
UNIVERSAL HEALTH COVERAGE: LESSONS TO GUIDE COUNTRY ACTIONS ON HEALTH FINANCING

WHAT IS UNIVERSAL HEALTH COVERAGE (UHC)?

UHC embodies specific health and social goals: it is the aspiration that all people can obtain the quality health services they need (equity in service use) without fear of financial hardship (financial protection). As such, UHC promotes realisation of the human right to health, disassociating access to services from ability to pay. This right is declared in the World Health Organization (WHO) Constitution and increasingly in many national constitutions or laws, thereby reflecting universal social values such as human security, social cohesion, and solidarity.

WHY IS UHC IMPORTANT TO PEOPLE EVERYWHERE?

Over a billion people lack adequate access to needed health services and 100 million are pushed into poverty each year as a consequence of paying for the services they receive.¹ UHC is a response to this, providing the assurance that the health services people need are available, affordable and of good quality.

Expanding coverage of financial risk protection and effective health services improves population health and productivity, thereby contributing significantly to overall economic and social development. At the same time, financial protection prevents people from being driven into poverty as a result of paying for health services out of their own pocket.

The aspiration to move toward UHC is relevant to all countries, as reflected in the 2012 United Nations General Assembly (UNGA) resolution.² All countries can make progress on UHC, expanding the population covered, the package of services, and the extent of financial protection provided. These trade-offs must be considered as additional resources become available, technologies advance and population needs evolve.

WHAT ARE THE HEALTH FINANCING LESSONS FROM COUNTRY EXPERIENCES FOR PROGRESS TOWARD UHC?

Various countries at different income levels have recently made rapid progress towards UHC. There is no “one size fits all,” approach, and countries as diverse as Chile, China, Ghana, Kyrgyzstan, Mexico, Moldova, Rwanda, Thailand and Vietnam have each chosen unique pathways. However, the vast diversity in approaches to UHC does not mean anything goes. Country experience reveals common lessons for success and pitfalls to avoid. Here we outline six lessons in health system financing to guide progress toward UHC.

1. MOVE AWAY FROM OUT-OF-POCKET SPENDING TOWARD PREDOMINANT RELIANCE ON COMPULSORY AND PREPAID FUNDING SOURCES

No country has made substantial progress toward covering the entire population by relying on payments at the point of use or voluntary insurance contributions. Out-of-pocket payments are the most regressive way of financing the health system, placing financial burden on sick and poor people. Countries should eliminate or substantially reduce out-of-pocket payments and expand progressive mandatory prepayment (i.e. various forms of taxation, including compulsory social health insurance contributions) based on ability to pay.³ The aim is to ensure that there are sufficient resources pooled across the population, and in all cases, public resources have been essential to subsidise the cost of services for poor populations. For example, in China⁴, enrolment in the Rural Community Medical Schemes grew from approximately 10% of the rural population in 2003 to 98% in 2012 following a substantial increase in government subsidies that now contribute an average of 80% of the premium. Low-income countries may need to supplement efforts to improve revenue generation with development assistance to reach even the most basic level of coverage.

2. BREAK OR WEAKEN THE LINK BETWEEN ENTITLEMENT AND CONTRIBUTION

Entitlement should not depend solely on specific contributions made by individuals; otherwise those who are most in need will remain without adequate coverage. Where a high proportion of the population does not have regular, salaried employment, it is difficult to collect direct taxes (e.g. income tax or mandatory health insurance contributions). Greater reliance must be placed on general budget revenues sourced primarily from indirect taxes (e.g., value added taxes), which can be designed to be progressive and are an important untapped resource in many countries. For example, after many years of trying to expand coverage for the informal sector with a government-run and subsidized contributory voluntary health insurance program, Thailand abandoned this approach in 2002, introducing instead its “Universal Coverage Scheme” (UCS) that is funded entirely from general tax revenues. The UCS automatically covers all citizens who are not covered by either of the two formal sector health insurance schemes.⁵

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3. EXPAND FISCAL SPACE TO INCREASE PUBLIC SPENDING ON HEALTH

As demonstrated in the lessons above, public financing is critical to subsidise the costs of care for poor and sick populations and to ensure equity on the path to UHC. In many countries, this will require increasing public spending on health, either by prioritizing health financing in national budget allocations, expanding the overall level of public revenues (through progressive mechanisms) and expenditures, or implementing a combination of the two. Mexico's commitment to move toward UHC was reflected in an increase in public spending on health by an average of 5% annually from 2000 to 2006.⁶ Turkey's increases in public spending between 1995 and 2010 contributed greatly to significant improvements in service delivery and to improved access for the underserved and rural populations, with a key focus on priority services for mothers and children.⁷

4. BUILD STRENGTH IN NUMBERS AND ENABLE CROSS-SUBSIDIZATION BY CONSOLIDATING RISK POOLS

Fragmentation of risk pools inhibits countries' ability to distribute prepaid funds for health in accordance with need. To respond to this challenge, countries should build pools that cover people of different economic and health statuses to enable the redistribution of resources. Many countries, e.g. Thailand and Mexico, historically developed health insurance schemes for civil servants and/or formal sector workers before extending explicit coverage to the rest of the predominantly poor population. Recent efforts to consolidate the risk pools - incorporating the informal sector and the poor into the existing schemes - have proven difficult. As a result, governments have been forced to spend more resources to gradually equalize the benefits across the population.

5. IMPROVE EFFICIENCY AND EQUITY TO ENSURE MORE HEALTH FOR THE MONEY

WHO has estimated that between 20% and 40% of health expenditures are wasted in most countries. Effective purchasing of health services can improve efficiency and release funds that can be reinvested to increase the coverage and quality of care. Such strategic purchasing involves shifting from historical, bureaucratic resource allocation processes towards data-driven approaches that use information about the provider's performance and/or the health service needs of the population they serve. Kyrgyzstan and Moldova, for example, moved away from a system where the number of inpatient beds drove hospital budgets, to a mechanism that pays hospitals according to the number of treated patients and severity of their conditions. Hospital managers responded by reducing the fixed costs of their physical infrastructure, enabling them to shift resources toward medicines and supplies.⁸ This efficiency gain benefited those living in poverty most of all by reducing their need to pay for these items directly at the point of service. Similarly, global evidence on the effectiveness of interventions delivered by relatively low-cost community health workers have been shown to improve health outcomes and access to health services for remote and disadvantaged populations.⁹



6. ALIGN PURCHASING WITH BENEFITS TO TURN PROMISES INTO RESULTS

One particularly promising direction has been to create an explicit link between purchasing mechanisms and declared benefits for the population. For example in Kyrgyzstan, when an ineffective fee exemption system was replaced in 2001 by a mechanism to pay providers more to treat people in exempt categories, there was a dramatic decline in out-of-pocket payments by people in exempt groups.¹⁰ Chile introduced the same principle with its Universal Access with Explicit Guarantees (AUGE) program in 2005, which guaranteed the entire population a set of 69 defined interventions.¹¹ Provider payment arrangements were designed to increase access and quality while reducing wait times and co-payments for these services. It is also the same principle reflected in Burundi's free maternal and child health services program, which is supported by a mechanism that pays providers for the services provided to pregnant women and children under 5.¹² These experiences highlight the importance of aligning declared service entitlements with payment mechanisms that enable such promises to be realized.

CONCLUSION

Experience demonstrates that real progress is possible in countries at all income levels. Each country's pathway will differ depending on the local context, however the above lessons are essential for equitable and effective progress.

Country experience provides valuable lessons that are derived from specific technical details in health financing arrangements rather than the reform labels. Labels such as "social health insurance," "community insurance," or "tax-funded systems" have little meaning by themselves and hide the complex choices and options available to countries as they raise, pool, and use funds to ensure the availability and use of quality services.

Health system financing is an essential component of UHC but progress toward UHC also requires coordinated actions across the pillars of the health system with particular attention to strengthening human resources for health.

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