UNIVERSAL HEALTH COVERAGE: *holding countries to account*

UHC AND SUSTAINABLE FINANCING

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WHAT IS UHC?

WHO definition

‘... all people receiving the health services they need, including health initiatives designed to promote better health, prevent illness, and to provide treatment, rehabilitation, and palliative care of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship.’

http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf
WHY UHC?

UHC -

- A shared global goal (SDG 3) ‘... not only good health, but also arrangements that ensure everyone obtains the quality health services they need without financial hardship’.
- ‘Everyone’ – services are available equitably, minimising disparities in use of care between rich and poor.
- ‘Needed quality health services’ – everyone obtains adequate amounts of appropriate, acceptable, and quality health care.
- ‘Without financial hardship’ – organising health systems so that no-one faces financial hardship from having to pay for needed health services.

UHC promotes social equity, social cohesion, and stability.
WHY UHC?

An ideal UHC model will provide:

- sufficient resources (public funding),
- remove financial risk and barriers,
- promote efficiency and eliminate waste,
- remove inequalities in coverage.

However there is a lack of consensus on how countries can and should finance UHC.
WHAT ARE THE DIFFERENT FINANCING OPTIONS TO ACHIEVE UHC?

All countries use a mix of out of pocket spending, savings accounts, community-based health insurance, private insurance, social health insurance, taxation, and foreign aid.

No country has achieved UHC through reliance on out of pocket spending, community-based health insurance, private insurance, or traditional social health insurance.

All countries achieving UHC rely on taxation and sometimes social health insurance as well.
How countries pay for health care

- Low income
- Lower-middle income
- Upper-middle income
- High income

ODA | Government | Social insurance | OOPE | Other private

http://www.chpa.co
Routes to achieving UHC: Social Health Insurance (or Bismarck Model)

- Successful only in upper-middle to high income nations: France, Germany, Japan, Korea
- Funded by mandatory contributions from workers and employers to an insurance fund.
- Services delivered by private or public providers.
- Traditional social health insurance is never able to achieve UHC as it cannot cover the poor and those outside formal sector.
- Government tax money contributions required to extend insurance to all citizens.
- Feasibility depends on ability to overcome opposition from formal sector to extension of coverage to non-contributing beneficiaries and political willingness to mobilise additional taxation.
Proportion (%) of countries at different income levels with significant social health insurance, Commonwealth and other countries (2013)
Routes to achieving UHC: National Health Service (or Beveridge Model)

- Successful only in upper-middle and high income nations: United Kingdom, Denmark, New Zealand
- Expansion of government financing and public delivery systems to cover almost all services for all people
- Government uses taxes to pay for 80% or more of all health care.
- Increase in government spending to >3% of GDP.
- Government funding to cover most outpatient care, including general practitioners.
- Delivered predominately, but not exclusively, in the public sector.
- Reduction or elimination of user fees in public sector.
- Building a delivery network that is accessible to all.
- Feasibility depends on political and economic ability to mobilise additional taxation.
Government tax revenues as share of GDP (%) by level of income (2012)

- Low-income: 13%
- Lower-middle income: 15%
- Upper-middle income: 20%
- High income: 24%

Minimum tax revenues needed to achieve UHC using NHS or SHI approaches
How feasible are the NHS and SHI models in developing countries?

- Governments must spend 3-5% of GDP in tax money, however most low or low-middle income countries cannot afford to do this.
- Limited ability to raise tax revenues or social health insurance contributions.
- Attempts to implement NHS or SHI models usually result in unequal and inefficient coverage:
  - Public services are inadequate and end up being captured by rich and urban populations.
  - OR SHI coverage remains confined to the formal sector OR does not pay for adequate care.
- There is no example of UHC through SHI in any low or low-middle income economy, and almost no case of a true NHS model.
A third Commonwealth route to achieving UHC: Mixed Public/Private Systems

- Economic and political constraints prevent full public funding of a NHS, but government faces strong pressure to provide universal coverage.
  - Parallel free government services and non-free private services.
  - Access of poor to quality public services ensured by removing public sector user fees and good physical access.
  - Public services targeted to poor by encouraging non-poor to seek private care for better consumer quality.
- High degree of UHC with public spending of <3% of GDP.
- Health indicators comparable or better than some high income countries.

Examples: Australia, Sri Lanka, Ireland, Jamaica, Malaysia, Mauritius, Hong Kong. Mostly Commonwealth nations with no history of SHI.
Comparison of LMIC mixed systems with better known UHC stars

<table>
<thead>
<tr>
<th>Country</th>
<th>Public health spending (% GDP)</th>
<th>Out-of-pocket funding (%)</th>
<th>Skilled birth attendance (%)</th>
<th>IMR</th>
<th>Life expectancy</th>
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</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
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<td>44</td>
<td>99</td>
<td>8</td>
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<td>75</td>
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<tr>
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<tr>
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<tr>
<td>Turkey</td>
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<td>Brazil</td>
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<td>30</td>
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</table>
Comparison of high income mixed systems with better known UHC stars

<table>
<thead>
<tr>
<th>Health system</th>
<th>Public health spending (% GDP)</th>
<th>Private funding (%)</th>
<th>Skilled birth attendance (%)</th>
<th>IMR</th>
<th>Life expectancy</th>
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<tr>
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Mixed model aims to be universal and comprehensive

**Universal**
- Access is not based on income or means testing.
- Strong emphasis on being free at point of use.
- Strong emphasis on providing services close to people.

**Comprehensive**
- Offer full range of services and do not explicitly confine services to ‘essential’ or ‘basic’ care.
- Substantial funding for hospitals and inpatient care.
Characteristics of the model

- Majority funding for health from government and exclusively tax based: no adoption of social health insurance mechanisms.
- Public funded package includes services that are genuinely available to the poor through a widely dispersed delivery network.
- Focus is on maintaining core clinical quality not on consumer choice.
- Private financing of health care provision is allowed to meet consumer demand for additional ‘add on’ services, for example, doctor of choice, reduced waiting times, enhanced inpatient amenities such as private rooms and choice of food.
- Limited public funding benefits the poor more than the rich, not by means testing, but by differences in consumer quality.

Pro-poor: quality publicly funded health care at low-cost

Pro-rich: allowing access to better consumer quality private health care
Universal – but in practice, pro-poor in reach
Rely on rich to voluntarily opt out and pay for care in private sector

Use of public and private care by poor and rich

- Public
- Private

<table>
<thead>
<tr>
<th>Poor</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Richest</th>
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<td>1.5</td>
<td>1.7</td>
<td>1.4</td>
<td>2.8</td>
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Mixed systems are not perfect

- Vocal middle class who want better consumer choice often unhappy and problem for political leaders.
- Poor may opt to use private care and put themselves at financial risk.
- Rich may selectively opt to use public health care to reduce out of pocket expenses on high cost services.
- Often poorly regulated private sector of variable clinical quality.
- Health care workers may migrate to private sector putting stress on public system.
Concluding thoughts

- High income is not a necessary pre-condition for UHC. Developing countries can achieve UHC.

- Tax money is critical for financing UHC.

- The standard NHS and SHI models of UHC are hard to implement in most developing countries.

- A mixed public-private model found in many Commonwealth countries provides an alternative model for countries with limited tax resources.