



Universal Health Coverage from the bottom-up: How it is being done in 25 countries and how researchers can help

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Introduction

UNICO activities

- 27 case studies of programs that expand health coverage from the bottom-up (in 25 countries)
- Develop tool to help countries identify their strengths and weaknesses in the implementation of UHC

Objectives of the case studies

- Make WB dialogue on UHC more systematic in our countries of engagement
- Identify global trends in UHC implementation
- Identify the operational challenges facing policy-makers

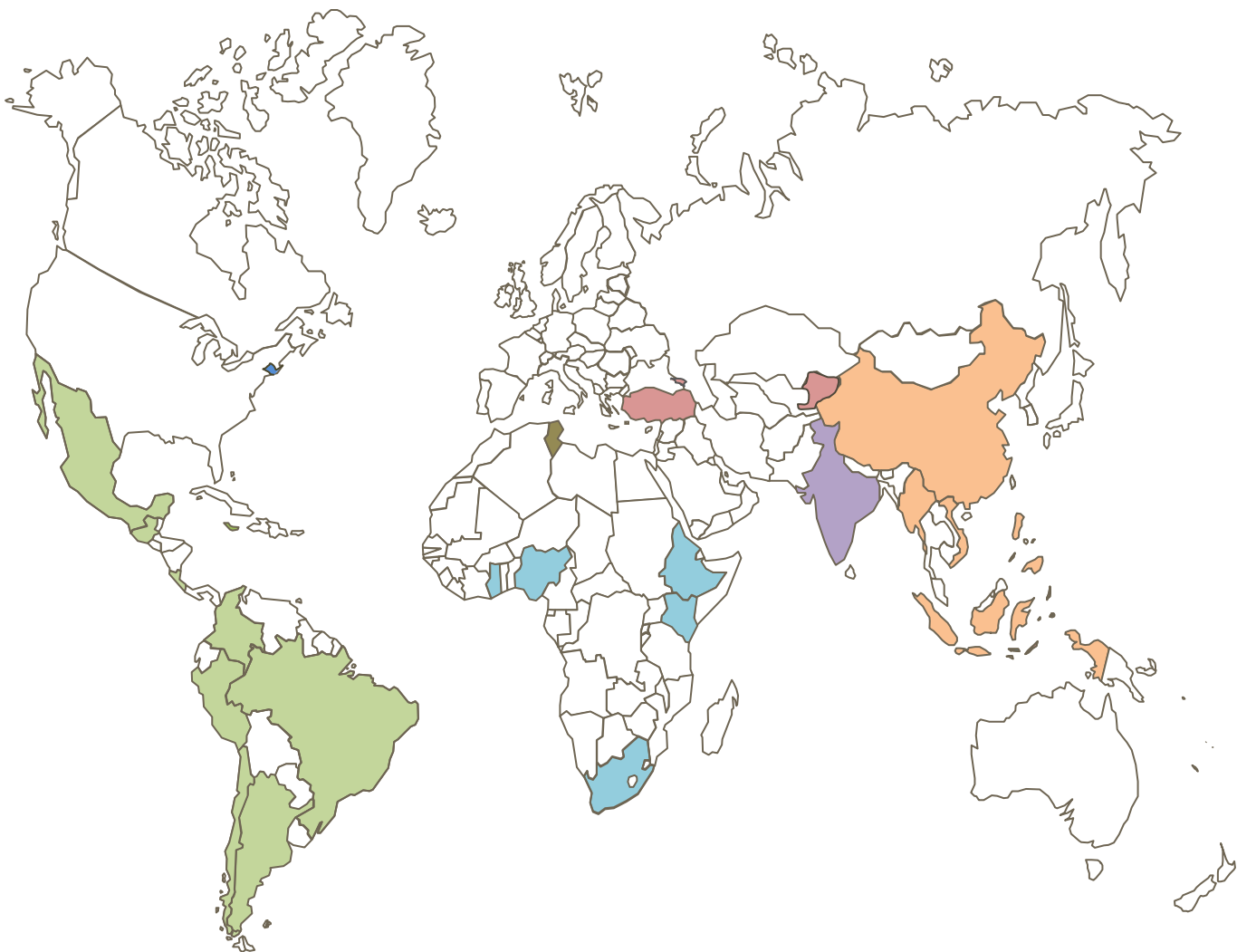


Themes covered by case studies

1. Primary care pillar – strengths and new challenges
 2. Financing – Revenue collection, pooling, allocation, purchasing
 - 3. Managing Benefit packages**
 - 4. Managing inclusion of the poor and vulnerable**
 - 5. Nudging reforms to the provision of services**
- (this presentation will deal only with 3, 4 and 5)



25 UNICO Countries



- Argentina
- Brazil
- Chile
- China
- Colombia
- Costa Rica
- Ethiopia
- Georgia
- Ghana
- Guatemala
- India
- Indonesia
- Jamaica
- Kenya
- Kyrgyz Republic
- Mexico
- Nigeria
- Peru
- Philippines
- South Africa
- Thailand
- Tunisia
- Turkey
- USA- Massachusetts
- Vietnam



Methodology

- Not an attempt to establish impact/identify best practice
- Health systems/Public sector management (“Science of Delivery”)
- Focus on one health coverage program per country – policy flow rather than policy stock
- “Sample” – as many countries as possible within the universe of countries which in the last decade made significant efforts to expand coverage in inclusive ways.
- No attempt to emphasize a “model”.
- A common questionnaire: 9 modules, 329 questions
- Answers by client-facing Bank staff (case-study authors)
- Quantitative results are simply orders of magnitude



Findings and implications for research

Findings

- Despite the diversity of “models”, countries implementing UHC are converging to a common set of operational policies
- Rights and Accountability are at the center of this convergence

Implications for operational research

- Focus on the areas of policy convergence (to be responsive to policy makers)
- Focus on strengthening accountability
- Be aware that multiple objectives are present in each program



The new convergence

- Political commitment to UHC (23/27)
- Revenue – expansion financed by general taxes (24/27)
- Purchasing – expansion purchases outputs, not inputs (24/27)
- Primary care: moving beyond “strong MDG interventions” (23/27)
- Benefits package is made explicit (25/27)
- Programs require enrolment (22/27)
- Programs nudge reform of public providers (20/27)
- Little monitoring of health outcomes – only 12/27!



Managing Benefit Packages

Description and Design:

- BPs are increasingly: explicit, positive lists, of health conditions (but not ICD10 codes)
- Design of “Basic Package” based on cost-effectiveness
- Beyond basic package based on “affordability” and guesswork

What is covered?

- All include immunization and child and maternity
- Few LICs but most MICs cover primary outpatient care (OPC) – including pharmacy, lab, basic radiology and specialist consultation. Also high-end diagnostic imaging
- Inpatient care coverage (IPC) slightly less common than OPC; also grows with income



Managing benefits (continued)

Cost sharing

- Rare in maternity and public health
- Required in a third of IPC and in half of OPC (especially for drugs).

Enforcement of the right to a benefit package

- Big effort to publicize rules for BP, especially in MICs
- Complaints: Areas of strength...process of complaint, use of local languages, existence of redress, use of NGOs, no fees. Areas of weakness...process of response, independence of adjudicator, use of internet, publication of complaint statistics, systematic learning by agency from complaints



BP --Policy makers struggle with...

- The tension of using explicit BP with a fixed tax-financed budget.
- Prioritization. The question is not what to cover first. The real question is what to cover second.
- Covering outpatient care (especially drugs) or inpatient care?
- Reinvent systems to manage the BP? – costing, pricing, claim management, medical audits, financial audits, prior authorization, clinical pathways



Managing inclusion – “from the bottom-up”

Mechanisms to manage inclusion:

- Eligibility criteria – as defined in the statement of objectives of the HCP
- Identification system of beneficiaries – as it is determined in practice
- Enrolment of beneficiaries
- Self-selection



Eligibility – per programs' objectives

- Multiple target populations
- Most programs aim for the poor, but few are only for the poor
- Most programs aiming for the poor are also for the near-poor
- “Vulnerable” often mothers and children, rural, specific diseases; the elderly
- Risk of medical impoverishment increasingly recognized
- Special historical categories. Hot political groups.



Identification and Systems to identify the poor

Criteria utilized: Demographic 40%, Geography 52%, Proxy-means test 59%, Local Government procedures 52%. (Categories overlap)

Systems to identify the poor (SIPs)

- o Most countries have a SIP (18/25 countries).
- o 20 programs are in countries w/SIP, however only 9 programs use the SIP. Why?
 - Politics: Focus not really the poor; Inter-ministerial or central/local government politics
 - Universality: Target geographically and make them locally universal
 - Logistics: out of date, has data on households but not on individuals), poor quality,
 - SIPs don't recognize Medical need: Demographic, illness do.
 - Medical risk: monetary poverty is inadequate indicator



Enrollment

Most programs require enrolment. Why?

- Not a signal of health insurance
- Not an instrument for revenue collection – rare fees

Hypotheses:

1. Enrolment is a way of prioritizing
2. Enrolment is a contract, it strengthens the entitlement of users to benefits -- accountability
3. Enrolment provides incentives for outreach
 - Enrolment is done by HCP, providers, insurers, local governments
 - Enrollers face financial incentives to enroll. Key to get the incentives right.



Self-selection as a tool for targeting

- Rich and the poor rarely use the same primary or secondary facilities. Integrated use is only common for tertiary
- Even as they access the same tertiary hospital, the poor often have significantly less access to high tech services
- In almost half the countries, social security systems run their own segregated hospitals



What are policy-makers struggling with?

- Politics – interagency; central/local; SIPs
- Developing voluntary contributory schemes for the non-poor in the informal sector (a red herring?)
- Who to prioritize? Often clear who goes first, but who goes second?
- How to identify your desired beneficiaries?
- Improving quality loses self-targeting
- Politics. Universal vs. Targeted – clear in theory, much less clear in practice



Reforms to the provision of services

Reforming provision is a key benefit of 20 of the 27 programs

- Most link new financing to greater accountability
- Most introduce accreditation, a few choice and competition
- Almost all focus on improving public delivery:
 - o Generalized use of signaling with output-related payments
 - o Output payments are a small complement to input payments – no transition from supply to demand subsidies
 - o Flexible cash for hospital and clinic managers
 - o Incentives for civil servants or new cadres of health workers
- Few programs/countries report on health indicators



What are policy makers struggling with?

- The politics of quality by accreditation
- The politics of autonomy of third party purchasers
- Reinventing purchasing systems for public providers
- Struggling to gain flexibility within rigid fiduciary rules
- Why are they not reporting on health indicators?



Conclusions

- Despite diversity of models, there is a new convergence in operational policies
- Accountability is key for the successful implementation of UHC:
 - Empowering users with an explicit BP to demand the promised benefits
 - Using technical criteria to expand BP
 - Using enrolment to empower users, to strengthen outreach, to follow bottom-up path to UHC
 - Introducing output related payments, quality conditions, choice to extract greater accountability from providers
 - Insufficiently in use for the reporting of health indicators
 - Healthy tensions: Users/providers/purchasers/local & central Government; MoH/MoF. Tensions designed to improve bottom-up inclusion, efficiency, fiscal sustainability



Benefits: Researchers could...

- Evaluate the impact of various accountability systems. How best to empower users to obtain the benefits promised to them?
- Multi-country comparisons of BP to identify use of recommended best practices
- Investigate the transportability of existing systems to manage BPs. How to purchase/adapt existing systems? Adoption of ICD10 codes would help?
- Compare lessons from different paths of expansion of BP – impact on BOP, impoverishment, fraud, politics.



Managing inclusion: Researchers could...

- Seek lessons from history about the path to “universal coverage” and integrated schemes
- Look for evidence about successful contributory efforts to expand coverage of the non-poor in the informal sector
- Develop incentives for the enrolment agent in ways that generate outreach
- Look for lessons on how to manage the double cost of improving public hospitals: (i) the investment; (ii) the loss of self-selection as a targeting tool as the better off begin to use the public services



Reforming Provision - Researchers could...

- Look for evidence:
 - Does accreditation “work” to improve quality?
 - Does “choice and competition” work?
 - What set-ups work best for third-party purchasers?
- Transfer and adaptation of technology on “payment systems for public providers” (with supply subsidies and limited autonomy). Operators need to learn about elasticity, threshold values for impact, minimum operational autonomy.
- Lessons from countries that have transitioned to more flexible fiduciary systems –and management of risk of “fraud”
- Successful human resource practices in reformed environments