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WHAT IS ESSENTIAL HEALTHCARE: LESSONS FROM HEALTH INSURANCE STUDIES FOR RESOURCE POOR COUNTRIES

Background

Resource poor countries face a double dilemma. They have limited resources to spend on health and too often much of these are spent inefficiently. Pakistan is facing a similar problem in that its public sector spends only 0.9% of the GDP on health and of this 56% goes towards hospital based care while only 19% - 5% of national health expenditures - pay for preventive services. On the other hand, over 60% spending on health is out of pocket by individuals and is availed from a large array of healthcare providers that include licensed (doctors, paramedics, hakims, homeopaths, nurses, etc.) and untrained informal providers. Additionally, in the national debate most national experts consider primary healthcare as the provision of basic medical care but not necessarily preventive services such as immunization, family planning, management of chronic diseases, etc. which is how the WHO defines primary healthcare.

Objectives

This brief explores evidence from two large health insurance experiments: The RAND Corporation Study and Oregon Medicaid Study, to understand how provision of medical care contributes to the health of communities. These lessons can be valuable in prioritizing health funding.

Key points from the- RAND Study

The first study is a decade long experiment conducted by the RAND Corporation in 6 sites of the United States of America between 1971and 1982. They enrolled 7,700 individuals under the age 65 years from 2,750 families. They proposed five plans in which were: completely free services, 5% free, 50% free, 75% or an HMO-styled group cooperative insurance where payments were capped at USD 1000 and poor families' payments were income related. Each family participated in the experiment for 3-5 years[1]. Health status was measured at the beginning and end of the enrolment. The study found that:

- Those with free healthcare made 1-2 more visits to the doctor than those who had to pay some part of their care. They also had 20% more hospitalizations. These differences were similar for different types of services such as medical, dental and mental care. Those in the HMO group had 39% fewer hospitalizations than those with free care.
- Those in cost-sharing plans spent less on healthcare by availing fewer services. Those with 5% support spent 30% less than those with free care. Reduced costs were because they did not initiate care seeking. Once they sought some care, more healthcare was needed and this additional care cost about the same across the groups.
- The main improvement with free care was seen in better control of hypertension, slightly better vision and dental care and prompt management of worrying symptoms such as chest pain, bleeding, loss of consciousness, shortness of breath and unexplained weight loss. Patients on free and co-insurance plans were also less worried about their health and time lost in seeking healthcare.
- The quality of care provided to all groups was similar.

SALIENT POINTS & RECOMMENDATIONS

- Medical spending has limited benefit for health of communities and yet 81% of public sector spending in Pakistan is on medical care.
- Private sector provides most of medical care and does it more cheaply than the public sector
- Public sector insurance can reduce the burden of catastrophic health spending by the poor
- The government should prioritize its scarce resources to providing preventive services that the private sector does not provide.
- The government has a role in setting and disseminating standards of medical services

- Paying their own healthcare costs did not change health behaviors of individuals, as seen by similar rates of obesity and smoking between all groups.
- Finally and most importantly, although the study was too short to measure changes in mortality, the scientists extrapolated that the effects of better blood pressure control likely would have led to 10% reduction in deaths from hypertension. Beyond this no effect on the health of the individuals was discovered.

Thus the key finding was that although those who received free care availed more health services but their **overall health status was relatively similar compared to those who bore their own health expenses**.

Key points from The Oregon Medicaid Study

In 2008 the state of Oregon in the United States of America sought to expand its state sponsored health insurance program for 30,000 individuals through a lottery of 90,000 persons on their waiting list. Selected individuals won the opportunity to enroll in the program provided they met eligibility requirements. This randomization by lottery represented the opportunity to scientists in a natural experiment. Baicker[2] et al presented the results of this experience at 2 years.

Oregon Medicaid provides insurance for low income, able bodied, adults who can't obtain health insurance through other means. Nearly all recipients are poor. Qualifying individuals received comprehensive medical benefits and prescription medicines for a USD 0-20 co-pay. A managed care organization provided the benefits.

6,387 lottery winners were allocated as the study group and 10,340 of those who had not won the lottery as controls. Baseline evaluation included a comprehensive questionnaire about health status, medicines being used, mental health, quality of life, happiness and blood tests. Key **medical** findings are:

- Screening for depression increased by 4%, but was not followed by the use of antidepressant medicines. However the overall rate of depression decreased by 9% among Medicaid recipients.

- Detection of hypertension increased by 16%, but treatment or control of hypertension or high cholesterol remained unchanged.
- Detection and treatment of diabetes increased by 5%, but the overall level of control of diabetes remained unchanged.
- The modeled 10 year risk of heart attack or stroke (using Framingham Risk Scores[3]) did not decrease among recipient of Medicaid.
- Overall, 8% people reported that their health related quality of life was better. This effect was largely confined to mental and not physical health.

Since this was a poor group to start with, key **financial** implications of healthcare were:

- Nearly 40% of the controls and 55% of Medicaid recipients had no out of pocket health spending
- Mean amount of healthcare spending for control subjects was USD 553 (1.3% of their annual income). This reduced by USD 215 for Medicaid recipients. It cost Medicaid around USD 6600 to yield this saving.
- Catastrophic health expenditures were faced by 5.5% of controls and 1% of Medicaid recipients.
- Medical care related debts were faced by 57% of controls and 43% of Medicaid recipients.
- 24% of controls but only 10% of Medicaid recipients reported having borrowed money to pay health bills.

Interpretation of findings and implications for Pakistan

These USA based studies have profound implications for Pakistan where funds available for healthcare are even more limited and providing health insurance or otherwise funding healthcare is a complex proposition with health rights and political implications.

These studies have two key findings: 1) **Most healthcare that is sought, does not improve health status.** 2) Patients seek at least some medical care on their own even when free care was available and that the **financial burden of routine care is relatively small**. However, **governments can and should reduce the burden of catastrophic medical care** which is a major concern for the poor. The question is: Given the limited resources available for health, should poor countries support provision of non-health promoting routine medical care.

In Pakistan, the private sector provides more than 80% of routine medical outpatient care[4]. The government spends around PKR 80-90 billion a year (USD 1 billion, 0.9% of the GDP or 3% of the budget)[5]. Of these 19% goes towards preventive services that improve health status in Pakistan. Much of the remaining buys medical care that may be desirable for the people, but hardly contributes towards improving their health. In fact even going forward, the Health Sector Strategies of at least 2 provinces: Punjab and Khyber Pakhtunkhwa, continue to have this medicalized approach. To our knowledge, there is no mechanism or even debate on how to prioritize health spending in Pakistan.

Furthermore, government health spending is inefficient. In the Oregon study, Medicaid spent USD 6600 to save its recipients USD 215. Although healthcare costs are less well defined in Pakistan, at least some services such as family planning cost 5-10 times higher in the public than in the private sector[6].

Given this evidence, one wonders what would be a good use for health funding available in the public sector. For decades calls for increasing health funding have gone unheeded. In a country, where polio remains endemic, where every third child does not routine childhood vaccines, where only 1 woman out of 8 has access to family planning and where rates of mothers and their newborn dying at childbirth are among the highest in the world; the government should reconsider allocating its scarce resources on what is essential, i.e. preventive services – on which it spends around 19% of its budget[5] – rather than on everything as it currently does[7].

Admittedly, it would be politically difficult to set these priorities. Opening new hospitals centers carries higher political weight than providing vaccines. Politicians often view health as a means to provide jobs – which increases their electability. Thus, having many medical clinics – even if they remain underutilized - is politically desirable. Such re-prioritization will require national debate.

Recommendations and Suggestions

- Government should prioritize what health services it will provide and leave others to the private sector.
- If more funding is available, it should provide services such as safe birthing, routine vaccinations and family planning before they are used for medical care
- The government must reduce its role in medical care and instead help develop – with support from professional bodies – standards of medical care that are shared with communities using mass communication and social mobilization approaches. We believe that these will improve quality of private care far more than government enforcement of standards that seldom work.

1 The RAND Corporation. The Health Insurance Experiment: A Classical RAND Study Speaks to the Current Health Care Reform Debate. 2006.

2 Baicker K, Taubman SL, Allen HL et al. The Oregon experiment--effects of Medicaid on clinical outcomes. N Engl J Med 2013;368:1713-1722.

Baicker K, Finkelstein AN. Effects of medicaid on clinical outcomes. N Engl J Med 2013;369:583.

3 Hemann BA, Bimson WF, Taylor AJ. The Framingham Risk Score: an appraisal of its benefits and limitations. Am Heart Hosp J. 2007 Spring; 5(2):91-6.

4 Pakistan Social and Living Measurements Survey 2011.

5 National Health Accounts 2010.

6 Abbas K, Khan AA, Khan A. Costs and Utilization of Public Sector Family Planning Services in Pakistan. *J PMA* 2013;63:S-33-S-39

7 Ahmed S, Khan AA, Khan A. Prioritized Targeting or Mile Wide, Inch Thin: Time to Strategize Public Sector Health Investments. *Pakistan Journal of Public Health* 2011;1:59-60.

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