Annex: Country examples highlighting the need to focus on how much people spend relative to income to monitor financial protection

Coverage by a public health system is not a meaningful measure of financial protection because everyone everywhere has recourse to a network of their health ministry’s network of health facilities, i.e. their country’s “public health system”, where prices are zero or at least heavily subsidized. For example in the US everyone has access to emergency care.

Second, there’s a difference—often a big one—between theory and practice. According to their national policies, both Azerbaijan and the UK operate a national health service (NHS) health system, financed largely through general revenues, with patients paying nothing out-of-pocket at the point of service. That’s the theory. In practice, the share of total health spending in these two countries financed by out-of-pocket payments differs dramatically: in Azerbaijan it’s more than 70%; in the UK, it’s under 10%. In fact a study conducted in 2010 showed that across 186 national constitutions, 73% included a reference to the provision of health or the right to health. Of these 73%, only half explicitly mentioned access to health facilities, goods and services, and only 4 out of 9 included reference to equity and non-discrimination.

Third, in many countries, there are formal health insurance schemes that sit on top of the “public health system”. In countries like Brazil and South Africa, they’re voluntary private health insurance schemes. In many countries, they’re social health insurance schemes where formal-sector workers (and their employers) make mandatory contributions, and other groups often have the chance to enroll voluntarily. In some cases, other groups, such as the poor and near-poor, are enrolled at the taxpayer’s expense. This additional layer of coverage creates a gap between those without the additional layer and those with it, with people in the latter group, who are often the better off, getting access to different facilities and/or paying different amounts out-of-pocket. A tiered segmented system would do well in terms of the proposed new indicator—a lot of people would have coverage by both the public health system and a health insurance scheme. But it’s likely to perform badly when assessed in terms of UHC, i.e. everyone getting the services they need, and people not being exposed to financial hardship when they seek care.

Fourth, affiliation to an insurance scheme is not necessarily a good indicator of financial protection. China saw in the early days of its rural health insurance scheme, expanding formal insurance coverage can actually increase out-of-pocket payments. So greater scheme affiliation doesn’t necessarily mean better financial protection; and protection can get better (or worse) without any change in insurance coverage. In the United States, a large proportion of the population continues to face financial hardship from paying for health services and having health insurance does not provide adequate protection. It has been found that the leading cause of bankruptcies is from unpaid medical bills and a study estimates that bankruptcies will affect nearly 2 million people in the US in 2013.

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1. Health and the SDGs: Out of the doldrums, heading for the rapids: 4 reasons why assessing financial protection isn’t that simple