

# Preventing impoverishment through protection against catastrophic health expenditure

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The article by Kent Ranson on the experience of the Self Employed Women's Association's (SEWA) Medical Insurance Fund in Gujarat, on pp. 613–621 of this issue of the *Bulletin*, focuses on catastrophic health care expenditure and thereby underlines the importance of ensuring that community financing schemes effectively protect households from impoverishment. It may well be a hope that such schemes will enhance social cohesion and access to routine low-cost services; however, one of their prime objectives ought to be preventing impoverishment through protection against catastrophic health expenditure.

"Fairness in financial contribution" is defined by WHO to be one of the three intrinsic goals of a health system. The fairness in financial contribution index measures whether a country collects contributions from households to finance health in an equitable manner (7). It captures the extent of catastrophic health spending by households, and also identifies households thus affected. Catastrophic health expenditure is defined in relation to the households' capacity to pay.<sup>a</sup> Health spending is viewed as catastrophic when a household must reduce its basic expenses over a certain period of time in order to cope with the medical bills of one or more of its members. WHO proposes that health expenditure should be called catastrophic whenever it is greater than or equal to 40% of the capacity to pay. However, individual countries could well adopt a higher or lower percentage in their respective national health policies.

Catastrophic health expenditure is only observed when households need and use health services. Such services may, however, be less than those that would ideally be required. For example, there could be limits on use for geographical and/or financial reasons. In some Asian countries such as Indonesia, Malaysia, and some island countries where there are few or no health facilities in remote areas, geographical access to health services is limited. In other countries, such as United Republic of Tanzania and Zambia, households face

not only geographical but financial barriers to health service use because they are confronted with excessive fees and other large out-of-pocket payments.

A preliminary analysis that we have made of income and expenditure survey data for 60 countries shows that lower income groups have a greater proportion of households with catastrophic levels of health spending than do higher income groups. However, it is also true that the highest proportion of catastrophic health spending does not necessarily occur in the lowest income group. Further analysis at the sub-national level has confirmed this finding, since the poorest regions do not always have the highest proportion of households with catastrophic health expenditure (2).

A closer examination of the circumstances under which households face catastrophic health expenditure identifies important determinants such as income, age of household members, and employed/unemployed status of the household head. In addition, households with elderly, handicapped, or chronically ill members are more likely to be confronted with catastrophic health spending due to their greater need for health services and their lack of financial resources. Conversely, younger and healthy households have a greater likelihood of avoiding catastrophic levels of health spending.

High fees and out-of-pocket payments increase the probability of catastrophic health spending by households, as is the case today in India (3). Countries should be encouraged to establish prepayment schemes for health financing since there is strong evidence that the larger the proportion of prepayment, the smaller the proportion of households that will face catastrophic health spending.

Furthermore, pooling is a major way to spread risks by ensuring transfers of funds from higher to lower income groups, and from low-risk to high-risk individuals (1). According to Kent Ranson, a total of 23 214 SEWA members in Gujarat were

insured in the fiscal year 1999–2000. This represents 11.3 % of the 205 985 members of SEWA in that state (4), a proportion that implies a low degree of pooling, with the ensuing risk of adverse selection. Nevertheless, the SEWA community-based health insurance has achieved some degree of success, and has a strong administrative and management capacity, especially as a purchaser of health services (5). Including only the poor in community schemes, as is the case with SEWA, may be one objective, but it is more desirable to diversify scheme revenue sources by including higher income, premium-paying individuals. This diversification enhances risk-pooling, which will in fact reinforce the interests of the poor.

In general, there is a need for ever larger pools, and enhancing tax collection capacity or social insurance remain viable options to be considered for sustainability and risk-pooling. It is also essential to define carefully the benefits that the population will experience. Indeed, despite a declared universal coverage policy in a country, catastrophic health expenditure may continue to be widespread if the benefit package is too small. The same concern exists at the level of community financing schemes. In this respect, the need to enhance the protection of households against catastrophic health expenditure was rightly identified by Kent Ranson for the SEWA Medical Insurance Fund. ■

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<sup>a</sup> Capacity to pay is defined as household non-subsistence effective income. The subsistence spending is defined as one dollar a day per person according to WHO methodology on fairness in financial contribution.