Guiding principles for financing Universal Health Coverage

Universal Health Coverage: holding countries to account
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Joseph Kutzin | Coordinator, Health Financing | Health Systems Governance and Financing
Overview

Universal Health Coverage: concepts, measures and implications for public policy

WHO’s guiding principles for health financing
OPERATIONALIZING UHC: MEASURES AND IMPLICATIONS FOR PUBLIC POLICY
Enable all people to use the health services that they need (including prevention, promotion, treatment, palliation and rehabilitation) of sufficient quality to be effective;

Ensure that the use of these services does not expose the user to financial hardship

- World Health Report 2010, p.6
Operationalize UHC as a direction, not a destination

No country fully achieves all the coverage goals embedded in definition of UHC

But countries want to

- Reduce the gap between need and utilization (equity)
- Improve quality
- Improve financial protection

Thus, moving towards UHC requires health system strengthening actions to make progress on a combination of these objectives
UHC is not...

...having everyone in an insurance scheme
...establishing a basic package of services
...reaching some target level of health workers per 1000 population
...reaching some target level of the population within a certain distance of a health facility
...having medicines in all facilities
...a “program” to be implemented

So how do we measure it?
Effective service coverage concept

• Obtaining needed services
• Services “good enough” to improve (maintain/promote/restore/palliate) health

Proxy by an index of service coverage

• Globally for lowest common denominator
• Nationally for highest relevance to context
• Quality a major challenge – important to define nationally relevant measures
Financial protection concept

• User/family does not suffer severe financial hardship as a consequence of paying for health services

Proxy by measures of catastrophic and impoverishing out-of-pocket spending

• Cata: OOPS as % of household consumption (basic needs adjustment?)

• Impov: OOPS sufficient to drive into/deeper into poverty

Qualitative measures relevant, e.g. sale of assets
Must consider jointly to assess progress towards UHC

Unmet need

Financial protection
Coverage as a “right” (of citizenship, residence) rather than as just an employee benefit

• Critically important implications for choices on revenue sources and the basis for entitlement

Unit of analysis: system, not scheme

• Effects of a “scheme” is not of interest per se; what matters is the effect on UHC goals considered at level of the entire system and population

An explicitly political agenda...because it involves redistribution
2. GUIDING HEALTH FINANCING POLICY CHOICES FOR UHC
### Key questions to ask of different (?) financing models (one way to frame options)

<table>
<thead>
<tr>
<th>Bismarck/SHI</th>
<th>Beveridge/NHS</th>
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<tbody>
<tr>
<td>What are the sources of funds, and how are they collected?</td>
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<td>How are funds accumulated on behalf of the population?</td>
<td>How are funds accumulated on behalf of the population?</td>
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<td>How are providers paid?</td>
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<td>How do funds flow through the system, and what are the associated institutional arrangements?</td>
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<td>What are the entitlements and obligations of the people?</td>
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<td>What is the basis for entitlement?</td>
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What health financing policy addresses

People

Revenue raising

Pooling

Purchasing

Service provision

People

and also this:

Reforms to improve how the health financing system performs

Priorities and tradeoffs with regard to population, service, and cost coverage

This

Coverage mechanisms

Reduce cost sharing and fees

Extend to non-covered

Include other services

Financial protection: what do people have to pay out-of-pocket?

Services: which services are covered?

Population: who is covered?
Even though broad UHC goals are shared by all...

- Specific manifestations of problems vary, so how the goals should be operationalized will vary as well
- Every country already has a health financing system, so starting point for each country is unique
- Mix of fiscal and other contextual factors also unique

But this should not be interpreted to mean that “anything goes” – we have learned a few things over past 30 years

- Some “do’s” and “don’ts” in health financing policy
- We can avoid repeating mistakes made by others
Three policy principles to guide health financing reform(ers)

1. **Focus on compulsory funding sources**: move towards predominant reliance on public funding for UHC

2. **Reduce fragmentation** to enhance redistributional capacity (more prepayment, fewer prepayment schemes) and reduce administrative duplication

3. **Move towards strategic purchasing** to align funding and incentives with promised services, promote efficiency and accountability, and manage expenditure growth to sustain progress
No country has made much progress by relying on voluntary prepayment (individual contributions)

- Private voluntary health insurance, community-based health insurance, or informal sector contributions to national schemes

Move towards predominant reliance on compulsory sources – some type of taxation
a) First principle is simple and very important: **public spending matters** (for financial protection)

Note: Each bubble represents one country, and the size of each bubble represents the relative per capita GDP of the country.

Importance of “fiscal health” for UHC

Funding mix: richer countries more public, poorer countries more private, largely due to differences in fiscal capacity (linked to high informality)

Major LMIC challenge is to mobilize sufficient tax revenues

- Hence, the importance of good “fiscal health”, strong tax collection, and effective dialogue with Finance/Treasury on the level of funding, the budget process, etc.

The Addis Ababa Action Agenda matters (for UHC)

- Improve domestic tax systems, reduce illicit flows

Conclusion: general budget revenues need to be the main source of funds in LMICs
b) Reducing fragmentation: the problem with traditional approaches to SHI

Traditionally, countries have funded SHI through compulsory contributions from employers and employees.

Where each funding is associated with a different “scheme”, fragmentation arises and can reinforce existing inequalities.

In LMICs, formal sector is small and relatively privileged; traditional funding arrangements can drive inequalities.

In higher-income countries, concerns with employment limit scope to increase cost of labour.
Different schemes for different groups drove inequitable funding in Thailand: served “the workers” at the expense of “the people”.

Public insurance expenditure per capita, 1992

<table>
<thead>
<tr>
<th>Group</th>
<th>Baht per capita</th>
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<tbody>
<tr>
<td>Civil Servants</td>
<td>916</td>
</tr>
<tr>
<td>Social Security</td>
<td>541</td>
</tr>
<tr>
<td>Low Income</td>
<td>214</td>
</tr>
<tr>
<td>Elderly</td>
<td>72</td>
</tr>
<tr>
<td>Vol health card</td>
<td>63</td>
</tr>
</tbody>
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Source: Khoman (1997)
Many good examples of how countries have dealt with pool fragmentation

Re-configure and consolidate into larger pool(s)
- Thailand, Korea, Turkey, Scandinavian countries 1990s

Pool budget funds and wage-linked contributions
- Kyrgyzstan, Gabon, Ghana, Japan, Germany, Netherlands...

Compensation (↑ funding in non-formal sector scheme)
- Peru, Thailand, Mexico

Enable redistribution across pools
- High income countries with multiple funds, and also others such as earlier reforms in Rwanda
Reducing pool fragmentation

Aim is to increase redistributive capacity by reducing barriers – improve equity

Also can improve efficiency by reducing duplication

It only increases potential for improvement – needs to be aligned with provider payment and supply side development in order to realize the gains

Easier said than done – politically challenging threat to vested interests, and often need to rely on compensating measures rather than taking this on directly, especially in early stages of reform
c) You can’t just spend your way to UHC

To sustain progress, attention to efficiency!!

• “Strategic purchasing” as a critical strategy for this – linking provider payment to information on either/both their performance and population health needs

An illustration: China vs Thailand

• Both greatly increased public spending and enrollment in health insurance programs

• Thailand achieved gains in equity in service use and financial protection; China did not

• Thailand managed overall expenditure growth through coherent policies on benefit design and purchasing

• China relied on fee-for-service payment with cost sharing

• Getting people into a “scheme” is not enough
Chinese Public Hospitals – accountable for making money, not for efficiency

Advertising their CT scanner

Diagnosis: the common cold
Treatment: IV drips

Source of slide: Prof. Winnie Yip
Strategic purchasing can take many forms

Core is accountability mechanism for the use of funds

Moves away from 2 bad extremes

• Rigid input-based line-item budgets
• Unmanaged fee-for-service

Aligns payment with benefits to realize the promise and minimize risk of unfunded mandates

Data – especially unified national information platform – is at the core of this agenda

• There is no strategic purchasing without data
Final reflections

Make UHC operational by focusing on progress, not “achievement”

UHC implies change in public policy on health coverage

Be accountable for results by measuring progress

Don’t let labels limit your policy options

Principles: more public, less fragmented, more strategic

Financing important but can’t do it alone – stay for entire Forum!