Health financing

Who pays for equitable health systems?

A birth, an accident, a serious illness — any one of these can spell financial ruin for those in poverty. Researchers supported by IDRC are working with low- and middle-income countries to identify funding models that support health for all.

Countries rich and poor face difficult choices in funding quality health care for their citizens. Financing determines who can access care, what services are provided, and what costs are paid directly by users. For industrialized nations, some form of prepaid healthcare plan is the norm: their struggle today is to manage rising costs. Low-income countries, meanwhile, are striving to provide what others already enjoy: access to affordable and high-quality health services.

There are great disparities in global spending on health care. OECD countries spend an average of $US3,600 per person each year, while 31 member states of the World Health Organization pay less than $US35 per year, and four spend under $US10, even with donor aid. In some countries, more than 80% of health spending comes from patients’ own pockets despite evidence that user fees discourage the poor from seeking the care they need, and deepen the downward spiral of poverty. Most low- and middle-income countries rely on a mix of revenues — including public and private insurance payments, direct and indirect taxes, out-of-pocket payments, and donor aid — to finance their health systems. In these fragmented systems, benefits and risks are unevenly shared. The poorest have less access to medical care and face a higher risk of catastrophic expenditure.

Addressing the finance challenge through research

For more than a decade, IDRC’s Governance for Equity in Health Systems (GEHS) program has been helping to build expertise in low- and middle-income countries so that health financing solutions reflect their needs and priorities. Across multiple themes, research focuses on broadly strengthening health systems — improving access to and utilization of quality health services by addressing...
issues of governance, equity, and system integration.

In the area of health financing, GEHS-supported research teams are working with governments to identify financing options that widen access to quality health services and provide citizens with financial protection. Research is documenting the impacts of out-of-pocket expenditures and proposing sustainable alternatives to user fees. Others are analyzing the impacts of various financing options, with a focus on how poor families are benefiting from services — or being excluded. And a growing network of Southern-based researchers is joining forces to share their findings and expertise across borders, and magnify their voice in informing global and regional debates.

**Improving access to health services in Asia**

Since 2000, the Southern–led research network Equitap (Equity in Asia-Pacific Health Systems) has systematically documented the performance of 15 national health systems in Asia. Equitap’s first phase revealed stark disparities in access to health care and risk protection between rich and poor in most countries. However, it also identified a number of countries that were successfully reaching and protecting the poor.

In its second phase, funded by IDRC from 2008 to 2011, the network expanded to 20 countries and territories. It has updated and extended earlier analysis of country progress in areas such as reducing out-of-pocket spending and the incidence of catastrophic expenditure. While summary results are still to be published, early findings indicate that in the Asia-Pacific region, reliance on out-of-pocket financing has fallen, with significant reductions in its impacts, in China, Indonesia, and Vietnam. This latest phase has also identified new countries, such as Solomon Islands, where government health services are reaching the poor effectively.

India’s 1.2 billion people pay for most medical needs directly from their own pockets. In 2007, the state of Andhra Pradesh introduced the Rajiv Aarogyasri Community Health Insurance Scheme to widen access to essential health services. But a rapid assessment in 2008 found room for improvement. Officials in Andhra Pradesh have requested that an extensive evaluation be conducted.

With support from IDRC, the Administrative Staff College of India is leading a consortium of institutions in carrying out this evaluation. According to the principal researcher, Dr Mala Rao, evaluators are asking tough questions: Has the scheme widened access to

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**Picturing health concerns in rural Uganda**

In participatory research led by Uganda’s Coalition for Health Promotion and Social Development (HEPS) communities used “picture codes” to express their health care concerns. HEPS is among the organizations involved in EQUINET, an IDRC-supported network in East and southern Africa that promotes health equity through research, dialogue, learning, and critical analysis.

*The mother is worried about the bill she received for care. This happens in both the conventional health centre and with the traditional birth attendant. The woman’s husband is in a bar drinking and not at the hospital clearing her bill.*
care and reduced out-of-pocket expenses? Are patients receiving quality care? And do the homeless and other vulnerable people even know about the scheme? Researchers are paying special attention to the role gender plays in awareness and use of the scheme, and will identify areas of bias in its design.

**Weighing taxation vs. insurance in Africa**

From 2006 to 2011, IDRC supported SHIELD (Strategies for health insurance for equity in less developed countries), a research partnership which analyzed health system inequities in Ghana, South Africa, and Tanzania. These three countries rely partly on voluntary insurance and are adopting elements of mandatory insurance, or dedicated tax funding, into their health systems. SHIELD researchers used financing and benefit incidence analysis methods to shed light on the extent to which different socio-economic groups were benefiting from health services, and how fairly the burden of payment is shared between rich and poor. Their findings suggest low-income countries should look more closely at various forms of taxation.

SHIELD’s work is contributing directly to health financing reform debates, particularly in highlighting the potential role of indirect taxes. For example, Ghana has demonstrated that adding a 2.5% health levy to value added tax (VAT) was both feasible and progressive. Indeed, all forms of tax financing in Ghana — with the exception of an excise on fuel — were found to be progressive, of net benefit to the poor.

As research leader Di McIntyre explains, in low-income countries, “basic survival escapes the VAT net.” The majority of the poor, especially in rural areas, consume their own produce, or buy from small local markets. But as economies develop and urbanize, sales taxes hit the poor, as they have to purchase all their food and other items to meet basic needs. “So in South Africa,” says Professor McIntyre, “VAT is regressive. But the country could address this by exempting more basic goods.”

Building on SHIELD’s success, IDRC is supporting a second-phase effort that extends the network to researchers in Kenya, Uganda, and Zambia. As this pool of shared expertise grows, research is grounded in a larger, comparative base of evidence, of even greater value to regional policymakers.

**New insights into catastrophic expenditure in Latin America and the Caribbean**

As of 2012, Mexico is well on the road to universal health coverage. In less than a decade, thanks to Seguro Popular, a national health insurance program introduced in 2003, every Mexican is now covered by a public insurance scheme. The program offers health services and financial protection to over 50 million Mexicans who were previously uninsured.

For nearly a decade, a program of research fed into the design, implementation, and monitoring of Seguro Popular. According to research leader Felicia Knaul, documenting the extent to which small, health-related expenses were deepening poverty provided the evidence political leaders needed to commit to reforms.

“The research changed our conception of what is catastrophic,” says Dr Knaul. “For someone at the poverty line on minimum wage, having two kids with throat infections, losing a few days of work, paying to see a doctor and then for antibiotics… this kind of thing adds up quickly — in some cases to 30% or more of household income.”
To sustain and extend such policy-relevant analysis on health equity and financing, IDRC supported a seven-country project led by Fundación Mexicana para la Salud from 2007 to 2011. The project grew into LA NET-EHS (Latin American Research Network on Equity and Health Systems), a 12-country regional network. Through the network, country-based teams have collaborated and learned from each other, sharing evidence and methodologies and carrying out comparative cross-country research. Colombia and the Dominican Republic are just two countries in which current debates on health coverage are being shaped in part by evidence from LANET-EHS.

The network has disseminated its findings on household health spending and the fairness of health financing in policy briefs, research papers published in *The Lancet* and *Salud Pública de México*, and a forthcoming volume to be published by Harvard University Press.

**Building a global network for health equity**

Influencing policy on a global scale demands a global effort. In 2011, three regional networks that focus on equity in health financing and delivery — LANET-EHS, SHIELD, and Equitap — joined efforts to launch the Global Network for Health Equity (GNHE). Through exchange, comparisons, and collaboration among regions, they are building a more solid evidence base for policy design, and increasing the collective impact of research on equitable financing and delivery.

According to Equitap leader Ravi Rannan-Eliya, the three networks have much in common: “Health systems in our regions may differ, but many of the equity issues and mechanisms are the same.” Given their common aims, the networks began discussions with IDRC on ways of joining forces to increase their effectiveness and reach. Through GNHE, says Dr Rannan-Eliya, “we now collaborate to magnify the impact of what we are doing, while also doing things that we can’t do as separate networks.”

IDRC is proud to support the growing base of Southern-led research that is influencing global and regional debates. The ultimate aim is to see countries choose their own appropriate and sustainable financing models for universal health coverage.

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As of 2012, every Mexican is covered by public health insurance. Researchers with LANET-EHS are monitoring the impacts of Seguro Popular and analyzing health financing options for other countries in the region.