financial support isn't necessary. They want to see a day when the countries are running everything on their own and their macroeconomic development has reached a tipping point where they can pretty much fund everything on their own, and they are putting these systems in place that are well-developed, well-managed, properly financed, and reflect the latest knowledge, in terms of how to be efficient and equitable. These health insurance schemes are a huge leap towards that type of self-sufficiency.

Kirby Crider: With those last words from Catherine, I'd like to close out the episode with a thank you for listening. Another thank you to Abdo Yazbeck, Adam Koon, Hailu Zelelew, Catherine Connor, Jeanna Holtz, and Nathan Blanchet for all of their help on this episode, and a special thanks to Jen Leopold from the HFG project. Thanks to Blue Dot Sessions for our theme music for the series, and finally a thank you to the U.S. Agency for International Development for funding the HFG project. See you next time for our final episode, where we'll talk about health governance.

About the Advancing Health Systems Podcast Series

The Advancing Health Systems podcast series explores fundamental issues involved in expanding people's access to health care in low- and middle-income countries. The podcasts were produced by the USAID-funded Health Finance and Governance (HFG) project, which ran from 2012-2018. They were recorded in 2018.