

Health Financing for Universal Coverage: critical challenges and lessons learned

**Joseph Kutzin, Coordinator
Health Financing Policy, WHO**

Regional Forum on Health Care Financing

2-4 May 2012, Phnom Penh, Cambodia



Overview messages

- Think of Universal Coverage as a direction, not a destination
- By international standards, your governments don't devote much to health and could do more
- Conventional wisdom regarding how to scale up coverage may be a source of more harm than good
- Countries need to develop (and where relevant, external agencies should support) comprehensive national health financing policies and long-term capacity for health financing policy



TOWARDS UNIVERSAL COVERAGE



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

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

- Unattainable??

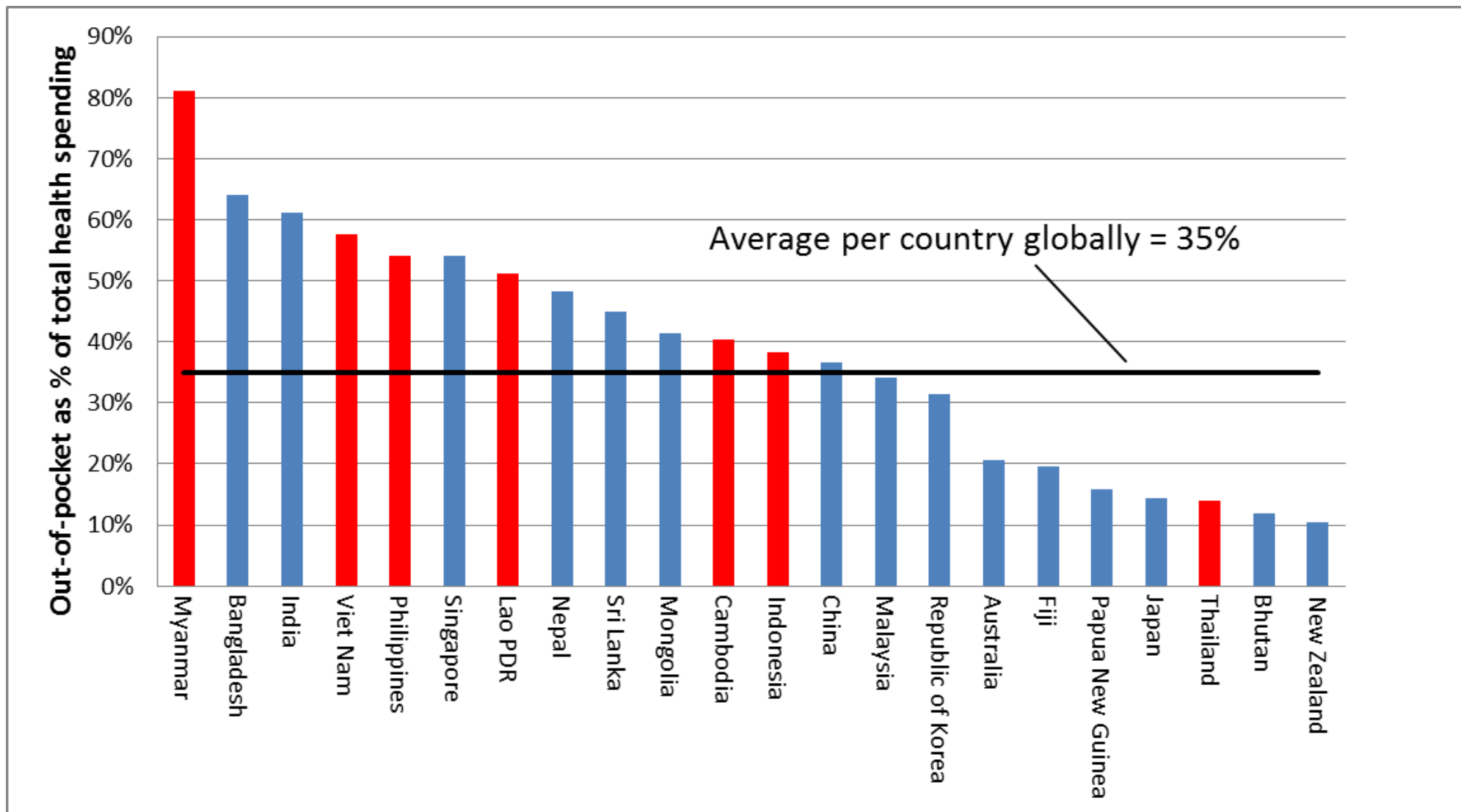
A direction, not a destination

- No country fully achieves all the coverage objectives
 - And harder for poorer countries (coming soon)
- But all countries want to
 - Reduce the gap between need and utilization
 - Improve quality
 - Improve financial protection
- Thus, moving “towards Universal Coverage” is something that every country can do

Out-of-pocket spending (OOPS) as a particular problem

- Widespread reliance on patient payments is contrary to Universal Coverage objectives
 - Compromises equity of access, because service use depends on ability to pay rather than medical need
 - Health care costs pose risk of impoverishment (“your money or your life”)
 - When payment is informal, there are problems of transparency, and it is also difficult to organize incentives for providers

OOPS is a problem in South/Southeast Asia



Source: WHO estimates for 2010, countries with population > 600,000

HEALTH SPENDING PATTERNS IN THE REGION



Accounting for government spending on health

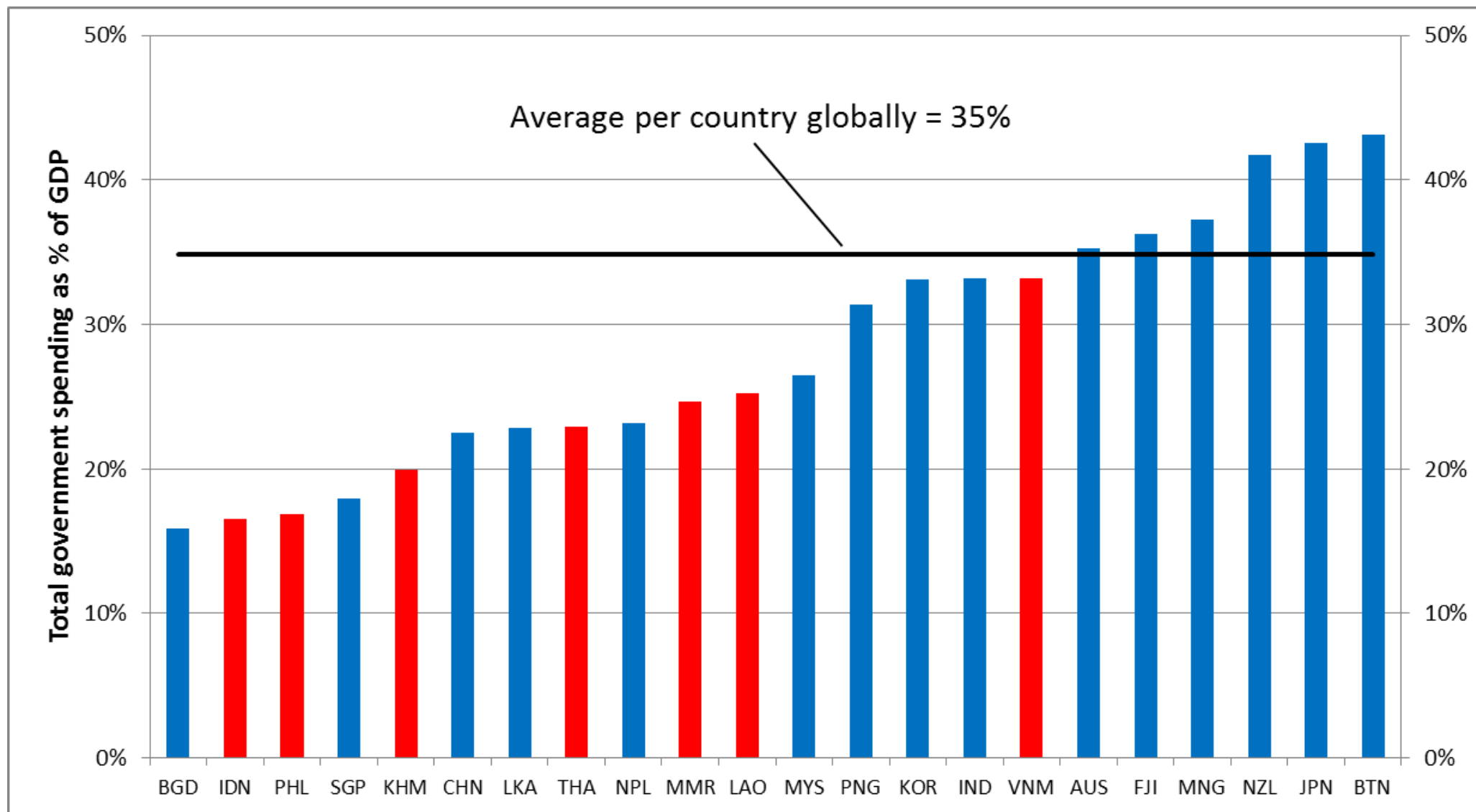
$$\frac{\text{Gov't health spending}}{\text{GDP}} = \frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}}$$

Government health spending as share of the economy

Fiscal context

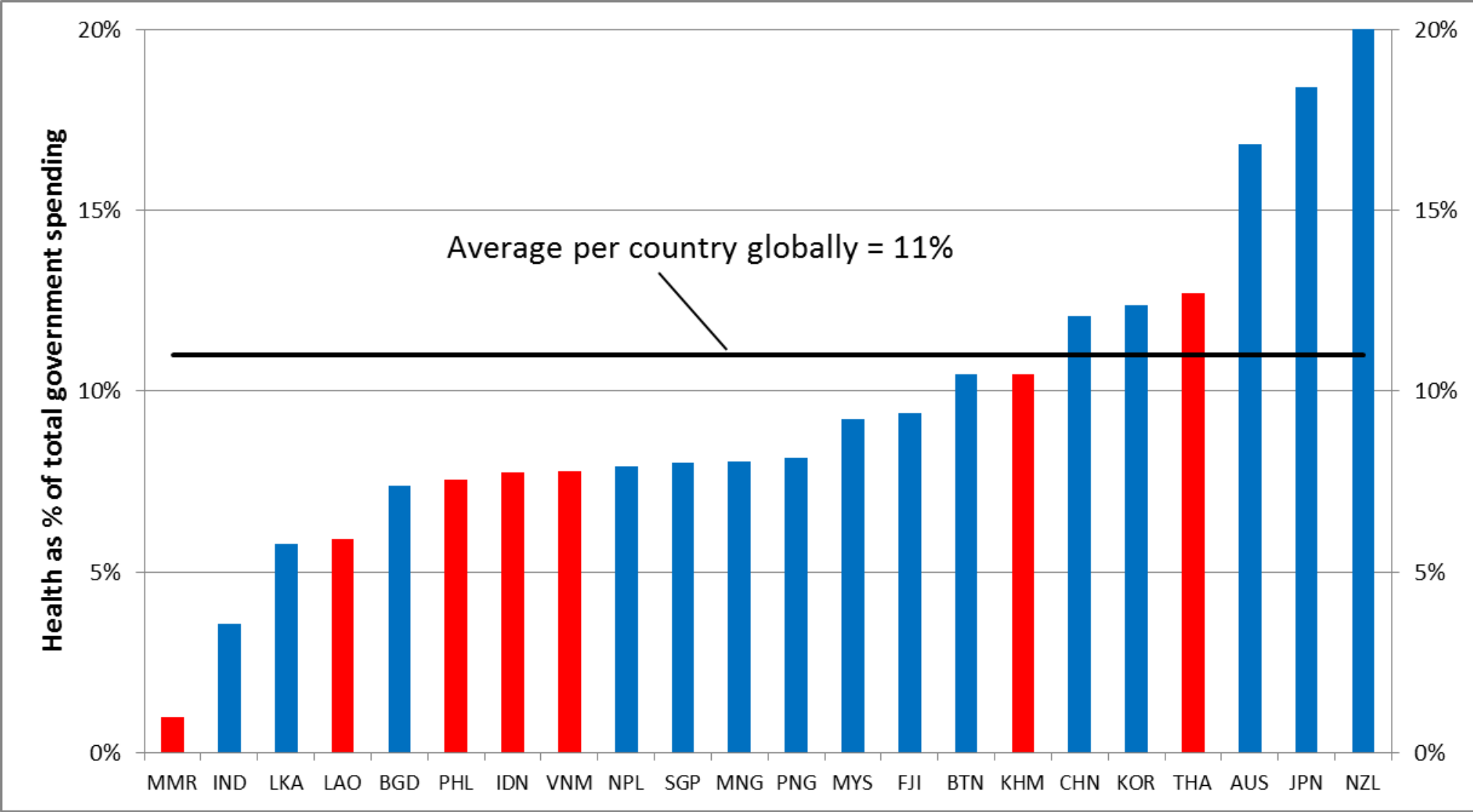
Public policy priorities

Asian countries have small public sectors relative to the size of their economies



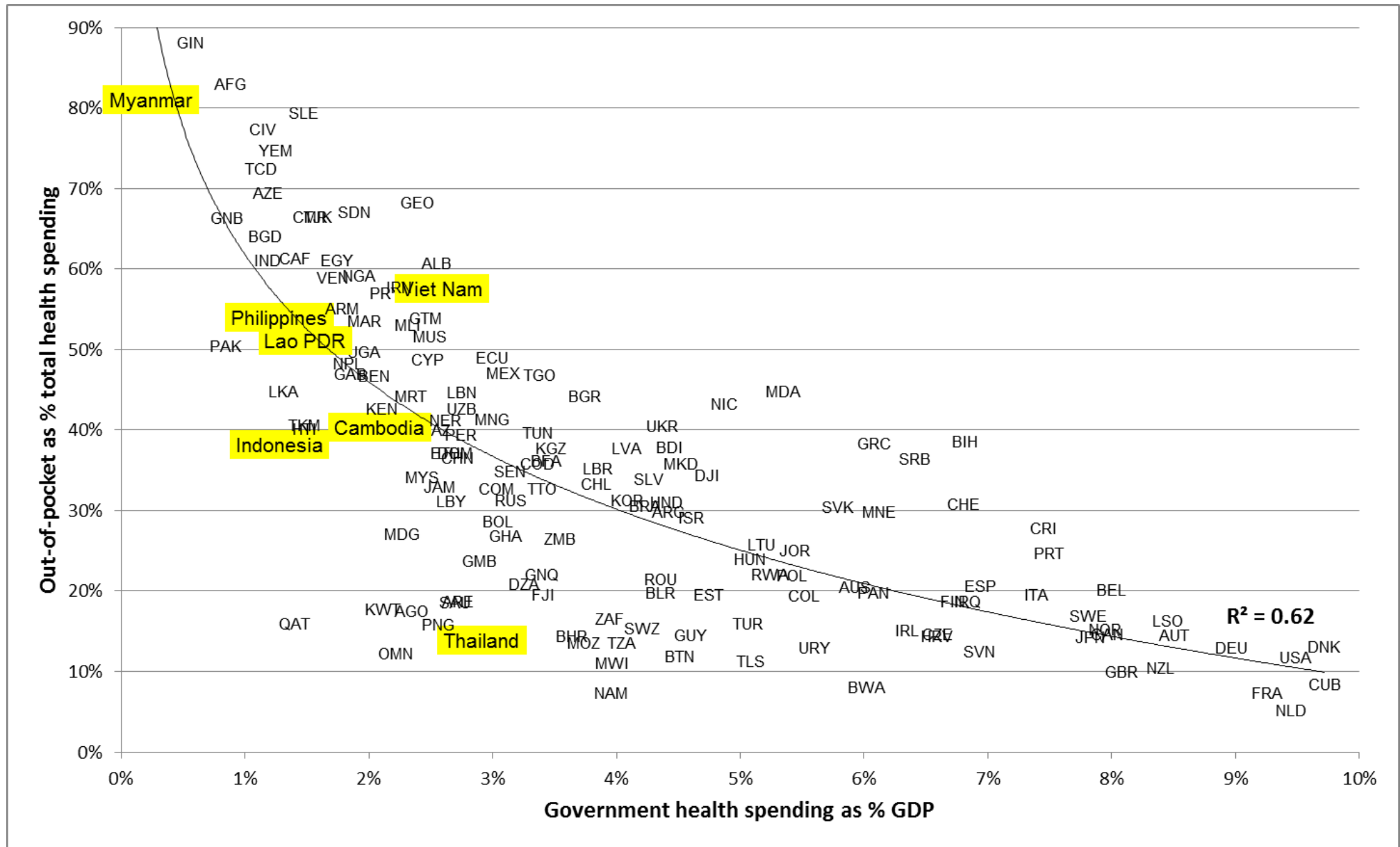
Source: WHO estimates for 2010, countries with population > 600,000

Most Asian governments give very low priority to health



Source: WHO estimates for 2010, countries with population > 600,000

It matters: more government spending on health is linked to lower dependence on OOPs



Source: WHO estimates for 2010, countries with population > 600,000

So to provide good financial protection...

- Context matters

- Much harder for poor countries with large informal sectors to raise tax revenues
- Scope for raising more revenues through income or payroll tax limited for the countries present here today

- Priorities matter

- Given a country's fiscal capacity, a higher (or lower) share that government devotes to health can make a big difference
- South/Southeast Asian countries give among lowest priority to health of any countries in the world

- Policy matters

- Variation around the trend suggests there is more to it than just spending levels; how you organize your health financing arrangements is important

WHO'S PERSPECTIVE ON HEALTH FINANCING POLICY: LESSONS LEARNED AND PITFALLS TO AVOID



WHO's position

- WHO is committed to help countries sustain progress towards Universal Coverage
- WHO is NOT committed to any particular model
 - We do not believe that Dutch or German citizens are somehow more "insured" than British or Swedish citizens, just because of the labels they use.
- 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 theory and evidence have taught us a few things

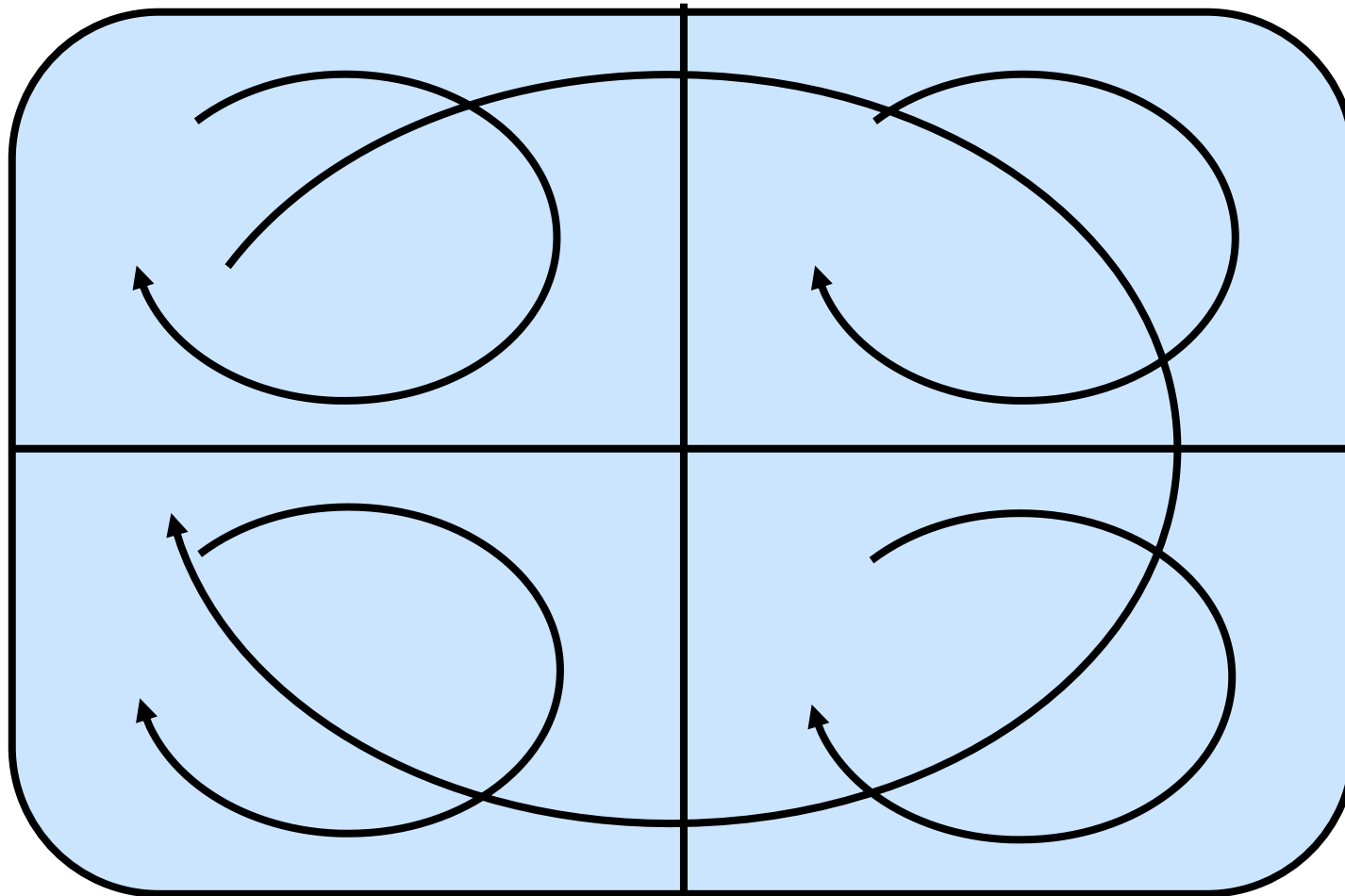
- No country gets to Universal Coverage relying principally on voluntary health insurance
 - Some who can afford it won't join, and some can't afford it
 - Compulsion or automatic entitlement is essential
- Because there are always some who can't contribute directly, all countries with universal population 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!)
- Both unmanaged fee-for-service and rigid line item budgets contribute to system inefficiencies
 - Need “strategic purchasing”: linking provider payment to **information** on their performance or population health needs

Fragmentation is an obstacle to equitable progress towards Universal Coverage

- 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

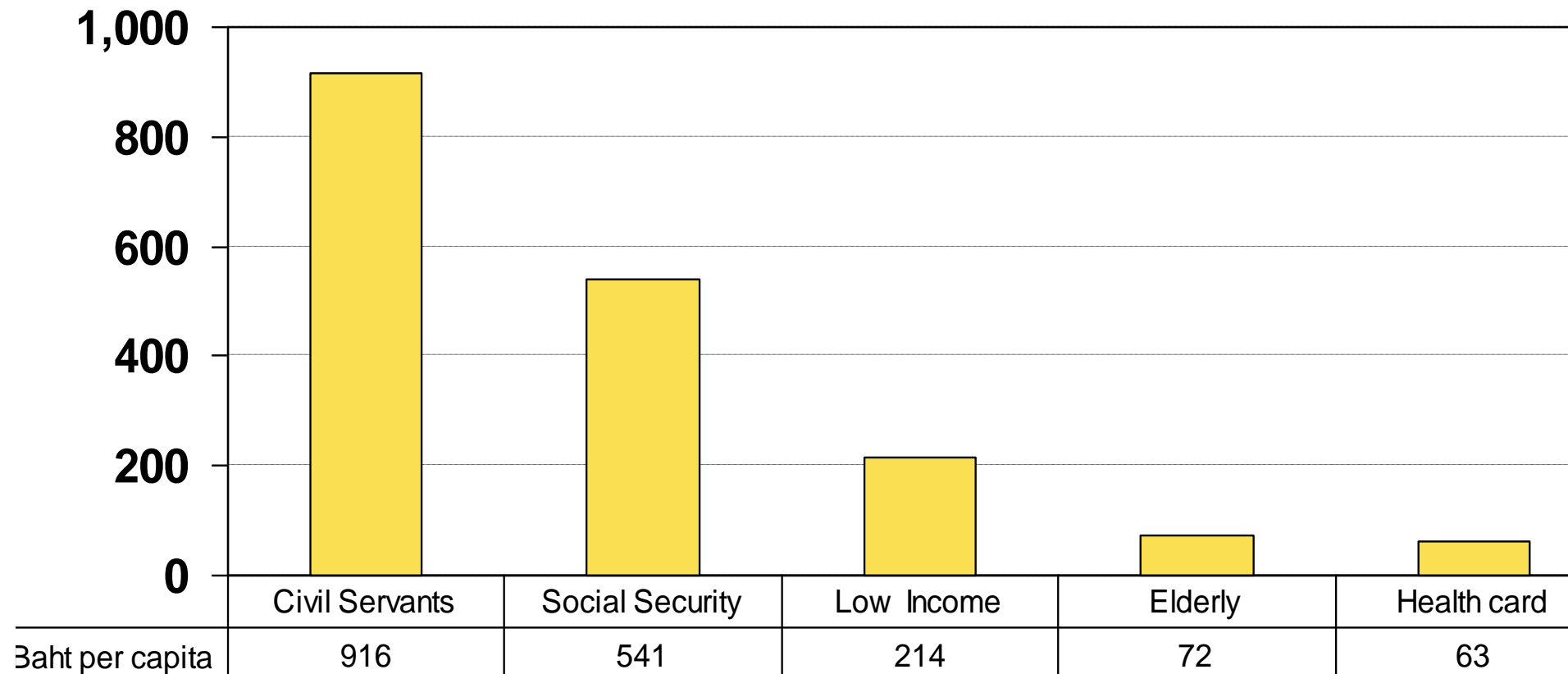


Reducing fragmentation increases the “insurance potential” of available funds



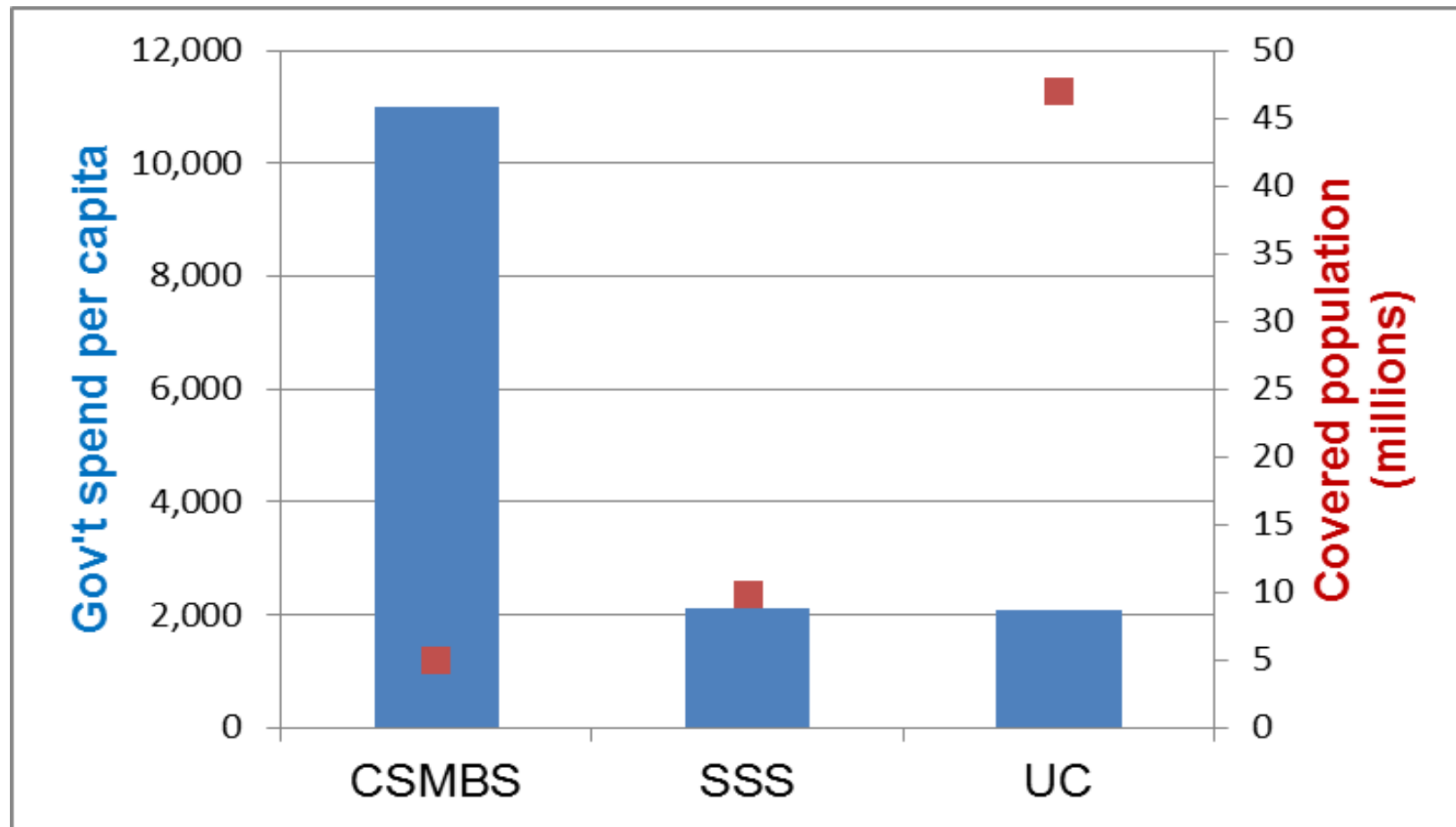
Fragmentation and inequity: benefits from public subsidies in Thailand, 1992

Public insurance expenditure per capita



Source: Prescott (2004)

Thailand merged 3 of the schemes into 1 funded by general revenues, but has not fully overcome the damage done by “starting with the formal sector”. Now the agenda is equalizing benefits



Source: Sawasdivorn 2010, based on 2008 data.

Re-thinking conventional wisdom and standard policy prescriptions

- Starting with the formal sector / civil servants
- Identify the poor for subsidies
- Contributory, voluntary, CBHI for the identified “non-poor” in the informal sector
- Many of your countries are doing this, or want to do it
 - The bad news is that it does not work very well, and tends to create new equity and efficiency problems
 - It also reduces pressure on governments to devote more to health
 - The good news is that there are other pathways

Following the historical path of western Europe and Japan problematic

- “Starting insurance” with the formal sector
 - Improves access and financial protection for the better off
 - Historically in western Europe and Japan, coverage grew with economic development, growing formalization of the economy and high employment
 - Today, however, developing country governments face decisions on the rationing of scarce medical technology that Western/ Japanese governments did not face a century ago
 - The initially covered groups defend their interests, demand more benefits and subsidies, and concentrate scarce administrative skills on their behalf
 - Exacerbates inequalities, fragments the system, and is very difficult to undo


Compounding the “scheme-itis” problem

- Having first created an SHI scheme for the 5-10% of the population that is in the formal sector...
- Countries recognized the need to cover the poor, and so often created “low-income cards”, i.e. targeted schemes
- What to do about the remaining 30-70% of the population?
 - Not in formal sector
 - Not the poorest, but hard to tax directly their income or earnings
- A common response in this region has been to invest a lot of time and effort in CBHI

What have we found?

- In most countries, even where participation is officially compulsory, it is de facto voluntary
- Not surprisingly, these health schemes have not been more effective than the tax authorities in raising money from persons outside the formal sector of the economy
 - And with health raising its own money, MOF doesn't have to
- CBHIs generally suffered the fate of voluntary health insurance everywhere: low coverage (perhaps a few exceptions)
- Many journal articles published saying that despite only reaching 5% of the target population, it is
 - a success, and anyway...
 - shortcomings are the fault of those who didn't enroll, as they obviously don't understand health insurance
- At best, where there are truly no alternative sources, CBHI may have substituted for OOPS for those who enrolled.

Towards Universal Coverage requires moving from scheme to system

- Whatever exists in your countries today is the starting point
 - a foundation on which to build (and from where to move)
- 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 for most of your countries, increased levels) of general revenues
 - 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)
- It's happening 

Different approaches depending on different starting points⁽¹⁾

- **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

Different approaches depending on different starting points⁽²⁾

- **Kyrgyzstan** and **Moldova** centralized the pool of budget funds, combined with new payroll tax, changed from input- to output-based payment, and increased provider autonomy
 - Impressive gains in geographic redistribution and efficiency
- **Ghana** and **Rwanda** have explicit coordination of bottom-up and top-down financing mechanisms to create a virtual national pool, with general revenues as main source
 - Gains in utilization and financial protection
- **India** has a general-revenue funded hospital insurance program for citizens below the poverty line

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
 - Similarly, there is no technical reason why Health Equity Funds, SHI, performance-based payment, selective free health services, etc., can't be aligned
- They moved away from thinking in terms of “schemes”
 - Pooled together or coordinated use of different revenue sources
 - 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

Countries need to develop comprehensive national health financing policies

- Does not necessarily imply “big-bang” approach of putting everything into one national pool
- Coherence, coordination, and complementarity among different funding sources rather than a random array of “schemes”
- Orient schemes (and assess them) to the objectives of Universal Coverage for the system as a whole, and not merely to the “financial sustainability” of the scheme (having an insurance scheme fully funded by contributions is not a health policy objective)

SOME CLOSING THOUGHTS FOR THE COUNTRIES AND AGENCIES PRESENT TODAY



Messages for countries

- More active and evidence-based advocacy for increasing the share of public spending devoted to health is needed
 - Especially Myanmar, Lao, Philippines, Indonesia, and Vietnam
 - A greater challenge in context of political and fiscal decentralization (Indonesia and Philippines)
 - Link to stronger purchasing mechanisms and greater accountability for the use of public funds
- Given limited potential, have realistic expectations about what can be achieved through voluntary CBHI
 - Don't let it deter efforts to move towards greater reliance on compulsory/public sources
 - Role should be seen as temporary and complementary
- Create a national health financing policy framework within which you can embed existing schemes and develop strategies to promote complementarity of funding sources

Understand the important lessons from Thailand's rich experience

● Negative

- If you start by giving entitlements only to civil servants and the formal private sector, it will be very hard to equalize benefits later. To the extent possible, try to get formal and informal sector (or formal sector and the poor) in the same pool
- [Myanmar: don't repeat this mistake!!]
- Using voluntary health insurance to extend coverage will not succeed due to adverse selection (this is a global lesson)

● Positive

- Build health policy analysis capacity and link to decision-makers
- Ensure the supply side (facilities and HR) is in place
- Focus on efficiency through strong purchasing
- Rely on general revenues to fund coverage for informal sector
- Consolidate pools to the greatest extent possible

Donors need to think and act long-term, and connect pilots to national policy

- Avoid promotion of schemes for part of the population unless these are clearly embedded in a comprehensive health financing policy framework
 - Can make system worse even as some people are better-off
 - Particularly for traditional “SHI for the formal sector”, recognize that this will institutionalize inequitable coverage in the long run
 - Ensure mutual reinforcement between pilot implementation work and national policy (especially on purchasing methods)
- Invest in national capacity (skills, systems, and platform)
 - Ultimately, this matters much more than the details of collection, pooling and purchasing

