Health system financing – what’s gender got to do with it?

1st July 2015
# Webinar Overview

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<td>Rob Yates, Chatham House, UK</td>
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<td>Gendered questions related to health financing and gaps in health literature</td>
<td>Sophie Witter, Queen Margaret University, UK</td>
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<td>Gender and health implications of health financing reforms</td>
<td>Veloshnee Govender, University of Cape Town, South Africa</td>
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<td>Lessons on health sector reforms and gender from India, and lessons for UHC</td>
<td>TK Sundari Ravindran, Sree Chitra Tirunal Institute for Medical Sciences and Technology, India</td>
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Financing Universal Health Coverage (UHC)

Gender and Health Systems Financing Webinar
1st July 2015

Rob Yates
Director UHC Policy Forum
Chatham House, London
What is Universal Health Coverage?

A simple definition of UHC:

All people receive the quality health services they need without suffering financial hardship.
UHC is fundamentally about EQUITY

- Universal = Everybody. Nobody left behind
- Health services allocated according to NEED
- Health financing contributions according to one’s ability to pay
- Healthy-wealthy cross-subsidise the sick and the poor
- Not just curative services: preventive, rehabilitative, palliative too
- Services must be good quality to be effective
The Three Dimensions of UHC

Towards universal coverage

Politics:
- Population: who is covered?
- Extend to non-covered

Coverage mechanisms
- Reduce cost sharing and fees
- Include other services

Economics:
- Financial protection: what do people have to pay out-of-pocket?

Health:
- Services: which services are covered?
Consensus on health financing for UHC

- Market-driven privately financed health systems do not result in UHC
- The state must force the healthy-wealthy to cross subsidise the sick and the poor - achieving this is inherently political
- The state must be heavily involved in all three main financing functions of raising revenues, pooling and purchasing services
- This doesn’t rule out private sector administration or provision of services
Emerging consensus on health financing for UHC

• User fees are “unjust and unnecessary”
  Jim Kim, President World Bank, May 2013

• Private voluntary insurance including community based insurance is ineffective, inefficient and inequitable

• Public financing (tax financing + compulsory social insurance) is the key to UHC

• All countries need to use tax financing to cover those not in formal employment
Figure 1: 
Demand for Preventive Healthcare Products Based on Price

www.povertyactionlab.org
Gender implications of UHC health financing policies

- Women are a high-need population group with often low access to financial resources and therefore have a low ability to pay.
- Many services that benefit women are extremely cost-effective and should be a top priority for universal coverage.
- We must encourage “progressive universalism” but recognise that achieving this will be a political struggle.
Thank you!
Health financing and gender – introduction and overview

Sophie Witter
Queen Margaret University, Edinburgh & ReBUILD consortium
Overview

• UHC and health financing functions

• What does health financing cover?

• Examples of gender questions on different HF functions – how much has been done and what are the gaps?
UHC goals and intermediate objectives influenced by health financing

Health financing arrangements

UHC intermediate objectives

UHC goals

Equity in resource distribution

Utilization
Need

Quality

Efficiency

Transparency and accountability

Universal financial protection

Revenue collection
Pooling
Purchasing

Rest of health system

What does health financing cover?

- The health system financing architecture, fund flows and agencies responsible for revenue collection, pooling, purchasing, and legal and regulatory aspects at national and sub-national levels;

- The sources of funds, contribution mechanisms, trends in level of public, private, external, and total health expenditures, as well as funding needs and gaps;

- Revenue pooling arrangements (single or multiple pools), elements of cross-subsidy, risk pooling, fund equalization, governance, and financial sustainability of different schemes;

- Resource allocation rules and patterns between geographical locations and health facilities (hospitals, clinics and health centres);

- Provision and use of health services (equity of distribution and use, access issues, financial barriers and burdens) relative to the health needs of the population, income groups and other indicators of vulnerability (such as sex or ethnicity), and location (urban and rural);

- Purchasing systems, performance of health service providers (public and private), payment mechanisms, and evidence of effects on health service quality and efficiency;

- Public financial management rules and systems, including how funds are planned and budgeted, transferred, used, reported on and controlled, which affects how much autonomy public providers have.

- Rules on cost-sharing and public awareness about health service benefits entitlements, payment
<table>
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<th>Health financing function</th>
<th>Examples of gendered questions</th>
<th>State of evidence</th>
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<td>Revenue raising</td>
<td>1. Fairness of financial contributions: who is paying for health care? How is that changing over time</td>
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<td>2. How far does the burden fall disproportionately on one sex?</td>
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<td>3. What is the gender implication of changing revenue sources (e.g. out of pocket likely to fall heavily on women; prepaid mechanisms may be more protective)?</td>
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<td>4. How do different payment systems affect men and women’s access to health care?</td>
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<td>5. How are they affected by household arrangements (livelihoods, access to cash, decision making power etc.) and how do they affect these in turn?</td>
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<td>6. What is the pattern of private and public funding and what does that mean for meeting the needs of different population groups?</td>
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Very little work done, except on 4 and 5, where there have been some studies, especially in relation to user fees.
| **Risk pooling** | 1. Who is protected under different risk pooling systems (tax-based, insurance, prepaid mechanisms etc.)?  
2. How effective are the risks pools in protecting men and women against health shocks (ensuring access and also financial protection)? | This question is usually examined in relation to quintiles, but not gender |
| **Purchasing** | 1. Which programmes are being prioritised for funding and how do these reflect different gender needs?  
2. Does the public/private mix serve the interests of both men and women effectively?  
3. Are gender-sensitive services being purchased (e.g. facilities which provide confidentiality, sensitivity, right staffing mix, at appropriate opening times etc.)?  
4. Are provider payment mechanisms incentivising appropriate and high quality services for both genders? | Some work on resource allocation to MCH and SRH programmes but limited wider analysis (including of gender implications of different public private partnerships) |
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<th>Resource allocation</th>
<th>1. How do patterns of resource allocation at different levels (national, regional, district) and within different systems and schemes affect equity of access and use for both genders, as well as quality of care? (Not just allocation of funding, but also infrastructure, HR etc.)</th>
<th>This is an important but neglected area.</th>
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| Benefits package | 1. Is there a clear and fair entitlement to services?  
2. Are different genders equally aware of them and able to access without stigma?  
3. Do utilisation patterns suggest that needs are being fairly met across the genders, or are there remaining financial and social barriers? | Not usually approached from a gender angle, but benefits packages do have gendered implications (e.g. may neglect some common male conditions, or important elements for women, such as FP, safe abortion, infertility treatment and treatment for victims of sexual violence) |
| Health financing governance | 1. Is there adequate and fair representation of different genders in health financing governance structures? Who is represented in health facility management committees, for example? Who decides on resource allocations? Etc.  
2. Does the regulatory system ensure fairness and quality of care for both genders? | Also neglected area. |
Summary

• Work on health financing and gender has been limited – we need to develop the conversation between people working in both areas

• Most work has been done on user fees and gender and household impacts, plus some analysis of funding allocations to MCH/RH

• All other areas remain under-explored
Gender and Health Implications of Health Financing Reforms
1 July 2015

Veloshnee Govender
Health Economics Unit
University of Cape Town
South Africa
Overview
Gender and Health Implications of Health Financing Reforms

• Health financing reform

• Gender and health implications of health financing reforms:
  • Cost recovery
  • Prepayment schemes (mandatory and micro-insurance)
  • Thailand: gender and health financing implications of health financing reforms

• Lessons learnt...features of health financing reforms schemes that improve gender access
Health Financing Reforms in LMICs

Examples of health financing reforms:
- Cost recovery
- Prepayment schemes
  - Mandatory social insurance
  - Voluntary private insurance

Health Financing Functions:
- Revenue collection
- Pooling
- Purchasing

Resource limitations in health sector:
- Macro-economic/global context
Revenue collection

Domestic
- Out-of-pocket payments
  - Cost-recovery

External
- Pre-payments
  - Mandatory
  - Voluntary
  - Private commercial insurance
  - Community-based health insurance

Source: McIntyre and Meheus, 2014
Gender implications of Cost Recovery Schemes

Cost Recovery
No prepayment
No cross-subsidies and risk pooling

Equity in financial contribution (regressive)

Financial Impoverishment

Catastrophic expenditure

Equity in Access and Utilisation

Vulnerable groups (women, minorities, adolescents, elderly)
Households (Low income & female-headed)

- Women incur more out-of-pocket expenditure than men
- Paying for delivery care and other reproductive health services places a higher financial burden on women
- OOP may discourage/prevent more women than men from utilising health services  {WHO, 2010}

Source: WHO 2010
Gender implications of Mandatory Pre-payment Schemes

Social Health Insurance

Cross-subsidies and risk pooling

Who is covered?
- Formal sector...entire population

What services are covered?
- Insurable (low probability, random events)
- Uninsurable (high probability, non-random)
- Chronic diseases

How are the services financed?
- Formal sector: payroll deduction
- Self-employed: flat rate/premium
- Low-income, unemployed: subsidised

- Covers those in formal sector, likely to exclude women, work in informal economy
- Funds typically exclude SRHS (non-random, high probability)

Source: WHO 2010
Gender implications of Micro-Insurance Schemes

Micro-insurance

Cross-subsidies and risk pooling

Who is covered?
Informal sector; women, indigent excluded

What services are covered?
Insurable: low probability, random events
Uninsurable: high probability, Chronic diseases

How are the services financed?
Nominal premiums; Subsidised by government and donors

• Voluntary, less likely to include women, unless initiated by women
• Funds typically exclude SRHS (non-random, high probability)

Source: WHO 2010
Thailand: Gender implications of Health Financing Reforms

Universal Coverage:
- SHI: Private sector employees
- CSMBS: Government employees, dependants
- UCS: Pop not covered by SHI/CSMBS (75%)

Who is covered?
- SHI: Private sector employees
- CSMBS: Government employees, dependants
- UCS: Pop not covered by SHI/CSMBS (75%)

What services are covered?
- Comprehensive: preventive, promotive, curative, rehabilitative services, ARVs, SRH services, limited TOP services, EMOC covered only for 1st 2 deliveries

How are the services financed?
- SHI: payroll deduction
- CSMBS: Tax revenue
- UCS: Tax revenue

Cross-subsidies and risk pooling

Equitable public financing reduced OOP
- Almost no rich-poor gaps in access to MCH, FP
- 100% utilisation prenatal care; 99.7% SBA (2012).

Evidence suggests ... features of HFRs that improve gender access

- Combination of tax and mandatory insurance
- Not restricted to formal sector workers/dependents, but includes households:
  - Not covered by other insurance schemes.
  - Can address gender biases within households
- Nominal premium; subsidy for those unable to pay
- Cover a wide range of SRHS including non-random and routine needs (e.g. contraception, pregnancy, delivery).
- Include those with pre-existing conditions so that middle-aged and older women, and men with chronic health conditions also covered

Source: WHO 2010
Health financing mechanisms in India and their implications for women’s access to health care

TK Sundari Ravindran
Professor
Achutha Menon Centre for Health Science Studies,
Sree Chitra Tirunal Institute for Medical Sciences & Technology, Trivandrum
Outline

• Some facts on gender-based inequalities that have a bearing on health financing

• Health financing mechanisms in India

• Implications for women’s access to health care
India (2005-06)- Percentage of women who do NOT have control over how they spend their earnings
Education, employment, or wealth do not ensure that women have money that they control (India-2005-06)

Percentage of women age 15-49 who have money which they can decide how to use

- Belong to the highest wealth quintile: 56%
- Are employed for cash: 55%
- Have 12+ years education: 60%
Percentage of women age 15-49 who are allowed to go alone to:

- Market: 51%
- Health facility: 48%
- Places outside the village/community: 38%
- All three places: 33%
- None of the three places: 4%
Gender barriers in accessing health care

• According to NFHS-3, 47% of women reported having one or more problems in accessing health care:
  • concern that no female provider available;
  • not wanting to go alone;
  • having to take transport;
  • no permission;
  • getting money from household for treatment
Health care financing mechanisms in India

• Predominantly financed by household out-of-pocket expenditure (61% in 2010)\(^1\).

• Tax based financing for government health services.

• Social Protection mechanisms for those living below poverty line:
  • *Rashtriya Swasthya Bima Yojana (RSBY)*; tax-funded and purchasing health care from public as well as empanelled private health care providers.
  • Conditional Cash Transfer Schemes for women: for institutional childbirth

• Low penetration by private-for-profit insurance, and a small number of community-based health insurance or micro-insurance schemes

• Increasing policy support for health care provision by private for-profit sector.
Implications of health financing mechanisms for women-1

• Tax-based financing: tax revenue principally (> 2/3rds) from indirect taxes\(^2\), regressive.

• Low tax-base\(^3\) and cuts to health (and other social sector) budget a common means of containing fiscal deficit.

• Very low public investment in the health sector - less than 1% of GDP currently.

• Consequence: Fewer service delivery points; inadequate staffing; shortage of drugs, non-availability of diagnostic services and limited range of services at the primary and secondary care levels.
Implications of health financing mechanisms for women -2

• India’s main social protection scheme – RSBY - covers only those living below-poverty line. But it is not only women from poor households who encounter financial barriers.

• Studies indicate that RSBY has increased access to care for low-income women. However, a more gender-aware design could have removed some major barriers. For example, Rs.30,000 per annum is available for covering hospitalization for the “household”. Further, only five members may be enrolled per household.

• Thus, RSBY leaves the choice of who is to be covered to household gender dynamics. It has been found that girls and elderly women are more likely to be the excluded ones when there are more than five members in a household. Overall, enrollment of women lower than that of men.

• Non-financial barriers arising from “gendered” inequalities: inadequate information on which health facilities are empanelled; what services are covered; lack of confidence to negotiate with health care providers.
Implications of health financing mechanisms for women -3

- Conditional cash transfers (CCT) for institutional deliveries has increased the proportion of women delivering in institutions significantly.

- Here again, gender-based vulnerabilities not factored into the design of the scheme:
  - Women from the most vulnerable sections affected by the exclusion from the scheme of women with more than two live births.
  - In “high performing” states, only women from households below poverty line, and those above 18 years of age eligible.

- In a Tamil Nadu study, only 25% of women who satisfied the eligibility criteria benefitted from the CCT scheme of the state government. Caste and landowning status significantly associated with receiving the benefit.\(^5\)

- Single minded focus on delivery care to the exclusion of essential SRH care in public health facilities especially at primary and secondary care levels.\(^6\)
Implications of health financing mechanisms for women -4

• Private insurance schemes do not cover routine delivery care or contraceptive services.

• Prepayment mechanisms that are not large enough find it unviable to cover many routine SRH services.

• Increasing privatization of health service provision affecting women not belonging to the “below poverty line” category disproportionately (e.g. high OOP for delivery care)\(^7\).

• Gender-biases and profit-seeking combine to produce peculiar distortions (e.g. unnecessary hysterectomies)\(^8\).
Universal health coverage for women?

• According to India’s National Sample Survey (2004), untreated morbidity was higher among women as compared to men, especially in the 15-45 age group.⁹

• Smaller scale studies have shown steeper differences: in low-income settlements in Mumbai, untreated episodes of illness 17.7% in men; in women, 20.3% (without probing) and 45.3% (with probing).¹⁰

• Among urban slum dwellers in Delhi and Chennai, 27.5% and 8.7% men stated financial constraints as the main reason for not seeking treatment; the figures were 46.0% and 25.0% for women from the same community.¹¹
What is to be done?
Some examples

• Tax-based public financing of health care services with resources mobilised from progressive taxation of income and wealth.

• Firm action by governments to regulate the private sector in health.

• Attention to coverage of all sections of women when implementing health financing reforms (e.g. social insurance, micro-insurance)

• Social Protection Schemes to go beyond only BPL women

• Essential Services Package to extend beyond MCH and factor in women’s health needs through their life cycle.

• Large enough social insurance schemes to ensure effective risk pooling and cross-subsidizing to include SRH services.
References

Commentary by:
Sarah Ssali, Senior Lecturer, School of Women and Gender Studies, Makerere University, Uganda
Questions?

QUESTION
THE
ANSWERS
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