

The challenge of private insurance for public good

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A fundamental principle of WHO's work in health financing is the concept of universal coverage. This requires access for all people to appropriate promotive, preventive, curative and rehabilitative health care at an affordable cost. This is one requirement of health for all and is consistent with the principle of equity in access. The objective of universal coverage is also associated with equity in financing, whereby households contribute to financing the health system on the basis of their ability to pay.

The goal of universal coverage is accepted in most countries, though its realization is dependent on organizational mechanisms that allow financial contributions to the health system to be collected efficiently from different sources, that pool these contributions so that the risk of having to pay for health care is shared by all and not borne by each contributor individually, and that use these contributions to purchase or provide effective health interventions.

A variety of different arrangements can be observed in how funds are raised, pooled and used for health care, and it is this mix that determines the efficiency and equity of health systems. Unfortunately, in the majority of the poorest countries, a major — and sometimes the primary — financing mechanism is out-of-pocket payments at the point of service, which is the most inequitable system of financing health care (1).

The paper by Sekhri & Savedoff (pp. 127–134) provides some valuable information on the significant degree to which private health insurance exists in many countries. Although the label “private” is quite comprehensive and merits further scrutiny (2), the authors posit that it can be one stepping stone or critical component on the way to universal coverage. The potential of a such a trajectory is contingent on two key

issues: integration of equity considerations, and control/regulation capacity.

The paper appropriately stresses the risk that private health insurance simply caters to the rich and to people at low risk of being ill. Avoiding these inequitable tendencies requires at least two complements. The first is norms on “compulsion”: balanced population pools that allow for persons at low risk of illness to subsidize those requiring more health care. The second relates to the need for “targeting” poorer and disadvantaged populations in terms both of their inability to make contributions and the challenges related to their accessing of care.

The capacity for appropriate control and regulation is a central issue and extends beyond the paper's focus on how private insurance raises revenues. Certainly the mechanics of risk-rated or income-based contributions are important, but perhaps more important is the question of how the pooled funds are used to purchase services. The way providers are paid is a key determinant of the efficiency of any health financing system, and unregulated health insurance combined with unregulated fee-for-service payments of providers is a recipe for increasing costs and inefficiency (3).

These equity and regulatory challenges invoke a strong stewardship role for government with respect to insurance institutions (whether private, public or parastatal). Government must ensure they develop according to social needs and do not get so entrenched that they oppose universal coverage or efficient and equitable processes for revenue generation, pooling and purchasing of services. The challenge of managing this balance will have considerable bearing on the success and speed of the journey towards equitable and efficient systems of health financing. ■

1. Xu K, Evans DB, Kawabata K, Zeramdini K, Klavus K, Murray CJL. Understanding household catastrophic health expenditures: a multi-country analysis. *Lancet* 2003;362:111-7.
2. Preker AS, Carrin G, editors. *Health financing for poor people: resource mobilization and risk sharing*. Washington, DC: The World Bank; 2004.
3. Carrin G, Hanvoravongchai P. Provider payments and patient charges as policy tools for cost-containment: how successful are they in high-income countries? *Human Resources for Health* 2003;1:6.

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