

Summary of the 7th World Congress on Health Economics – by Sofi Bergkvist



Health Insurance

There were more than 30 sessions addressing health insurance representing more than 12 percent of all sessions at IHEA. Most session discussed health insurance introduced by governments in low and middle income countries. It is evident that health financing is progressing as an area of importance and emerging evidence.

The main discussions were regarding coverage and sustainability of government subsidized health insurance schemes. Who benefits from the health insurance? Who is better and who is worse off by the health insurance? A main point was that many of these schemes are young. It is still unclear how effective they are in terms of reducing indebtedness due to health care expenditures and what the health outcomes really are. People providing policy advice to governments of low and middle income countries must be aware of this. Policy advisors must honestly communicate weaknesses and difficulties along the strengths of health insurances. Challenges with fiscal sustainability should be investigated as well as affects like increased prices for not insured population. This has been found in e.g. Ghana with escalating prices for people, many of these being poor, paying out-of-pocket. Adam Wagstaff at the World Bank, William Hsiao at Harvard School of Public Health and many others highlighted how health insurance can create distortions in systems, escalating prices and create perverse incentive systems affecting quality of care.

Most presentations did however point towards increased healthcare utilization and reduced out-of-pocket expenditure. Here are a few examples:

- It took Thailand three decades to achieve universal coverage. The social protection scheme was effective and catastrophic expenditure decreased with 5.4 percent in 2005 and 2 percent in 2007.
- Thailand and Colombia have been successful in reducing out of pocket expenditures and the poor population has benefited.
- The fiscal sustainability of the scheme in Thailand is yet uncertain but research in this regard has been initiated and the assumption is that healthcare expenditure by 2020 will remain below 10 percent of GDP (current level at 3.5 percent of GDP).
- Rwanda managed to scale rapidly and coverage grew from 7% in 2003 to 75% in 2007.

- It has been shown that the utilization of outpatient care increased with health insurance in Tanzania and a study of South Africa, Ghana and Tanzania proved reduced out-of-pocket expenditure.
- South Korea and Taiwan achieved universal coverage through mandatory social insurance schemes in 1989 and 1996 respectively. Research has demonstrated that household out-of-pocket payment still accounts for more than one-third of total health expenditures in both countries despite more than a decade of the respective social insurance schemes.

Many countries such as Ghana and Thailand were advised by international experts not to introduce comprehensive social protection schemes due to challenges with fiscal sustainability. The governments still decided to introduce the schemes. Looking back, it seems to have been the right decision. There are still uncertainties about sustainability of the schemes but it is evident how the financing mechanism has improved access to care and created an opportunity to affect quality of care through accreditation and curb over-prescriptions. What is needed is research on incentive systems and methods to improve the current schemes. The need for focus on implementation and guidance for improvement was highlighted by Kara Hanson from London School of Hygiene and Tropical Medicine who gave a presentation on “understanding processes to explain impact”.

The health insurance schemes differ in design, scope and scale. It is important not to make direct comparisons and generalize findings while it is evident that all health insurance schemes had strong political commitment in common. Representatives from Ghana stressed how the scheme was used as a political tool for votes. The political commitment has been critical for the introduction of health insurance in all countries. China is a recent example where \$US125 billion has been allocated the next three years in addition to current healthcare expenditures - currently \$240 billion in total. One-third of this is for supply-side funding with infrastructure in rural areas, salaries for primary healthcare etc. and two-thirds for demand-side funding with premium for health insurance schemes and a medical assistance program.

Health insurance is clearly a field of growing interest and emerging research. Questions to be asked are: How to utilize government purchasing of services to improve quality of care? How to mitigate escalating costs and distorted incentives? How to successfully improve equity in health care? There are now an increasing number of large scale health insurance schemes and there is now an opportunity to look into process differences and enabling factors to continuously improve the schemes and mitigate repeated mistakes by new schemes across the world.

Private Providers

It is now a recognized fact that healthcare for the poor is provided by the private sector. This includes informal as well as formal providers. The scenarios differ from country to country and many sessions at IHEA presented utilization and quality of care by private verses public providers in different countries.

The number of private providers in China is increasing but the treatment in private facilities is still limited compared to the public sector. The scenario in India is the other way around, most care is provided by the private sector. The quality was found to be better in private facilities than in public facilities in India while it in China has been found to be the other way around. A study of hospital governance in Brazil found private hospitals to be associated with higher efficiency and quality than public providers.

There are also clear differences of private providers within countries. A study between the states of Orissa and Andhra Pradesh in India found that the majority of primary care in rural areas was provided by informal Rural Medical Practitioners in both states while secondary care was provided by private providers in Andhra Pradesh but by the public facilities in Orissa. An interesting finding was that the health care expenditure at the secondary care level was the same in the two states. The cost for secondary care by private providers in Andhra Pradesh was the same as by public providers in Orissa. Further research is needed to look into differences in quality of care at the various levels and what incentives that can be found to improve the quality at affordable costs.

There is increasing research on the role of informal workers such as drug distributors in health care delivery. The findings are that informal workers often provide the majority of primary care services in low-income countries. Rural Medical Practitioners who practice modern medicines without any formal training, dominate the outpatient care market in India. People turn to the Rural Medical Practitioner because of distance – the proximity of service is the most important factor. Many drug manufacturers work actively with Rural Medical Practitioners and about 45 different brands were found among Rural Medical Practitioners. This included 14 different brands of antibacterials. Little is known about the role of Rural Medical Practitioners in the drug supply chain, including their impact in distributing medication, introducing new drugs to the market and providing health care. One study in Bangladesh by Johns Hopkins has recently been initiated to describe the training, knowledge, practices, incentives and sources of drug among drug detailers, and informal and formal providers.

The role of informal healthcare providers is clearly an area for further research. People are seeking care from the informal workers; these workers diagnose and distribute pharmaceuticals while the quality of care often is to be questioned. The drug distribution system links these workers and there is a need to better understand opportunities to incentivize these already existing workers to improve referral systems and quality care.

Highlight at IHEA, 2009

The ACCESS Health Initiative is focused on action and was found to facilitate implementation and scale up of best practices in health care. The numerous sessions on cost-effectiveness of single interventions where implementation challenges are not considered are of limited interest. One presenter at IHEA was speaking just along the lines of our mission. Keerti Pradhan at Right to Sight in India got inspired by the lack of healthcare in Africa and the advanced low-cost technologies in India. He decided to bring together expertise in India with knowledge gap in the Democratic Republic of Congo (DRC) and add local philanthropic funding. The result is an eye hospital. People from

DRC got training for low-cost and high quality cataract surgery in India and staff from India came to DRC to support implementation. The operations of the hospital were break even after one year. The same approach for knowledge transfer supported by local philanthropy is now practiced in Ethiopia and Mozambique. This is exactly what we hope to see more of. Not only eye care but maternal and child health, primary care and other types of care for which the population in Africa and many other regions face severe shortage.

IHEA 2009 was a unique opportunity to get an update on the current research in health economics and meet individuals and organizations for collaborations in research as well as implementation of customized concepts that have been proven successful.