JCHR

Journal of Community Health Research 2023; 12(2): 307-309.

Monitoring the Aspects of Financial Risk Protection regarding Universal Health Coverage

Anugraha John [1], **Hari Teja Avirneni** [2]*, **Sinthu Sarathamani Swaminathan** [3]

1. Department of Community Medicine, Sri Lalithambigai Medical College and Hospital, Chennai, Tamil Nadu, India
2. Department of Community Medicine, NRI Institute of Medical Sciences, Visakhapatnam, Andhra Pradesh, India
3. Department of Community Medicine, Trichy SRM Medical College and Hospital and Research Centre, Trichy, Tamil Nadu, India

ARTICLE INFO

Letter to the Editor

Received: 06 Jun 2021
Accepted: 19 Apr 2023

OPEN ACCESS

Corresponding Author:
Hari Teja Avirneni
haritejaavirneni26@gmail.com

Dear Editor,

Universal health coverage (UHC) is considered a powerful mechanism for achieving better health, promoting human development, and enabling equitable access to health services for all. In this regard, the whole idea of UHC rests on provision of a full range of essential health services and financial risk protection for all the citizens of a country. Therefore, UHC is advocated as a mechanism to ensure health equity, that is, to ensure equal access to healthcare services for all the individuals. The United Nations' Sustainable Development Goals (SDGs) to be achieved by 2030 also advocates achieving UHC as an important milestone accomplished under larger health goal. With UHC becoming a major policy goal globally and its increasing adoptions at policy levels across various member states of the World Health Organization (WHO), the progress toward UHC should be continuously monitored across respective states (1).

According to the WHO's report in 2000, one of the fundamental functions of a health system is to establish a health financing system that protects the population against the financial risks associated with poor health. Such risks can be assessed in terms of catastrophic health expenditure (CHE) and impoverishment from medical expenses (2). The goal of UHC is to provide protection from such risks by providing equitable, affordable, and accessible healthcare to all the individuals. Such protection from financial risks is directly affected by the financing policy of health system. When direct payments to obtain healthcare services do not expose people to financial threats and do not affect their standards of living, financial protection is achieved (3-5). The out-of-pocket health expenditures (OOPHE) on healthcare, made by households at the healthcare delivery point, can sometimes push them into the boundaries of poverty. Therefore, the extent of protection from financial risks regarding payments of healthcare delivery can be indicated by OOPHE (6).

Since the commitment to UHC by all the members of the WHO in 2005, the advances have been made in providing affordable healthcare and also in reducing risk related financial threats from OOPE; they are illustrated by the progress toward Millennium Development Goals in the form of a worldwide fall in OOPE for using health-related services. Despite such continuous efforts to progress toward UHC, the universal access to health-related services and financial risk protection has not reached the level envisioned by UHC. For example, it was estimated that nearly half of the people infected with human immunodeficiency

[DOI: 10.18502/jchr.v12i34.14791]

virus were not receiving anti- retroviral therapy. The numbers of people who paid for such services from their pockets and suffered from catastrophic effects of such payments are estimated to be 150 million (1). Furthermore, the conditions that cause health-related problems and the financial power of a nation to protect its citizens from such conditions are different. Therefore, it is highly important for the respective countries to plan for health services coverage and ensure financial risk protection while effectively utilizing the limited resources (7).

To keep a continuous track of health services coverage and also the indicators related to financial coverage, WHO and World Bank jointly developed global monitoring framework to observe the progress toward UHC. Financial coverage indicators in this framework include those derived from OOPHE including the proportion of households that spend more than 10–25% of their income on health and those who are impoverished. OOPHE is the money paid by people for any type of service (preventive, curative, rehabilitative, palliative, or long-term care) provided by any type of provider. The payment includes cost sharing (the part not covered by a third party like an insurer) and informal payments (for example, under-the-table payments), but they exclude insurance premiums. OOP payments could be financed through household's income, remittances, savings, or borrowing (8).

There are many countries in which people do not pay for the required health services due to the fear of the burden coming from OOPE (9). The highest rate of OOPHE has been recorded in Pakistan, India, Bangladesh, in comparison to other countries in the world. Such imposition had a direct effect on their living conditions and may also lead to impoverishment when OOPE is considered catastrophic (5).

WHO proposed that health expenditure should be called CHE whenever it is ≥40% of the household's capacity to pay (10). However, there is no right or wrong approach to measure CHE. Different studies adopted different approaches. Some studies defined CHE as the OOPE surpassing a specified percentage, for example, 10% or 25% of income. This was the approach adopted in SDG 3.8.2 (8). Other studies relate health expenditures not just to income but also to the income less a deduction for necessities; the argument is that this may provide a better measure of a household's capacity to pay OOPHE. These approaches are part of WHO regional frameworks to monitor CHE (11). Global monitoring report on UHC demonstrated the number of people with CHE. It is estimated that in 2010, 808 million people incurred CHE at 10% threshold, equivalent to 11.7% of the world's population in 2010. At 25% threshold, the figures were 179 million and 2.6%. The report also noted that the rate of CHE was higher in Asian regions, hence contributing a significant portion to the global rate (8). Although estimating OOPHE reveals the status of CHE, identifying factors that increase the chances or lead to CHE is also important. The factors include socioeconomic status, history of financial losses or loans in households, the type of the condition (acute or chronic), and incurred expenditures for diagnosis and management. Other factors include loss of wages or job and the means of managing such expenditures in both short term and long term mainly in the event of financial distress (12).

With the adoption of UHC globally and countries making their national health policies in line with UHC, it is highly important to continuously monitor such progress toward UHC. This can be done by constantly measuring the OOPHE and CHE and assessing the levels of financial protection for all the citizens, especially among those from economically weaker sections of society. Regarding low- and middle- income countries with high CHE, support systems has to be built for continuously measure the progress toward UHC by monitoring CHE and impoverishment. More research should be conducted, with emphasis on the financial aspects of receiving healthcare. The range would be from general descriptive studies to more specialized studies focusing on specific disease conditions or a specific aspect of the treatment among the beneficiaries of various financed health insurance plans. Findings from such research facilitate policy

[DOI: 10.18502/jchr.v12i34.14791]

reforms targeting the effects of CHE on households. This forms the basis for monitoring the progress toward UHC in any given setting.

Acknowledgement

The authors would like to thank Dr. N. Seetharaman, Head, Department of Community Medicine, KMCH for being a continuous source of inspiration and in mentoring providing their valuable time and support.

Conflict of interest

The authors declared no potential conflicts of interest.

Funding

None

Authors' contributions

All the authors contributed equally in literature search and in preparation of the first draft of the manuscript. All authors contributed to the preparation of the final manuscript and jointly approved the final version for submission.

Open Access Policy

JCHR does not charge readers and their institution for access to its papers. Full text download of all new and archived papers are free of charge.

Keywords

Universal Health, Health Expenditures, Universal Health Insurance.

References

1. World Health Organization. World Health Statistics 2020: Monitoring Health for the SDGs. WHO; 2020. Available at: URL: https://www.who.int/whr/2013/report/en. Accessed Oct 09, 2021.
2. World Health Organization. Health Systems: Improving Performance. World Health Report. Geneva: WHO; 2000. Available at: URL: https://www.who.int/whr/2000/en. Accessed Sep 15, 2021.
3. Bennett S, Ozawa S, Rao KD. Which path to universal health coverage? Perspectives on the world health report 2010. PLoS Med. 2010; 7: e1001.
4. Kawabata K, Xu K, Carrin G. Preventing impoverishment through protection against catastrophic health expenditure. Bull World Health Organ. 2002; 80: 611-2.
5. Frenk J, De Ferranti D. Universal health coverage: Good health, good economics. Lancet. 2012; 380: 862-4.
6. National Health System Resource Centre, Ministry of Health and Family Welfare, Government of India. National Health Accounts Estimates for India 2015-2016. Available at: URL: https://www.mohfw.gov.in/sites/default/files/NHA_Estimates_Report_2015-16_0.pdf. Accessed Aug 10, 2021.
7. Savedoff WD, De Ferranti D, Smith AL, et al. Political and economic aspects of the transition to universal health coverage. Lancet. 2012; 380: 924-32.
8. World Bank, World Health Organization. Tracking Universal Health Coverage: Global Monitoring Report. Washington, DC, Geneva: World Bank, WHO; 2017. Available at: URL: https://www. worldbank.org/en/topic/universalhealthcoverage/publication/tracking-universal-health-coverage-2017-global-monitoring-report. Accessed Oct 05, 2021.
9. McIntyre D, Thiede M, Dahlgren G, et al. What are the economic consequences for households of illness and of paying for health care in low and middle-income country contexts? Soc Sci Med. 2006; 62: 858-65.
10. Xu K, Evans DB, Carrin G, et al. Protecting households from catastrophic health spending. Health Aff. 2007; 26: 972-83.
11. Xu K, Evans DB, Kawabata K, et al. Household catastrophic health expenditure: A multi-country analysis. Lancet. 2003; 362: 111-7.
12. Daivadanam M. Pathways to catastrophic health expenditure for acute coronary syndrome in Kerala: Good health at low cost? BMC Public Health. 2012; 12: 306.

[DOI: 10.18502/jchr.v12i34.14791]