Health Policy 121 (2017) 315–320

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

# Financial hardship on the path to Universal Health Coverage in the Gulf States

Riyadh Alshamsan[a,b,c,*], Hannah Leslie[b], Azeem Majeed[c], Margaret Kruk[b]

[a] King Saud bin Abdulaziz University for Health Sciences, Saudi Arabia
[b] Department of Global Health and Population, Harvard T.H. Chan School of Public Health, United States
[c] Department of Primary Care and Public Health, Imperial College London, United Kingdom

ARTICLE INFO

*Article history:*
Received 2 November 2016
Received in revised form
22 December 2016
Accepted 31 December 2016

*Keywords:*
Health care reform
Financial hardship
Health system financing

ABSTRACT

*Background:* Countries globally are pursuing universal health coverage to ensure better healthcare for their populations and prevent households from catastrophic expenditure. The countries of the Gulf Cooperation Council (GCC) have and continue to implement reforms to strengthen their health systems. A common theme between the countries is their pursuit of universal health coverage to provide access to necessary health care without exposing people to financial hardship.
*Methods:* Using nationally representative data from the Global Findex study, we sought to analyze the hardship faced by individuals from four high-income countries in the GCC. We estimated the weighted proportion of individuals borrowing for medical reasons and those who are not able to obtain emergency funds. We further examined variations in these outcomes by key socioeconomic factors.
*Results:* We found up to 11% of respondents borrowed money for medical purposes, double of that reported in other high-income countries. In contrast to affluent respondents, we found that respondents from deprived background were more likely to borrow money for medical purposes (adjusted odds ratio: 1.81, $P < 0.001$) and expected to fail in obtaining emergency funds (adjusted odds ratio: 4.03, $P < 0.001$).
*Conclusion:* In moving forward with their reforms, GCC countries should adopt a financing strategy that addresses the health needs of poorer groups in their pursuit of universal health coverage.

© 2017 Elsevier B.V. All rights reserved.

## 1. Introduction

There is a global push towards Universal Health Coverage (UHC). The relevance of it can be seen in its inclusion in the Sustainable Development Goals [1]. Many countries are developing and monitoring their efforts towards UHC, as UHC is viewed as one of the most important investments that governments can make and more importantly, because of its potential effect in addressing equity [2,3]. Indeed, the World Health Organization referred to UHC as "the single most powerful concept that public health has to offer" [4].

In the Arab world, one of the priorities that have been set in the region is accelerating the progress towards UHC [5]; however, the region has been criticized for not embracing the health equity movement observed in other parts of the world [6].

* Corresponding author at: College of Public Health and Health Informatics, King Saud bin Abdulaziz University for Health Sciences, P.O Box 86803, Riyadh 11632, Saudi Arabia.
*E-mail address:* riyadh.alshamsan@gmail.com (R. Alshamsan).

http://dx.doi.org/10.1016/j.healthpol.2016.12.012
0168-8510/© 2017 Elsevier B.V. All rights reserved.

**Table 1**
Selected country and health system indicators.

| | Bahrain | | Kuwait | | Saudi Arabia | | United Arab Emirates | |
|---|---|---|---|---|---|---|---|---|
| | 1990 | 2014 | 1990 | 2014 | 1990 | 2014 | 1990 | 2014 |
| Life expectancy at birth (years) | 73.0 | 77.0 | 72.0 | 75.0 | 69.0 | 74.0 | 72.0 | 77.0 |
| Infant mortality rate (per 1000 live births) | 20.0 | 6.0 | 15.0 | 8.0 | 36.0 | 13.0 | 14.0 | 6.0 |
| Human development index | 0.646 | 0.824 | 0.75 | 0.816 | 0.69 | 0.837 | 0.726 | 0.835 |
| Health expenditure per capita (PPPs) | 1505 ϒ | 2273 | 2164 ϒ | 2320 | 755 ϒ | 2466 | 2066 ϒ | 2405 |
| Health expenditure, total (% of GDP) | 4.1 ϒ | 5.0 | 3.7 ϒ | 3.0 | 2.9 ϒ | 4.7 | 2.6 ϒ | 3.6 |
| Out-of-pocket health expenditure (% of total expenditure on health) ϒ | 22.6 | 23.3 | 16.2 | 12.7 | 34.2 | 14.3 | 14.9 | 17.8 |
| Female literacy (percent) | 77 | 92* | 74 ϒ | 94 | 57 | 91 | 69 ₸ | 91 |

Source: World bank, United Nations Development Program.
₸ 1985 data, ϒ 1995 data, * 2010 data, T 2001 data.

The countries of the Gulf Cooperation Council (GCC) are a group of six high-income countries, four of which—Saudi Arabia, Kuwait, United Arab Emirates (UAE), and Bahrain—are included in our study. These countries have enjoyed rapid economic and developmental growth over the last few decades. For example, in Bahrain, the infant mortality rate decreased from 20 to 6 per 1000 live births between 1990 and 2014; similarly, the human development index improved from 0.646 in 1990 to 0.824 in 2014, and female literacy improved from 77 percent in 1990 to 92 percent in 2010 (Table 1). However, increased prevalence of non-communicable disease, their risk factors, and road traffic injuries are some of the common challenges facing the countries. For instance, road injuries and ischemic heart disease are the leading contributors to the disease burden in Saudi Arabia and the UAE [7,8]. Investment in health in these countries is relatively low compared to other high-income countries. The percentage of gross domestic product dedicated to health range from 3% in Kuwait to 5% in Bahrain in 2014 compared to an average of 10% in high-income OECD countries. Although healthcare expenditure per capita increased since 1990, it is still almost half of that reported in OECD countries. In addition, concerns over the quality of care and the availability of resources persist. For instance, in Saudi Arabia, shortcomings in patient safety and effectiveness of care have been reported in the hospital settings [9]. Similarly, shortcomings in the quality of care in the primary care setting in the region have also been documented [10]. Further, use of public health preventative measures is a continuing challenge. For example, recent findings from Saudi Arabia shows extremely low uptake of breast cancer screening [11].

In addition, the countries share a number of characteristics. The governments primarily provide health financing, and some non-nationals working in the private sector have access to health insurance through their employer or pay directly to the healthcare provider. For instance, in Saudi Arabia, although the government requires employers to insure their employees, this still does not include domestic workers. The main source of national income is oil and gas; with decreasing oil prices, sustaining government health expenditures is a challenge. Finally, expatriates make a large proportion of the population and coupled with high population growth, future demand on services is likely to increase.

In response, the governments in the four countries have engaged in reforms to expand health coverage to their populations and improve access to healthcare. The UAE has implemented tiered health insurance to expand access to nationals and expatriates in the country, in addition to increased privatization to enhance competition and improve quality [12]. Saudi Arabia implemented private health insurance primarily for employed residents and now plans to expand the coverage and expand the participation of the private sector [13]. Similarly, in Kuwait, plans to expand insurance coverage are underway [14].

UHC can lead to improved population health [15]. Accessing necessary health without financial hardship is one of the key components of UHC. Financial protection is not routinely monitored in high-income settings; however, given the recent global financial crisis, there is growing interest in monitoring financial hardship in these settings. For instance, early findings from the European region show that disadvantaged individuals are experiencing financial hardship [16]. Evidence from the GCC countries is lacking, but inequalities between the poor and rich in terms of financial hardship have been reported from upper-middle-income countries in the region [17]. In Tunisia, for instance, exposure to financial hardship was mainly concentrated amongst the poor [18], and some estimates found 12% of households had a catastrophic expenditure incident [19]. Similar estimates have also been reported in Lebanon [19]. As an extent of the measure of financial hardship, we aim to examine whether individuals living in the four countries have ever borrowed money for medical or health purposes and their perceived ability to access emergency funds. We further aim to assess any inequalities in the distribution of financial hardship drivers.

## 2. Methods

### 2.1. Sample

We analyzed data from the World Bank Global Findex study conducted in 2014 [20]. The survey was performed in 143 countries and asked individuals questions on how they save, borrow, and make payments. We used surveys conducted in Saudi Arabia, Kuwait, Bahrain, and the UAE. The countries have a similar economy, share similar social and political background, and have a substantial expatriate population. In each country, individuals were identified using a nationally representative list of phone numbers.

Download English Version:

https://daneshyari.com/en/article/5723488

Download Persian Version:

https://daneshyari.com/article/5723488

Daneshyari.com