MAKING PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE: COUNTRY POLICIES AND GLOBAL SUPPORT

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Improving health worldwide

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The goal of Universal Health Coverage

- Growing momentum behind Universal Health Coverage as a key global goal
  - World Health Report 2010 on universal coverage of health care
  - Declaration of the World Health Assembly urged member states to “aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity”
  - 2012 declaration by UN General Assembly
  - Strong lobby to have universal health coverage in post 2015 MDGs: endorsed by WHO DG at 2014 WHA

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Key issues

- What are implications for health systems design in low/middle income country context?
- What can be learnt from the experiences of countries who have made progress towards universal health coverage?
- What are priorities for countries on the path towards universal coverage?
- How can the international community better support countries?

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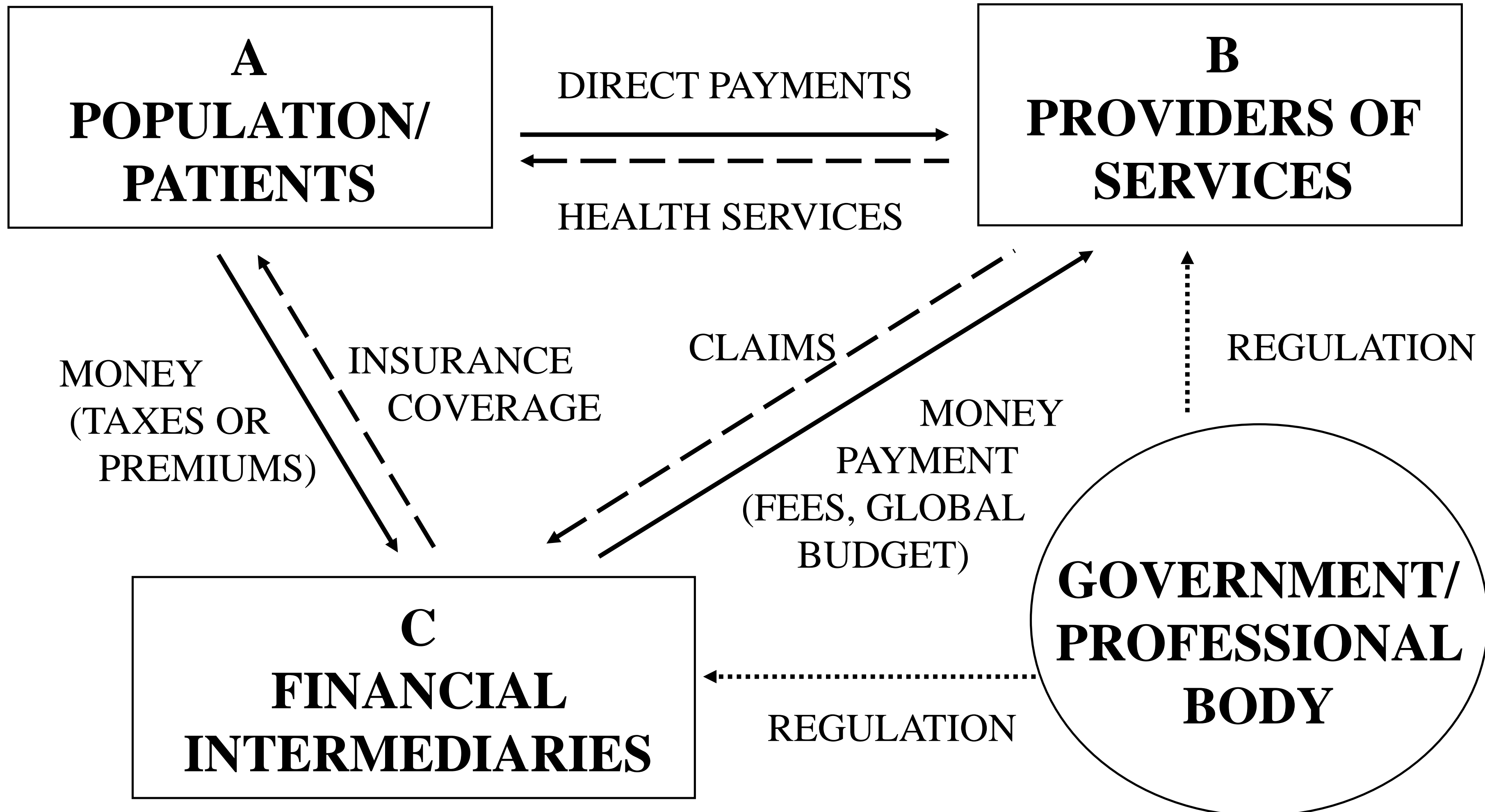
The health system



What is universal health coverage?

- ‘ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship’ (WHO)
- IE three related objectives:
  - equity in access to health services - those who need the services should get them, not only those who can pay for them
  - sufficient quality of health services - enough to improve the health of those receiving services
  - financial-risk protection - the cost of using care should not put people at risk of financial hardship.

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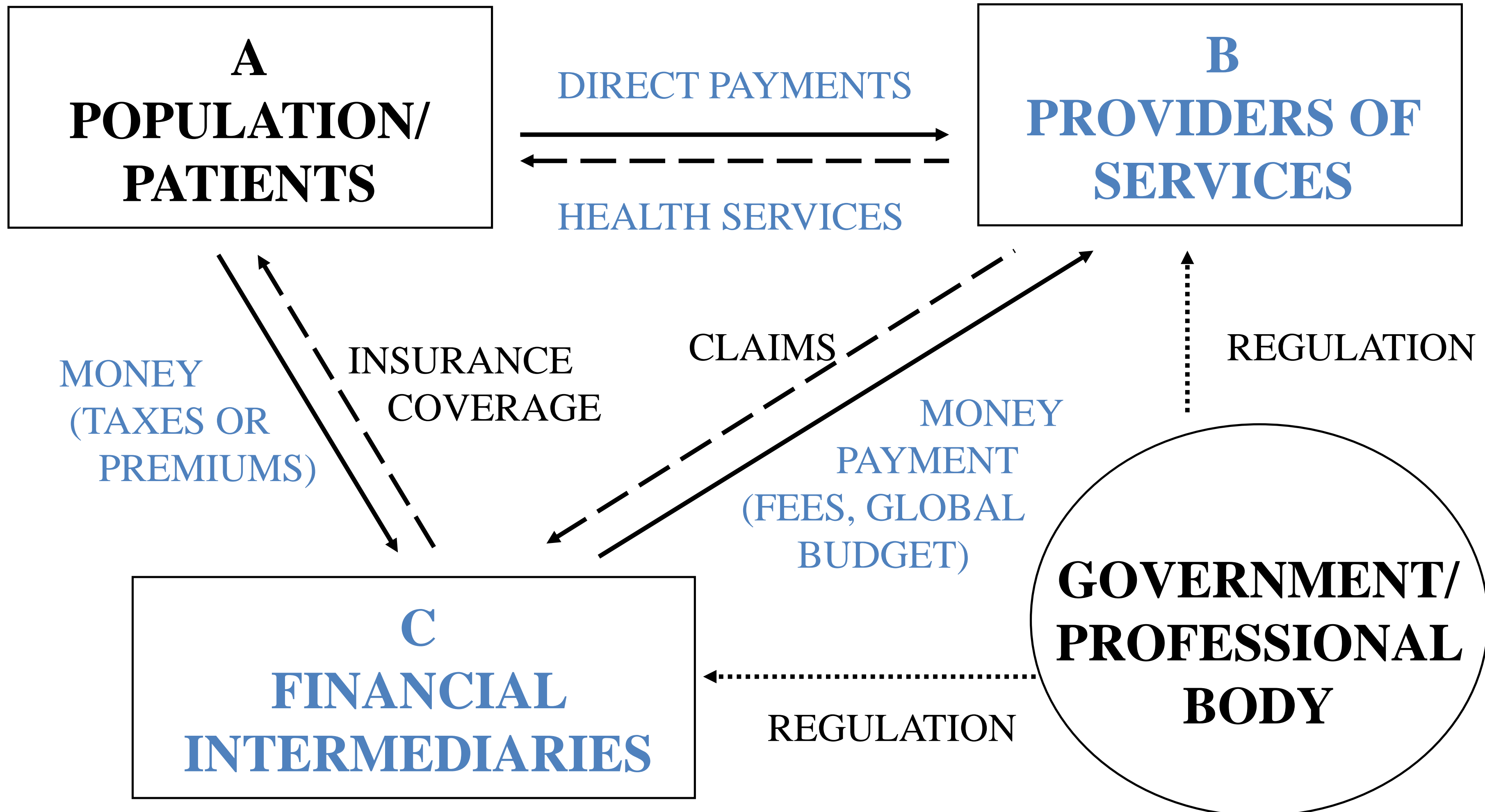
Key components of a system of universal coverage

1. Sources of finance
2. Financial intermediaries
3. Service providers

The health system



Sources of finance

- Mix of sources common:
  - general tax, payroll tax, other earmarked tax (Philippines, Thailand, Ghana)
  - plus Medical Savings Accounts (Singapore, China)
  - plus voluntary contributions, copayments (Korea, China, Philippines, Ghana)
- Core mandatory financing mechanism needed: social health insurance and/or general tax revenues

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UNIT

Mandatory pre-payment

Sources of finance

- Population in formal sector (public and private) relatively easy to cover
- Social health insurance usually the chosen main route
- Challenges are:
  - Low income workers and self employed in informal sector
  - Those outside the workforce: young, old, disabled, and unemployed

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Extending financial protection to the informal sector

- Via compulsory social health insurance
  - Social insurance scheme cross-subsidises low income worker premiums (Mexico)
  - Public funds subsidise compulsory health insurance premiums (all Thailand; targeted Korea, Singapore)
  - Premiums kept low by continuing some supply side subsidies (Colombia scheme for poor households)
- Via ‘voluntary’ insurance schemes (Ghana, Rwanda, Philippines, India - RSBY, China) eg through partial or full subsidies for premiums from tax funding
- Via universal entitlement and general tax funding to health services (Thailand)

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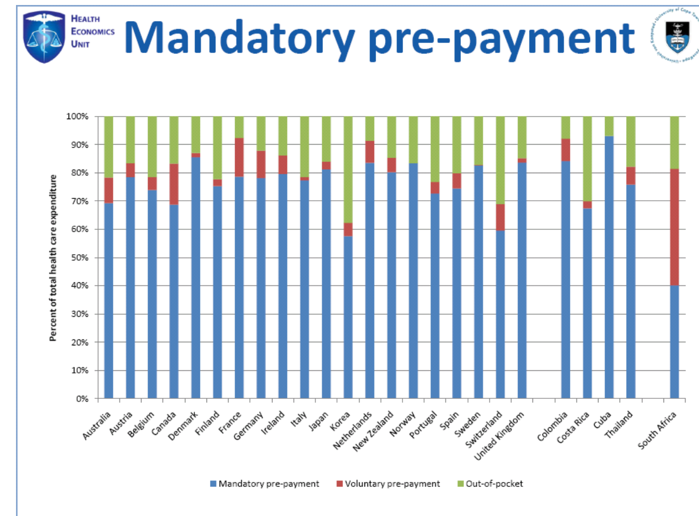
Extending financial protection to non working population

- Dependants (elderly, children) covered within compulsory social insurance schemes
- General tax used to pay for insurance card for poorest and sometimes elderly (Rwanda, Ghana)
- Via universal entitlement and general tax funding to health services

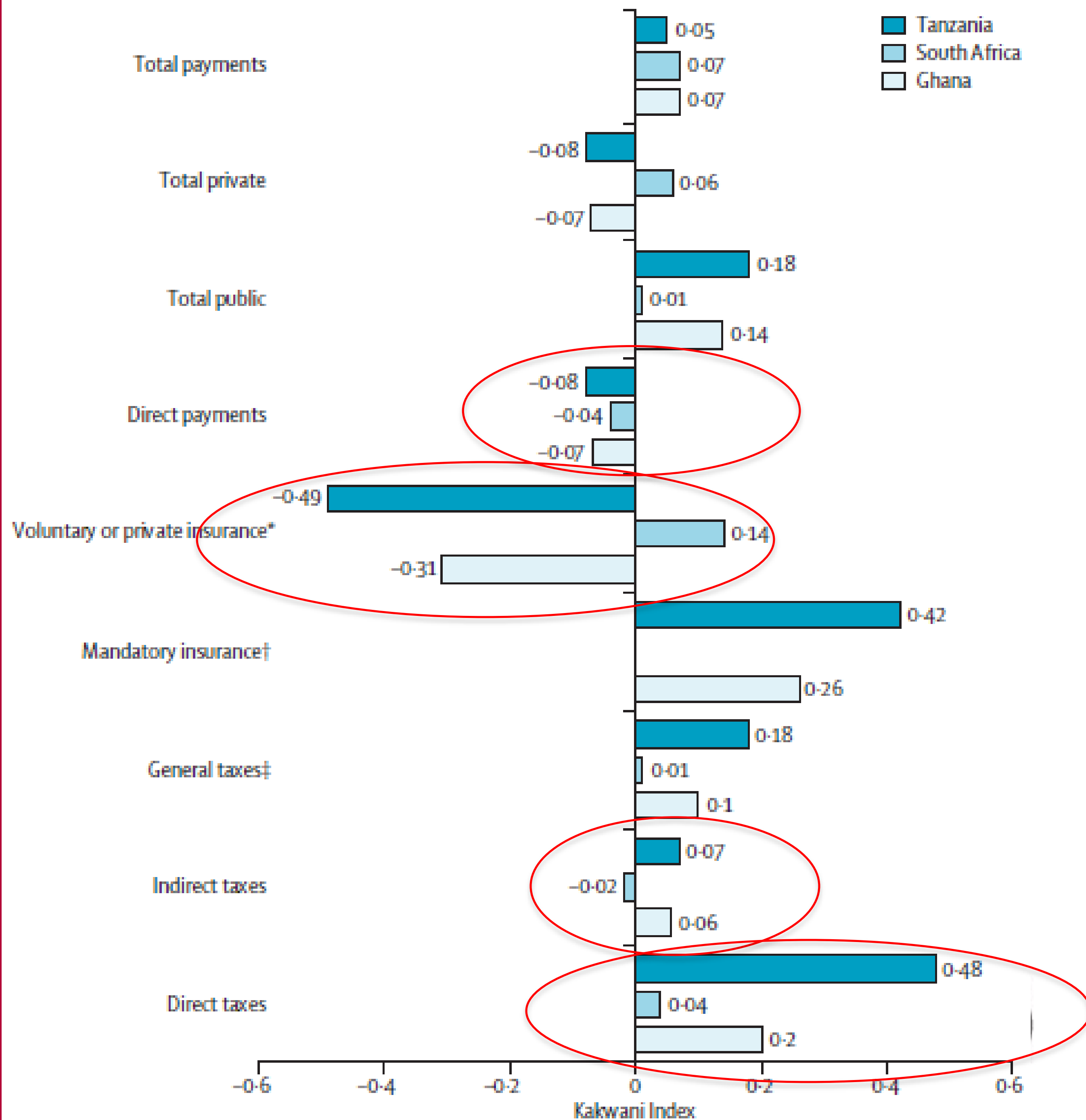
Role of co-payments

- Permits contribution rate to be set at a level that is viewed as affordable/acceptable (Korea, Philippines)
- May help to constrain demand in the early (or later) years of extension of coverage (Korea, Philippines)
- May be symbol of family responsibilities (Korea, Singapore)
- But regressive - weighs most heavily on poorer groups – and discourages use



Kakwani indices for financing sources Tanzania, South Africa, Ghana

(Mills et al 2012)



Financial intermediaries

- Historical legacy of segmented funds: should aim be single payer system? (Korea merged; Thailand not yet)
- Public or private agencies?
  - One or more public bodies (traditional for social health insurance)
  - Government regulates competing private insurers within social health insurance arrangements (eg Colombia, discussed in South Africa)
  - Government contracts with insurance companies to manage schemes (eg RSBY in India)

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Rashtriya Swasthya Bima Yojana (RSBY)

- Targeted at families below the poverty line
- Premium of max Rs750 (£7.50) per family: shared 75%/25% by central/local government; beneficiary family pays Rs 30 pa for registration
- Insurance companies bid for contract to insure families in each district
- Hospitalisation benefits up to ceiling of Rs 30,000 per family pa (max of 5 beneficiaries per family)
- Insurance company contracts a Third Party Administrator to manage the smart card system
- Currently 37m active smart cards (families)

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Service providers

- Public only or public and private? (Thailand SHI, India RSBY)
- Benefit package?
  - List what is included (eg RSBY) or excluded (eg Thailand)?
  - Ensuring continuum across primary and hospital care problematic
- Payment method (avoid fee for service unless within strong global budget)
- Encourage strong primary care role:
  - primary care gatekeeper (Korea)
  - bypass fees (Thailand)
  - primary care budget holder (Thailand sort of)
- Extend services first to poorer areas (eg Brazil Family Health Programme)

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Development of Thai health system from 1970s

(Balabanova et al 2013)

Figure 7.6 Under-5 mortality, development of human resources and infrastructure, and financial protection, 1970–2010

Mortality per 1000 live births

100
80
60
40
20
0

-4.2/year
-3.3/year
-2.2/year
-1.3/year
-1.0/year
-0.8/year

Low-income card scheme
Civil Servant medical benefit scheme
Community health funds
Social Security Act 1991
Voluntary health card scheme
Universal coverage scheme

Mandatory rural service for doctors
Village health volunteers
Scaling up of district hospitals
Introduction of technical nurse curriculum

Asian economic crisis

National economic and social development plans
3rd 4th 5th 6th 7th 8th 9th 10th

1970 1975 1980 1985 1990 1995 2000 2005

Human and infrastructure resources
Financial risk protection

Thai Universal Health Coverage arrangements

- Universal coverage via 3 schemes:
  - Social Health Insurance for formal sector employees (with public subsidy)
  - Non contributory scheme (so tax funded) for civil servants
  - Universal coverage scheme (from 2001) for rest of population, general tax funded
- Gradual progress in harmonising benefit package, payment methods, service provision arrangements
- Performance:
  - relatively equitable: pro poor benefits; financing becoming less regressive; reduction in catastrophic payments
  - inequities remain between schemes in benefit package and level of expenditure
  - Good cost containment in SHI and UC

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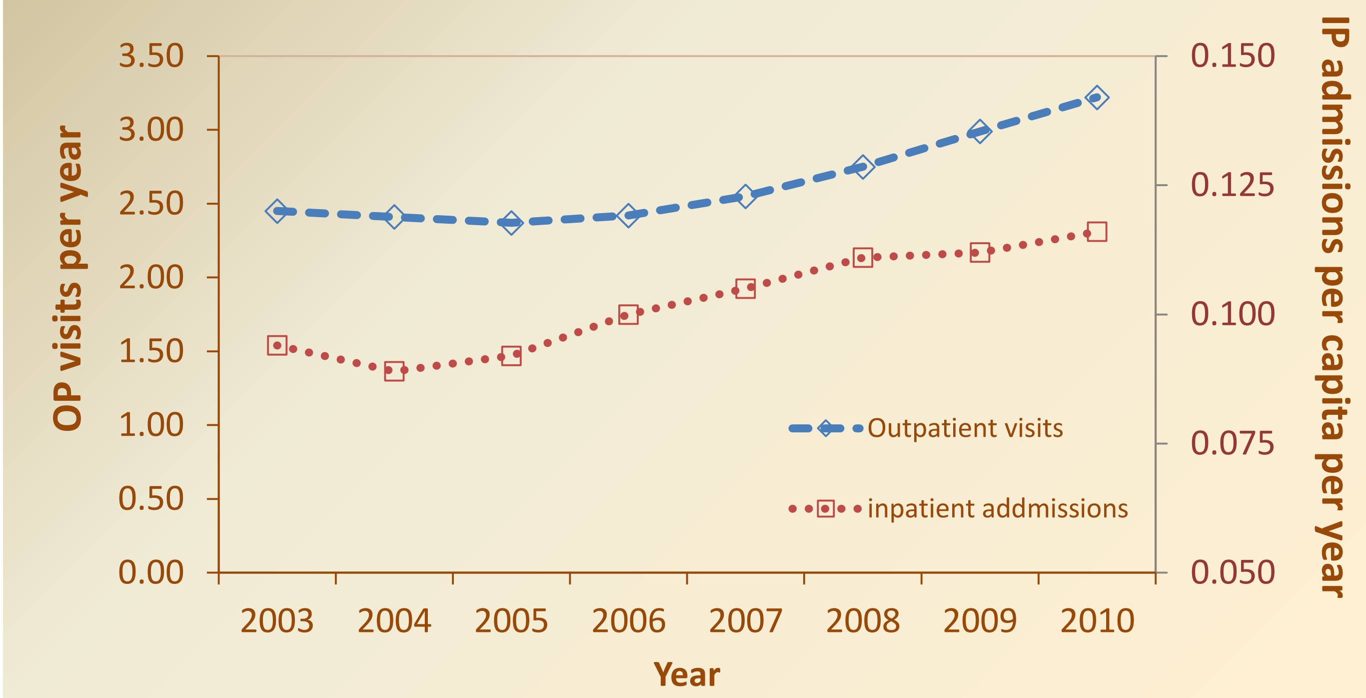
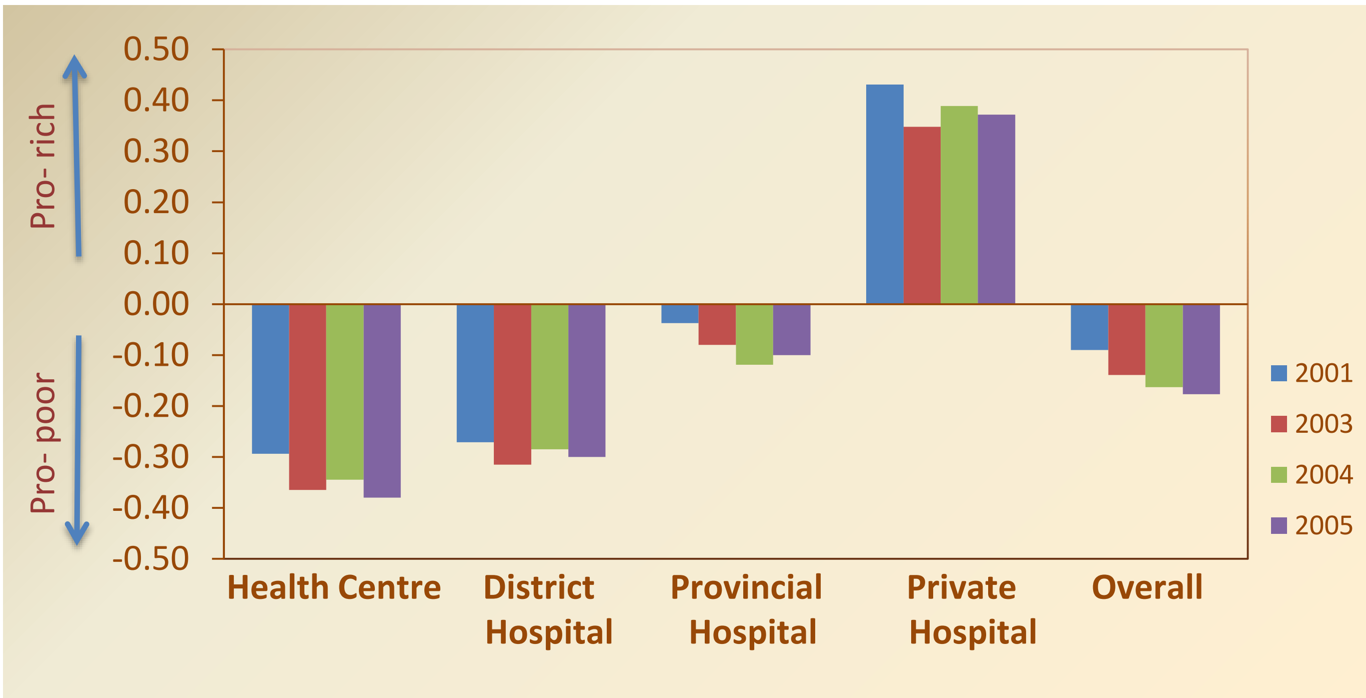
Increased service use



Improved equity in service use

(ambulatory care, concentration indices)



Reduction in catastrophic health expenditure by wealth quintile

% of households in each quintile Incurring catastrophic health expenditure %

8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0

Q1 (Poorest)
Q5 (Richest)
All

6.8%
6.1%
4.7%
2.9%

1996
1998
2000
2002
2004
2006
2007
2008
2009

Year

Catastrophic health expenditure refers to household spending on health care >10% of total household consumption expenditure

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Key concerns with UHC

- Concern on rising costs: increased utilisation, expansion of benefit package (eg renal dialysis in Thailand)
- Lack of evidence on link between increased coverage and health outcomes
- Lack of evidence on relationship of performance to numerous design options
- What is best way to make progress in low income countries?

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Learning lessons to apply elsewhere

- ‘Technical’ assessment - evaluation of performance and explaining it by reference to design features
- Performance criteria: eg
  - Efficiency (allocative, technical)
  - Equity of financing (who pays?)
  - Equity of access to care (who benefits?)
  - Extent of catastrophic payments
  - Responsiveness

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Technical lessons

- Critical to put in place early the necessary elements:
  - Combination of financing sources
  - Strong purchasing role encompassing both public and private providers and including emphasis on health promotion and prevention
  - Payment systems with appropriate incentives for cost containment and quality of care
  - Strong primary care and ‘district’ level infrastructure with good geographical access

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Learning lessons to apply elsewhere

- ‘Technical’ assessment - evaluation of performance and explaining it by reference to design features
- ‘Institutional’ assessment: what political, economic, social and cultural institutions enable governments to pursue universal health coverage?

Key institutional aspects

- Existence of a civil service which has the capability to implement programmes and policies: eg merit based recruitment and retention, hierarchical structures with impersonal application of rules
- Existence of institutions which allow the voice of the less-well-off to be expressed in policy debates and decisions
- Including majority of population within the universal coverage arrangements (ensuring better off groups influence arrangements via ‘voice’ not ‘exit’)
- Encouraging the social solidarity needed for merger of funds and universalist approaches (contrast of Thailand and South Africa)

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How can international community better support countries?

- Address funding patterns of DAH
- Improve advice given to countries
- Support development of local capacity to generate knowledge and advise local stakeholders

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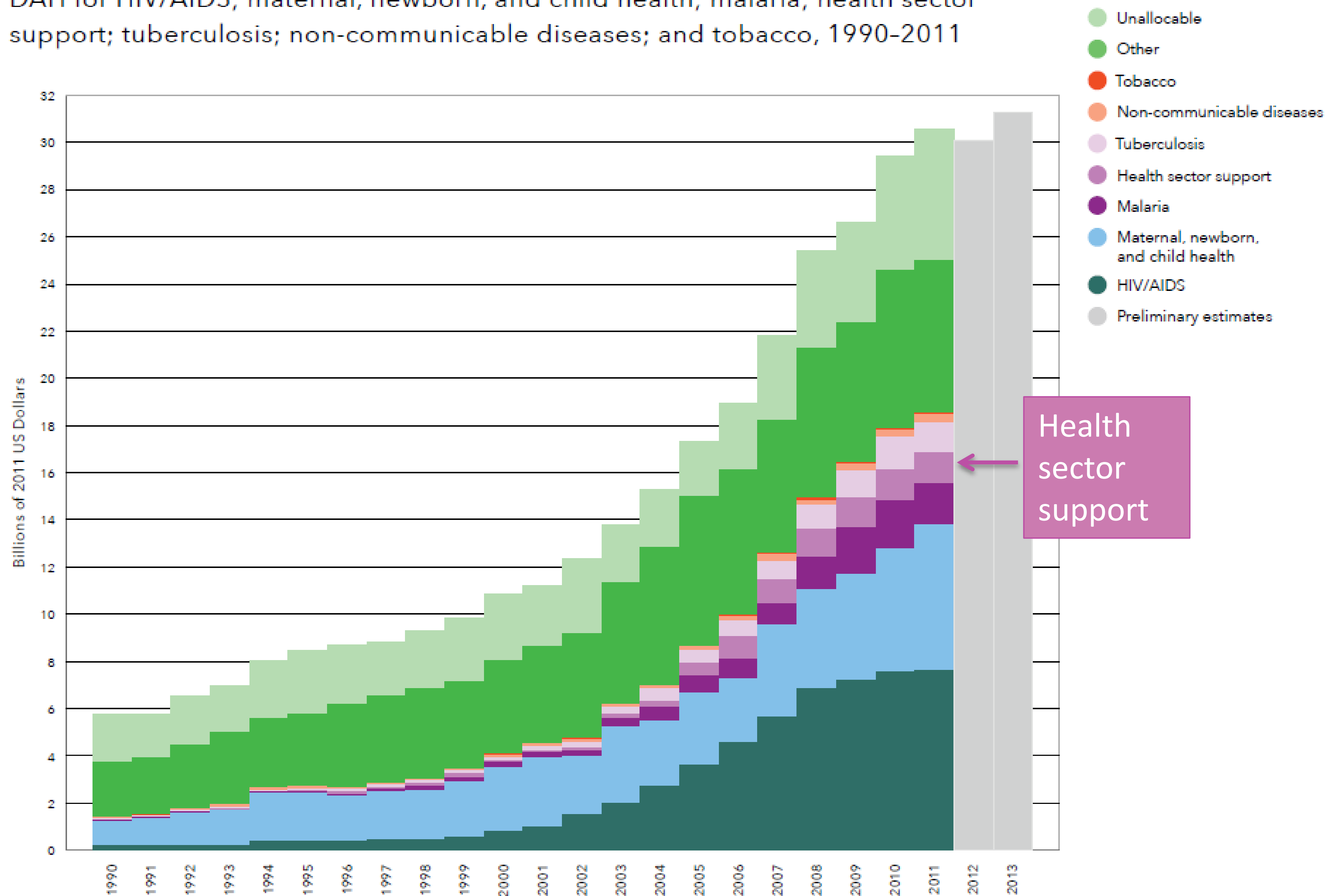

Source: IHME DAH database

Funding patterns

- Insufficient support for cross cutting systems issues – eg primary care and district infrastructure; general training programmes; drug supply systems
- Insufficient attention to long term development of sustainable financing system
- Multiple, uncoordinated channels of funding primarily targeting diseases and specific programmes hamper health systems development

    ‘narrow disease focus and lack of coordination with national governments call into question the efficiency of funding and sustainability of Global Fund investments in HRH and their effectiveness in strengthening recipient countries’ health systems’ (HPP 2014:29:986-97)

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Advice

- Insufficient understanding of transferability of health systems design features from one country to another – tendency to draw on rich world's experience
- Insufficient understanding of how limitations of government capacity, especially in low income countries, affect ability to implement programmes
- Inadequate attention to institutional aspects of universal health coverage

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Development of local capacity

- Provide greater funding for comparative health systems research and analysis
- Support capacity building in country universities, research institutes and health agencies
- Encourage countries to begin to fund their own knowledge generation and analytical capacity

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