

Policy responses to financial protection challenges

Joseph Kutzin

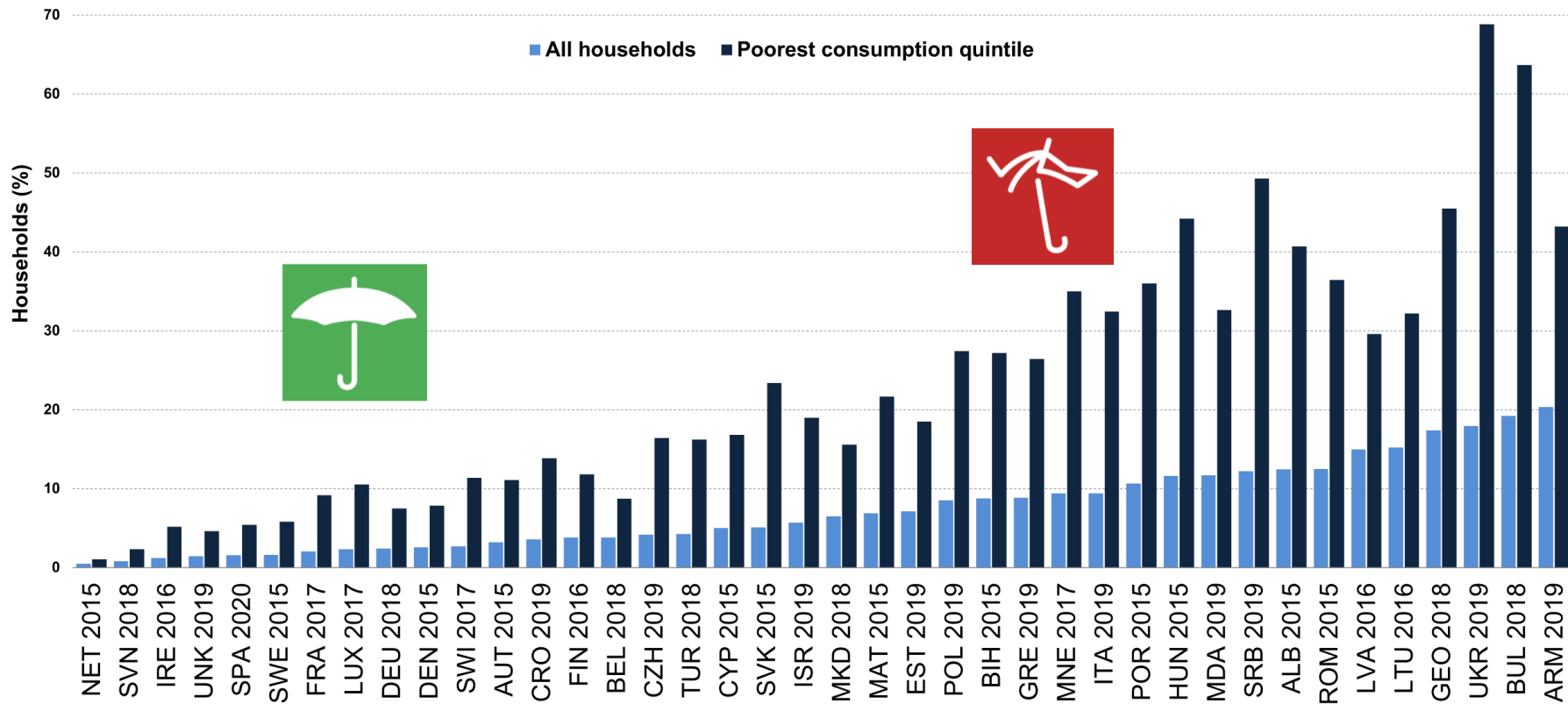
Independent Consultant and Senior Fellow, Results for Development, Inc
Former Head of Health Financing, WHO

ECA Talk: Out-of-Pocket Health Expenditures – Challenges and Policies in ECA

21 March 2024, The World Bank (virtual)

Both level and distribution of cata are problems in the region; there is no upside to OOPS

The **poorest households** are most likely to experience catastrophic health spending



Global evidence on user fees as a policy instrument to influence demand

User fees deter use and don't discriminate between so-called "necessary" and "unnecessary care"

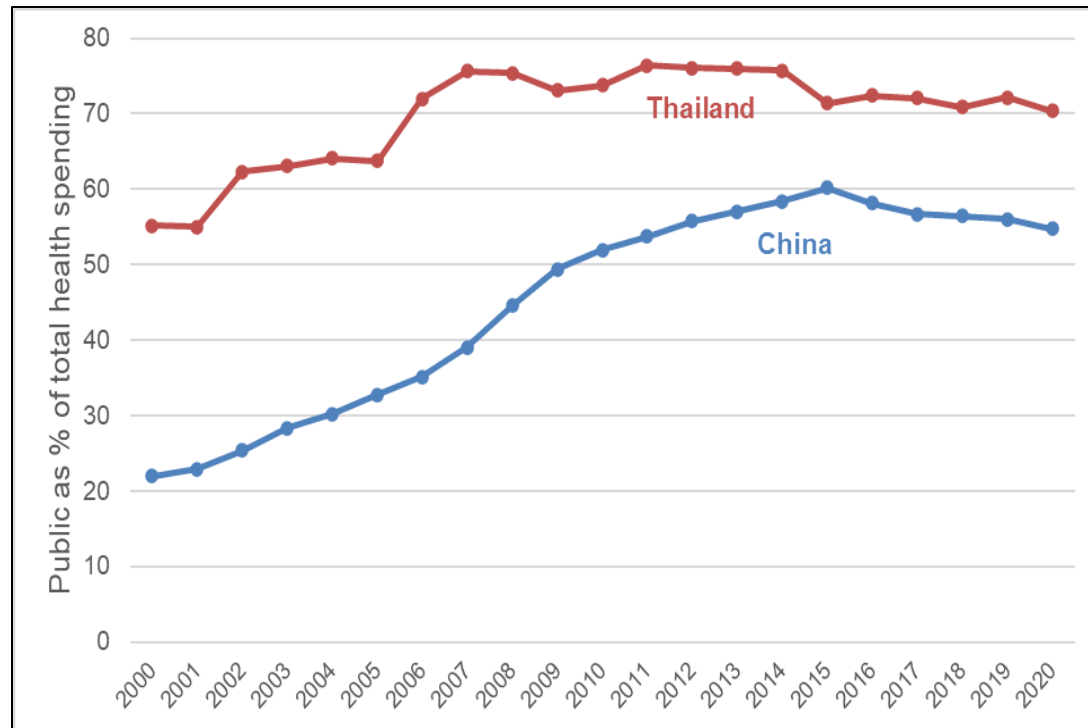
- These are ex post assessments, not ex ante
- I'm not rushing out tomorrow to get a hip replacement because they are on sale
- Information market failure in health care is real (and severe)

In many settings, indirect costs of care seeking are already a barrier

Incentives to providers are much more powerful than incentives to consumers – that's where the efficiency agenda is

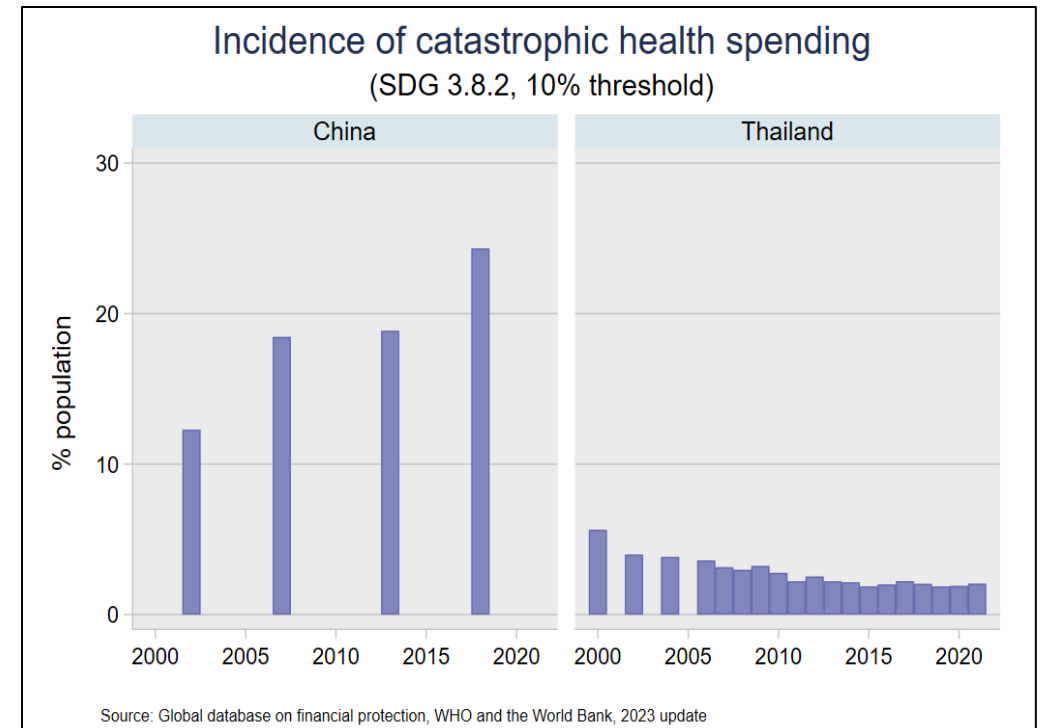
“Insurance” is not an adequate description of what’s needed. China and Thailand spent a lot to ensure entire population covered, with very different results. Why?

Public spending share greatly increased in 2000s in both countries



[WHO Global Health Expenditure Database](#)

But very different patterns of change in financial hardship



Source: Global database on financial protection, WHO and the World Bank, 2023 update

Provider incentives and copayment policies together influence results

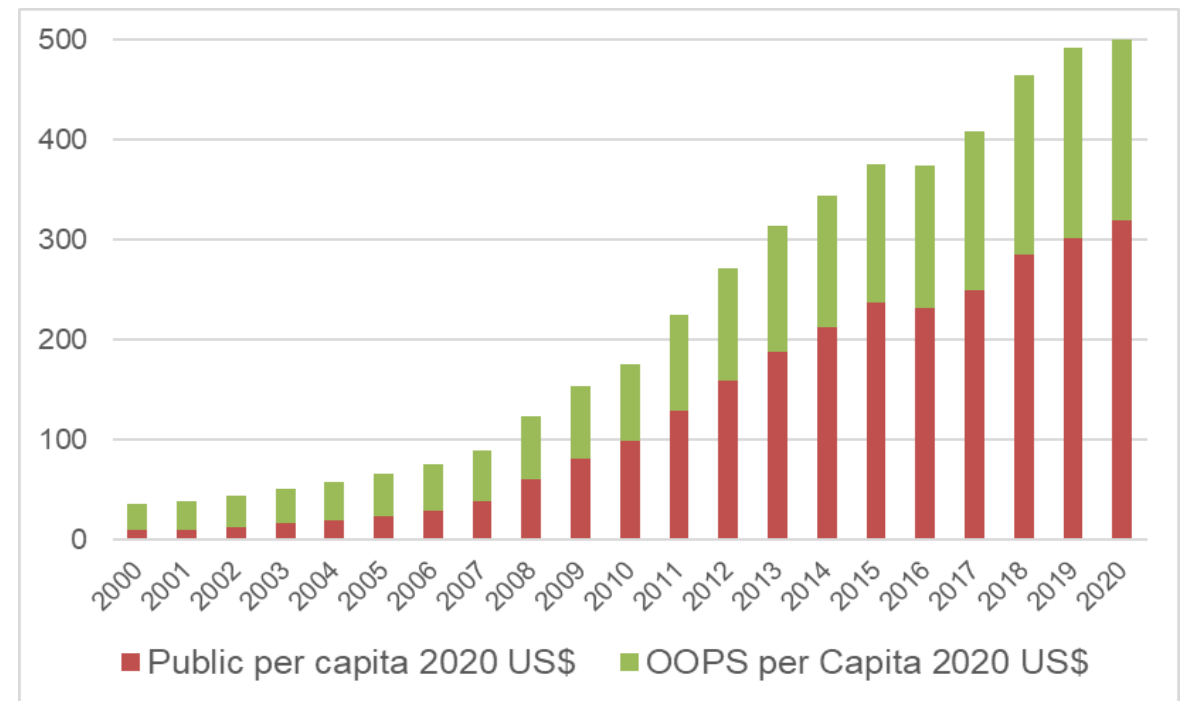
Thailand

- Fixed and then no copayment
- System operates within budget ("closed end payment")
- Result: good for patients

China

- Percentage copayments
- Fee-for-service provider payment;
no budgetary control
- Result: good for doctors and hospitals





China's public spending was like adding fuel to the fire








[WHO Global Health Expenditure Database](#)

A lot has been learned (thanks, Barcelona!!)

Coverage policy choices to avoid

-  Basing entitlement on payment of social health insurance (SHI) contributions
-  Excluding people from coverage
-  Applying user charges without effective protection mechanisms
-  Failing to cover treatment in primary care settings
-  Thinking voluntary health insurance (VHI) is the answer

Good practice checklist for policy-makers

-  Entitlement is de-linked from payment of SHI contributions
-  All people are entitled to the same benefits
-  User charges are applied sparingly and are carefully designed
-  Primary care coverage includes treatment
-  Coverage policy is supported by adequate public spending on health

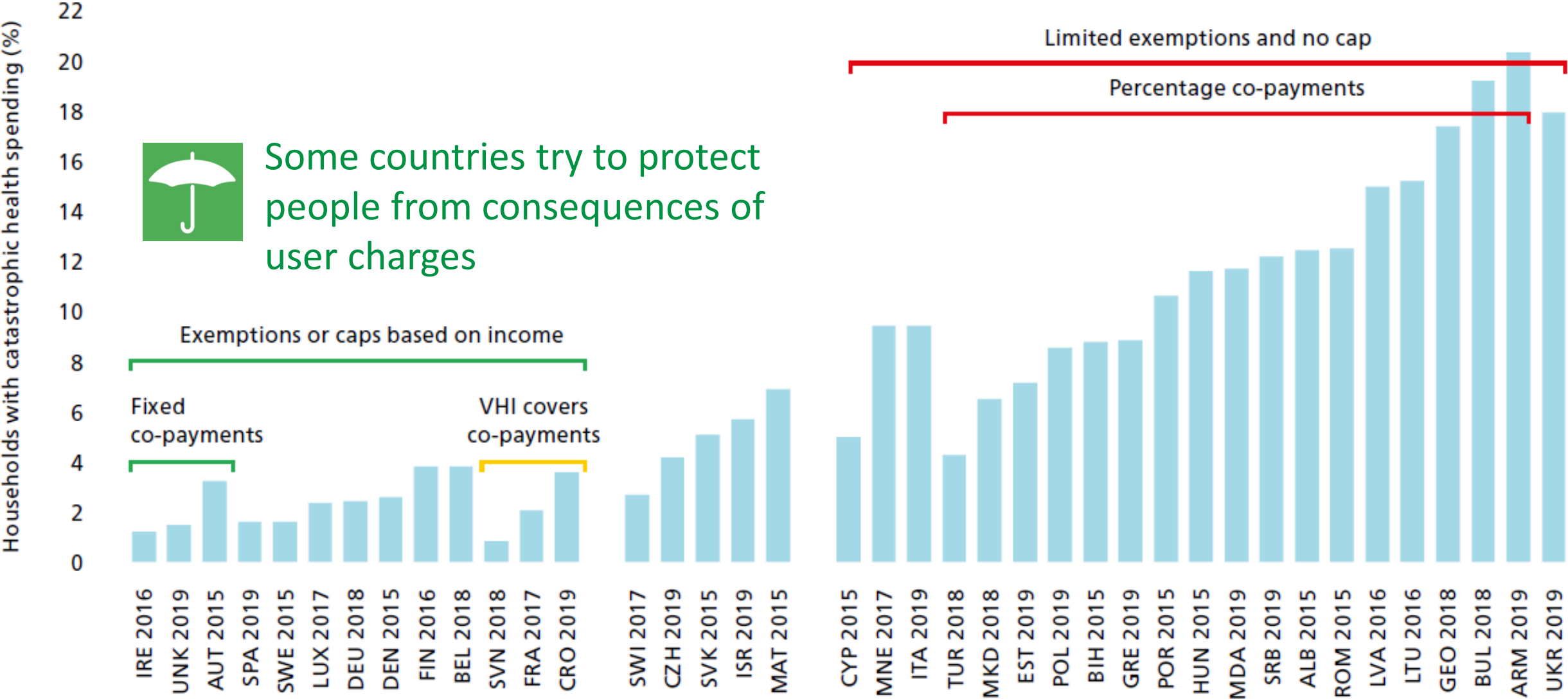
Co-payment design matters!



Others...not so much



Some countries try to protect people from consequences of user charges

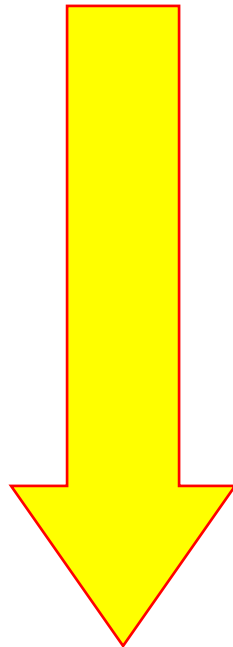


Free until the point of use? How Kyrgyzstan supported their promised benefits (20 years ago)

Purchaser pays:
hospital base rate

Less

More



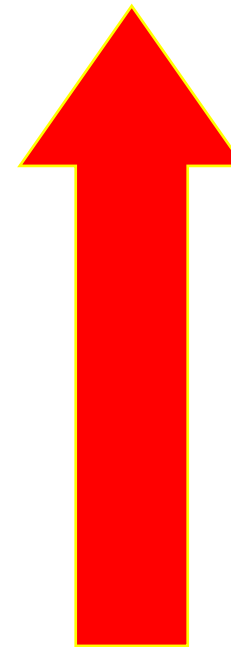
Self-referred

Fully exempt

Patient pays:
co-payment

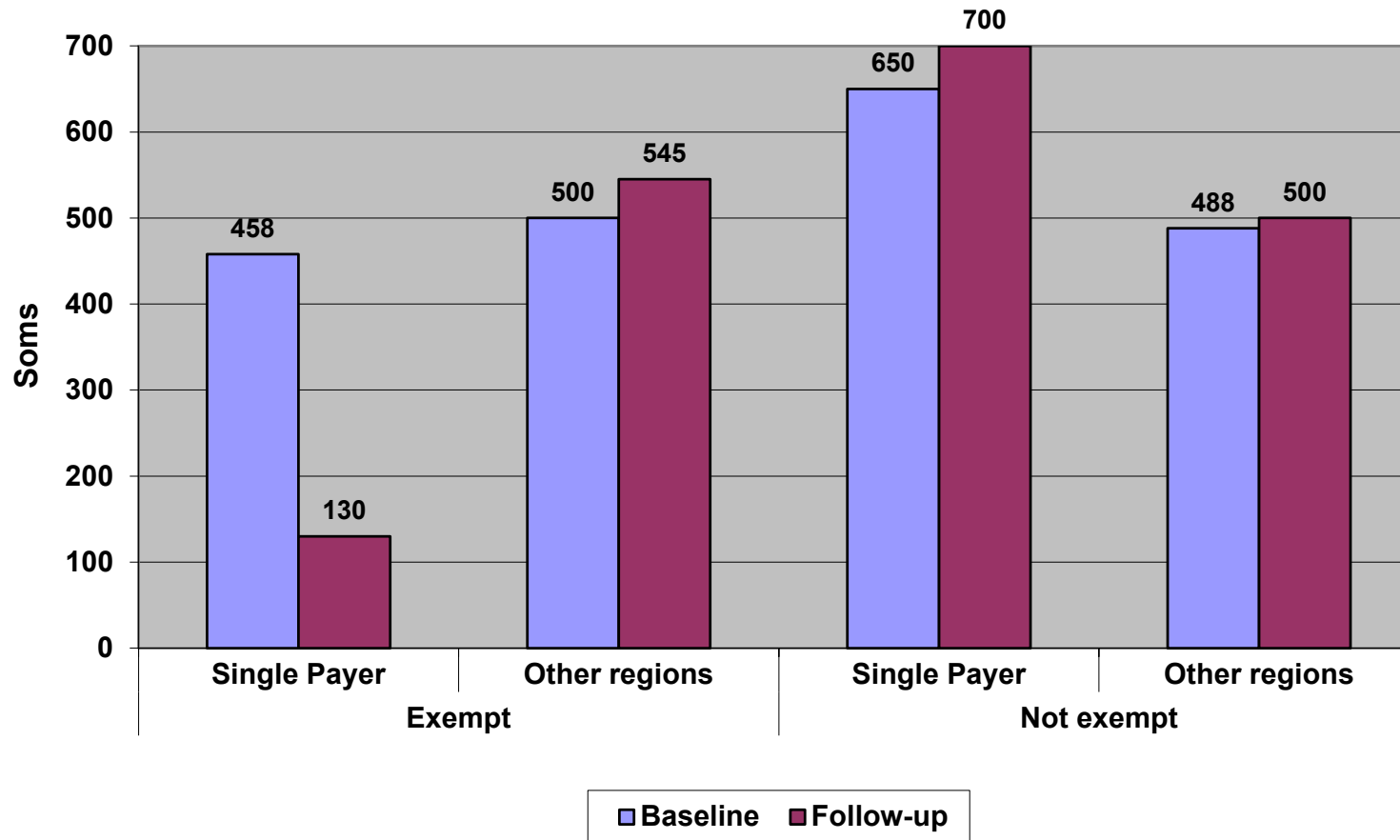
More

Less



Linking purchasing to entitlement enabled the reform to work

Median spending by exempt and non-exempt patients before and after reforms



Source: WHO surveys of discharged hospital patients

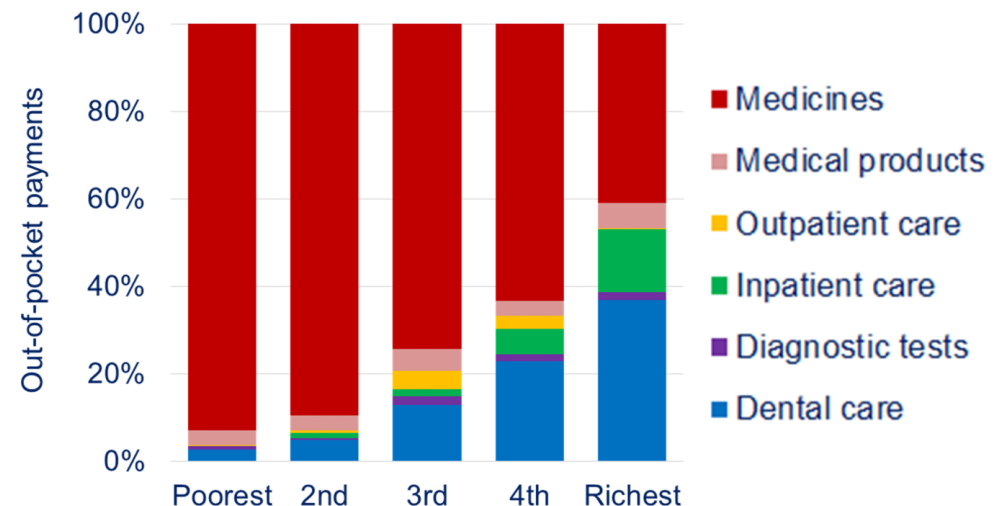
Predictable, chronic risks drive financial hardship (health insurance is not earthquake insurance)

Avoid #4: failing to cover treatment in primary care settings undermines financial protection, equity, efficiency + resilience

Out-of-pocket payments affect people differently:

Poorer households can't afford to pay for dental care and experience **unmet need**

Poorer households prioritise medicines and experience **financial hardship + unmet need**



Good practice #4: primary care coverage includes treatment: medicines, medical products + dental care are affordable for all