

Implications of the analysis of financing and benefit incidence in Ghana, South Africa and Tanzania for health insurance policy debates

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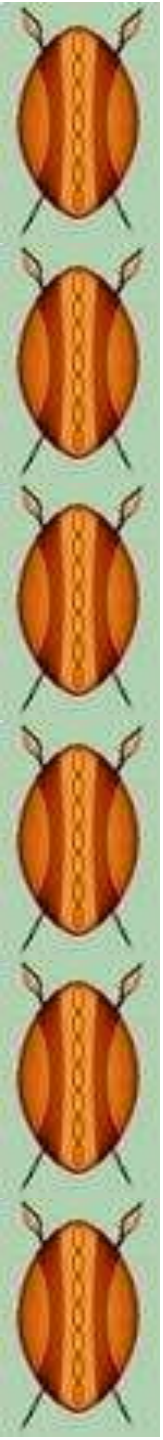


Presentation Outline

- **Part I**
 - Health Insurance in Ghana, South Africa and Tanzania
- **Part II**
 - Financing incidence results
 - Benefit incidence results
- **Part III**
 - Synthesis
 - Implication of the findings

Part I

Introduction to the debate on financing and use of health care services in Ghana, South Africa and Tanzania





Introduction

- SHIELD – Strategies for Health Insurance for Equity in Less Developed Countries
 - identifying major equity challenges in the health systems of Ghana, Tanzania and South Africa
 - Documenting current trends in the distribution of the burden of health care financing across socio-economic groups → financing incidence
 - Documenting the current distribution of health care benefits across socio-economic groups → benefit incidence



Introduction

- Identify and critically evaluate current country experiences (esp. health financing and delivery)
- Identify options for the likely future development of health insurance mechanisms → NHIS
- Major output
 - Develop strategies and policy recommendations on health insurance mechanisms addressing health system equity challenges



Prepayment schemes in Ghana, South Africa and Tanzania

- Ghana: Health Insurance (NHI) ~ 60% of the population
- South Africa: Private voluntary health insurance ~ < 14% of the population
- Tanzania: Several public and private schemes
 - National Health Insurance Fund (NHIF) – public civil servants ~ 5% of the population
 - Social Health Insurance Benefit (SHIB) – mainly formal sector private employees ~ <1% of the population
 - Community health fund (CHF) – voluntary (rural informal population)



Problems in financing

- Fragmentation in the insurance schemes:
 - South Africa, >120 schemes with different risk pool and benefit packages
 - Ghana, ~ 130 district mutual health insurance schemes with different risk pool
 - Tanzania, distinct mandatory type schemes for private and public employees; and community insurance schemes → different risk pools



Why universal coverage?

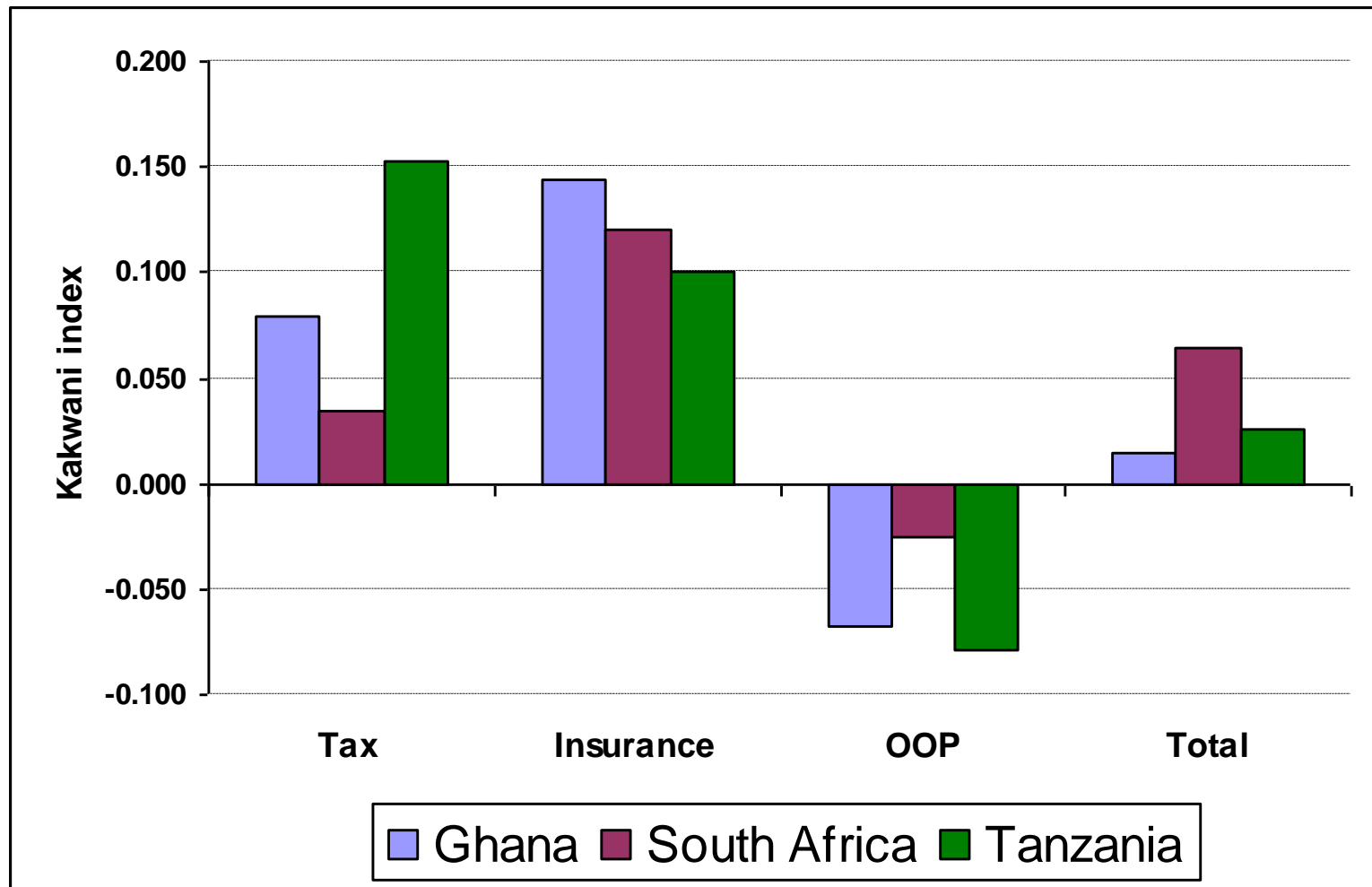
- Universal coverage requires
 - income and risk cross-subsidies in the health systems (McIntyre et. al 2008)
 - Financial risk protection (out-of-pocket payment still represent a significant proportion of health care finance → most fragmented)
 - Ability to access care when needed



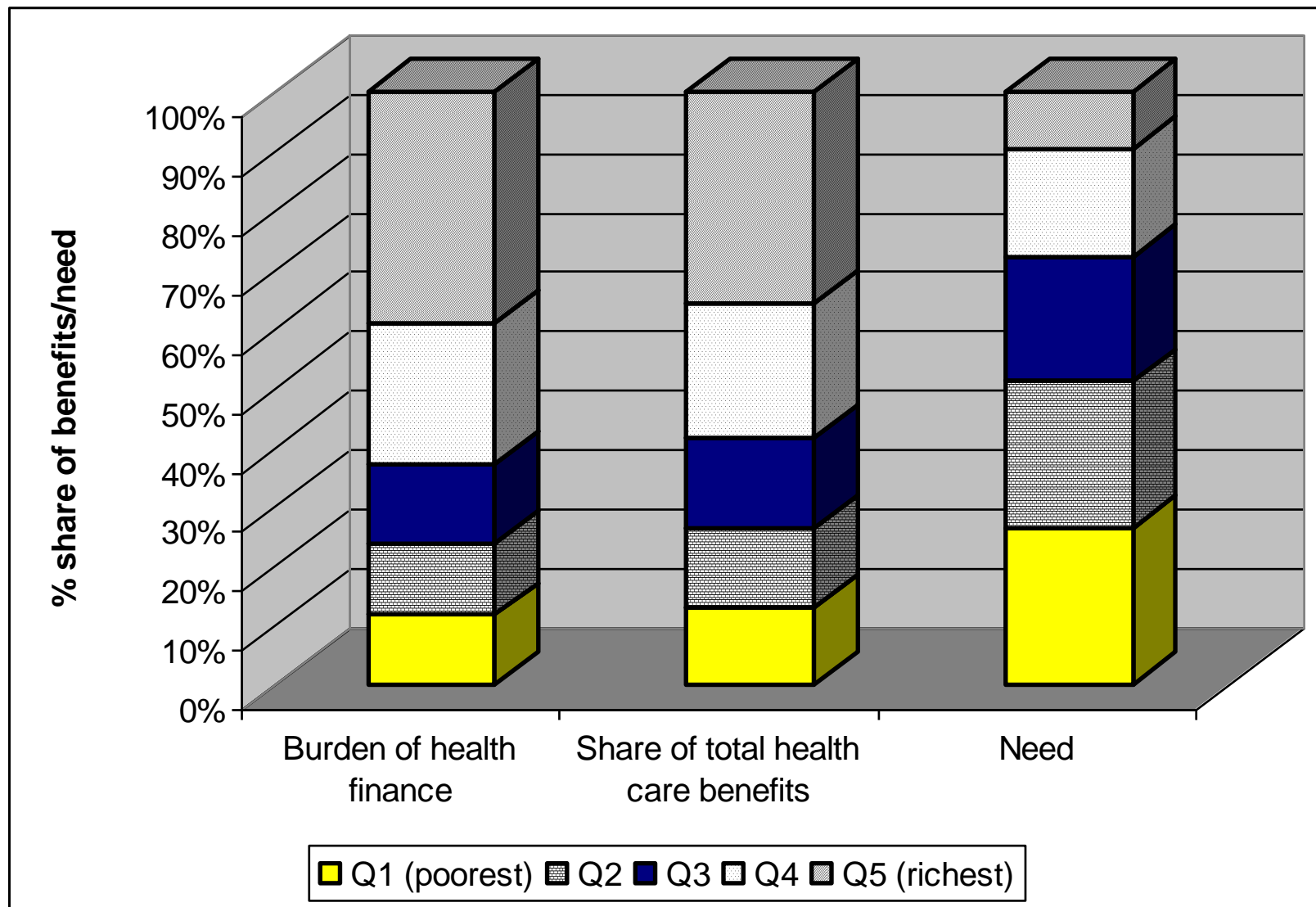
Part II

Overview of the burden of Health care finance; and the distribution of health care benefits in South Africa and Tanzania

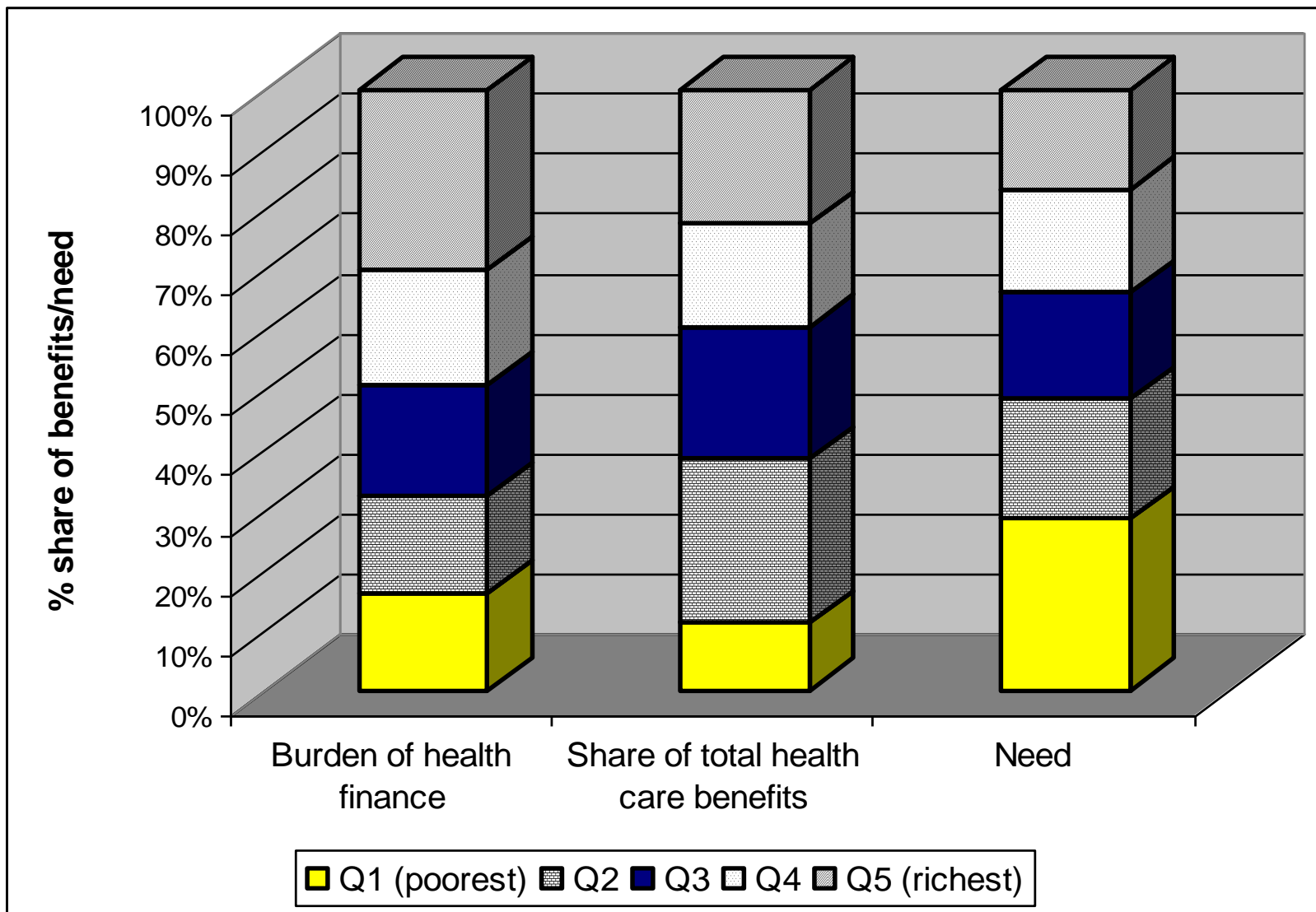
Progressivity in health care financing in Ghana, South Africa and Tanzania



Health care finance, benefits and Need – South Africa

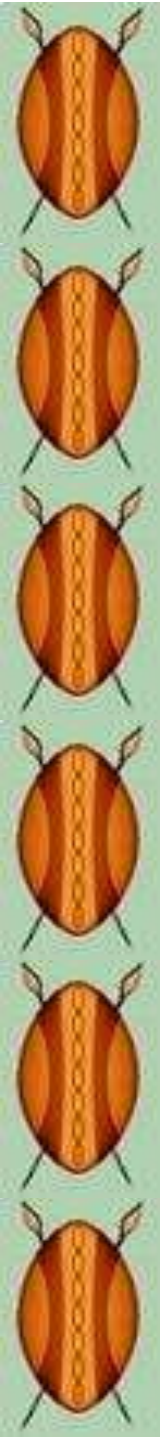


Health care finance, benefits and Need – Tanzania



Part III

Implications of the distribution of health care benefits and the burden of health care finance in South Africa and Tanzania





Synthesis [1]

- Overall financing incidence is progressive in all three countries
 - The poor pay less than their income (consumption expenditure) share in health finance
- Overall the distribution of health care benefits is pro-rich in all three countries
 - The poor receive less than their population share of health care benefits



Synthesis [2]

- The distribution of health care need is higher among the poor than the non-poor
 - The poor ‘need’ more health care than the non-poor
- The distribution of health care benefits varies inversely to the distribution of need for care in all three countries
 - The poor that need more health care are receiving less than they ‘need’

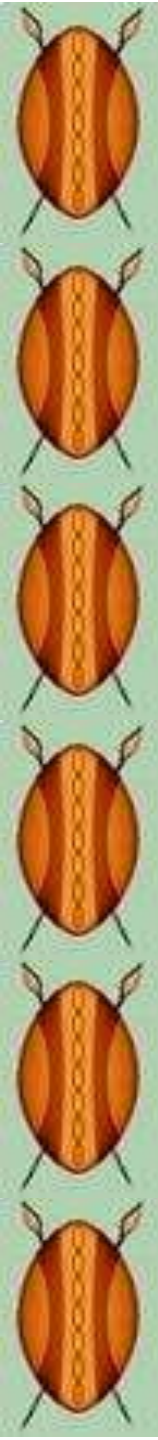


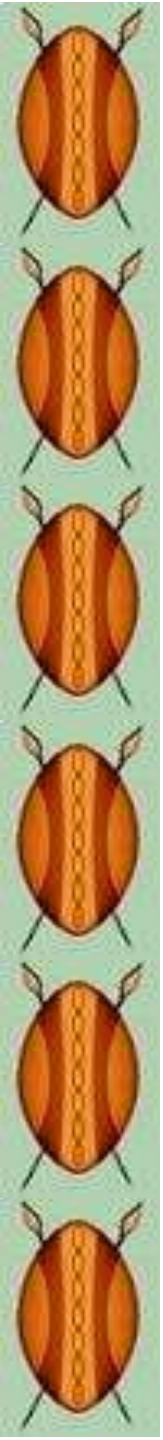
Implications [1]

- Progressive financing system → good?
 - South Africa – private insurance and income tax accounts for the progressive results
 - Only the rich benefit from insurance premiums
 - Tanzania – income tax, VAT, health insurance contributions accounts for the progressive results
 - Insurance contributions fragmented
- Pro-rich benefits from health care (public and private) → disturbing?
 - Factors underlie the pattern → access

Implications [2]

- Access barriers
 - SHIELD is exploring barriers to care (esp. for public health services)
 - Exploring how access barriers can be mitigated
- Major problems with fund pooling
 - Fragmented pools
 - Lacks cross-subsidization





Thank you all for your attention