The Path to Universal Coverage

Lessons of the latest World Health Report (2010)

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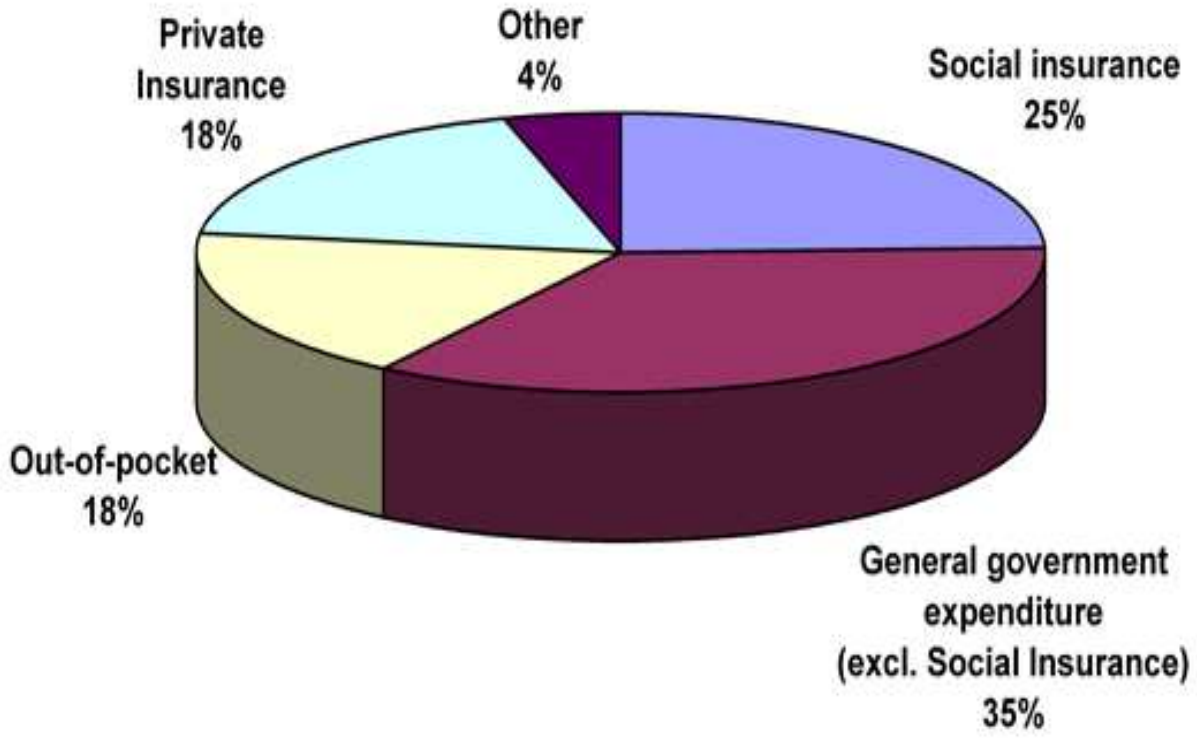
World Health Organization

Overview

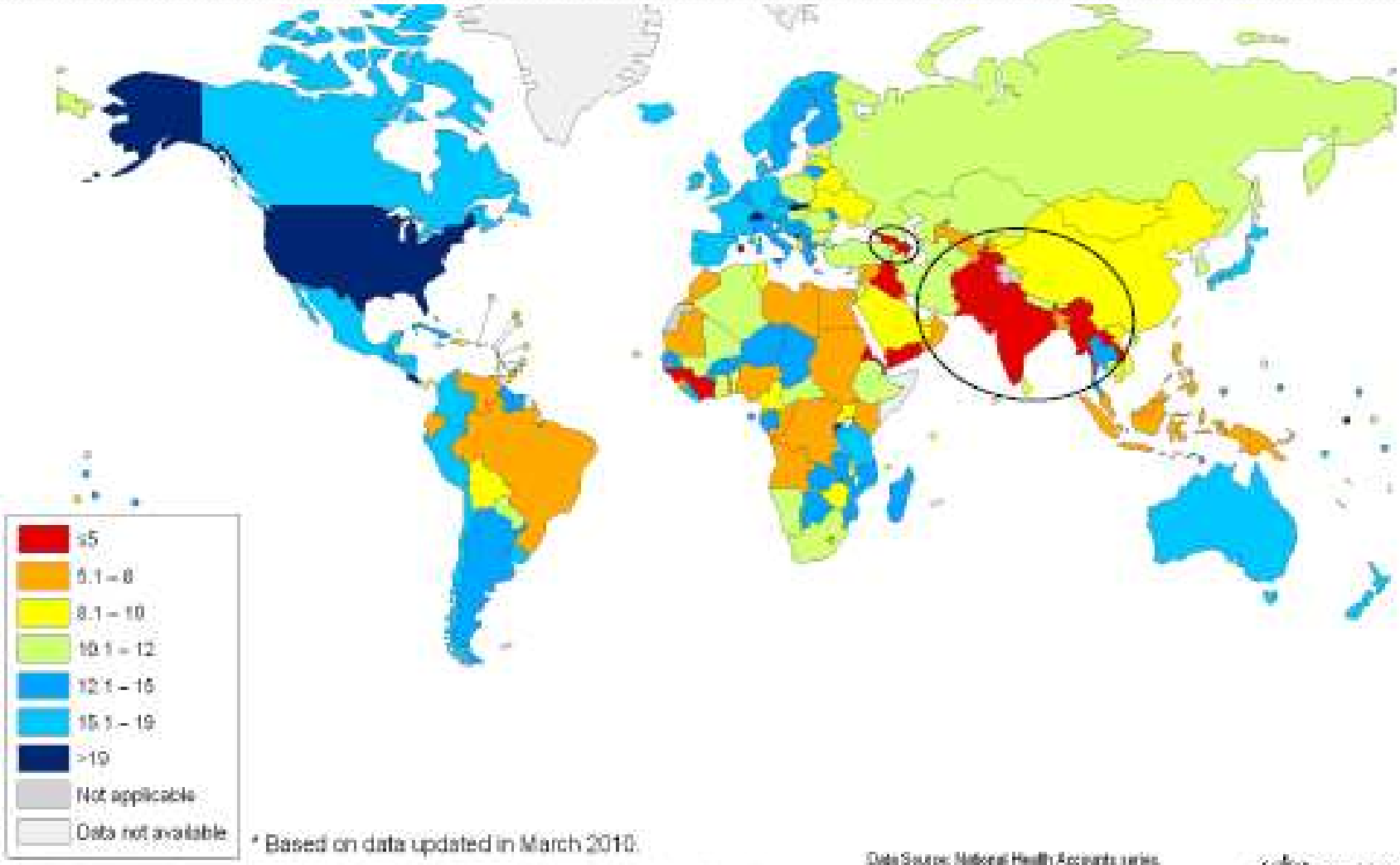
- **Health financing patterns**
- **Sustainability tradeoffs – conflicting values**
- **Messages of the World Health Report (2010)**

1. Health financing patterns

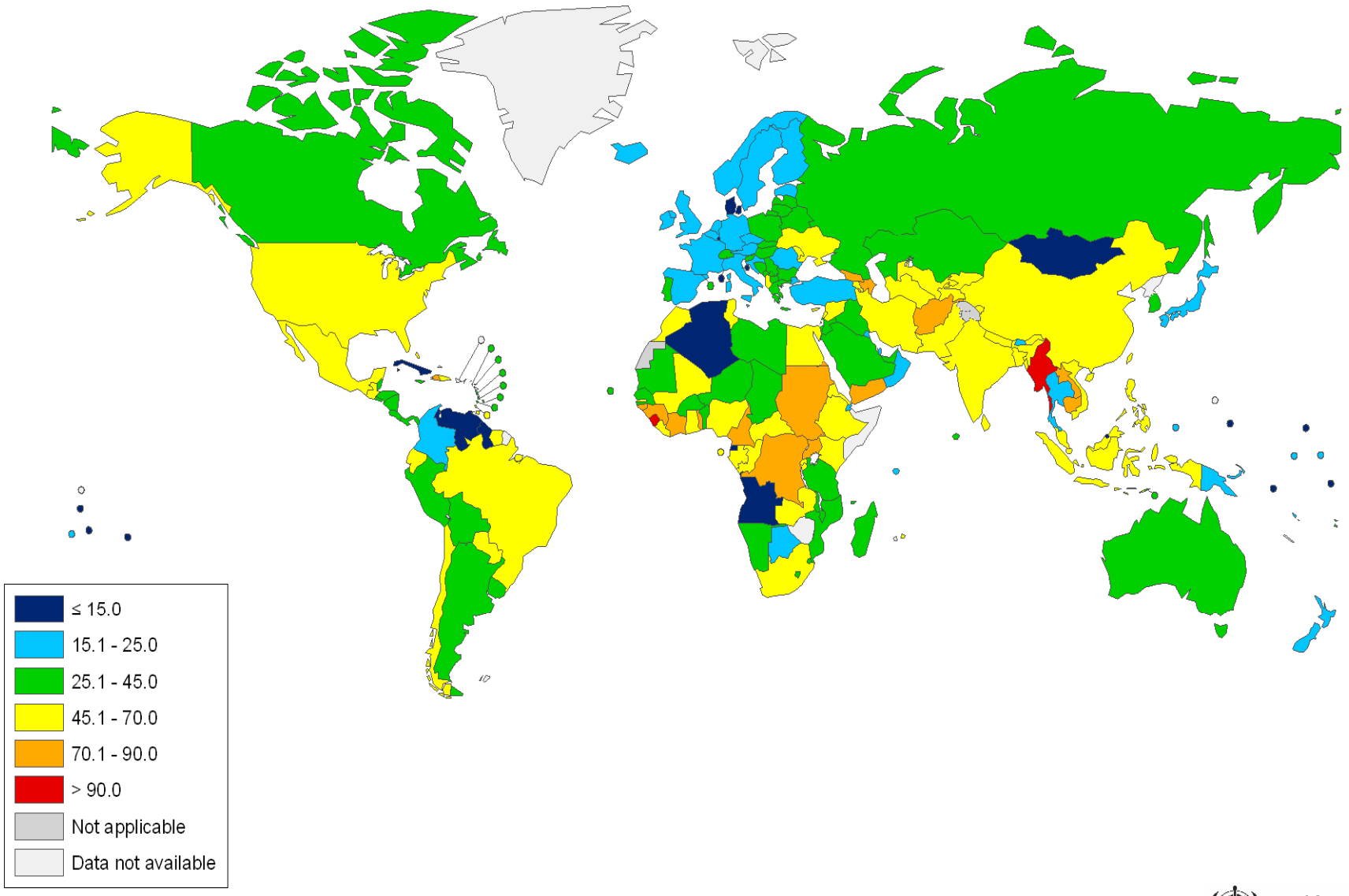
Composition of World health expenditures (World spent US$5.3 trillion on health in 2007)



Globally, quite diverse shares that governments devote to health



Private expenditure on health as a percentage of total expenditure on health, 2009



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: Global Health Observatory, WHO
Map Production: Public Health Information and Geographic Information Systems (GIS)
World Health Organization

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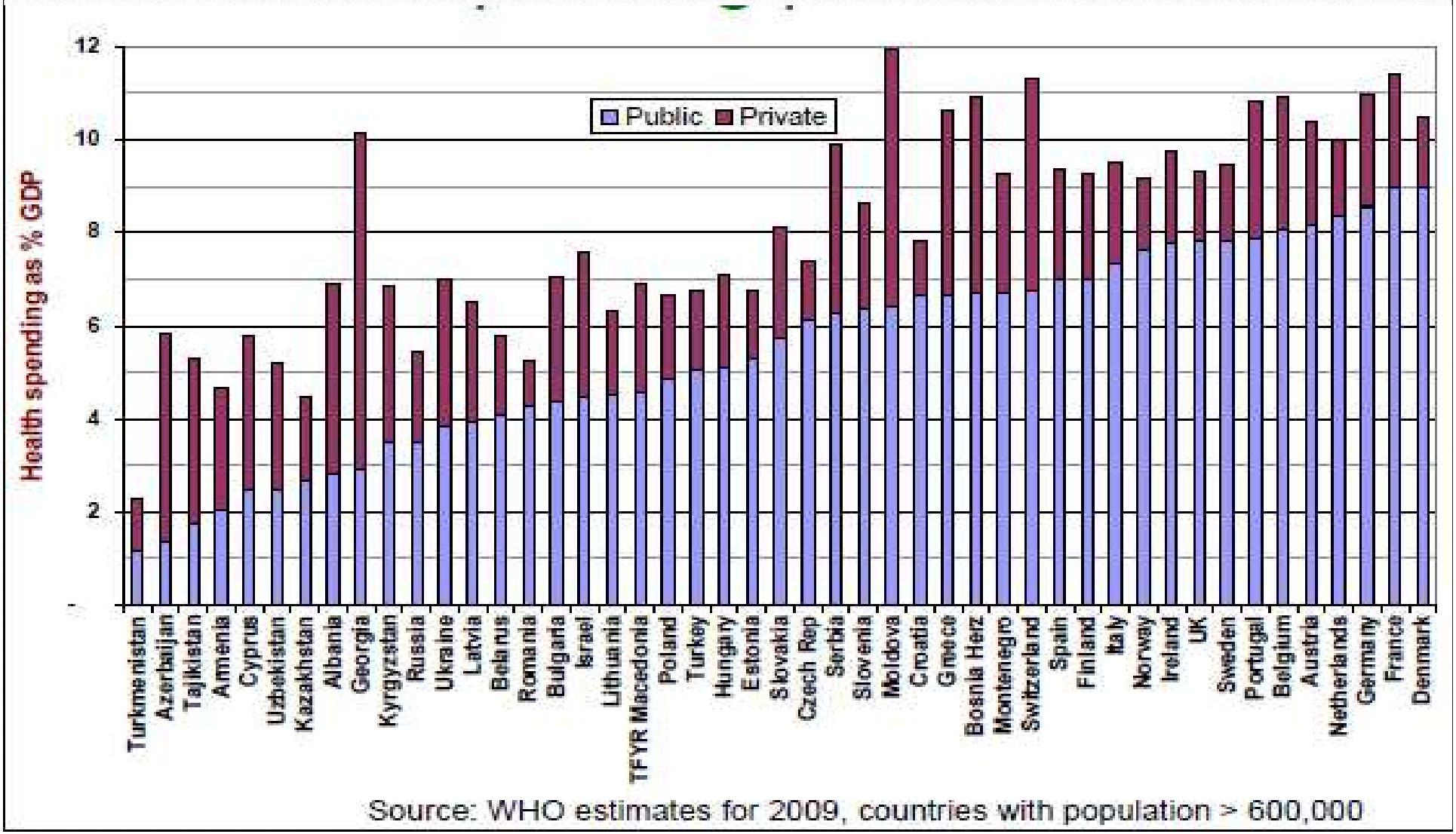
Health spending patterns



Source: WHO estimates for 2009, countries with population > 600,000

What these trends tell us ?

- Low income countries tend to suffer from poor tax collection
- Their populations are hard to tax
  - More rural
  - More informal employment
- Implications for health spending:
  - More private; more out-of-pocket; more regressive

Country income group	Government revenues as % GDP	Private as % of total health spending
Low	20%	53%
Middle	31%	43%
High	42%	33%

Source: Schieber and Maeda 1997

Accounting for government spending on health

Public expenditure on health depends both on fiscal context and **government priorities!**

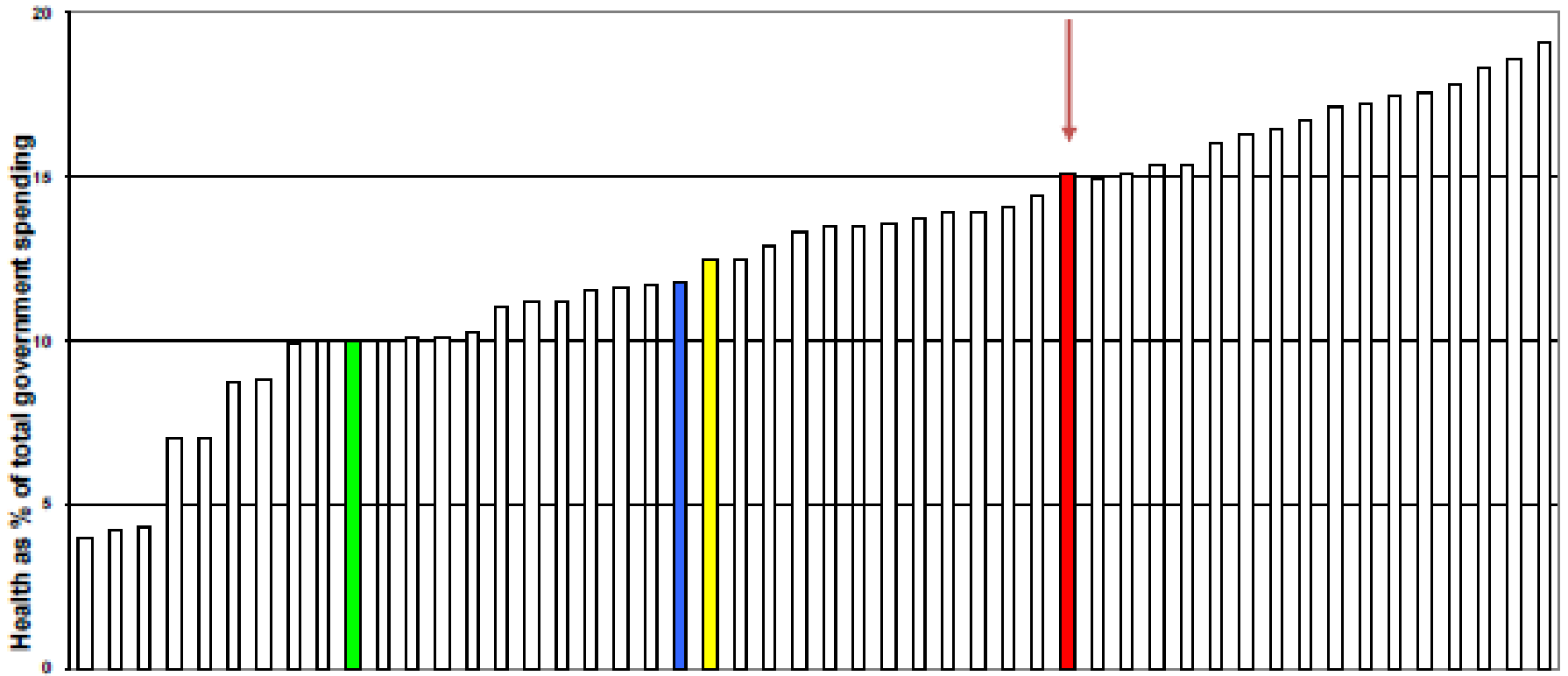
$$\frac{\text{Gov't health spending}}{\text{GDP}} = \frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}}$$

Government health spending as share of the economy

Fiscal context

Public policy priorities

The real measure of “priority”: government spending on health as a % of total government spending



WHO HFA database

Public spending on health depends on both context and choice

- Overall fiscal context
  - Level of overall public spending, limited (eventually) by levels of overall public revenues
- Policy priorities of government
  - Share of the budget allocated to health
  - Reflects the level of spending a government chooses to sustain

Protecting public spending for health during the crisis: some options

1. Those who accumulated savings have room to maneuver
2. Those who balanced the budget and reduced government debts during the years of economic growth can opt for deficit financing
3. Those who failed to do the above are in a more vulnerable position when the crisis hits, but can still avoid adverse effects on health and equity by giving higher priority to health

⟹ It is a matter of choice in public policy

2.Sustainability tradeoffs – conflicting values

Conflicting values

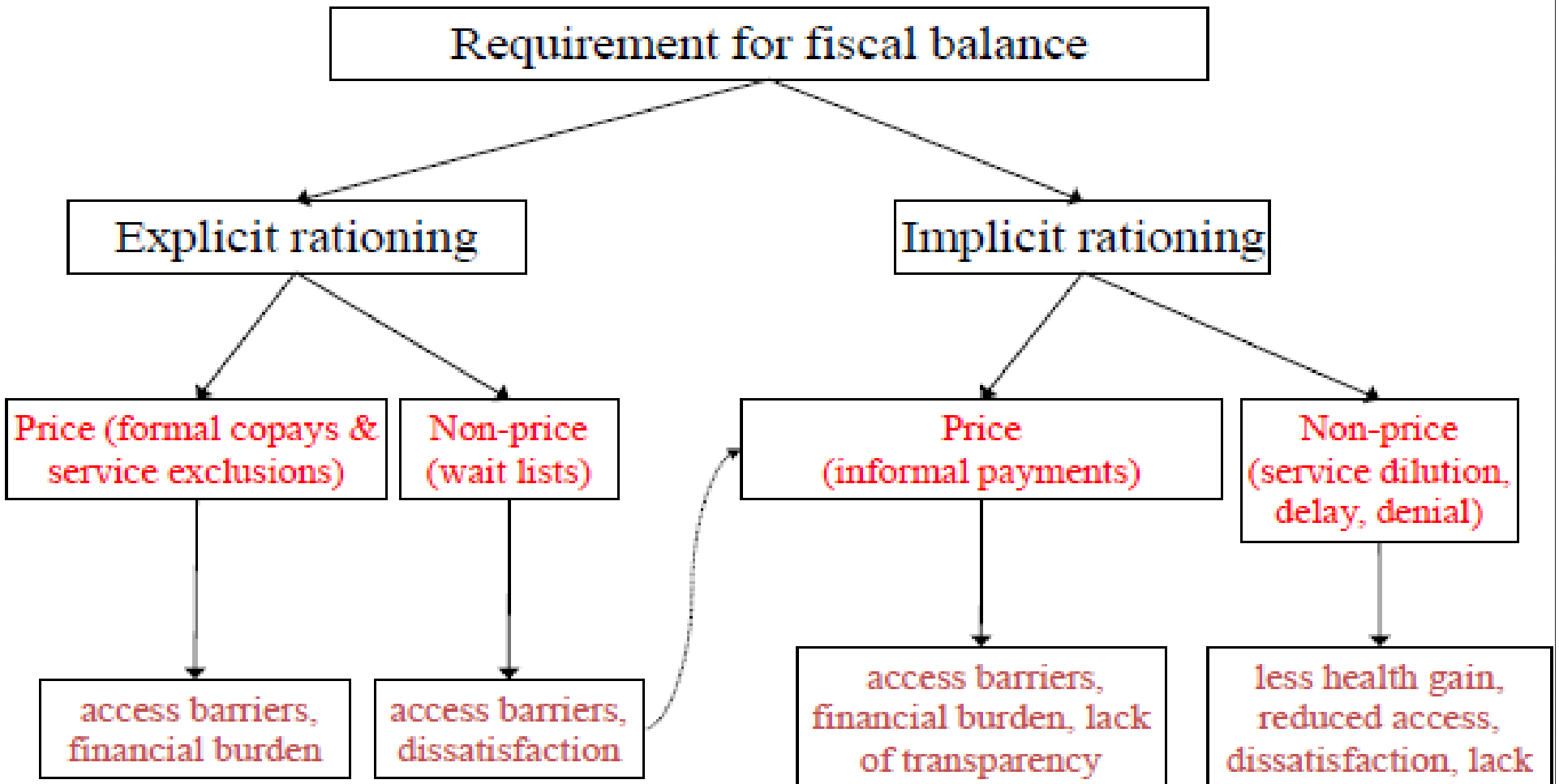
Everyone wants a health system that is free of charge, provides instant access to all services for the whole population, and is of high quality. Unfortunately, the most that can be attained is two out of three.

- Resource constraints faced by all countries mean that tradeoffs must be made
- The severity of these tradeoffs is affected by the wider context, and particularly fiscal constraints. The greater these fiscal constraints, the more severe (in terms of health policy objectives) are the consequences of the tradeoffs.

Components of sustainability

- Technical : human resources
- Social: community participation
- Political: coping with risks
- Financial: cost-containment
- Managerial: efficiency

Exploring the sustainability tradeoffs 1.

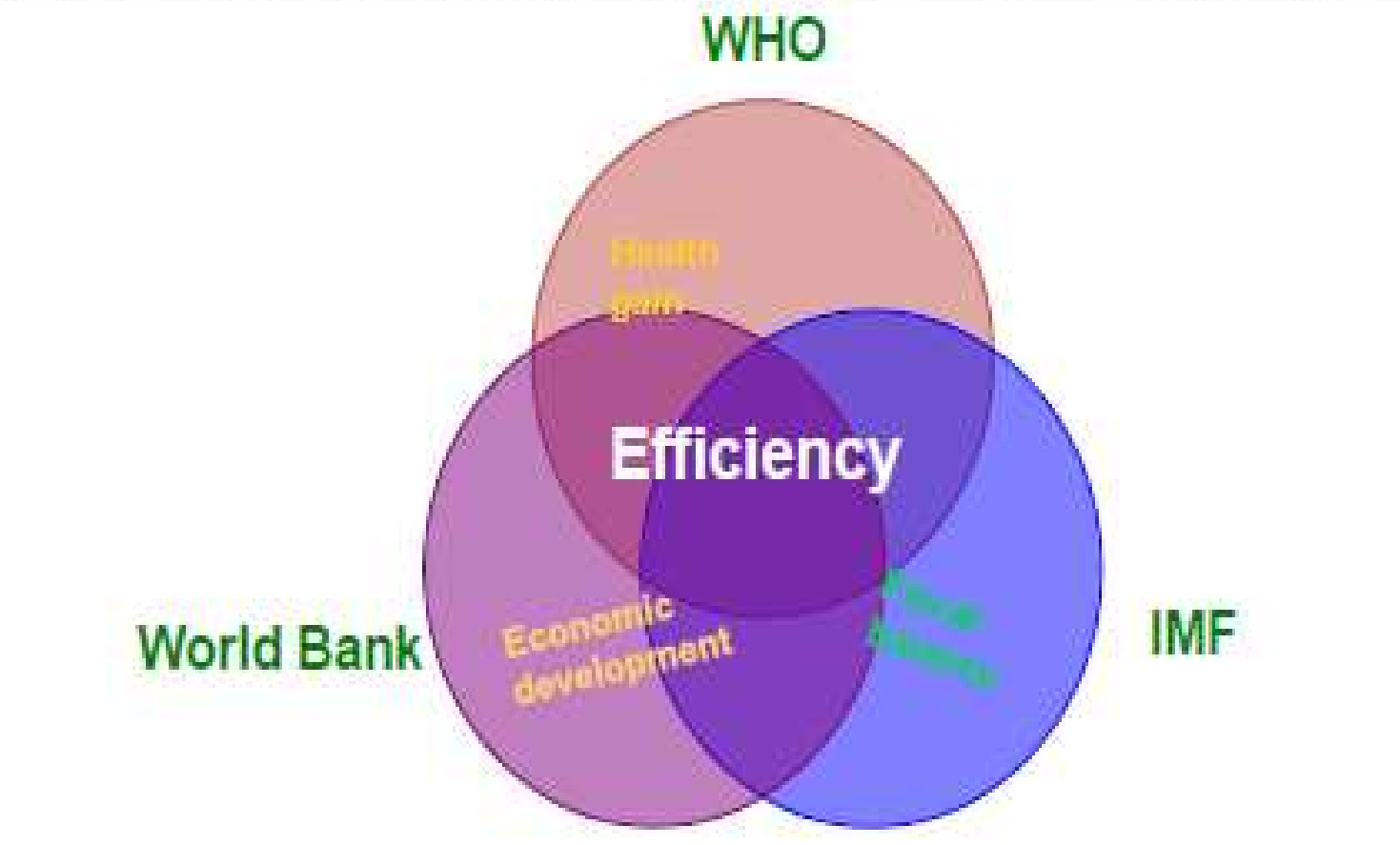


Source: Kutzin and Evetovits 2007

Exploring the sustainability tradeoffs 2.

- The need to give up something in order to meet the fiscal sustainability requirement...
- ...and as a result settle for lower financial protection, solidarity, access to services or quality
- But these trade-offs can be less severe if
  - efficiency gains are utilized instead of shifting cost to patients
  - expenditure cuts are selective and focus on least cost-effective services

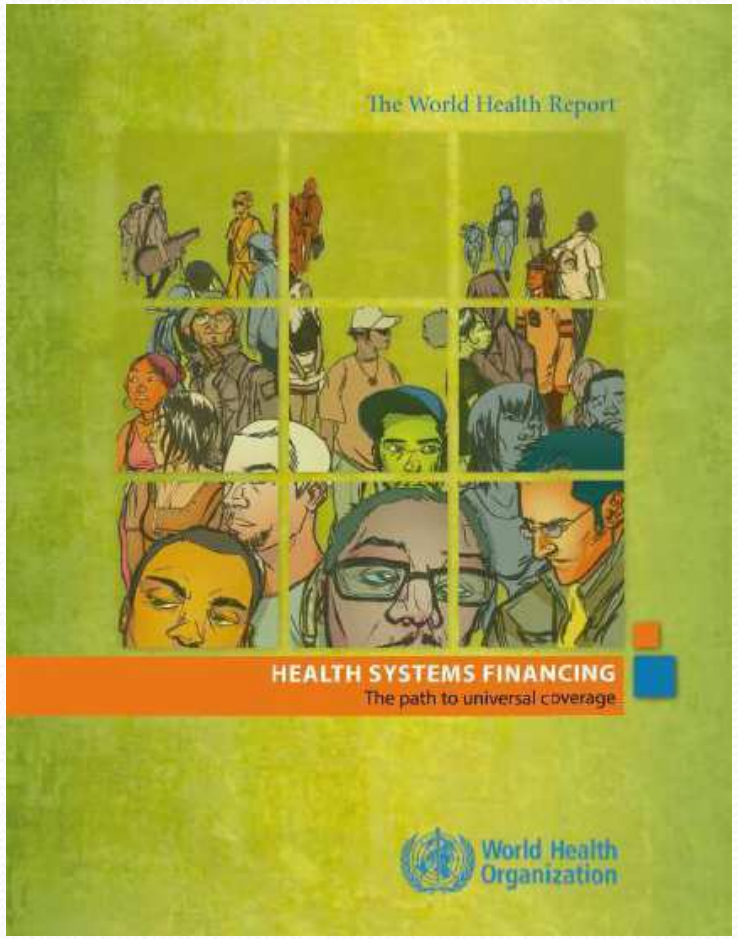
What do the IMF, the World Bank and WHO have in common on the issue of sustainability ?



3. Messages of the World Health Report

Commitment to solidarity

- **Economic and social distress tests attitudes to solidarity**
- **Equity in finance and utilization**
  - ***–The larger the share of public financing for health, the greater the scope for solidarity***
  - ***–Targeting the poor and vulnerable requires political commitment: in many systems the rich benefit more than the poor!***



Millions suffer financial ruin when they use health services

When people use health services:

- Globally around 150 million suffer severe financial hardship each year
- 100 million are pushed into poverty because they must pay out-of-pocket at the time they receive them.

Diagnosis:

What are the causes?

1. **Exclusion linked to factors outside the health system** – inequalities in income and education and social exclusion associated with factors such as gender and migrant status.
2. **Weak health systems:** Insufficient health workers, medicines and health technologies. Ineffective service delivery. Poor information systems and weak government leadership.
3. **Health financing systems that do not function.** The other parts (frequently called health system building blocks) cannot function if the financing system is weak.

Health Financing and Universal Coverage?

1. A World Health Assembly Resolution in 2005 urged countries to develop their health financing systems to:

   - ☑ Ensure all people have access to needed services without the risk of financial hardship linked to paying for care.

   - ☑ The Resolution defined Universal Coverage as coverage with: needed health services; financial risk protection; for everyone.

2. The aspiration to attain universal coverage was in WHO's constitutions of 1948; in the Alma-Ata declaration of 1978; in the World Health Report of 2008 on Primary Health Care

Proposing Solutions:

The World Health Report 2010

1. Draws on country experiences and the best available evidence to suggest options that countries can consider to address their own specific health financing problems.

2. The WHR is aimed solely at **all** countries. All countries, rich and poor, face at least one of the following health financing problems:

   - *The continual need to search for sufficient funds for health*
   - *Direct out-of-pocket payments (e.g. fees and charges) discourage the most vulnerable people from seeking care and result in financial hardship, even impoverishment, when they do*
   - *Inefficiency and inequity in use of resources.*

Problem 1:

Insufficient funds: low-income countries

- A set of essential health services focusing on the Millennium Development Goals would cost on average US$ 44 per capita in low-income countries in 2009, rising to US$ 60 in 2015.
  - None of the 49 low income countries reached the necessary level in 2008, and 31 them spent less than US$ 35 per person
  - 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.**

Insufficient Funds: high and middle-income countries

High and middle-income countries are also constantly searching for sufficient funds because:

- *Technological advances (e.g. in medicines, diagnostics, surgical procedures, prevention options) increase the opportunities for promoting and maintaining health*
- *Technical advances generally come at higher cost and*
- *Aging populations and the increase in non-communicable diseases increase needs.*

Options for raising more domestic funds for health (1)

1. **Increase the priority given to health in government budget allocations**
   - ⇨ If the 49 low-income countries increased the share of government expenditures going to health to 15%, as promised by African heads of state in the 2001 Abuja declaration, an additional US$ 15 billion per year for health would be available – almost doubling the government funding available for health.
2. **Raise revenue for health more efficiently – e.g. increase the total availability of resources**
   - ⇨ In Indonesia, clear and consistent regulations and a policy of zero-tolerance for corruption increased tax yield from 9.9% to 11% of non-oil GDP over four years – with a subsequent increase in health expenditures.

Raising more domestic funds for health (2)

❸ Find new sources of domestic funds e.g.

- ⇨ **Indirect taxes**: *Ghana funded its national health insurance partly by increasing the value-added tax (VAT) by 2.5%*
- ⇨ **"Sin" taxes** *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. This could increase government health expenditure by up to 25%*
- ⇨ **A currency transaction levy** *would be feasible in many countries – e.g. India could raise US$ 370 million per year from a very small levy (0.005%)*
- ⇨ **Solidarity levies** - *Gabon raised US$ 30 million for health in 2009 partly by imposing a 1.5% levy on financial transactions abroad.*

Problem 2: *Direct payments prevent some people using health services and result in financial ruin for many who do*

- Direct, out-of-pocket payments include charges or fees (official and unofficial) levied for consultations, investigations, hospitalization, medicines and other supplies that patients must pay themselves.
- They also include all charges that are not reimbursed or paid directly by health insurance systems.
- Direct payments are the major reason why a large proportion of the world's 1.3 billion poor cannot use the health services they need, and why 100 million are pushed into poverty simply because they use health services.
- 33 countries currently depend on direct payments for more than half their funds for health, while another 75 raise more than 25% of their health fund through direct payments.

Reducing the impact of direct payments on the vulnerable

1. **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.**

2. **Opt**ions that have been used include:

   - **Reducing or eliminating charges in government health facilities, sometimes for groups of people (e.g. mothers and children), or types of conditions (e.g. tuberculosis)**
   - **Vouchers to allow people to obtain health care**
   - **Increasing "prepayment" and pooling through health insurance and/or taxes.**

3. **Community and micro-insurance can play a useful role in the early stages, but plans to merge them over time are important - bigger pools are more financially viable than small community-based pooled funds.**

4. **It is difficult to ensure universal coverage without making contributions (taxes and/or insurance) compulsory. If the rich and the healthy opt out, the poor and sick are left with sub-standard services from the limited funds that remain.**

Problem 3:
Inefficient use of resources

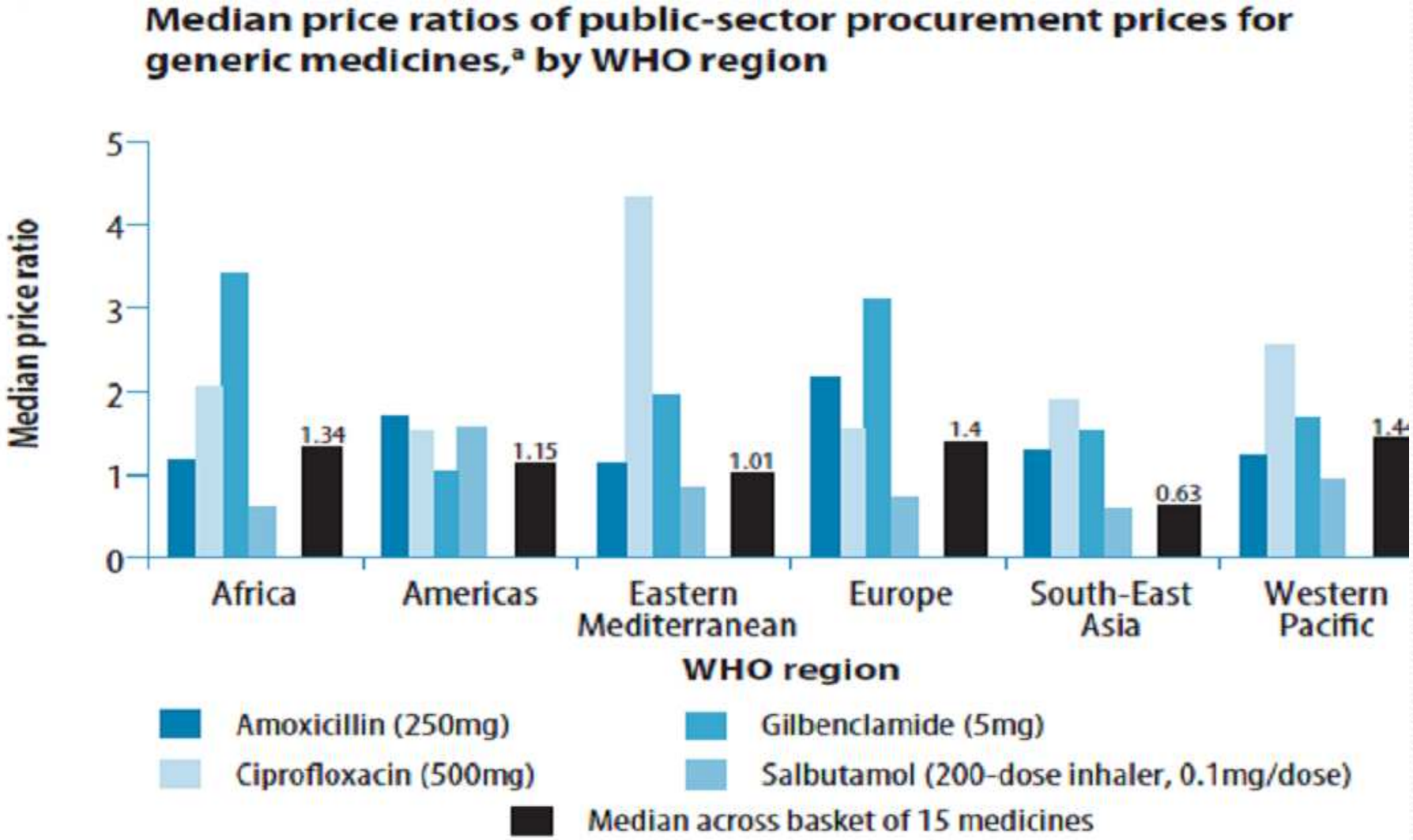
- Inefficiency is found in all countries.

  Common causes:

  - *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*
  - *An inappropriate mix between prevention, promotion, treatment and rehabilitation*

- If all inefficiency types are present, efficiency gains would allow maybe 20-40% more health for the money.

Inefficiency: example



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

Encourage greater efficiency

- Identity and reduce the sources of inefficiency.
- Examine and reduce incentives that current encourage inefficiency.

For example:

1. Paying providers: move away from fee for service if possible. Consider results-based payment where good monitoring is possible.

2. Reduce duplication – e.g. reduce duplicative:

- Funding channels
- Laboratory systems
- Auditing and monitoring systems
- Reporting systems including reporting to donors.

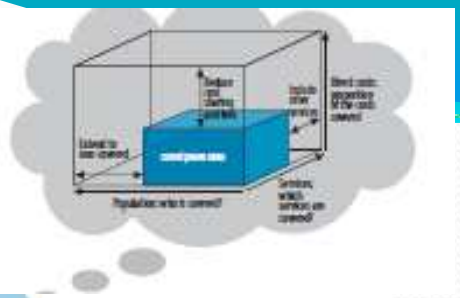
Protect the poor and vulnerable

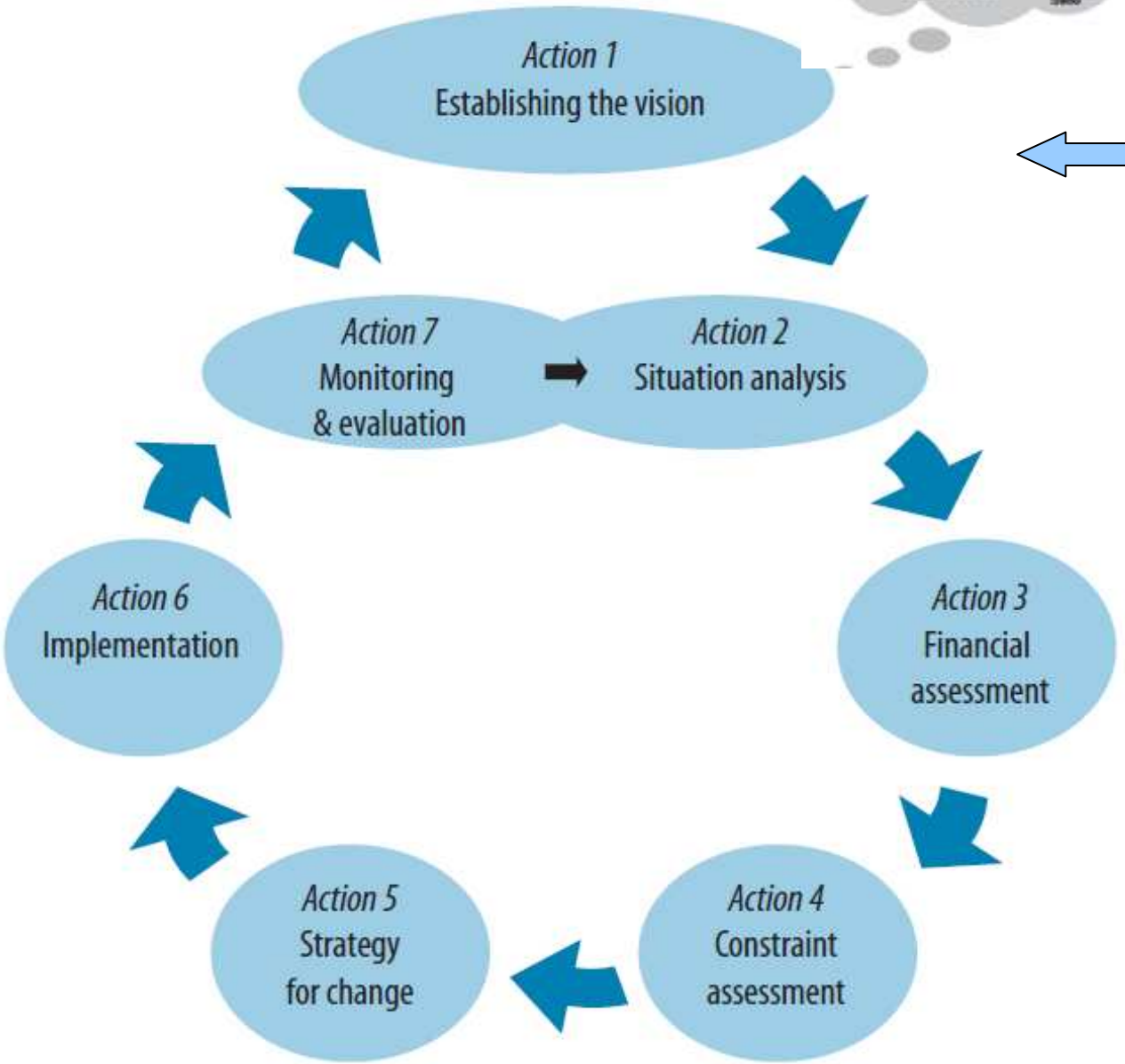
- Special attention needs to be paid to the poor and vulnerable everywhere.

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).
- Subsidized or free insurance contributions for the poor and vulnerable
- 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.

The path to universal coverage: *domestic*





National health plans

The path to universal coverage: *international (1)*

- Keep current promises: Much of the current deficit in funding in low income countries would disappear if bilateral donors kept their existing promises. Increased, predictable and stable flows for health are necessary.
- Innovative international financing such as that undertaken by the Millennium Foundation is valuable to supplement traditional sources.
- Stop introducing more global initiatives with more secretariats at the international level, with funding channelled through an increasing number of initiatives and mechanisms.

The path to universal coverage: *international (2)*

1. Reduce the costs imposed on countries in accessing external funding - Rwanda has to report on 890 different health indicators to the various donors, almost 600 for HIV and TB alone. Vietnam had 400 aid missions to review health projects in 2009.

2. Support countries to develop and implement national health financing strategies, and consistent health plans, to move more quickly towards universal coverage.

3. Buy into these plans and channel funds to countries in ways that build domestic financing capacities and institutions, rather than bypassing weak systems – e.g. fund Sector Wide Approaches, General Budget Support, health insurance systems.

The path to universal coverage: *WHO*

1. Actively support countries who wish to develop and implement domestic health financing strategies, and consistent health plans, to move more quickly towards universal coverage.

2. Facilitate dialogue and understanding with ministries of finance and the international financial institutions such as the World Bank, IMF and the regional development banks so that these plans can be developed and implemented.

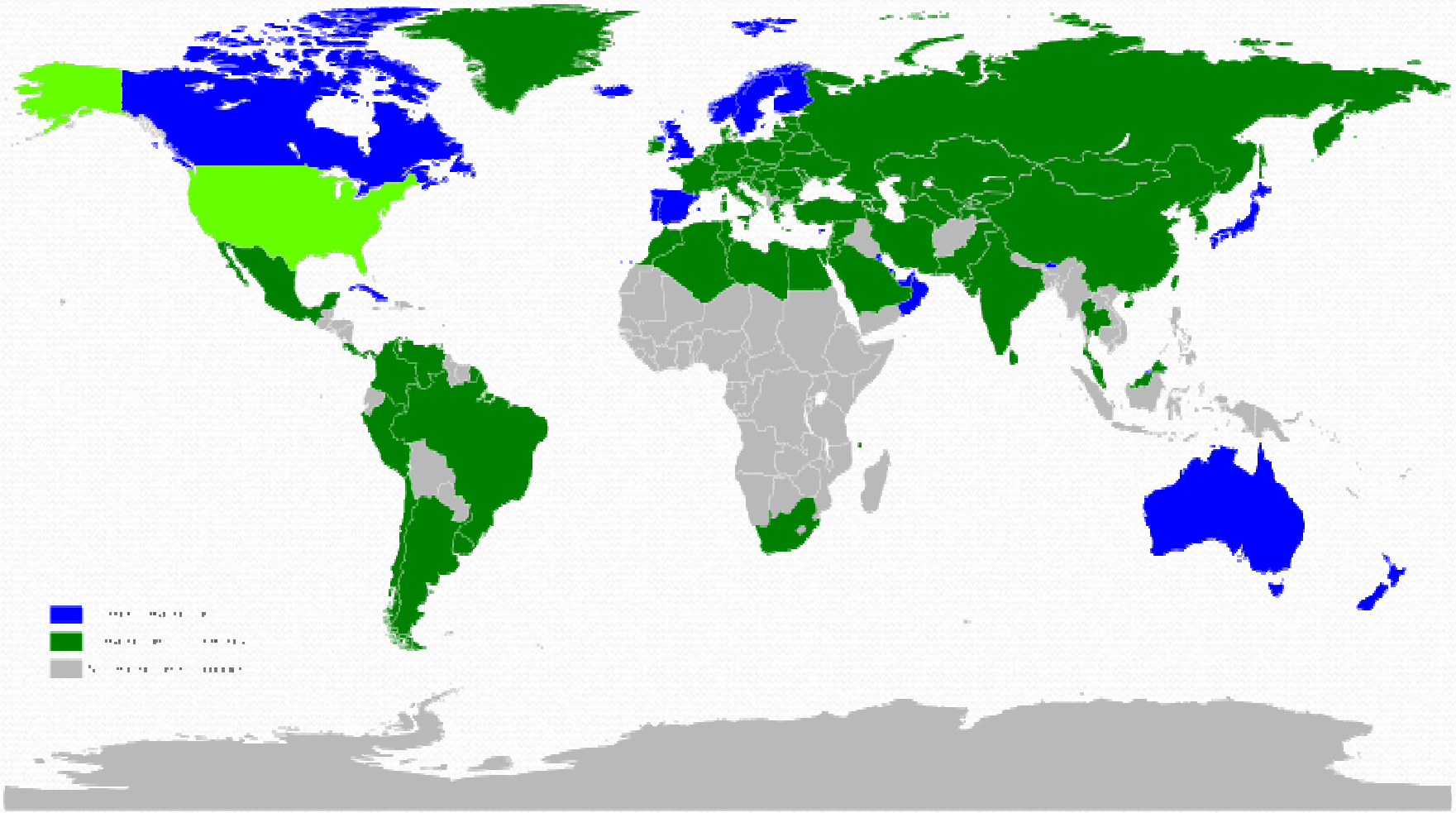
3. Act as an information exchange, sharing experiences across countries of what has, and what has not worked in modifying financing systems for universal coverage.

4. Provide technical and policy support and leverage support from others where necessary.

Summary

- The world is still a long way from ensuring that everyone can use needed health services without the risk of financial ruin.
- Even richer countries struggle to raise sufficient funds and to protect the poor and vulnerable in the face of aging populations and increasing options for improving and maintaining health.
- The global community can do more to raise needed funds in poorer countries to improve the efficiency of the global architecture, and to ensure that funds channelled to countries strengthened domestic financing institutions and capacities
- All countries can do something more to develop their financing systems to move closer to universal coverage or maintain it where it has been achieved

Public universal health care around the world as of December,2009

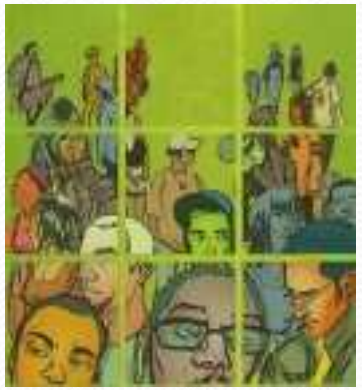


Should the US provide universal health care for all Americans ?

Be careful:

„**Even if you are on the right track you will get run over if you just sit there**”

Mark Twain



Thank you

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