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Need for Health Insurance

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In Pakistan public healthcare provision has not been successful in creating health security for the poor. The sector remains grossly underfunded, with public expenditure on health accounting for barely 0.5% of GDP (of which close to 75% is spent on salaries). There are only 2 countries in the world-Nigeria and Sudan that spend less than this proportion on health. It is around 1% for India, 2% for Bangladesh and Nepal and 3% for China, while for most developed countries it ranges from 5 to 7 percent. Resultantly, compared with our mortality rate of 100 per 1,000 less than five year olds, that of Bangladesh is 77, of Sri Lanka 14 and India 85.

Furthermore, more than 70% of total healthcare expenditure is spent by the private sector and almost all of this is out-of-pocket expenditure on curative care – consultations, in-patient diagnostics care, laboratory tests and medicines. Moreover, even the benefits from the low levels of government spending on health are spread unevenly between the relatively prosperous and the more vulnerable segments of the population. The health sector is also characterized by inefficiency and corruption. Most government operated outlets for primary healthcare are on the verge of collapse. Quality standards are practically non-existent as are performance measures, with little accountability. The consequence is a large private sector that, as Amartya Sen said in the case of India, thrives on quackery and crookery. A progressive vision has to be grounded in principles of equity, rights and respect for human dignity.

Poverty reduction and health outcomes are integrally linked as improved health outcomes contribute to reduction in poverty and vice versa. Several studies have shown that expenditure on healthcare is more effective in reducing poverty than expenditure on poverty alleviation programs, because a significant factor in the impoverishment of households is lack of protection from the economic outcomes of ill health or death. A major illness of a family member (and worse still if he is the primary bread earner) can throw the family into poverty- the poor have difficulty in adjusting to shocks arising from unplanned and lumpy expenditure on heath related treatments. A study in India claims that 39 million people fall into poverty each year because of such expenditure. Caught in a vicious circle of poverty – poverty breeds ill-health, ill-health results in impoverishment and indebtedness. Hence, efforts to tackle poverty should consider the role of health and health security should not be viewed not as an end in itself but for achieving the broader goal of poverty reduction.

Those hardest hit by lack of health coverage are the poor, who suffer from higher levels of mortality and malnutrition than the rich. A relatively recent World Bank study on India shows that

24% of the poorest quintile do not seek medical care when ill because of poverty compared to 9% in the richest 20%. Furthermore, hospitalized Indians spend more than 58% of total annual expenditure on healthcare and that almost 25% of them fall into poverty every year as a direct result of medical expenses they pay directly on hospitalization.

There is a need for alternative financing mechanisms and instruments to achieve health related objectives, e.g., health insurance. The poor can make small, periodic contributions that could go towards meeting their healthcare needs.

India introduced a Universal Health Insurance scheme, targeting the poor, in 2003. The benefits of the scheme include reimbursement of hospitalization expenditure of up to Rs. 30,000 for upto five members of the family for a year and illness compensation of Rs. 50 per day for the period of hospitalization of the earning head of the family. It also provides for Rs.1,000 per year for transportation costs. The problem with the scheme is that the premium is too low for insurance companies to offer good coverage and too high for the poor to pay upfront.

To make such schemes financially viable the transaction costs for insurance companies need to be lowered by educating people to buy insurance as a 'group contract'. The concept of a group contract is important because apart from age and sex we need heterogeneity of membership for effective pooling-a sizeable pool of both low and high risk persons for keeping insurance premiums affordable. The insurance of a homogenous group like poor households who are likely to be more susceptible to diseases because of poverty, poor hygienic facilities and lack of safe drinking water, is a weakness of the BISP pilot scheme. However, getting the required size of pool will not be easy because paying for a future and uncertain benefit has a high opportunity cost for the poor.

Since the old and the poorest will not be able to make any contribution, they would have to be provided free access to public health facilities- a tough ask in financial terms. Therefore, health insurance as a financing mechanism would be appropriate only when part of the cost is recovered from the beneficiaries, which means that beneficiaries (low income groups) should be in a position to contribute something, provided this enables them to meet their priority health needs cost efficiently.