Extending coverage: concepts, context, question, and options

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How to improve coverage by inclusive health insurance mechanisms in LMICs

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Objectives and context

Enable equitable use of services and protection against financial hardship

- Progress ("moving towards UHC")
- Design in aspects of universality from the beginning

In context of high informality – constrained fiscal capacity in particular

Concepts: what is health insurance?

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Models?	Functions and policies?
"National Health System"	Revenue raising
"Social Health Insurance System"	Pooling
CBHI, etc.	Purchasing
	Benefits and co-payments

Are German citizens *more insured* than British citizens, just because coverage is operated by "insurance schemes"?

- Understand systems (and reform options) in terms of functions, not labels or models (RIP Bismarck, Beveridge)

For policy, it's essential to get the question right

No! "How do we target the poor for subsidies and get the rest of the informal sector to contribute?"

- You have limited yourself to one option

Yes! "How can we reduce the barriers to effective service use and improve financial protection for the poor and other persons in the informal sector?"

- Many choices available

Categorization of financing policy options in terms of basis for entitlement

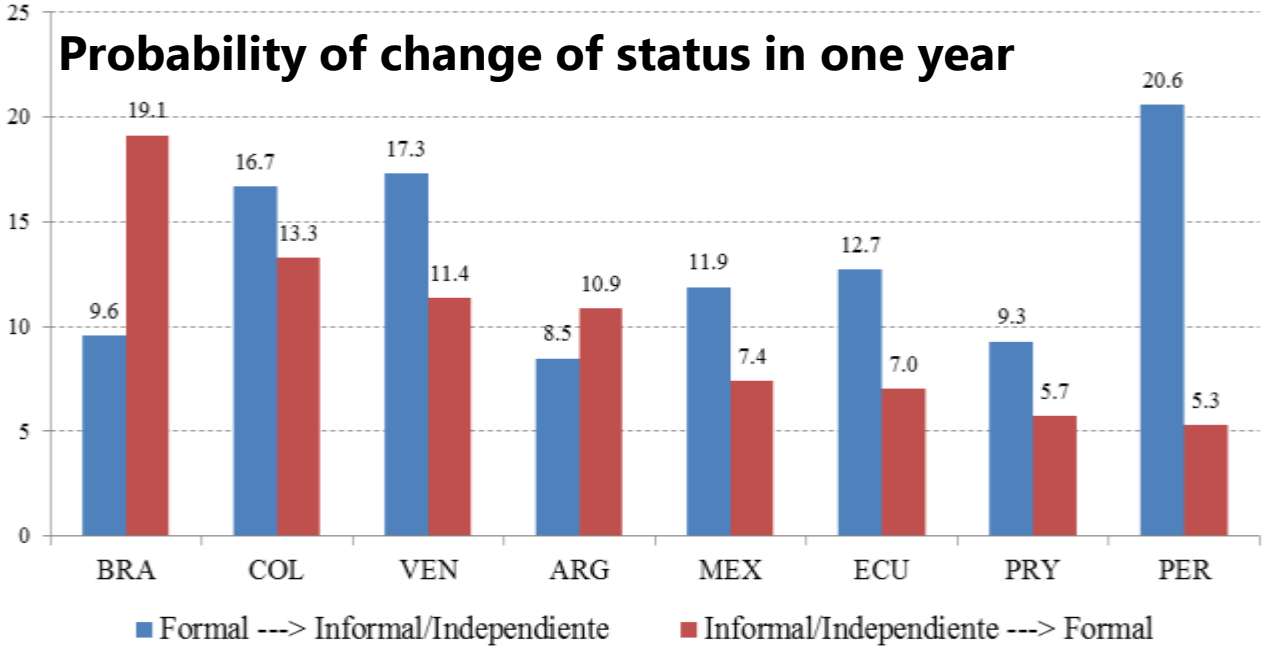
Entitlement to benefits can be based on

- Contribution made by or on behalf of each individual (contributory-based entitlement), e.g., as with social/mandatory health insurance, but also including budget transfers for specific groups
- Some other basis, e.g. citizenship, residence, income level, etc. (non-contributory-based entitlement)

Either choice can be called "insurance" – what you call it depends on your political situation, history, and communications strategy, not the content of the actual reform

One problem of traditional contributory health insurance: informality is not a fixed condition

- Formal job entry or exit means gain or loss of health coverage
- That's not consistent with design of systems for UHC
- Tracking this is expensive



Source: Santiago Levy, WIDER Development Economics Lecture, 2019

Raises even more concerns about contributory-based entitlement in LMICs: is it worth it? Isn't there a simpler way?

Overview of broad types of (HI) policy options

A. Non-contributory-based

1. Universal, budget funded, population-based system
   - UK, Sri Lanka, Brazil
2. Budget-funded for all not covered by explicit social security mechanism
   - Thailand, Mexico
3. Entitlement for some people to range of services
   - Targeted insurance (India), fee exemptions (Cambodia)
4. Universal population guarantee for specific services
   - Burundi, Chile

B. Contributory-based

1. De facto voluntary prepayment for coverage, unsubsidized
   - Many countries have tried this…and failed
2. Fully (for poor) and "heavily" subsidized prepayment for coverage (complementarity)
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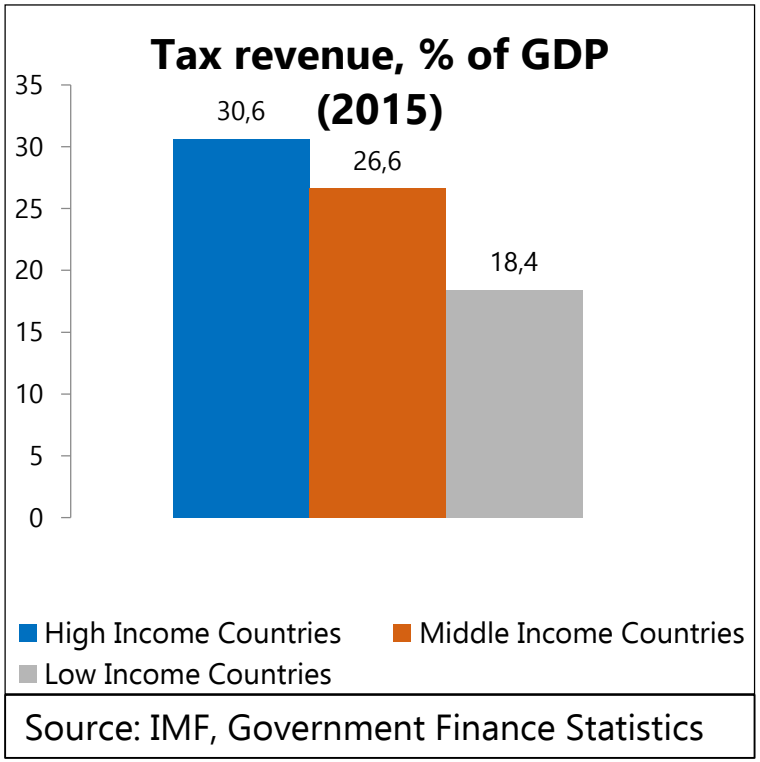
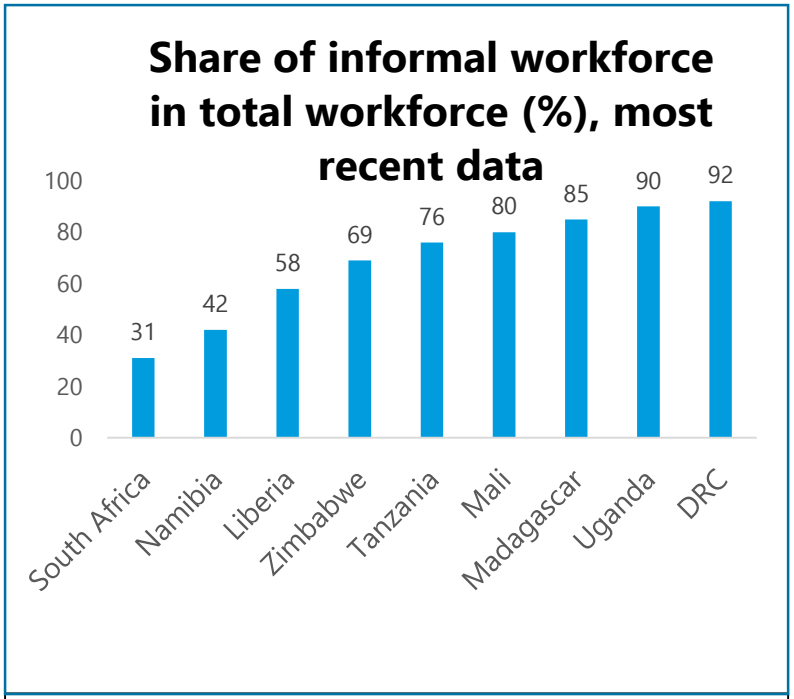
These approaches to "insurance" most promising for LICs – expand via benefits, purchasing, PFM, general revenues

Yes, LMIC context poses severe fiscal challenge



Source: IMF, Government Finance Statistics



Source: World Bank, 2016

Greatly constrains public spending on health, limits speed and extent of progress, but

this shouldn't constrain what we know about health financing

Finally, the policy question is not about health financing

There are important challenges on the "demand-side" that financing reforms won't address, for example

- People have very limited time to seek care
- Services (especially public) often not convenient
- People not very aware of their entitlements, or else they just can't take advantage of them

We need to put more attention on service delivery strategies for the poor and persons in the informal sector (and possibly cash transfers as well)

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THANK YOU