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Chapter

Health Insurance for Economically Disadvantaged People in LMICs: What are the Best Options?

Samuel George Anarwat

Abstract

The choice of a health care financing system can have both good and unintended devastating consequences on access to and delivery of quality affordable universal health care of a country. This paper aims to explore successful factors of health insurance schemes and health policies that will ensure universal health coverage (UHC). The chapter explores equity or fairness as defined by the theory of justice to elucidate why there tend to be inequities in health insurance coverage. It proposes measures that could be adopted to ensure social health protection and financial sustainability of health financing schemes to achieve universal health coverage in low- and middle-income countries (LMICs). Good health is an essential capital good for promoting well-being and longevity, and quality health care is a derivative of good health among other social and economic determinants of health. Universal health insurance schemes provide financial risk protection for many population groups, especially the less privileged, against catastrophic episodes of illness and injury. However, inequities in health care are pervasive and have impoverished many because of catastrophic health care expenditures. Health insurance based on solidarity and progressive tax financing system with premium exemptions for the vulnerable, might be best for LMICs.

Keywords: health insurance, social health insurance, universal health coverage, low- and middle-income countries, equity, social justice, health care financing systems financial risk protection

1. Introduction

Good health is an important capital good for well-being and longevity [1], and quality health care is a derivative of good health among other social and economic determinants of health [2]. Universal health insurance schemes provide financial risk protection for many population groups, especially the poor, against catastrophic episodes of illness and accidents. However, inequities in health care are pervasive and have impoverished many because of excessive health care expenditures.
The choice of health care financing systems can have good or unintended devastating consequences on access to and delivery of quality affordable universal health care. Several countries in low- and middle-income countries (LMICs) are exploring and developing different health care financing mechanisms to pay for health care for the poor, while advanced nations are proposing new methods, revising, or reviving their health financing policies to ensure equitable and sustainable health care for all. These efforts are imperative because access to health care is a fundamental human right. However, unfair national health policies have left millions of people, especially the poor with no or scarce access with low quality. Those who are fortunate to have access do not have the expected quality when and where they need it. The Alma Ata declaration of universal health care, and “Health for All by the year 2000”, though achieved some increase in anticipated health care. The Millennium Development Goals Policy and its targets were very good international public health financing strategies, but many developing countries could not achieve the set targets because of inequities in funds to implement the proposed strategies. Notwithstanding the difficulties in funding and other challenges, there were some improvements in global health status indicators.

Today, the global health community has set itself to achieve universal health coverage (UHC) through Goal 3 and Goal 6 of the United Nations’ Sustainable Development Goals (SDGs), also known as the agenda 2030 [3]. These two goals, among others, seek to achieve universal health care for everyone, located everywhere, with all ages without discrimination in terms of financial ability to pay. Goal 6 that is directly linked to Goal 3 seeks to provide sufficient water and sanitation for all global communities (www.sustainabledevelopment.un.org).

Again, I hypothesize that this policy of universal health coverage would not also be realized unless there is concerted effort to ensure fair financing strategies, adequate funding for its implementation, and efficient monitoring systems to reduce corruption and duplication of financial resources. The paper further inquires into selected best choices and methods that will ensure efficient and sustainable health financing in LMICs. The concept of health insurance, health equity, examples of best practice health financing models, success factors, and red flags of selected health financing systems are illustrated in this paper. The impact of coronavirus-19 (COVID-19) on health systems financing in LMICs is also elaborated in this chapter.

2. Concept of health insurance

In the past, people would pay for their health care just as they would buy a shirt in the market. Thus, they would pay out-of-pocket (OOP) for their health care. This mode of financing health care is largely outmoded, but poverty, poor health care systems, and policy compel many countries to finance health care by OOP. Financing health care through these direct OOP can impoverish countless households, especially in LMICs. Health insurance can solve the problem of OOP in most poverty endemic countries.

Health insurance is a system of financing health care through resource mobilization and risk pooling where risk-averse individuals prepay some amount of money into a pool for future health care benefits. Using the principle of large numbers, a third party manages the pool and purchases health care for members (the insured)
in the case of illness. For the pool of funds to grow substantially to serve the interests of members, there must be large numbers of individuals collectively contributing equitable amount of money into the financial resource pool and sharing their financial risk to enjoy the collective financial protection.

To sustain the financial pool, there must be cross-subsidization across all the members contributing to the health insurance pool. In the spirit of fairness, there must be established policy measures to ensure that the rich pays more and the poor pays less, each pays according to their abilities (proportion of their income) into the health insurance fund; also, the healthy pays for the sick and economically healthy people pay for children and elderly. It is important to, however, check adverse selection in the risk and resource pooling process.

Adverse selection in health insurance is a situation where majority of health risk persons, people with preexisting health conditions, vulnerable population such as children, aged persons, and women are those mostly registered in the health insurance scheme, while healthy people enroll less in the insurance scheme. When this adverse selection of members occurs in a health insurance scheme, the likelihood of it collapsing is very high. The reason is that utilization of health care tends to increase, and claims cost also increases above revenue, unless there are huge subsidies from the government or philanthropic organizations to supplement the revenue stream of the organization to offset the catastrophic health care expenditures.

In addition to adverse selection, two forms of moral hazards are very common in health insurance that are worth mentioning under concepts of health insurance: consumer and provider moral hazard.

Consumer moral hazard means that the individual alters his or her behavior inappropriately to benefit from the health insurance scheme. For example, the individual could impersonate with someone else's insurance card to obtain health care. When the hospital authorities are not very vigilant, the insurance member could also intentionally seek health care unnecessarily just because the person is insured and has not falling ill or gotten an accident to make a health claim.

However, in developing countries, and selected advanced countries, like Canada and United Kingdom where there is waiting time to see a physician, especially, the medical specialists which take very long time, no rational individual would want to wait in the long line for no apparent sickness or health condition, just because of being insured.

Provider moral hazards emanate from the health care organizations or health professional to unduly benefit from the health insurance of patients. Providers alter their behaviors to “cheat” the health insurance system to make supernormal profits. There is a huge perception that the health insurance fraud in advanced countries is an albatross in the health care financing system. Provider moral hazards are facilitated by the information asymmetry that health care providers or health care professionals wield. They can use the information asymmetry to manipulate the health insurance system to make additional money. Information asymmetry arises because health care professionals are the vital repository of knowledge of the health condition and treatment regime of the patients and can therefore manipulate the information to their (providers’) advantage. For instance, if the health specialist decided to admit a patient on a health condition for 10 days instead of 5 days, the patient, though has the right to reject the number of days of the hospitalizations, does so at his or her own peril.
3. Methods of financing health care

The World Health Organization (WHO) defines health financing as the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system .... The purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” [4].

Health care can be financed through various methods, including resource pooling through health insurance, out-of-pocket payments, and public finance through direct or indirect taxes.

Health care financing can be classified into three different typologies: private health insurance (PHI), social health insurance (SHI), and national health insurance (National Health Service) [5]. Both government and third-party payers, as in organized private health insurance schemes or government agencies, play an especially key role in purchasing and pooling risk. The choice of the financing mechanism would depend on numerous factors, including the political economy of health, the political ideology of the country, equity principle, social solidarity, economics and financial strength of the country, and organization of the social and economic structure of the country, including labor unions, financial systems, health systems, and political systems of governance [5]. The choices made are associated with various advantages and disadvantages. It suffices to say that there is no perfect system, and there is no blueprint for each country. There can be a mix of both Beveridge and “Bismarckian” health care financing systems. There are no pure Beveridge or Bismarck systems. The choice of health financing system, to the best of my knowledge, will depend, to a considerable extent, on the health financing goals and several variables of the country in question. Selected methods of health financing and payment methods and government of health care financing schemes are discussed in the following section.

As already stated, different countries have different methods of financing health care. The most common methods include but not limited to:

3.1 Free medical care (usually financed by progressive direct taxes)

With this system, every resident of a country is covered by the health care system and receives free medical care irrespective of income level or type of employment. The government pays for the entire cost of the health care, the cost of health professionals, and health infrastructure. In theory, this system is equitable, provided there are strong monitoring mechanisms put in place to ensure quality of care, and there is a large and consistent source of government revenue allocation to the health sector. Most developing countries practiced the free medical systems in the 1950s to late 1970s, but it was not sustainable because dwindling government revenue and quality of care were questionable [5, 6].

3.2 Social health insurance (SHI)

Social health insurance scheme is another method of health care financing through compulsory or voluntary health insurance. Ghana’s National Health Insurance Scheme (NHIS), for instance, is a combination of mandatory NHIS Levy, mandatory social security contribution of formal sector workers, and voluntary premium payment.
Health Insurance for Economically Disadvantaged People in LMICs: What are the Best Options?
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by the informal sector workers. In the case of compulsory social health insurance, all citizens contribute a prepayment determined by the terms and conditions of the scheme either based on income or through employment or flat sum, or through direct or indirect taxes. In turn, members of the social health insurance scheme benefit through the insurance coverage for their health care. With (private) voluntary social health insurance (as in the case of mutual health insurance schemes of Senegal and Ghana in the early stages of the introduction of health insurance), the underlying principle is solidarity, where members voluntarily contribute a premium to a pool for risk sharing and financing of their health care needs [7]. Social health insurance scheme can be an equitable way of financing health care with the employed when premiums are based on income and determined by the ability to pay. However, with the unemployed the government must pay premiums for the poor, vulnerable, and unemployed. This affords both the poor and the rich to contribute their respective quotas to the health insurance fund to ensure a buildup of large numbers and large pool of resources. In this case, there is a large pool of financial resources to ensure financial risk protection and sustainability of the scheme, all things being equal.

The German social health insurance scheme (SHI) with substitutive private health insurance scheme (PHI) is worth emulating in LMICs, because it has stood the test of time and all odds for over 100 years with near universal coverage of the population and with sustainable quality health care. A snapshot of the German SHI is given in the following section. Germany was the first country in Europe (may be in the world) to establish SHI with substitutive PHI in Europe, in 1883, by Chancellor Otto Von Bismarck. The German SHI is dubbed the “Bismarckian” SHI system, attributed to Chancellor Bismarck. The main takeout of the scheme is that is backed by a strong legislation which makes it mandatory for both employees and employers. It is based on strong solidarity principle with members. Both employees and employers pay equal share of premium (50% employee and 50% employer contribution) to finance the SHI. Also, employees pay 14.7% of total gross income toward the SHI. The scheme is very democratic in terms of organization and governance and has disintegrated service providers throughout the country. The German SHI is one of the most sustain-able SHI systems in the world which is worth replication in other countries. The key principles and success factors of the German SHI are summarized in Table 1.

The dual system of health insurance (SHI and PHI) enhances coverage of the population. In Ghana, Nigeria, and Senegal, like many LMICs, the health insurance systems are hybrid and enrollment are voluntary. But in Ghana, for instance, the enrollment in PHI is very insignificant due to the high premiums of private health insurance.

Most LMICs including Ghana, Nigeria, Rwanda, Uganda, and Thailand, and high-income countries such as Canada, Germany, the Netherlands, and Switzerland, among others have adopted the social health insurance model and are at various stages of achieving universal health coverage. Germany, for instance, is well known for the “Bismarckian” social health insurance health system, which has existed and provided quality health care for citizens and residents over 100 years, using the dual model: SHI with PHI. As already stated, the German SHI is worth replicating in LMICs and even other advanced countries.

3.3 Universal health insurance coverage (UHC)

“UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential,
Health Insurance

quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course” [8].

Universal health insurance coverage ensures that every resident of a country has health insurance coverage, either financed through social security contribution or tax financing as in the case of United Kingdom, New Zealand, and Sweden, among others, with varying degrees of implementation structures. Everyone pays through different forms of taxation, irrespective of the risk burden of the individual. This system of financing ensures equity in financing because members pay for their health care through different forms of taxation based on their incomes and are provided universal health coverage. However, it should be noted that universal health coverage has different dimensions and usually covers the entire population but may not cover all health care services. Also, it may not be completely free at the point of use. Members may subscribe to supplementary health insurance schemes to cover expensive services that may not be covered under the universal health scheme or pay out-of-pocket, as in the case of France. Universal health coverage is also a sustainable way of financing health care as tax payment is compulsory. The caveat is when the tax is regressive which can perpetuate inequities. The question that remains is whether members of the universal health insurance scheme may receive quality health care, where and when needed, without a long waiting time to see specialist health professional.

3.4 Private health insurance

Private health insurance (PHI) is an alternative mechanism of financing health care for populations. PHI schemes are independent private entities usually

<table>
<thead>
<tr>
<th>Success factors</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>• First country to establish SHI in Europe, in 1883, by Chancellor Otto Von Bismarck.</td>
<td>• Complex health systems governance.</td>
</tr>
<tr>
<td>• SHI backed by strong legislation</td>
<td>• Decentralized health systems governance can stifle decision-making in the SHI</td>
</tr>
<tr>
<td>• SHI sustained over a century.</td>
<td>• Health care sectors are subject to different legislative.</td>
</tr>
<tr>
<td>• Uninterrupted development and reforms of the SHI system.</td>
<td>• Health care sectors are separated in terms of governance, financing, and reimbursement.</td>
</tr>
<tr>
<td>• Strong principle of solidarity among members.</td>
<td>• Fragmented health service provision.</td>
</tr>
<tr>
<td>• Continuous coexistence of statutory health insurance (SHI) and substitutive private health insurance (PHI).</td>
<td>• Quality assurance and coordination across are of continuous grave concern to health policy.</td>
</tr>
<tr>
<td>• Provision of universal health coverage.</td>
<td>• Lack of integrated health information, a concern to health policy.</td>
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<tr>
<td>• Free choice of sickness funds to enroll in SHI.</td>
<td></td>
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<tr>
<td>• Free choice of PHI to enroll.</td>
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<tr>
<td>• Equal employee and employer contribution in SHI premiums.</td>
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<tr>
<td>• Mandatory SHI (more population coverage – about 87%).</td>
<td></td>
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<tr>
<td>• PHI coverage (the rich – only about 11%).</td>
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<tr>
<td>• Self-governance.</td>
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<tr>
<td>• More sickness funds than PHI.</td>
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<tr>
<td>• Decentralized health systems governance.</td>
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Table 1. Key principles and success factors of the German SHI.
established to provide health care for populations usually for profits. Profit is the main motive of PHI schemes [9]. PHI is both a “bad” and a “good” in the sense that it provides both challenges and opportunities for the attainment of universal health coverage goals. Many LMICs have a combination of PHI and public or social health insurance schemes as part of their health financing systems, as in the case of Ghana, Nigeria, Uganda, Rwanda, Kenya, La Cote d’Ivoire, and Senegal, among others. The choice of private or public health insurance scheme as a health financing system policy has consequences. Countries like the United States, France, Germany, Canada, the United Kingdom, Ireland, and Switzerland have different forms and policies of PHI schemes, providing choices and health coverage for distinct categories of populations. Private health insurance usually thrives well in high-income countries, though, not without challenges.

PHI in the United States, for instance, is organized in different forms: a) employer-based health insurance plans through employee-employer contribution, b) direct purchase of insurance, where the individual buys health insurance direct from the private health insurance companies, or through a state or federal marketplace, and c) private health insurance for uniform service [10].

Germany operates a substitutive PHI the for the rich, alongside the mandated social health insurance as far back as the nineteenth century (1883) known as the Bismarckian Health System. Although, there is opportunity for members of the SHI to opt out to join the PHI, there are legal restrictions for opting out of the SHI for the private health insurance once enrolled, to protect the social health insurance scheme.

It is important to note that PHI is based on voluntary enrollment and can contribute to huge uninsured populations, especially if the cost of PHI is not regulated by the state to make it affordable, especially for the poor. Usually, PHI premiums are actuarially determined making the premiums expensive for less privilege health care consumers to afford. Private health insurance can contribute to large uninsured populations, especially in LMICs, and even in certain advanced countries like United States. In the Netherlands, for example, the state subsidizes those who are unable to pay for health insurance. In Ghana, the poor and the vulnerable are covered under the social net premium exemptions program. PHI in Ghana, though optional, is expensive and benefits mostly rich people. Arguments for and against PHI are illustrated in Table 2.

The dual system of health insurance (SHI and PHI) enhances the coverage of the population. In Ghana, Nigeria, and Senegal, like many LMICs, the health insurance systems are hybrid and enrollment are voluntary. But in Ghana, for instance, the enrollment in PHI is very insignificant due to the high premiums.

Most LMICs including Ghana, Nigeria, Rwanda, Uganda, Thailand, and high-income countries such as Canada, Germany, the Netherlands, and Switzerland, among others have adopted the social health insurance model and are at various stages of achieving universal health coverage. Germany, for instance, is well known for the “Bismarckian” social health insurance health system, which has existed and provided quality health care for citizens and residents over 100 years and still thriving.

### 3.5 Community-based health insurance (CBHI)

Despite the call for health care financing through health insurance by the WHO since 2010, and the recent commitment through the UN Sustainable Development Goals (Goal 3 and its targets) for universal health coverage, out-of-pocket spending still accounts for large proportions of total health spending in LMICs. For reasons
Health Insurance

of inadequate financial mobilization capacity and fiscal space, many LMICs have adopted community-based health financing schemes (CBHIs) as alternative means of financing health care for financial risk protection. This informal sector mechanism of financing health care aims to reduce out-of-pocket payment for health care which can impoverish low-income households.

“Community-based health insurance is an umbrella term for the various types of community financing arrangements that have emerged because of high out-of-pocket spending, uncertainty surrounding anticipated financial flows from donors, and large and unregulated private sectors” (...) “CBHIS refers to prepayment plans that attempt to pool risks to reduce the financial risk an individual faces because of illness” [12–14].

The main distinguishing features of CBHI from other health insurance schemes are 1) diverse groups of population coverage, 2) strong solidarity among members, 3) differentiated services in terms of benefits package, 4) variability in regulations and democratic governance, 5) different management styles, and 6) objectives. CBHI is not new in the global arena, but they are prevalent in sub-Saharan Africa. The classical examples are the “Mutuelles de Santé” (Mutual Health Organizations) in Senegal, Mali, Burkina, and Ghana in its formative stages of health insurance [6, 12, 14].

Ample evidence suggests that CBHI has been significant in providing financial protection and health care access to many rural and low-income populations. But, where premiums are somewhat high, affordability hampers access for the very poor in the community [8]. Notwithstanding, strong evidence suggest that that community-based health insurance (CBHI) provides some financial protection through reduction in out-of-pocket expenditure on health and enhance cost recovery. But there is little or no evidence on the effect of quality of health care and efficiency of care. In totality, the impact of CBHI on access to health care is insignificant [14].

CBHI schemes serve only a small section of the population and cannot be guaranteed as a measure for achieving universal health coverage. They can however set the

<table>
<thead>
<tr>
<th>Arguments for PHI</th>
<th>Arguments against PHI</th>
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<tbody>
<tr>
<td>1. Best model in terms of providing efficiency and quality health care.</td>
<td>1. In LMICs, PHI is mostly operated in the cities for the benefits of the privilege.</td>
</tr>
<tr>
<td>2. Reduces public health sector costs and expenditure.</td>
<td>2. There are barely private pharmacy shops in rural areas in LMICs.</td>
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<tr>
<td>3. PHIs have the capacity to finance and find solutions to public health systems challenges in the public sector.</td>
<td>3. Have no capacity to deliver equitable health care services.</td>
</tr>
<tr>
<td>4. Competition in the private sector (PHI sector) coupled with profit motives can enhance efficiency, quality of care, and reductions in costs of care.</td>
<td>4. Not able to efficiently manage health care costs, raising grave equity concerns.</td>
</tr>
<tr>
<td>5. PHI markets are innovative, dynamic, and more sensitive and responsive to health care consumer needs than public sectors.</td>
<td>5. High administrative costs and unhealthy competition can lead to high health care costs which are usually transferred to health care consumers.</td>
</tr>
<tr>
<td>6. Additional funding sources to complement public health services.</td>
<td>6. May affect incentives for growth in health expenditure and the production of health.</td>
</tr>
<tr>
<td>7. Provides alternatives for the haves.</td>
<td>7. Mere demand and supply interplay imbalances coupled with information asymmetry can drive health care costs and perpetuate inequities in health care.</td>
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Table 2. Arguments for and against PHI.
pace as a complementary scheme to other more efficient systems of health financing such as national health insurance schemes [15].

Despite the strong contribution of CBHI in providing financial protection for members and some level of resource mobilization, the general effect is somewhat small. CBHI schemes are insignificant in reaching the very poor. Hence, CBHI is necessary but may not be sufficient solution for risk pooling and revenue mobilization for health care in LMICs because of low population coverage and fragmented groupings.

“Both theory and evidence suggest that the traditional CBHI model – relying only on voluntary, small-scale schemes with little or no subsidization of poor and vulnerable groups – can play only a limited role in helping countries move towards universal health coverage (UHC). CBHI schemes cannot be expected to provide a major source of funding or coverage, and hence can at best provide only a complementary role as part of a national health financing strategy toward UHC. This is partly because people with few health needs tend not to join on a voluntary basis, and there is usually little or no subsidization for poor and other vulnerable groups. Health service utilization rates of members, however, generally increase after enrollment” [15].

Among other things, health insurance thrives on large numbers (risk pool) and sustainable revenue. However, with strong legislation and community solidarity, LMICs can merge CBHI schemes to form a single-payer national health insurance scheme, as in the case of Ghana and Rwanda. CBHI schemes can be a springboard for the establishment of national health insurance scheme in countries where they exist, but they may not ensure equity in access to health care and cross-subsidization of risks.

In the next section, the paper expounds on John Rawls’ theory of justice and its linkages with equity in health care financing.

4. Rawls’ theory of social justice

John Rawls denotes equity as social justice and fairness [16]. He argues that the main pillar of social justice is grounded on the basic social structure and the social institutional distribution of fundamental rights and duties. Consequently, the political institutional and economic and social arrangements decide the division of advantages from social cooperations. Also, social structure is the central pillar of social justice because it is composed of diverse social strata. People are born into the society with different opportunities and different expectations which are often decided by the political systems, as well as economic and social determinants in life. This implies that social institutions are structured in such a way that provides advantages to some groups of the society than others. According to Rawls [16], these social inequalities from the onset become pervasive and affect individual’s chances in life. Rawls, therefore, proposes the application of social justice to cure or remedy unavoidable inequalities (inequalities) in the society.

In the context of health financing, thus, buying health insurance for the people, social justice must regulate the fundamental elements of the economic, social, and health system so that the distribution of health care is fair. Social justice must be the cardinal principle and the applied strategy to distribute the fundamental health rights, to ensure that both economic and social opportunities prevail in various parts of the society. Rawls recommends social justice and economic redistributive justice [16].

Contextualizing health care financing by social justice and equity lens, it means providing health insurance coverage to all without jeopardizing their livelihood.
It also implies providing both the insured and the uninsured the best quality health care with maximum respect and dignity. Additionally, it suggests that health care providers and political systems should eschew greed, avarice, and corruption, and instead, be transparent and accountable to provide equitable universal health coverage to all, everywhere, at the right time, right quantities, and quality.

The ideals of social justice connote the adoption of the universal health coverage principles to provide financial risk protection for all residents irrespective of their ability to pay or not. No one should be impoverished because of catastrophic health care costs, usually, out-of-pocket. Consequently, social institutions mandated to purchase health insurance should do so based on equity and social justice. The guiding principle of universal health coverage should be equity, thus, reducing avoidable unfairness in health care financing coverage and access.

5. Equity in health care financing

Equity has been one of the important variables in health care systems, but inequalities in health care financing and access are still very pervasive. Ample evidence suggests that the poor have less access to health care and suffer more devastating consequences of morbidity and mortality than the rich. The poor have lower levels of health care utilization than the rich, though they have more health needs and spend more on health care as percentage of their income than the wealthy individuals [17].

In this section, equity is contextualized as equity in access to health insurance, health care, and equity in health care delivery: distribution of health care services, urban-rural dichotomy, and ethnic minority communities. The Nobel Prize winner Amartya Sen [18] argues that health is one of the most important variables of human life and an important constituent of human capability, but the pervasiveness of inequalities in health care access and delivery is more disturbing than any other sectors.

Equity in health means that ideally everyone should have a fair opportunity to invest in their health to attain full health potential without any one being disadvantaged from achieving this potential if it can be avoided [19]. Equity can, thus, be explained as an ethical concept which is grounded in the principles of distributive social justice. Regrettably, different people and different authorities tend to interpret equity in diverse ways. To counterbalance the open interpretation of equity and create an operational concept, Braverman and Gruskin [20] defined equity (in health) as “the absence of socially unjust or unfair health disparities, the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage.” This definition reminds us that the society is composed by diverse groups of people with different capabilities, sexual orientation, and different wealth gradients with unique needs in various locations. We call for a society where both the haves and the have-nots have equitable health insurance and universal health coverage without discrimination.

Based on the experts’ definitions and Rawls’ theory of justice, I conceptualize equity in this paper, as fairness in financial contribution (premium payment), fairness in health insurance coverage and access to health care, fairness in health care delivery, and fairness in the determination of benefits package. For example, the premiums of health insurance should be based on individuals or households’ ability to pay. The wealthy individuals or households should pay more, according to some progressive principle while poor pay less, and indigents should be covered by safety net insurance.
6. Sustainable health care financing

Financial sustainability of health care financing is explained based on WHO’s sustainable health care financing framework [21]. The frameworks explain sustainability in health care financing as the inter-relationship between revenue mobilization, risk pooling for financial protection, and efficient purchasing to meet the needs for all. The sustainability goal requires that the three interconnected health financing system functions: revenue collection, financial and risk pooling, and purchasing of health care services are met. Additionally, health care services should be provided according to need, quality, opportunity, and dignity, regardless of individual’s ability to pay [6]. Sustainable health care financing can be conceptualized as the best and efficient mechanisms of organizing three components of the health insurance functions to provide continuous health care to the population, explained as revenue mobilization.

6.1 Revenue mobilization

Revenue mobilization means the measures adopted to raise revenues from various sources, identification of funding sources, and collection methods to finance the health services as well as the provider payment mechanisms. Sustainability of health insurance scheme depends on the quantum of the funds raised and the efficient management of the funds.

6.2 Fund pooling

Fund pooling refers to policies established to build an advanced accumulated funding from various sources on behalf of the population. Pooling also means risk sharing between different people who have different incomes, ages, and illness risk.

6.3 Resource allocation and purchasing

Resource allocation and purchasing simply means paying providers health care services on behalf of the insured. It refers to the measures used to buy health care services from public and private providers for and on behalf of health care consumers.

These three financing functions interact at country health policy level and translate into mobilizing adequate and sustainable revenues in an efficient and equitable manner to provide individuals with the needed essential health services and financial risk protection against unforeseen catastrophic episode of illness or injury.

Effective and efficient combination of the health financing functions and the policies together, through the intermediate sustainability goals such as transparency and accountability, can yield a sustainable and resilient health financing system for a country.

7. Health financing schemes in LMICs, lesson from Ghana and Thailand

Since the adoption of the WHO’s world health report in 2000, governments of LMICs have formulated strategies to finance health care to increase equity in access
to health care in their respective countries. Despite the frantic efforts and success chalked by various countries in this direction, there are still rooms for improvements. Rwanda, for instance, has achieved near-universal health coverage, and Ghana, Nigeria, Senegal, and Tanzania have made giant strides in the establishment of national health insurance schemes. However, many countries in sub-Saharan Africa are at various stages of their health financing schemes. This section expounds on selected health financing schemes that have successfully been applied to cover all categories of individuals, including poor people to draw useful lessons for adaptation and replication in other peer countries. Ghana and Thailand are excellent examples of robust and successful health financing schemes worthy of emulation. These two countries present excellent best practices for replication, but not without challenges on their path to universal health coverage. The two countries’ insurance schemes were chosen because of their uniqueness. The successes and challenges are elucidated in the following section.

7.1 Success factors and red flags of Ghana’s National Health Insurance Scheme

Ghana’s National Health Insurance Scheme (NHIS) was established in 2003 by an act of parliament (Act 650, 2003 [22], revised by Act 852, 2012 [23]) to provide equitable health care to all residents of Ghana. The NHIS was meant to be pro-poor recognizing the gap in health care between the poor and the rich in access to health. Funding of the scheme is tax-based (3.5%) which accounts for the National Health Insurance Levy, an indirect value-added tax on purchase of goods and services; it is also financed by a voluntary contribution (NHIS Premiums of the informal sector population GHS240 ($34.00, in 2022 exchange rate), and social security contribution (2.5%) applied to formal sector employees, and other financing sources such as grants, donations, and investments returns. It is worth noting that about 75% of the total NHIS funding is from NHIS Levy. The scheme has a comprehensive and generous benefits package covering close to 90% of all diseases, health conditions, and accidents. However, major and complicated surgeries often may not be covered. Medications and prescribed drugs are covered, but most often there are limited supply of essential medication at the hospitals, and patients are given prescription paid out-of-pocket [6, 22, 23].

After almost two decades of its implementation, the scheme has still attained the required universal population coverage. Only about 50% of diverse groups of the population have enrolled in the NHIS, which raises the question why are the rest of the 50% not covered under the NHIS? What is not going right in the NHIS policies and strategies? Notwithstanding the challenges, the NHIS is considered a best practice scheme for replication on other African and other LMICs. In the following section, I analyze the success factors but also indicate the red flags of Ghana’s NHIS. As much as these success factors can be replicated or adopted in other countries on their paths to health insurance, it is important to note that replication of these success factors in other LMICs should be done with caution in the cultural-specific and political context of the country. The underlying key factors that influence the success of Ghana’s NHIS are illustrated in Table 3. The list is not exhaustive, as suggested by Anarwat and Shepard in 2020.

7.2 Thailand’s universal health care coverage scheme (UCS)

Thailand’s National Health Insurance Scheme (UCS) was established in 2001. The UCS is organized in three different forms of schemes: 1. Social Security Scheme
Health Insurance for Economically Disadvantaged People in LMICs: What are the Best Options?
DOI: http://dx.doi.org/10.5772/intechopen.105679

(SSS) for private sector workers; 2. Civil Servants’ Medical Benefits Scheme (CSMBS) for government employees, their spouses, dependents less than 20 years, and their parents; and 3. UCS for the rest of the population which aims to cover all the population not covered by the SSS, mostly informal sector workers.

The UCS has 99.8% population coverage. It is funded through a combination of taxes and contribution (premium) from members. This premium is exceptionally low, about 30 Baht ($1.00) the starting based level [25]. The success factors and challenges are illustrated in Table 4.

8. Impact of COVID-19 on health financing systems in LMICs

SARS-CoV-2 virus, a highly infectious and deadly disease, popularly known as coronavirus (COVID-19) after it was first reported in Wuhan, China, in 2019, has devastated global public health and global health systems. In a spate of 3 months, the disease took global leaders by surprise and spread through the world like wildfire, destroying health systems, wiped out populations in advanced and developing countries. COVID-19 caused panic, anxiety, and mental health challenges, devastated families, destroyed business, increased health care financing and delivery costs, and

<table>
<thead>
<tr>
<th>Success factors</th>
<th>Red flags</th>
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<tr>
<td>1. Strong political will.</td>
<td>1. Nonadherence to the gatekeeper system.</td>
</tr>
<tr>
<td>2. Appropriate legislation</td>
<td>2. Provider shopping on the part of NHIS members.</td>
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<tr>
<td>5. Safety nets for the poor and vulnerable</td>
<td>5. NHIS provider collusion.</td>
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<tr>
<td>11. Hospital user-fees (“Cash and Carry”) policy challenges.</td>
<td>11. Delays in claims processing.</td>
</tr>
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<td>12. Multifaceted communication and marketing approach.</td>
<td>12. Undue political influences on the NHIS.</td>
</tr>
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<td>15. Very low-cost premiums.</td>
<td>15. Continuously low enrolment of the economically active populations in the informal sector.</td>
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<tr>
<td>17. Health insurance user portability.</td>
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<td>18. Academic and operational research</td>
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<td>19. Multiple providers and free choice of providers.</td>
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Analyzed from [24].

Table 3. Success factors and red flags of Ghana’s NHIS.
brought down global travels to a near halt. Several cities in both advanced countries and LMICs experienced lockdowns for several months. For the first time in the history of the world, international and domestic flight in many countries were banned for more than a year, since COVID-19 was declared a global pandemic on March 11, 2019 by the World Health Organization (WHO).

On May 2, 2022, WHO reported a global total of COVID-19 infections stood at 511,275,451 COVID-19 cases and 6,238,320 deaths with a case fatality ratio (CFR) of 1.2% in 227 countries and territories. The reported cumulative cases (percentage of global cases) from the WHO regions except Africa were Eastern Mediterranean Region 18,377,400 (4%), European Region 215,216,599 (42%), Region of the Americas 153,175,779 (30%), South-East Asia Region 57,870,460 (11%), and Western Pacific Region 54,757,461 (11%). At the same period, a total of 11,453,205 COVID-19 cases and 252,165 deaths, with CFR of 2.2%, were reported by the 55 African Union (AU) Member States (MS). Although the incidence in Africa represents only 2% of all cases and 4% of all deaths reported globally, the impact on individual AU Member States was catastrophic. Forty (73%) of individual AU Member States reported CFRs higher than the global CFR [26].

The good news is that the collaborative scientific research which led to the production of vaccines with boosters in advanced countries, such as the United States, the United Kingdom, Germany, and Russia, among others, is expected to curtail the mortality rates of the pandemic and the impact. Unfortunately, LMICs are still struggling to produce their first COVID-19 vaccine, and therefore, must rely on the collective benevolence of advanced countries through the COVAC initiative to vaccinate their populations.

The evidence suggests that over 4.6 billion people constituting 58% of the global population have been fully vaccinated. But, only 17% of the total population of Africa was fully vaccinated, as of May 2022 [27], which could be attributed to inadequate...
vaccine supply, vaccine myths and hesitancies, funding and procurement issues, among other factors. The economies of many LIMCs experienced negative economic growth, and huge negative impact on their health systems are still recuperating since the outbreak of COVID-19. The impact of COVID-19 pandemic should be a wake-up call for LMICs to adopt measures to strengthen their health systems and make them resilient.

9. Discussion, conclusions, and recommendations

Inequities in health insurance coverage and access to health care between people with different incomes and wealth are pervasive in several LMICs. Based on Rawls’ theory of social justice, there is unfairness in health insurance coverage of which the less privilege people in society, especially in LMICs, have always been disadvantaged. The paper explored the types of health insurance schemes and the choices LMICs policymakers can make to ensure equitable health care for all. It elucidated on successful factors of key health insurance schemes and health policies that can ensure universal health coverage for all without anyone left out. The question often posed by LMICs policymakers is which type of health insurance scheme to implement and what should be the strategic factors to adopt for success.

To answer the question which insurance model to choose, it is important to conclude that there is no blueprint for successful implementation of a health insurance scheme that will cover the poor. However, the review of the existing types of health insurance schemes shows that publicly taxed-financed health insurance schemes tend to cover and benefit the poor. Publicly financed single-payer national health insurance schemes, as in Ghana, Thailand, United Kingdom, and Canada, facilitate the achievement of universal health coverage than private health insurance schemes. However, they all have their ups and downs. Proponents of PHIs argue that they ensure freedom of choice of health insurance, efficiency, and quality of care. But in most cases, PHIs are limited to the privilege, are profit-oriented, and do not ensure equity in health insurance coverage [11].

Where there is multiplicity of private health insurance schemes of all forms, as in the case of the United States, the poor tend to suffer in terms of coverage because of high premiums [10]. It is argued that PHI breeds competition and enhances technological advancement in health care and therefore promotes the quality of care delivery [11]. But what is the point of quality of care where large majority of the population have no health insurance and find it difficult to access health care? PHI might not be a good option for LMICs striving to achieve UHC. At best, private health insurance can be encouraged as a supplementary insurance to cover for highly sophisticated health care services, while the government subsidizes for the poor to ensure equity of access. Where PHI is the health financing policy, the government should adopt measures to cover the poor through subsidies or premium exemptions.

Though it would be naïve to recommend a particular health insurance model for any country as the best model for replication, the “Bismarkian” model has stood the test of time of time and, therefore, worth replication in LMICs but with caution. The caveat might be the large informal sector in LMICs and high unemployment rates, which might be difficult to mandate insurance contribution through social security. Even though CBHI is a community initiative based on social solidarity, the evidence suggests that they do not have the capacity to mobilize large pools or revenue and risk, and they may not be able to ensure universal health coverage [15]. Consequently,
CBHIs might not be recommendable option for LMIC who are about to start universal health insurance scheme. In LMICs with high prevalence of CBHIs, it is imperative that governments legislate to merge them to form a single-payer national health insurance scheme.

Progressive tax-based health insurance schemes, in the case of Ghana and Thailand, present best practices that LMICs can adapt while marking the red flags to avoid on their pathways to universal health insurance coverages. It is crucial for LMICs to understand that there is no perfect health insurance scheme or straight jacket strategies for success. It all depends on the terrain and the dynamics of the political economy.

Both advanced and developing countries are continuously experimenting models for equitable and sustainable health financing for quality UHC. There is no straight jacket or blueprint method to achieve Universal Health Coverage. Nonetheless, to implement a viable and sustainable health financing systems for universal health coverage, the best health financing and organizational options should be derived from a broad spectrum of choices, including, but not limited to, private financing options, tax-based financing, social health insurance, single-payer system, and mixed models’ health financing systems. The choice of health financing systems should be driven by prevailing social, economic, and political economy factors. Progressive tax-based single-payer systems with strong mechanisms put in place to check that abuse and corruption would be a better option to cover the poor and to achieve UHC. It is imperative to implement policies that are preponderantly country context-specific and culturally acceptable to get the people’s buy-in. We recommend LMICs to adopt and adapt the best practice models of health insurance schemes to suit their prevailing economic, social, political, and cultural situations. COVID-19 had a huge devastating impact on the economies of LMICs. Implicitly, it behooves on LMICS to invest in research, health systems strengthening, financing, and human resource for health to establish strong health sectors against such unanticipated epidemics and pandemics. More in-depth and further research is needed to look at the impact of COVID-19 on health systems financing of LMICs [28].

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References


