Universal Health Coverage: Concepts and Principles

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Health Systems Financing

Outline

1. **Universal Coverage: definitions and the state of the world**
2. **Health financing systems for Universal Coverage**
3. **The way forward**

Formal Definition of Universal Coverage

World Health Assembly Resolution 58.33, 2005:

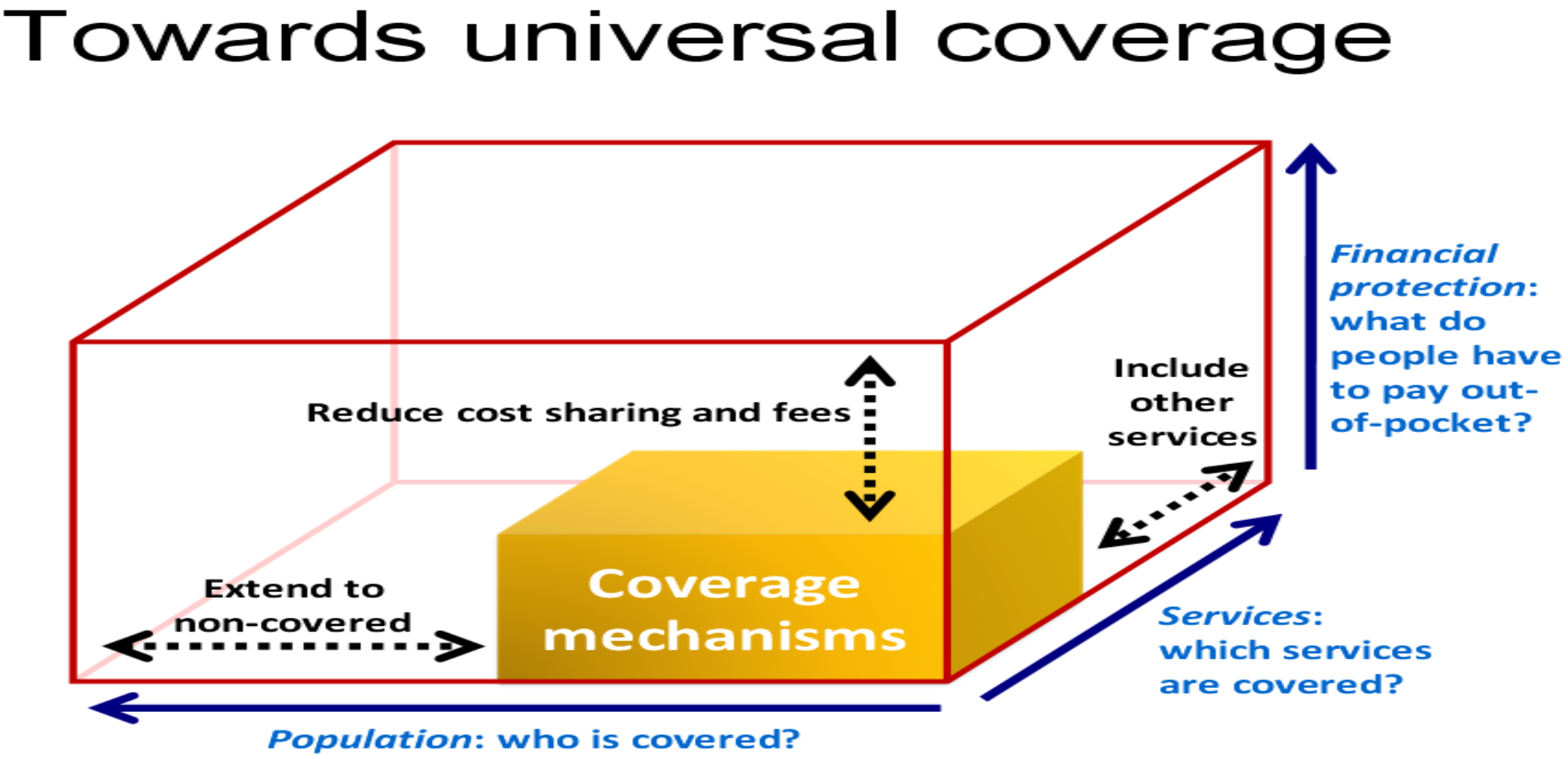
Urged countries to develop health financing systems to:

- ☑ **Ensure all people have access to needed services**
- ☑ **Without the risk of financial ruin linked to paying for care**

Defined this as achieving Universal Coverage: coverage with health services; with financial risk protection; for all

Reconfirmed in WHA64.9 of 2011 and many Regional Committee Resolutions

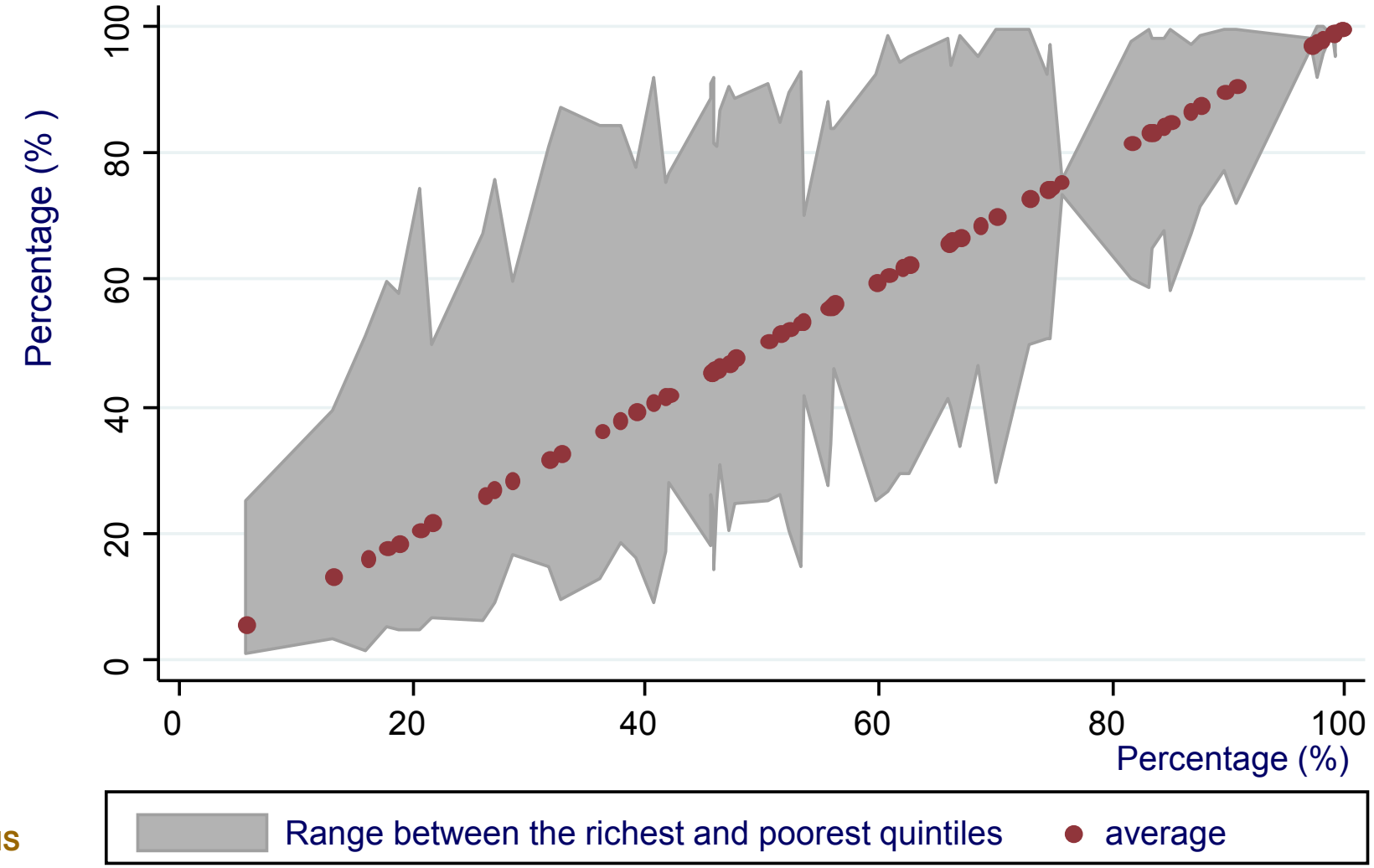
The Three Dimensions (policy choices) of Universal Coverage



Universal Health Coverage

1. Health services: prevention, promotion, treatment, rehabilitation – not just treatment
2. Coverage with services of good quality
3. Universal Health Coverage (UHC) for MDG and sustainable development dialogue
4. UHC is a destination:
   - **New technologies**
   - **Increasing costs**
   - **Increasing population or changing in population age structure**
   - **Changing disease patterns**

Births Attended by Skilled Health Personnel in 64 Developing Countries



Data from DHS

World Health Organization

Coverage in Caribbean Countries (not just Caricom)

1. **Skilled birth attendants: all >90% except**

   Belize: 88%

   Guyana: 87%

   Surinam: 87%

   Haiti: 26%

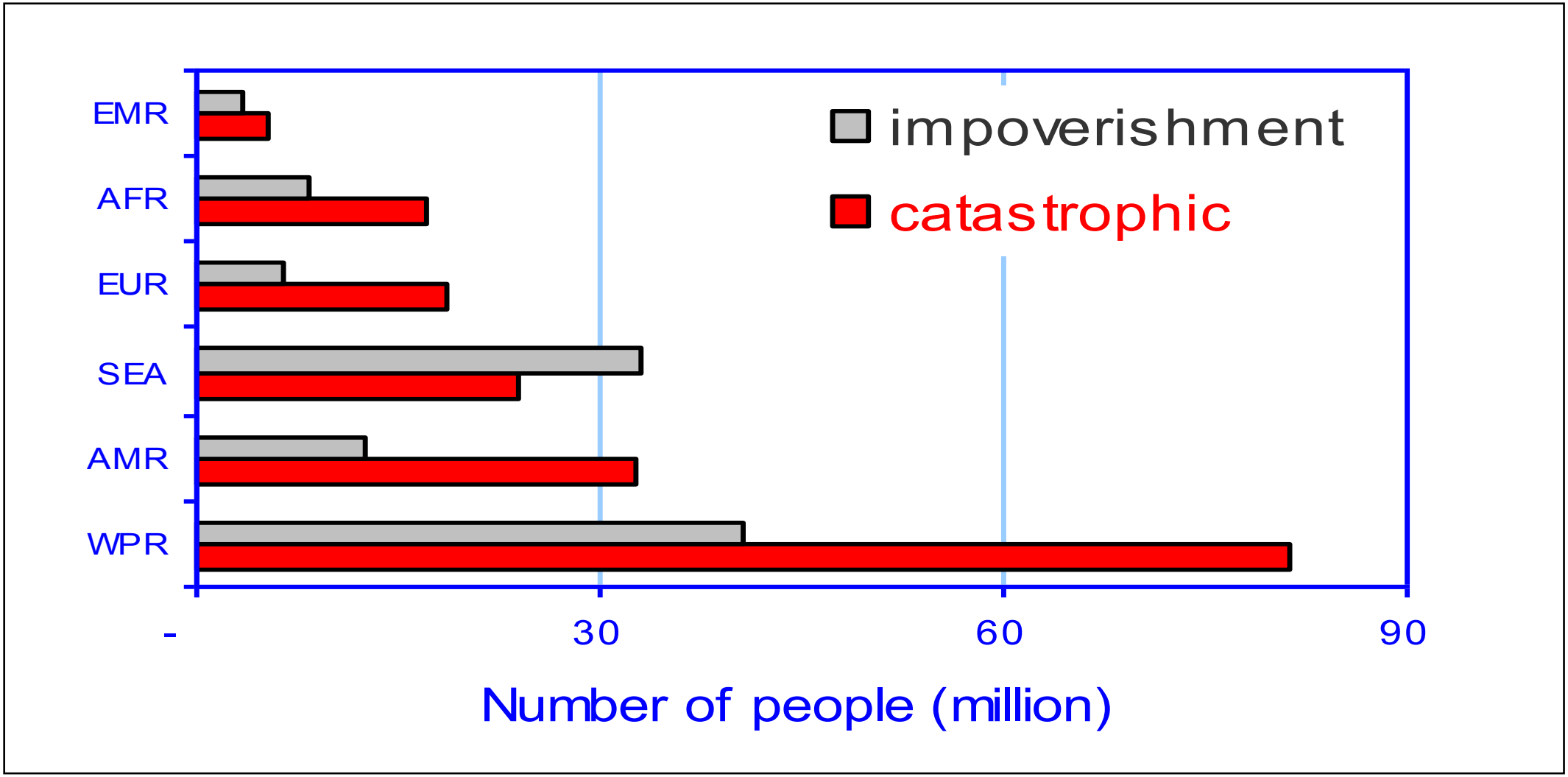
2. **Measles Immunization: all >90% except**

   Dominican Republic: 79%

   Haiti: 59%

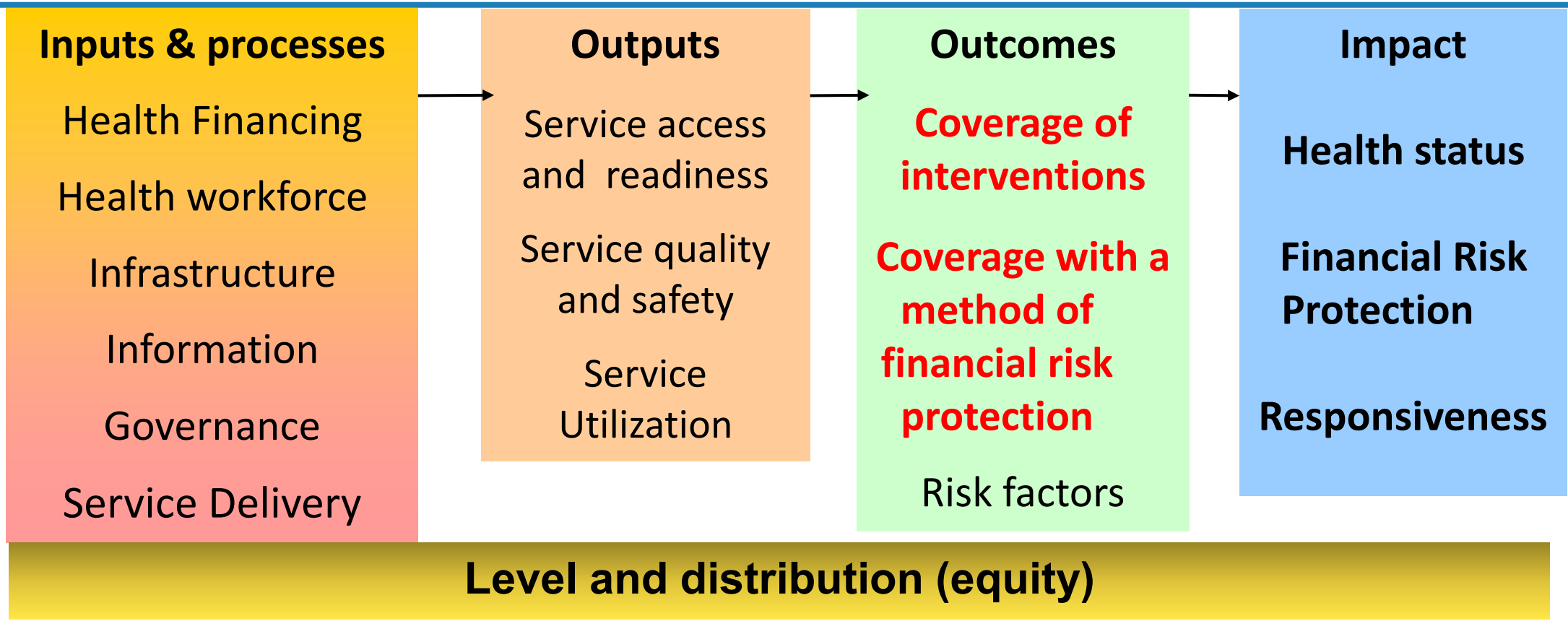
3. **NCD service coverage including prevention and promotion?**

Millions more suffer financially when they use health services



World Health Organization

Monitoring and evaluation results chain

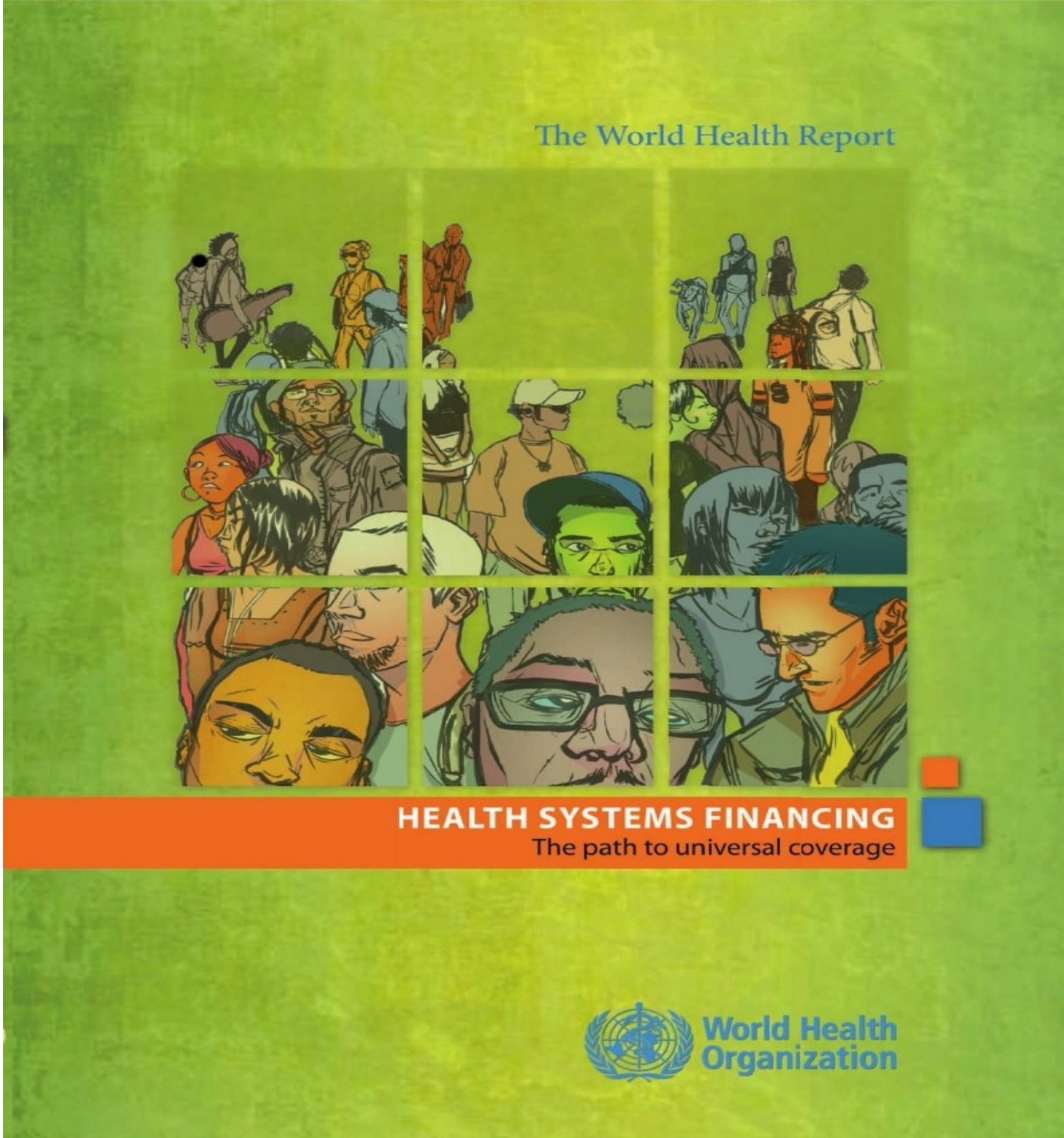


Social Determinants

Outline

1. Universal Coverage: definitions and the state of the world
2. Health financing systems for UHC
3. The way forward

The World Health Report 2010



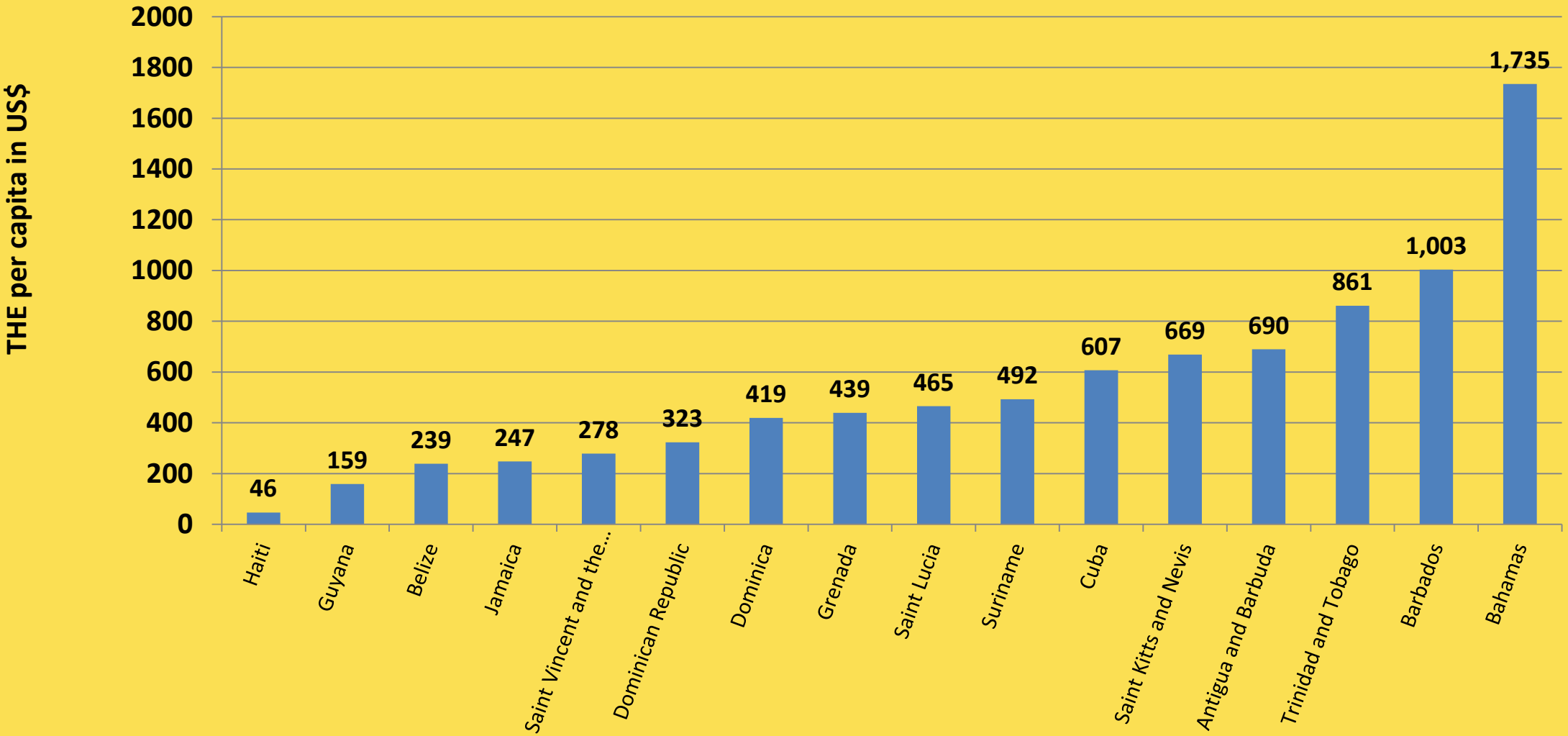
Three Fundamental Health Financing Challenges for Achieving Universal Coverage

1. *Raise sufficient funds for health;*
2. *Ensure/maintain financial risk protection – i.e. ensure that financial barriers do not prevent people using needed health services nor lead to financial ruin when using them;*
3. *Minimize inefficiency and inequity in using resources, and to assure transparency and accountability.*

1: *Insufficient funds: low-income countries*

- **A set of essential health services focusing on the Millennium Development Goals would cost on average US$ 42 per capita in low-income countries in 2009, rising to US$ 65 in 2015.**
  - **Despite the vast scale up in aid for health since 2000, 31 of the 49 low-income countries spend less than US$ 35 per capita**
  - **Only 8 have any chance of reaching the required funding from domestic sources by 2015 - even assuming rapid growth of their domestic economies.**
  - **More, and more predictable external funds for health are urgently needed.**

Total Health Expenditure (THE) per capita in Caribbean countries, 2010, in US$



World Health Organization

Raising Sufficient Funds: Domestic Options

1. **Increase priority for health in budget allocations (45 governments devote less than 8% of their spending to health, and 14 devote less than 5%)**
2. **Caribbean: Average: 10.4%;**

   Range: 4.5% Haiti; 16.7% Antigua and Barbuda

   6 countries under 10%

Raising sufficient Funds: Domestic Options

1. Increase priority for health in budget allocations (45 governments devote less than 8% of their spending to health, and 14 devote less than 5%)
2. **Find new or diversified sources of funds e.g.**

– **Sales taxes:** *Ghana funded its national health insurance partly by increasing the value-added tax (VAT) by 2.5%*

– **"Sin" taxes, particularly on tobacco and alcohol:** *a 50% increase in tobacco tax alone would yield an additional US$1.42 billion just 22 low income countries for which sufficient data exists – allowing government health expenditure to increase by 25%.*

– **A currency transaction levy would be feasible in many countries -** *India could raise US$ 370 million per year from a very small levy (0.005%)*.

– **Solidarity levies -** *Gabon raised $30 million for health in 2009 partly by imposing a 1.5% levy on companies handling remittances from abroad*

2. Increase or maintain financial risk protection

- **Reduce out of pocket payments at the point of service**
- **Increase "prepayment" through health insurance and/or taxes with pooling – aim for 15-20% Out of Pocket Payments (OOPs) as % of Total Health Expenditure (THE)**

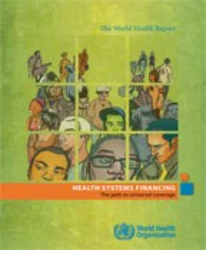
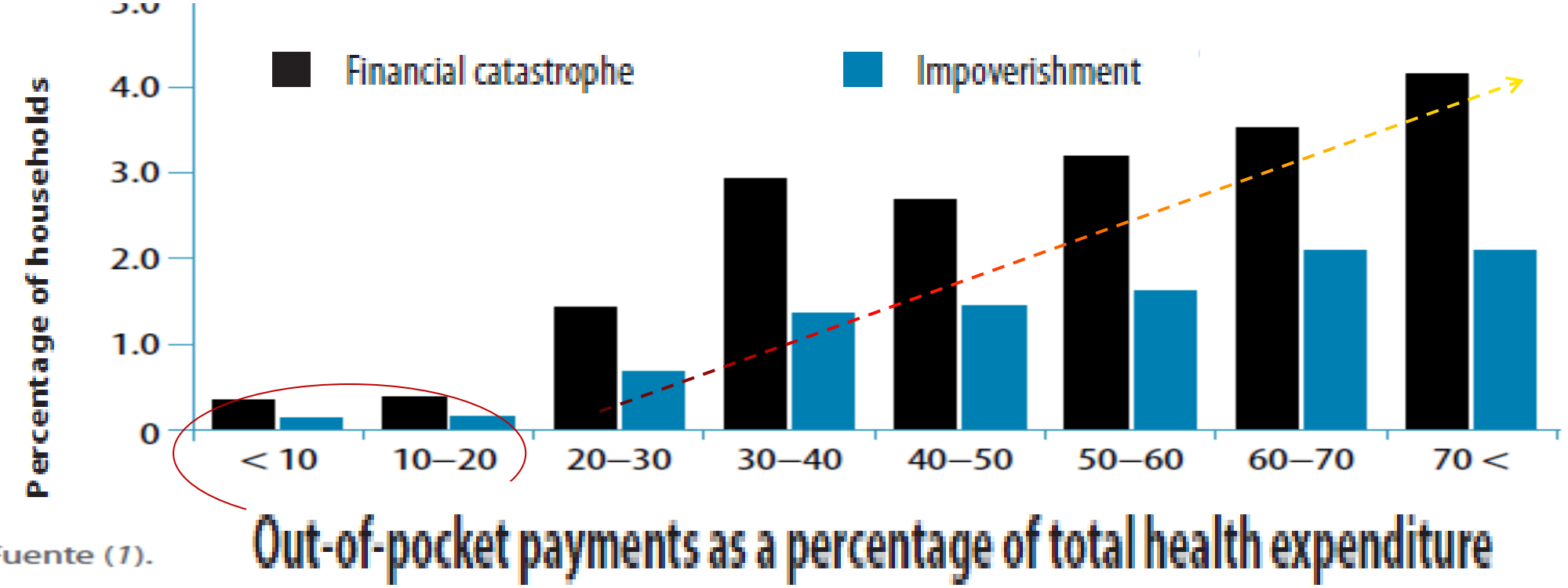


Fig. 3.2. The effect of out-of-pocket spending on financial catastrophe and impoverishment



Fuente (*1*).

2. Increase or maintain financial risk protection

- Reduce out of pocket payments at the point of service
- Increase "prepayment" through health insurance and/or taxes with pooling – aim for 15-20% Out of Pocket Payments (OOPs) as % of Total Health Expenditure (THE)
- **OOPs/THE: averages 29.6% in Caribbean countries in 2010**
- **Above 25% in all except Cuba 9%. Above 30% in 7 countries.**

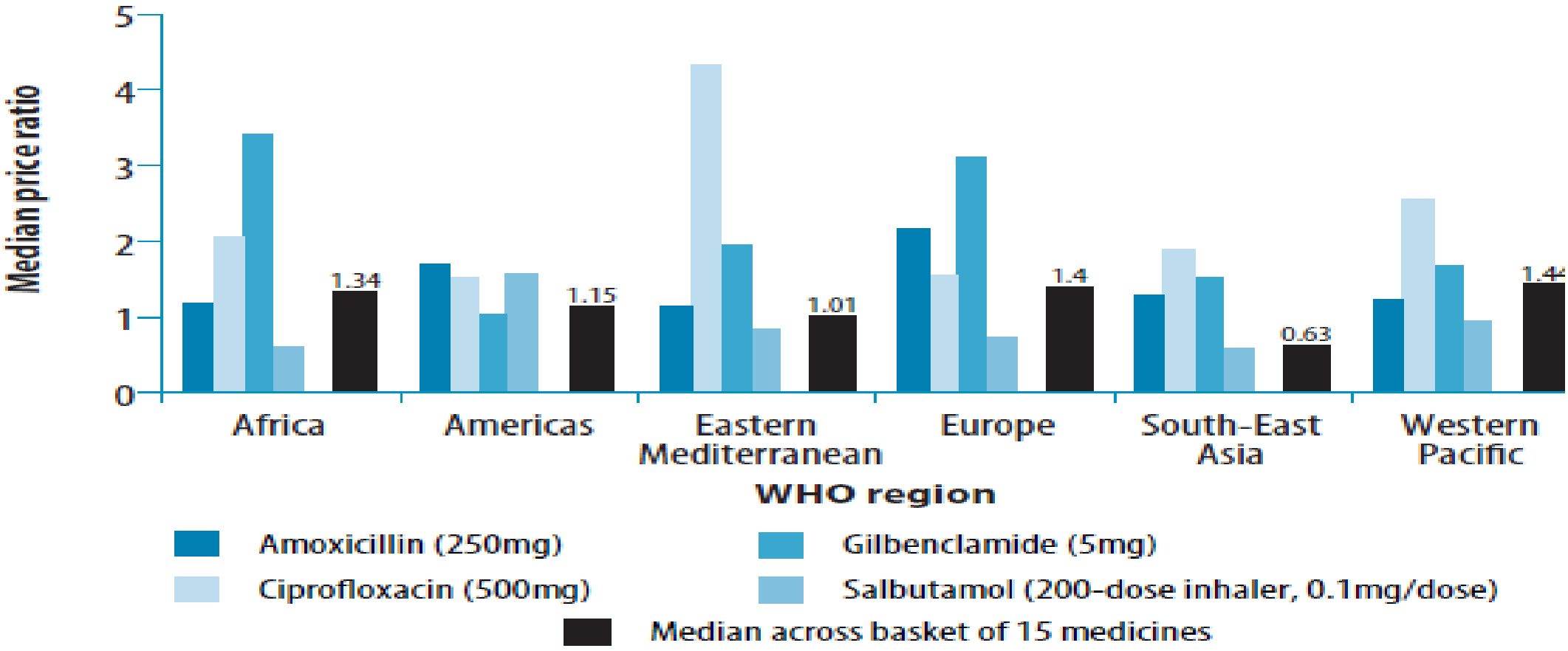
2. Increase or maintain financial risk protection

- Reduce out of pocket payments at the point of service
- Increase "prepayment" through health insurance and/or taxes with pooling – 15-20% OOPs/Total Health Expenditure
- **Recent experience in Brazil, Chile, China, Colombia, Costa Rica, Ghana, Kyrgyzstan, Mexico, Republic of Moldova, Rwanda, Thailand, Turkey and Sierra Leone show that major advances can be made even in low- and middle-income countries.**

1. ***Community and micro insurance have not proved capable of being financially sustainable – pools too small.***
2. ***It is difficult to ensure universal coverage without making contributions (taxes and/or insurance) compulsory.***
3. ***There will always be poor who cannot contribute and must be subsidized from pooled funds – generally from tax revenues***

3. Reduce Inefficiency

Fig. 4.2. **Median price ratios of public-sector procurement prices for generic medicines,[a] by WHO region**



[a] Ratio of the median procurement price to the international reference price of the Management Sciences for Health.

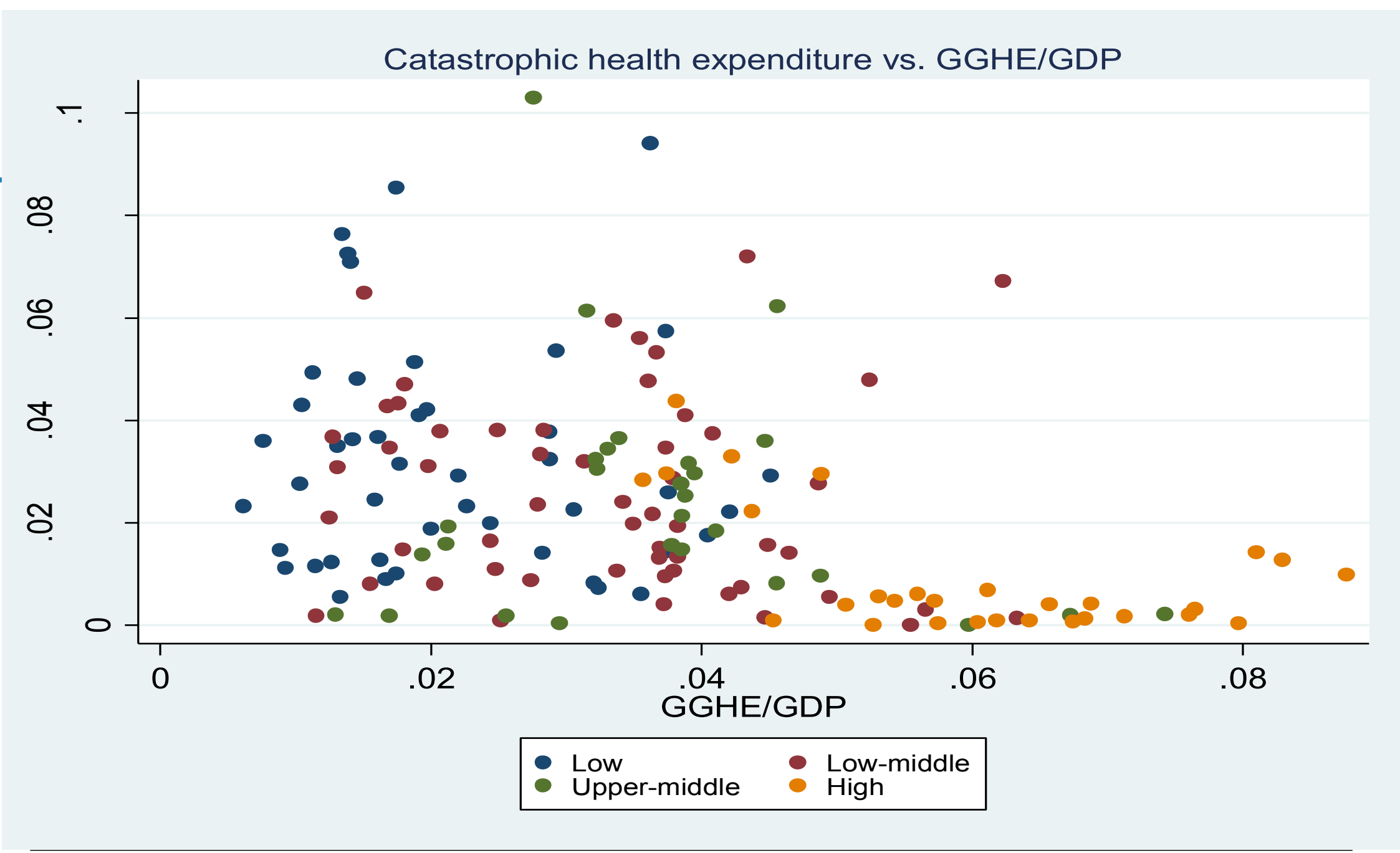
Common Forms of Inefficiency

- **10 common causes of inefficiency including:**
  - ***Spending too much on medicines and health technologies, using them inappropriately, using ineffective medicines and technologies***
  - ***Leakages and waste, again often for medicines***
  - ***Hospital inefficiency particularly over-capacity***
  - ***De-motivated health workers, sometimes workers with the wrong skills in the wrong places***
  - ***Inappropriate mix between prevention, promotion, treatment and rehabilitation, or between levels of care***

- **If all types are present, efficiency gains would effectively result in increasing the available funds for health by 20-40%. i.e. substantially more health for the money could be obtained by reducing inefficiency**

Reduce Inequity: Protect the poor and vulnerable

- Special attention needs to be paid to the poor and vulnerable
- Requires general government revenues – government health expenditure (GGHE) as % of GDP over about 5%
- GGHE/GDP: average of 4% in 2010
- From 1.4% Haiti to 9.7% Cuba: 7 countries less than 4%


Catastrophic health expenditure vs. GGHE/GDP
0
.02
.04
.06
.08
.1
0
.02
.04
.06
.08
GGHE/GDP
Low
Low-middle
Upper-middle
High

Reduce Inequity: Protect the poor and vulnerable

- *Special attention needs to be paid to the poor and vulnerable*

Options (in addition to prepaid and pooled resources) to ensure greater coverage and lower financial barriers:

- **Free or subsidized services** (e.g. through exemptions or vouchers) for specific groups of people (i.e. the poor) or for specific health conditions (i.e. child or maternal care) e.g. Sierra Leone.
- **Subsidized or free enrolment in health insurance** –e.g. Mexico, Thailand
- **Cash payments** to cover transport costs and other costs of obtaining care reduce some financial barriers for the poor. Sometimes these are paid only after the recipient takes actions, usually preventive, that are thought to be beneficial for their health or the health of their families.

WHR 2010 Conclusions: Domestic Financing

- **Every country could do something to move closer to universal coverage or maintain the gains they have made, through:**
  - ***Raising more funds for health AND/OR***
  - ***Reducing financial barriers to access and increasing financial risk protection AND/OR***
  - ***Improving efficiency and equity.***

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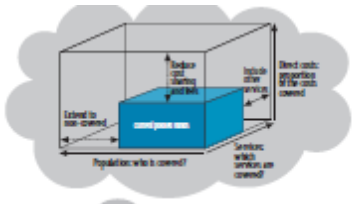
What next?



Action 1
Establishing the vision

Action 2
Situation analysis

Action 3
Financial assessment

Action 4
Constraint assessment

Action 5
Strategy for change

Action 6
Implementation

Action 7
Monitoring & evaluation

National health plans

World Health Organization

Health Financing Policy for UHC?

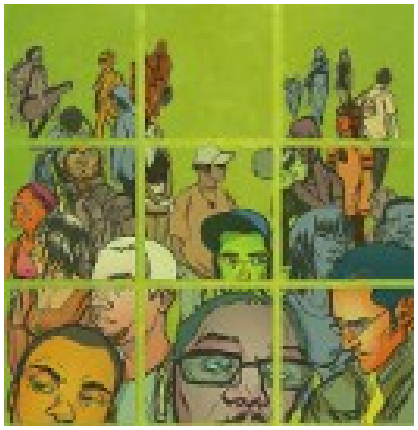
- Interplay of raising money, pooling it, and using it well that is important
- e.g. introducing health insurance or reducing user-fees does not necessarily reduce out of pocket payments or patients without focusing on how providers are paid
- *Setting rules and ensuring they are followed, effective governance is key to improving financing function*

WHO Action Plan: Country Focus

1. **Facilitate country "dialogues" or health financing reviews followed by health financing strategies:**

- **Situation analysis – levels of financial risk protection and service coverage; who misses out on what and why?**
- **What changes in the financing system would help?**
- **Constraint and stakeholder analysis – understanding obstacles, what is feasible in what time frame**
- **Develop plans, strategies, policies**
- **Implementation with associated advocacy**
- **Monitoring and evaluation followed by adjustments**

www.who.int/whr/2010



Thank you

Supportive regional/global actions

1. Develop and agree on indicators of universal coverage
2. Facilitate international sharing of experience – physical exchanges between countries; collate, distil, disseminate best practice; web-based, other forms of new technologies
3. Ensure "successes" made available to other countries and external partners – e.g. improvements in efficiency and value for money in health.
4. Capacity building: required particularly to facilitate dialogue and understanding between people from very different academic backgrounds
5. Continued advocacy: many competing demands; maybe changing mood among traditional bilaterals linked to the financial crisis, UN?

UHC : instrumental and desirable for its own sake

Financial risk protection helps to increase coverage with needed services: instrumental goal.

Coverage with health services helps improve and maintain health: instrumental

BUT: UHC is valued for its own sake as well: intrinsic goal

People sleep well at night knowing the health services they might need to use are available and affordable (but they hope they don't ever have to use them)

Current MDGs

- eradicating extreme poverty and hunger;
- achieving universal primary education,
- promoting gender equality and empowering women
- reducing child mortality rates,
- improving maternal health,
- combating HIV/AIDS, malaria, and other diseases,
- ensuring environmental sustainability, and
- developing a global partnership for development.[1]

Post MDGs

Achieve universal ~~primary education~~ health coverage

Possible Targets:

- Reduce maternal mortality by xxx
- Child health
- HIV/AIDS, TB, malaria
- NCDs
- Reduce impoverishment due to out of pocket payments in health by 50%