POLICY BRIEF

Policy Brief 002

Health Insurance: Opportunities for Protecting All Afghans

INTRODUCTION

Households in Afghanistan contribute more than 70 percent of the country' s healthcare spending (GIRoA, 2013). These funds come directly from households through out-of-pocket (OOP) payments for healthcare services. The high costs of medical care can result in catastrophic expenditures that may force households to sell their land, sell their agricultural or animal livelihoods, or prevent children from obtaining education due to extra fees (Xu et al., 2005). Alternatively, poor households may not seek care, choosing to avoid impoverishment and prolonging ill-health. These decisions may lead to further impoverishment for households. Yet, currently there are no risk-protection mechanisms for households.

The Government of the Islamic Republic of Afghanistan (GIRoA) has the opportunity to protect all Afghans from catastrophic health payments; the opportunity to ensure that all Afghans have access to healthcare services; and the opportunity to ensure that all Afghans can use healthcare services. This opportunity is called health insurance.

CONTEXT AND PROBLEM STATEMENT

Due to the unavailability of data, Afghanistan has not been included in multi-country studies looking at levels of catastrophic payments, however, these studies have found that catastrophic payments are positively correlated with the levels of out-of-pocket health spending as part of the total health expenditure (Xu et al., 2007; Xu et al., 2003). Additionally, they found that preconditions for catastrophic payments include three components: availability of health services requiring payment, low capacity to pay, and lack of health insurance (Xu et al., 2003). Afghanistan faces the challenge of all three preconditions.

Availability of Health Services Requiring Payment:

The Ministry of Public Health (MoPH) has made great strides in expanding the availability of health services across the country, especially in rural and remote areas, through the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). The coverage of the BPHS is estimated to be up to 65 percent of the population. By law, BPHS and EPHS services are fully subsidized by the government with the support of international donors. However, the 2011-12 National Health Accounts (NHA) found that 38 percent of household OOP expenditures were made at public facilities, about 30 percent for inpatient services and 11 percent for outpatient services. Furthermore, with the expansion and availability of public services, households continue to use and pay for private services. Of the 62 percent of OOP spending on private facilities, 36 percent is spent in Afghanistan and 26 percent is spent outside of the country. What does this tell us?

- Even with the increased coverage of public services, households continue to utilize private health services in and outside of the country.
- Afghans are paying for both public and private healthcare.

LOW CAPACITY TO PAY

Afghanistan is considered a low-income country with a GDP per capita of US702$ and a total health expenditure (THE) per capita of US56$, of which households pay for US$41 (GIRoA 2013). The poverty headcount is 36 percent, with more than half of the population unemployed, underemployed, or not gainfully employed (CSO, 2014).

LACK OF HEALTH INSURANCE

Afghanistan has had a short period of experiencing the benefits of social health insurance, but there has been no formal introduction of health insurance schemes since the 1970s. More recently, small private health insurance schemes have been made available by private hospitals in Kabul city; however, they are neither expansive nor available for the larger population.

WHY HEALTH INSURANCE?

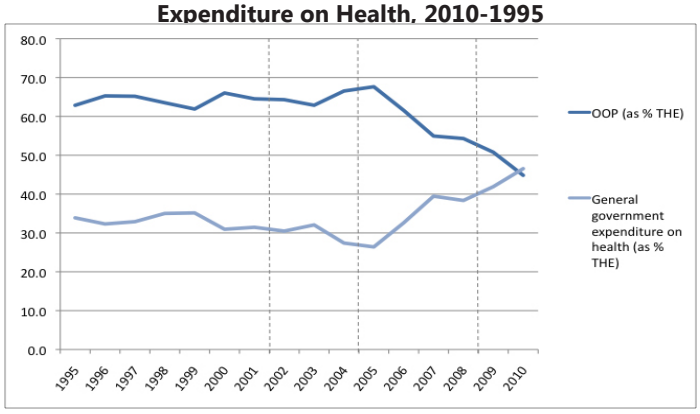
Globally, evidence shows that the larger the proportion of prepayment schemes, the smaller

the proportion of households facing catastrophic expenditures. Pooling risks across households is a way to transfer risk and funds from high-income groups to low-income groups and from low-risk individuals to high-risk individuals (Kewabata et al., 2002).

Health insurance increases access to health services for the poor who are enrolled and participate in a risk-pooling scheme. Countries have seen increases in utilization rates and decreases in household catastrophic expenditures. The introduction of social health insurance in Kyrgyzstan resulted in a decline of OOP expenditures from 7.1 percent to 4.9 percent over two years among the poorest quintile of the population. Thailand's Universal Health Coverage scheme resulted in an even more dramatic decrease in OOP expenditures, from 6.8 percent to 2.8 percent from 1996 to 2008 among the poorest quintile of households. Thailand also saw large increases in utilization of outpatient services (31%) and inpatient services (23%) (WHO, 2013).

Figure 1 shows trends from Vietnam throughout its health finance reform, starting since the late 1990s. Gray dotted lines highlight the years 2005 ,2002, and 2009. Each of these years was pivotal in the health financing reform of the country: in 2002, a Health Care Fund was established for the poor; in 2005, free care was provided for children under age six; and in 2009, the government of Vietnam passed a Social Health Insurance law. Over time, as the general government contribution to health increased as a percentage of THE, the percentage of household spending decreased (WHO, 2014).

Figure 1. Vietnam: OOP and General Government Expenditure on Health, 2010-1995



There are also economic and political benefits from introducing health insurance. Families who are protected from catastrophic health expenditures are in a more financially healthy situation and are able to save, work, spend, and contribute more to the economy in the longer term. Studies in India, China, and the United States have shown that households fear excessive healthcare bills and report bankruptcy due to the inability to pay (WHO, 2013).

Many health insurance schemes have been introduced nationally during significant political shifts that allow for sending strong statements to the public about social and health reforms that benefit households. This creates a legacy and social platform for the new government. Countries that have successfully introduced health insurance this way include Ghana, Georgia, and Thailand.

APPROACH MOVING FORWARD

The government of Afghanistan is in a strong position to decrease the health system' s reliance on OOP expenditures and develop the necessary policies, regulations, and institutional frameworks for creating an environment that is conducive to introducing health insurance mechanisms. As a diverse country, one system will not be the solution.

An innovative, comprehensive approach will be the best option for Afghanistan to target specific groups and ensure that all Afghans are included in risk-pooling schemes. Some options may include:

- National Health Insurance
- Social Health Insurance
- Community-based Health Insurance
- Health Equity Funds

Currently, the MoPH is undertaking a Health Insurance Feasibility Study that aims to identify a road map for the most feasible risk-pooling options in the country. This is the first step in laying the foundation for possible risk-pooling mechanisms for the country. But more needs to be done.

The high levels of OOP expenditures by Afghan households should not be ignored any longer.

POLICY RECOMMENDATIONS

- Assess the burden of catastrophic payments by households
- Create an enabling environment for health insurance in Afghanistan
- Consider a mix of risk-pooling mechanisms for protecting all Afghans within the regulatory and financial framework of the country
- Support the pilot implementation of a community-based health insurance program
- Introduce forms of pre-payment risk pooling schemes for hospital services

ENDNOTES

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