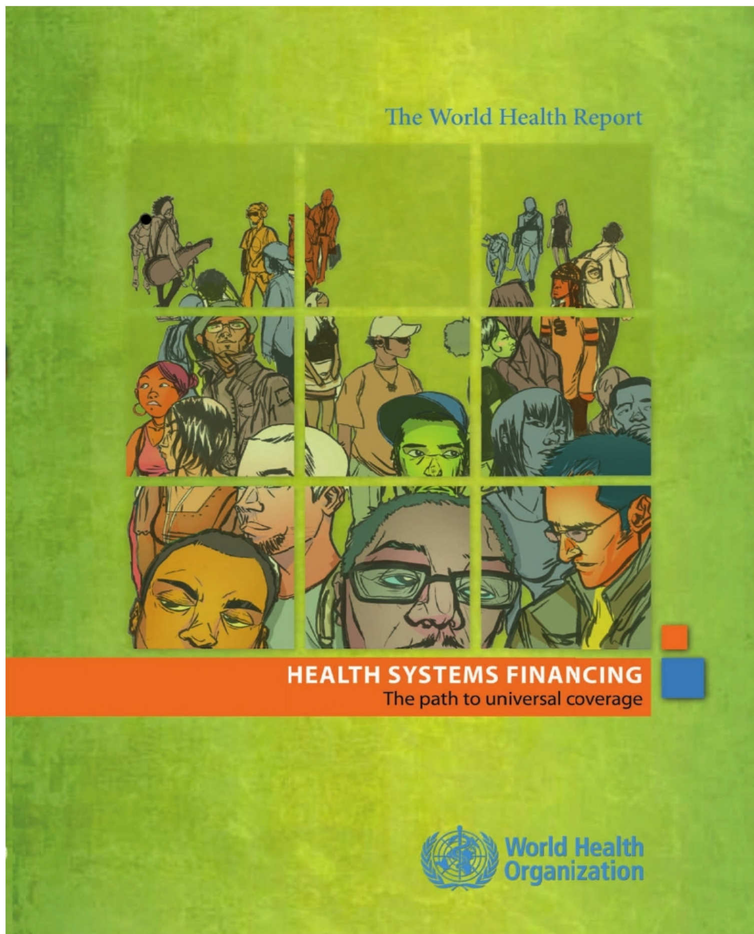

Universal Health Coverage: concepts and principles

Alaka Singh
WHO SEARO

Overview

- Universal Health Coverage: concepts and measures
- Implications of UHC for health financing policy (what's new about all of this?)
- WHO's approach to health financing policy for universal coverage

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UNIVERSAL COVERAGE: CORE CONCEPTS AND DEFINITIONS

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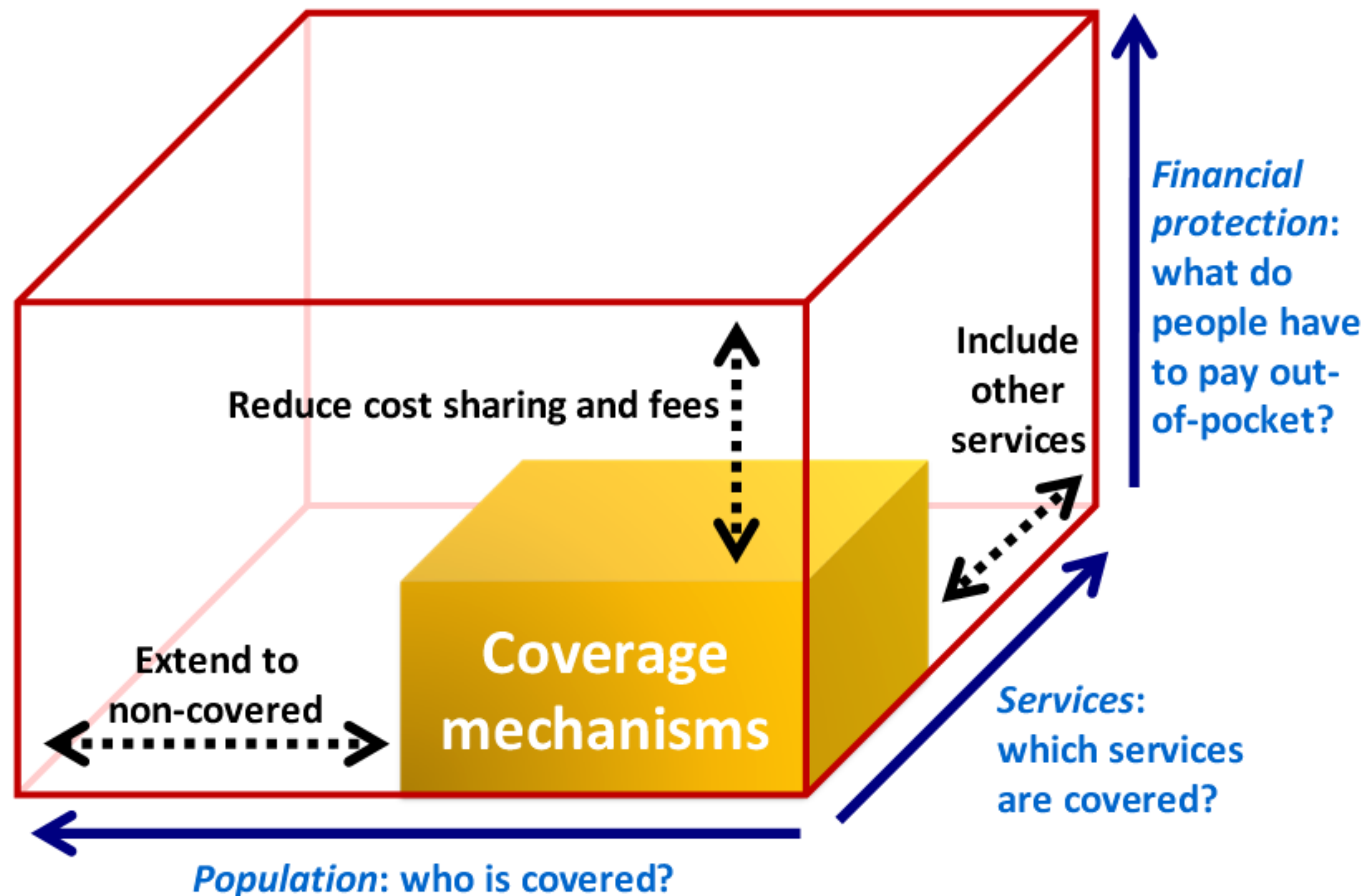
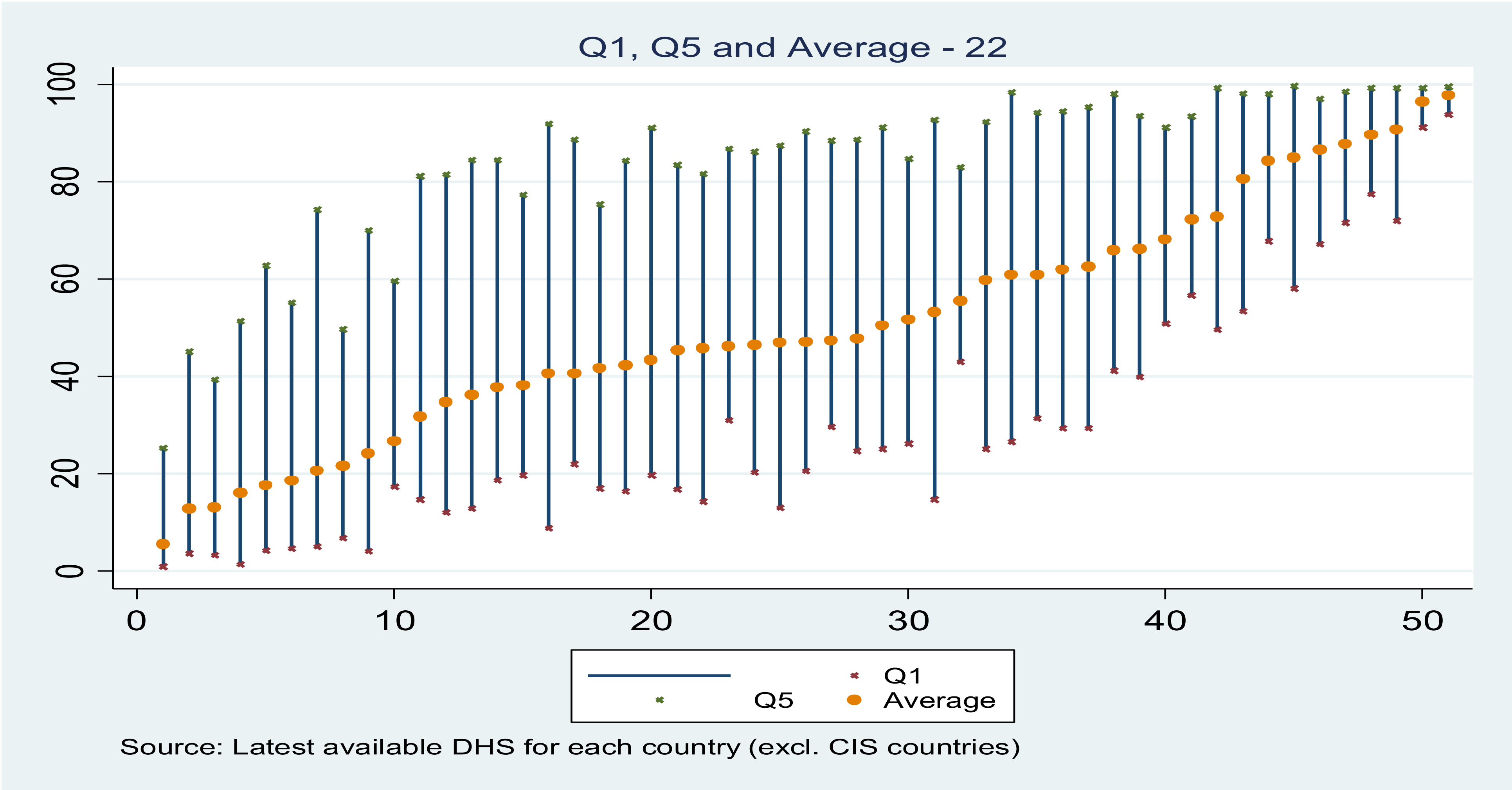
Three dimensions (policy choices) of Universal Coverage as portrayed in WHR

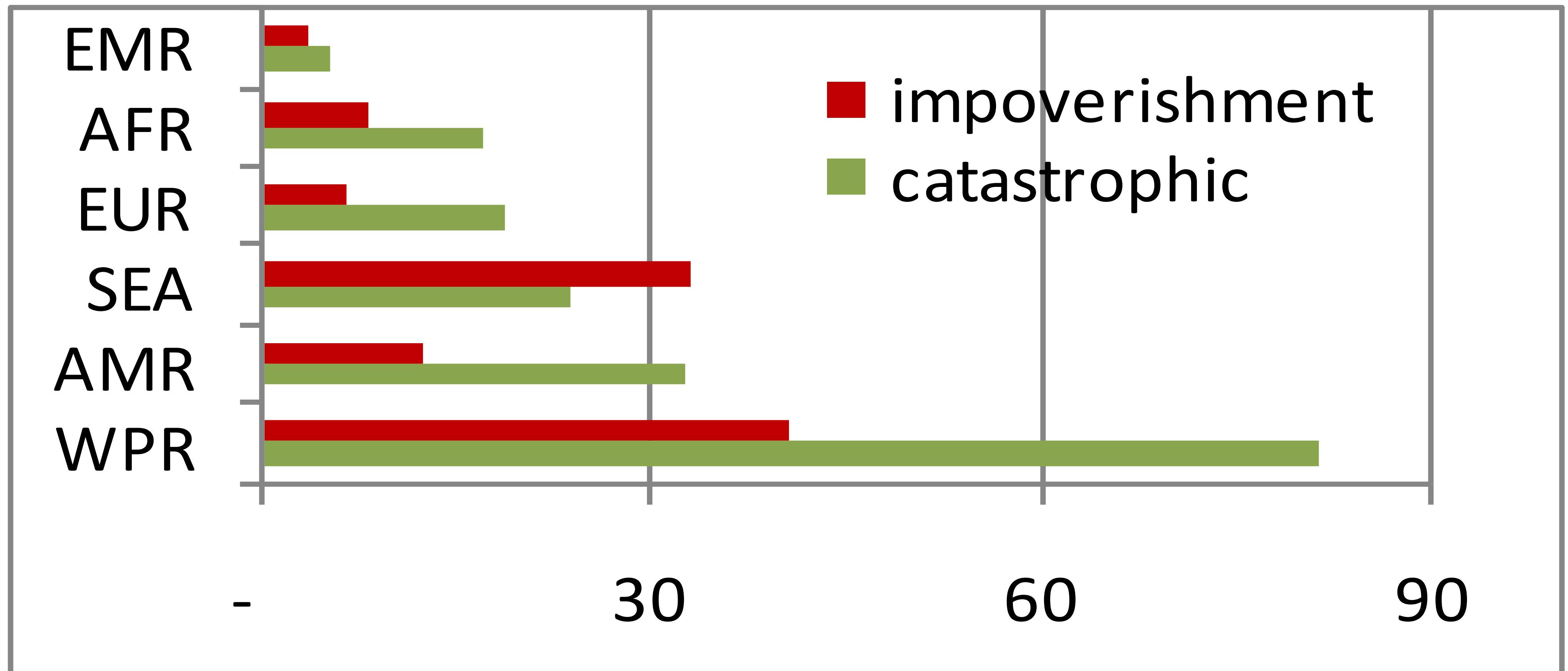


One view of the challenge: millions miss out on needed health services

Percentage of births attended by medically trained persons



Millions more suffer financially when they use health services



Number of people (million)

Definition: Financing for Universal Coverage

- "Financing systems need to be specifically designed to:
  - Provide all people with access to needed health services (including prevention, promotion, treatment 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

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Definition embodies specific aims (universal coverage objectives)

- Access (reduce gap between need and utilization);
- Quality (sufficient to make a difference); and
- Financial protection…
- …for all

- Isn't this Utopian and unattainable??

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UHC is a direction, not a destination

- No country fully achieves all the coverage objectives
  - And harder for poorer countries
- But all countries want to
  - Reduce the gap between need and utilization
  - Improve quality
  - Improve financial protection
- Often, it translates into reducing explicit inequalities in benefits and funding per capita between groups
  - Mexico, Thailand, South Africa using this as political driver of their reform agendas
  - Relatedly, UHC as a means to the end (or the embodiment) of having “fairer societies”
- Thus, moving “towards Universal Coverage” is something that every country can do

The concept is operational, but measurement is a challenge

- Currently, we have measurable concepts for the financial protection objective
  - Catastrophic and impoverishing expenditures, extent to which poverty is “deepened” due to health payments
- There are challenges in measuring the other aspects
  - Level/equity of utilization relative to the need for services
    - Information on non-MCH service utilization rarely available
  - Quality of the services
- Measurement framework in progress

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International vs national relevance

- A single international measure for tracking progress on all UHC objectives (access, quality, financial protection) is not likely to be available, particularly given data limitations on "need" and "quality"
  - Concepts around financial protection are measurable, though always room for data and methodological improvements
  - Measures for other objectives need to be developed
- For individual countries, specific measures may be very useful for tracking progress…
  - E.g. Equity in per capita public subsidies, equity in utilization
- But not internationally comparable

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The concept also implies that more than health financing reforms are needed for UHC

- Health financing policy directly affects financial protection
- Financing and other parts of the health system (service delivery, human resources, medicines, technologies) combine to influence service utilization
- Health financing is only a complementary instrument for influencing quality (service delivery, human resources/ medical education, medicines, technologies, information)
- Health financing one part of overall health system; requires strong governance to ensure all the pieces fit together

SO WHAT IS NEW ABOUT ALL OF THIS?

Universal Coverage for health services is not a new concept

- Emerged in particular after 2nd World War
  - Push for "social cohesion" in Europe
  - Concept of "human security" in Japan
- WHO constitution "highest attainable standard…" for all
  - And later Alma Ata – "Health for All"
- Universal Declaration of Human Rights, includes "right to…medical care"
- Now embedded in many national constitutions

But UHC combines both service coverage and financial protection, explicitly

- This was new for the public health community
  - Financial protection as integral to the concept of UHC
  - Beyond "Health for All" to Health for All with financial protection
- Also new for (health) economists
  - Focus had been largely on financial protection and the "economics of health insurance"
  - Recognize that Universal Coverage is more than this, requiring as well a focus on services and their quality

Shift to UHC implied profound change in how we think about "health insurance"

- Health insurance emerged in Europe as a condition of labor (first formalized as public policy under Bismarck)
  - Increasing labor productivity (industrialization)
  - Reducing labor radicalism and unrest
  - Thus, social (compulsory) health insurance for wage earners
- After 1945, "universal coverage": affordable access to health services as a condition of citizenship or human/ constitutional right
  - Implies a shift away from a purely (direct) contributory approach
  - Also implies compulsion or automatic entitlement
  - Thus, health coverage for the entire population, with explicit policies to fund coverage for the non-salaried population

Early 21st century pathways to UHC

- Thailand merged several different schemes into one, funded from general revenues, using quasi-public purchasing agency
  - Overcame most but not all fragmentation across schemes, and progressively working to equalize benefits across them
- Mexico is addressing its legacy of a fragmented and unequal system by
  - creating a budget-funded insurance program for a defined list of high-cost services for the entire population
  - creating a program of "popular insurance" for informal sector funded largely by central budget transfers to the States, which in turn are responsible for enrolling the population
  - Also reducing gap in per capita funding and benefits across schemes

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These countries took a “functional approach” to health financing policy

- Recognized that the source of funds need not determine how money was pooled, how services were purchased, nor how benefits were specified
- They moved away from thinking in terms of “schemes”
  - Pooled together or coordinated use of different revenue sources (in fact, so do Germany, Japan, Netherlands, Czech Rep, etc.)
  - Introduced elements of performance-related payment from the prepaid funds to address specified utilization or efficiency issues
  - Progressively increased the size of the compulsory prepaid funds while reducing the barriers to redistribution within it

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Does UHC = Universal Health Insurance??

WHO’S APPROACH TO HEALTH FINANCING POLICY

What do we mean by "health financing policy"?

Classifications or models

- "National Health System" (Beveridge Model)
- "Social Health Insurance System" (Bismarck)

Old thinking, not helpful for analyzing systems and choices

Functions and policies

- Collection
- Pooling
- Purchasing
- Benefits and rationing

Relevant to all countries and essential for analyzing systems and choices

- **Understand systems (and reform options) in terms of functions, not labels or models**

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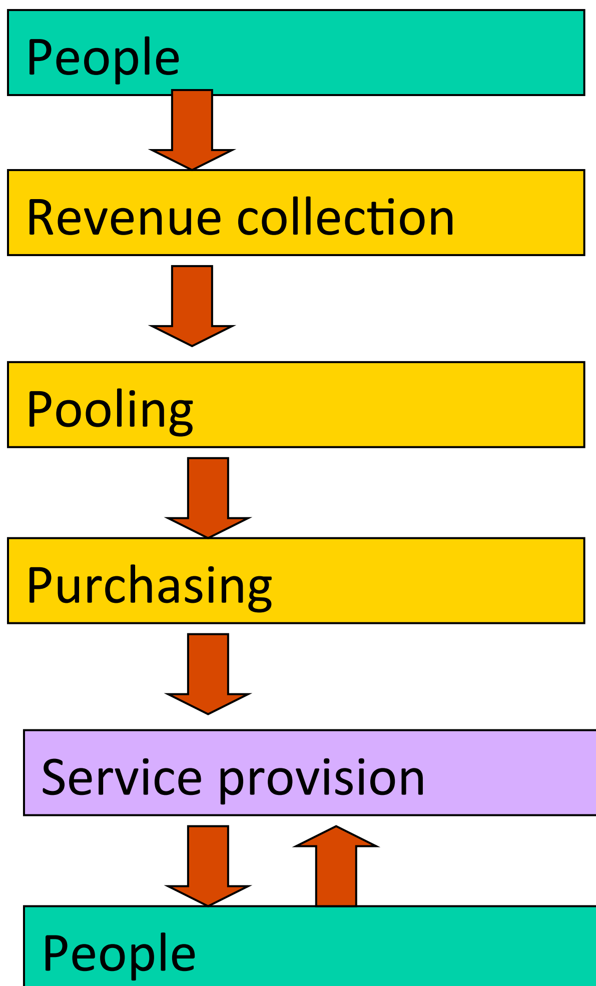
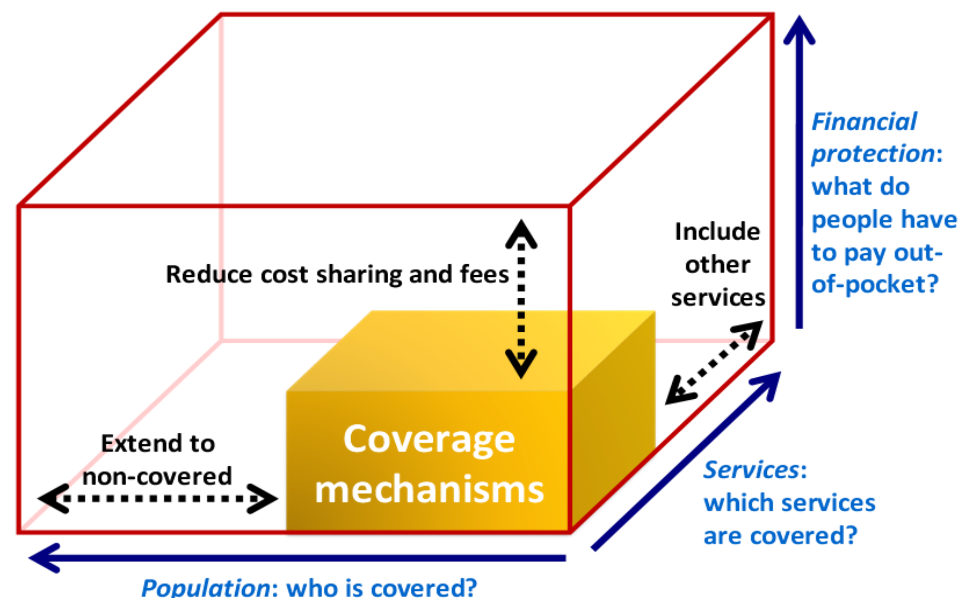
What kinds of choices need to be made?



and also this:

Reforms to improve how the health financing system performs

This



Breadth, depth and scope of coverage; level and distribution of utilization, extent of catastrophic and impoverishing payments…

Principles of our approach(1): insuring the population as a core objective

- All financing systems (other than pure out-of-pocket) are systems of insurance – assess performance by how well they do this job, not by what they are called
  - WHO is committed to the objectives of health financing reform, but not to any particular institutional form or model
  - Similarly, our core conceptual foundations are universal. We don't have separate concepts for low, middle, and high income countries (but of course, because the starting point and other aspects of context differ, so will the relevance of different policy choices)

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Principles(2): sources are not systems

- Effective policy, and policy analysis, requires thinking in terms of functions rather than models
  - Source of funds does not have to determine how they are pooled, how providers are paid, and how benefits and co-payments are specified
- Labels/models…
  - Can be politically useful in particular contexts as a communications tool ("we are changing to an insurance system")
  - But should not restrict our thinking about the choices that need to be made with respect to pooling, purchasing, benefit package, etc.

But…communication of this can be difficult

- Thinking in terms of functions may be correct, but speaking in terms of models is common and appears easier to convey for politicians and the public
  - “We are implementing a new social health insurance scheme” is easier than “we are reducing fragmentation in pooling”.
- Difficult terrain, given that many individuals and agencies are wedded to their models and frameworks
- Nevertheless, conceptual clarity is essential for good policy
  - For example, recognizing that financial protection and access can be provided from general revenues as well as “insurance contributions”

Communications challenges, continued

- Need to ensure that we communicate effectively while also thinking correctly and comprehensively
  - In Russia and Azerbaijan for example, it was important to say that “we are changing to an insurance system” as the means of communicating that “we need fundamental reform of our health financing system”. It did not mean a change to a fully contributory system.
- But also essential to avoid terminological imperialism
  - In any given country, what matters is the terminology that they are comfortable with and understand
  - WHO’s job is to ensure that, regardless of what words are used, the approach to financing reform is comprehensive and oriented to the objectives associated with universal coverage

Principles(3): we are not selling a model; always need to tailor to country context

- There is no blueprint: must understand country's current health financing arrangements and context (fiscal, administrative, political, social) as the starting point for reforms oriented towards the policy objectives, to develop a realistic, comprehensive and effective reform strategy

- This does not mean, however, that we are open to anything – certain approaches are clearly not consistent with moving towards UHC

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Theory and evidence have taught us a few things

- No country gets to UHC relying principally on voluntary health insurance
  - Some who can afford it won't join, and some can't afford it
  - Compulsion or automatic entitlement is essential
  - Issue is compulsory vs voluntary, not public vs private
- Because there are always some who can't contribute directly, all countries with universal population coverage rely on general budget revenues (in whole or in part)
  - And the larger the informal sector, the greater the need for using general revenues (but sources are not systems!)
- To sustain progress, need to ensure efficiency and accountability
  - "Strategic purchasing" as a critical strategy for this (and also for capacity strengthening, given the linkage between information and resource allocation)

And fragmentation is an obstacle to equitable progress towards UHC

- A system is fragmented when there are barriers to the redistribution of prepaid funds
- Fragmentation of pooling limits the ability to cross-subsidize
  - Can only cross-subsidize within pools, not between pools (unless there is central re-distribution mechanism)
- Fragmentation is a concern in virtually all health financing systems
  - Especially when you divide the population into different schemes with different benefits and funding levels per capita
- So while we want more pre-payment, we don't want more pre-payment schemes if this means more fragmentation

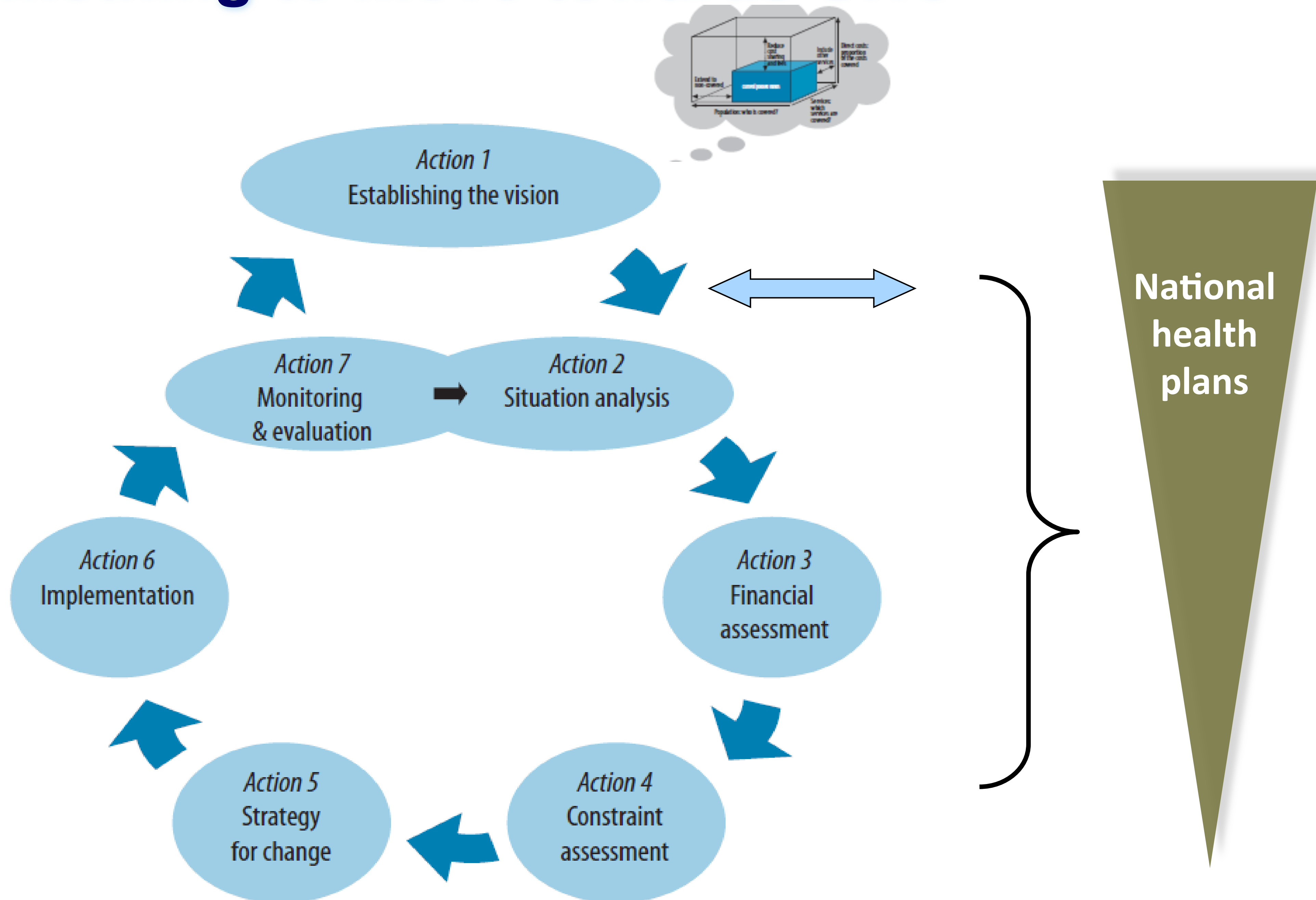
WHO' s position

- WHO is committed to help countries sustain progress towards Universal Coverage
- WHO is NOT committed to any particular model
  - We care about access, quality and financial protection, not the label (Germans are not more "insured" than the British)
- WHO does NOT believe in magic
  - Slogans or isolated instruments do not work
  - "just free care" or "just SHI" or just "results-based payment" unlikely to work: the pieces need to be coordinated
  - Requires a comprehensive approach to address a complex, ever-changing set of challenges
- While the goals of universal coverage are broadly shared, each country's context and starting point differs; thus, the path to universal coverage must be "home grown"
  - But some approaches are clearly not consistent with UHC, and we will make clear our views, as needed, in the policy dialog process

Towards Universal Coverage requires moving from scheme to system

- Operational principles to guide progress
  - Explicit complementarity of different funding sources
  - Focus on reducing fragmentation and expanding pool size (more prepayment, not more prepayment schemes)
  - Recognize that real progress will require an explicit role (and often, increased levels) for general revenues
  - Create unified information platform across all schemes to lay foundation for universal financing system
  - More money and larger pools not enough: need to move towards strategic purchasing to address inefficiencies and make progress on defined, measurable objectives by linking payment to core benefits (e.g. free deliveries)

Guided by these principles, every country can do something to move towards UHC



Regional Strategy for UHC

- Requested through SEA/RC63R/5 and endorsed through SEA/RC65/R6
- Country situation analysis and technical notes in collaboration with ministries of health and other experts.
- Expert consultation to review background documents.
- Regional consultation to discuss key area findings. from background work and agree on the outline of the Strategy document.
- A full draft of the document was then prepared by the responsible technical unit:
  - Significance of issues beyond health financing for UHC and, accordingly, includes with other areas of health systems.
  - Each section includes a summary discussion on the situation in SEAR; technical issues; country illustrations on the UHC experience; and, the way forward for UHC in SEAR.

Strategic Direction 1.
Placing PHC-oriented HSS at the centre of UHC

Countries in SEAR have defined UHC in different ways and are at different levels of achievement. The common underlying UHC policy goal in all countries is to improve equity in health.

It is useful to have a common framework for Member States and WHO as basis for taking forward the UHC agenda:

UHC may be defined as having three dimensions:

- *universal* or a population dimension (who is to be covered)
- *health* or a service delivery dimension (covered with which services)
- *affordability* or a financing dimension (covered at what cost)

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Strategic Direction 1.
Placing PHC-oriented HSS at the centre of UHC

The *definition* and *principles* of PHC are very relevant to informing strategic choices along these three dimensions: a benefit package that gives priority to the health needs of the poor and public health, delivered using appropriate technology and at sustainable cost.

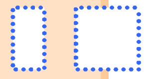
Using this definition, significant progress on UHC can be made at low cost and in resource constrained settings. A pragmatic way forward is to phase in UHC starting with PHC priorities to eliminate avoidable systems inequities and inefficiencies; and, extending to more comprehensive coverage as requisite systems and institutional capacities are developed.

Strategic Direction 1. Placing PHC-oriented HSS at the centre of UHC

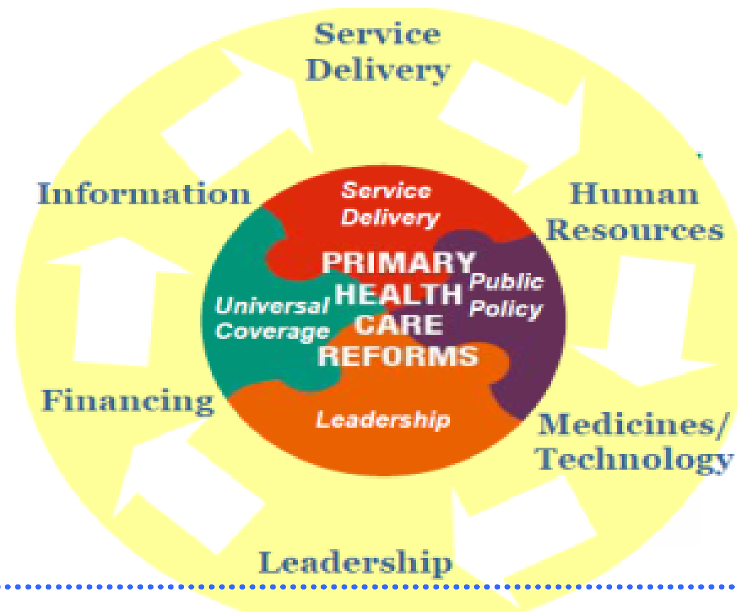
Definition
? Essential care
? Appropriate technology
? Universally accessible
? Affordable
? Community participation
? Self-reliance

Principles
? Country context
? Comprehensive care
? Poor a priority
? Community empowerment
? Effective referrals
? Appropriate skill mix
? Multi-sectoral

PRIMARY HEALTH CARE



PHC based UHC strategy



PHC oriented system strengthening: Equitable financing and efficient service delivery for UHC

STRATRGIC CHOICES FOR UHC

1. ***who*** **is to be covered**: the entire population, with priority to be given to the poor and vulnerable.

2. **covered *with which services*:** a comprehensive, cost-effective benefit package - prevention, promotion, curative and rehabilitative care - with a priority for health needs of the poor and public health needs of the overall population.

3. **covered *at what cost*:** affordable and sustainable at household and national levels.

Source: Author

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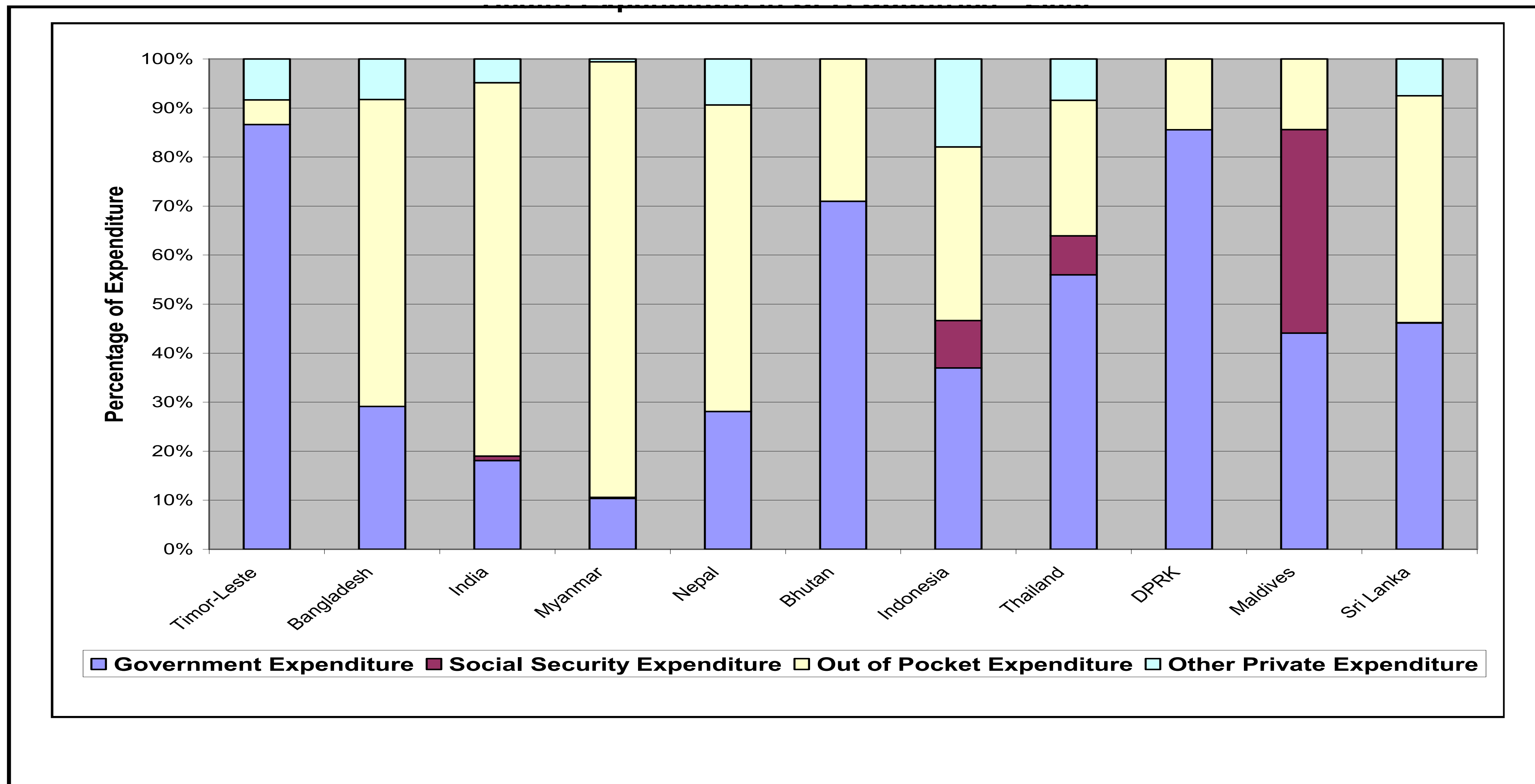
Composition of health spending in each SEAR country (2010)



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Strategic Direction 2.
Improving equity through social protection

OPP in SEAR is the highest among all regions and is a key driver of health-related inequities. Countries that have progressed well on UHC have reduced OOP to less than 1/3 of total health expenditure, with government spending at about 5% of GDP. Therefore, health financing is being reviewed as a lead area of HSS for UHC.

Experience suggests that the way forward on reducing inequities is through social protection by shifting to mandatory pre-payment and consolidated pooling through tax-based funding and/or social insurance contributions at national level.

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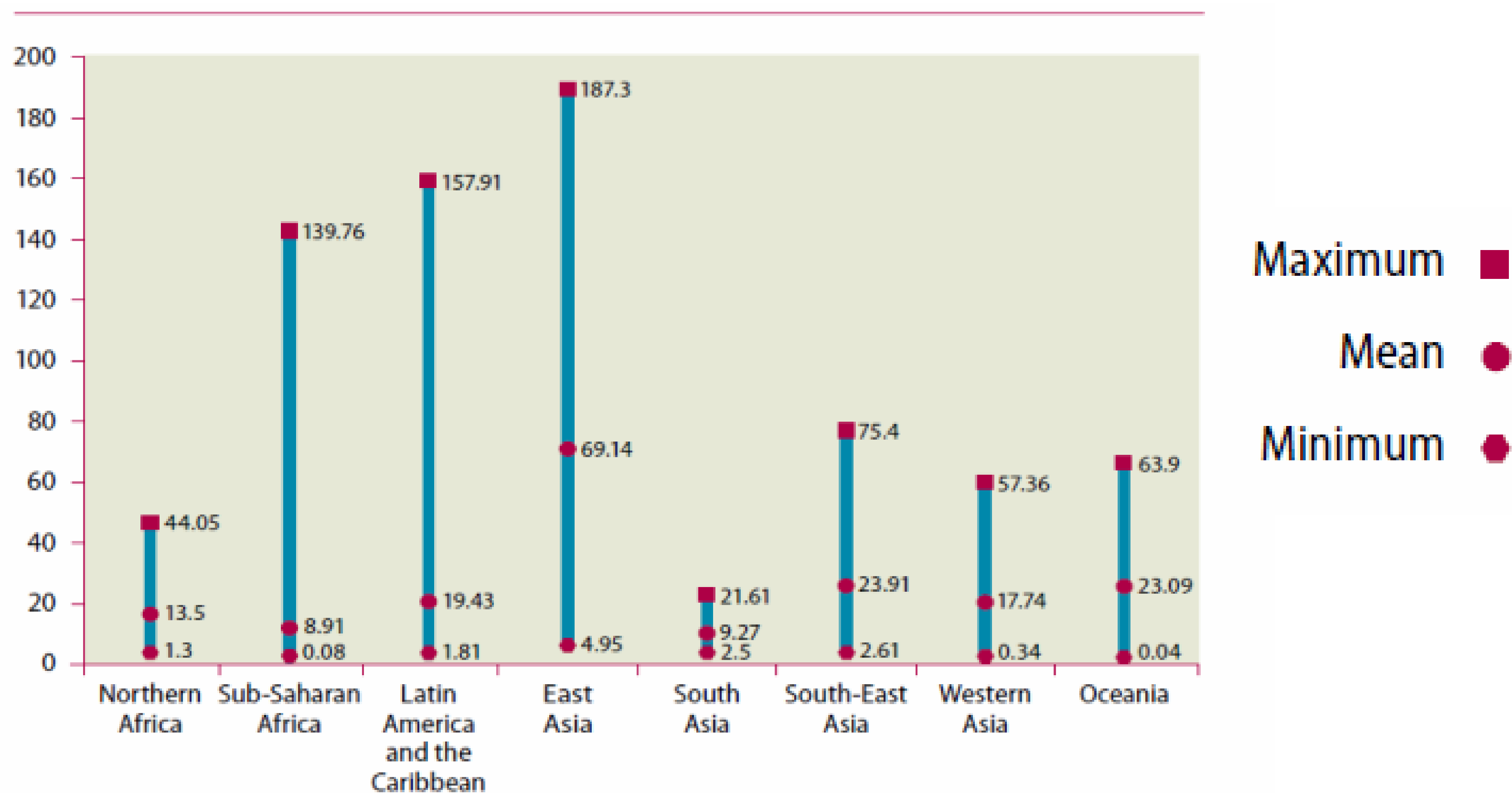
Strategic Direction 2.
Improving equity through social protection

There is potential to raise additional financing through a higher share of government revenue or ear-marked contributions to social insurance.

There is also some scope to raise marginal, supplementary resources from community based initiatives and innovative financing best used for specific activities and for targeted populations.

Importantly, these options have been implemented successfully for social protection in contexts similar to that in SEAR countries.

Per capita public expenditure on medicines (2007)



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Producer and consumer margins in medicine prices in select countries.

Country	Public sector markup	Private sector markup
China	24-35	11-33
El Salvador		165-6 894
Ethiopia	79-83	76-148
India		29-694
Malaysia	19-46	65-149
Mali	77-84	87-118
Mongolia	32	68-98
Morocco		53-93
Pakistan		28-35
Uganda	30-66	100-358
United Republic of Tanzania	17	56

Strategic Direction 3.
Improving efficiency in service delivery

- In addition to improving equity or distributional efficiency through better health financing, technical and allocative efficiencies in service delivery are equally relevant for UHC – they determine which services are provided and at what cost and, therefore who can has access to them. In SEAR, there is push away from low-cost alternatives (including public health) to high(er)-cost curative care driven by the dominance of private provide, increasing burden of NCDs and availability of high-end technology.

- There are four main areas of broad systems inefficiencies (Note: these are not independent of systems financing nor are they independent of each other implying the importance of an integrated approach in policy development):

Strategic Direction 3.
Improving efficiency in service delivery

- Expenditure on medicines is the largest component of OOP in SEAR and experience highlights the significance of increased public investment in medicines, better price control and use of generics.

- Experience also shows that provider payments can be used to 'correct' the health systems incentive structure to influence the type of service, cost of provision and overall performance in both the public and private sectors, including supporting public-private partnerships. In decentralised service delivery structures, inequities between decentralised units must be minimised through e.g. needs-based allocation criteria of central funds.

Strategic Direction 3.
Improving efficiency in service delivery

- Further, it is also important to review administrative decentralization from the perspective of health systems needs – some health function may not be appropriate for decentralization e.g. procurement or financing public health.

- Effective response to address these issues requires strengthening of regulation overcoming political, administrative and information constraints.

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Strategic Direction 4.
Strengthening capacities for UHC

National health policy strategy and planning (NHPSP) is key to the UHC effort in countries.

Countries in SEAR need to strengthen both process and content so as to use NHPSP more strategically for UHC.

Critical capacity gaps are in evidence building for and effective use in NHPSP; resource planning; process management; linkages between all health-related plans; and, monitoring and evaluation.

- **Economic evaluations and impact assessments**
  - **Health technology assessments**

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Global health 2035: a world converging within a generation
The Lancet Commission on Investing in Health

The report was developed by an independent commission of 25 international economists and revisits the case for health investment made by *Investing in Health*, the World Bank's 1993 World Development Report (WDR 1993) on its the 20th anniversary. The commission was chaired by Lawrence Summers, the Chief Economist at the World Bank responsible for choosing global health as the focus of WDR 1993, and co-chaired by Dean Jamison, lead author of WDR 1993. The report has four key messages, each accompanied by opportunities for action by national governments of low-income and middle-income countries and by the international community.

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Global health 2035: a world converging within a generation

The Lancet Commission on Investing in Health

The returns on investing in health are even greater than previously estimated
Within a generation—by 2035—the world could achieve a "grand convergence," bringing preventable infectious, maternal and child deaths down to universally low levels
Taxes and subsidies are a powerful and underused lever for curbing non-communicable diseases and injuries
Progressive universalism, a pathway to universal health coverage (UHC) that targets the poor from the outset, is an efficient way to achieve health and financial protection.

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