Financing a Health System to Deliver Universal Health Coverage

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HEALTH ECONOMICS AND HIV AND AIDS RESEARCH DIVISION

Overview

- MDGs and Unfinished Business
- Disease and Health Expenditure Patterns
- Health Financing Functions
- Universal Health Coverage

Millennium Development Goals

MDGs: progress

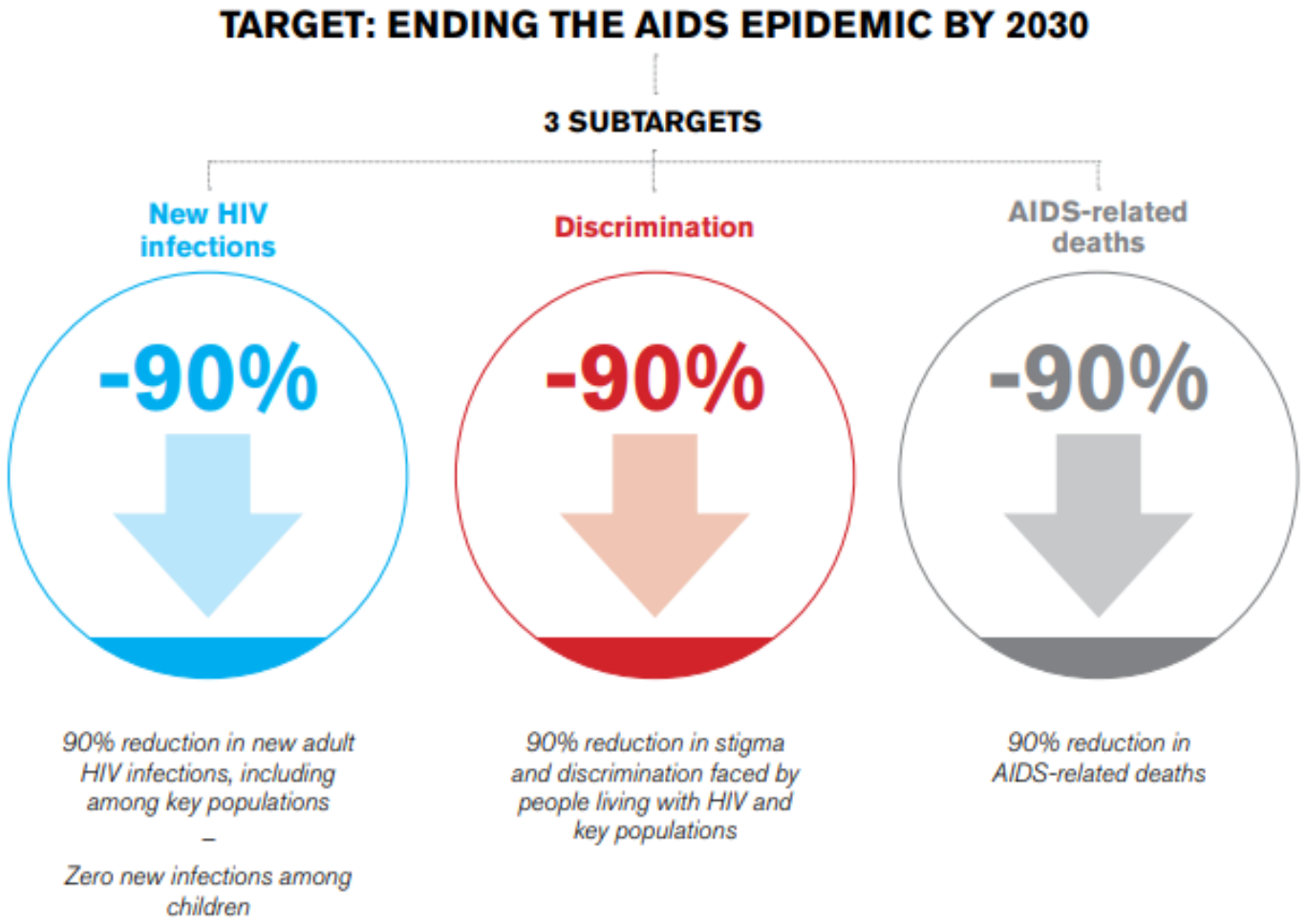
- The MDGS have played a critical role in guiding the HIV, Health and broader development agenda since 2000.

- Under the MDGS (1990-2015)
  - mortality declined by 47% among children <5 yrs.
  - Maternal mortality almost halved between (543 000→287 000 deaths).
  - Mortality related to TB has decreased by 42%.

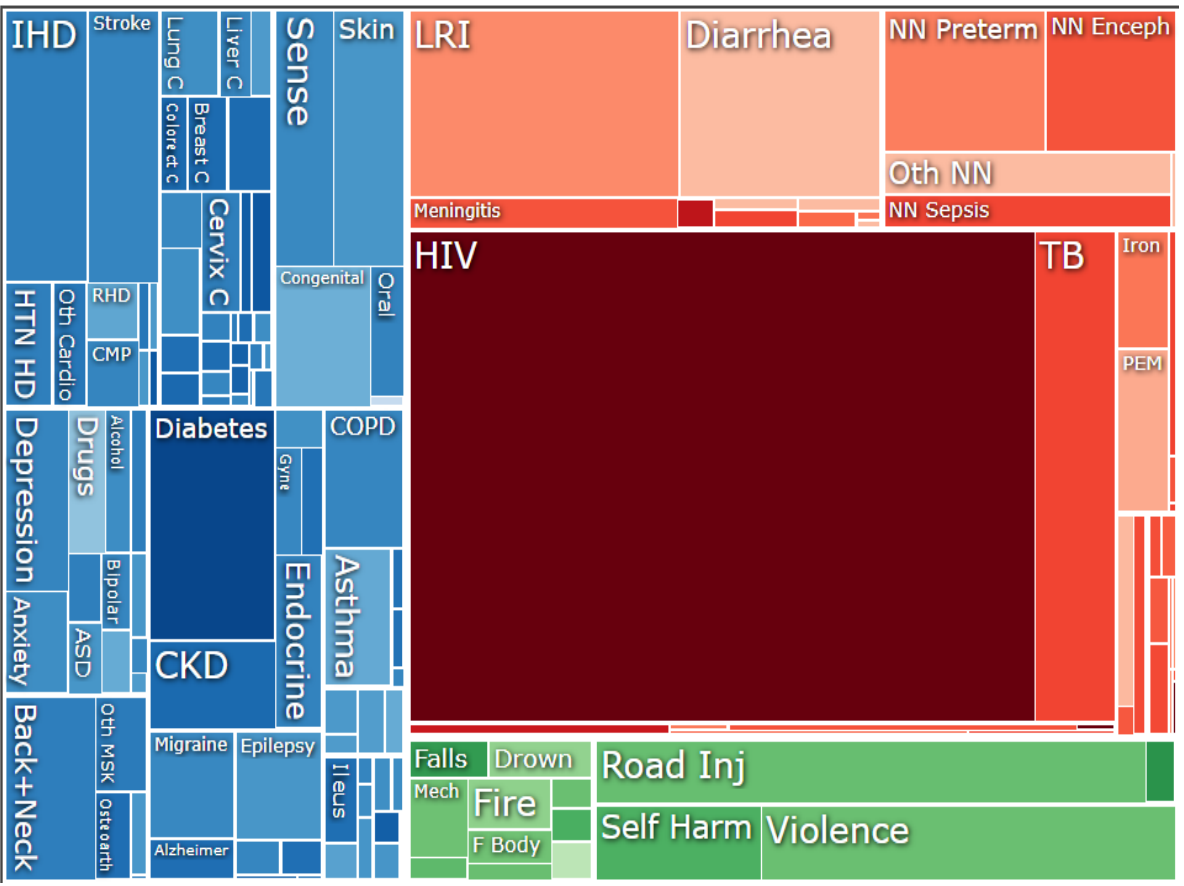
- Among health related MDGs, greatest progress has been made with HIV.
  - Reduction in HIV incidence
  - Scale-up of ART
  - Reduction in HIV mortality

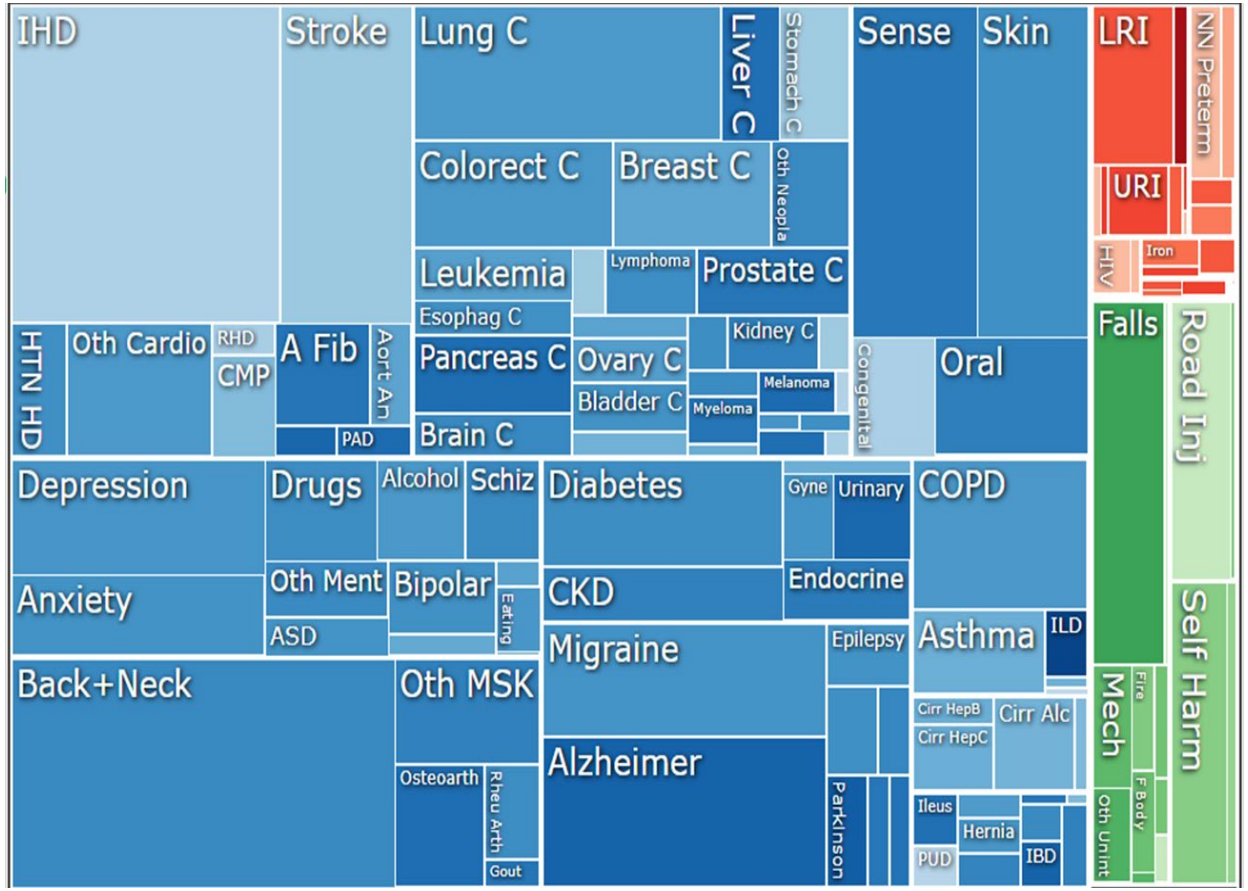
MDGs: Unfinished business

- A key element of the post-2015 SDG health goals will be to complete and expand the MDG agenda.
- Critical to this is the need to end the AIDS by 2030.
- Three targets have been proposed to end the AIDS epidemic



Causes of Disability adjusted life-years in Southern sub-Saharan Africa vs Western Europe

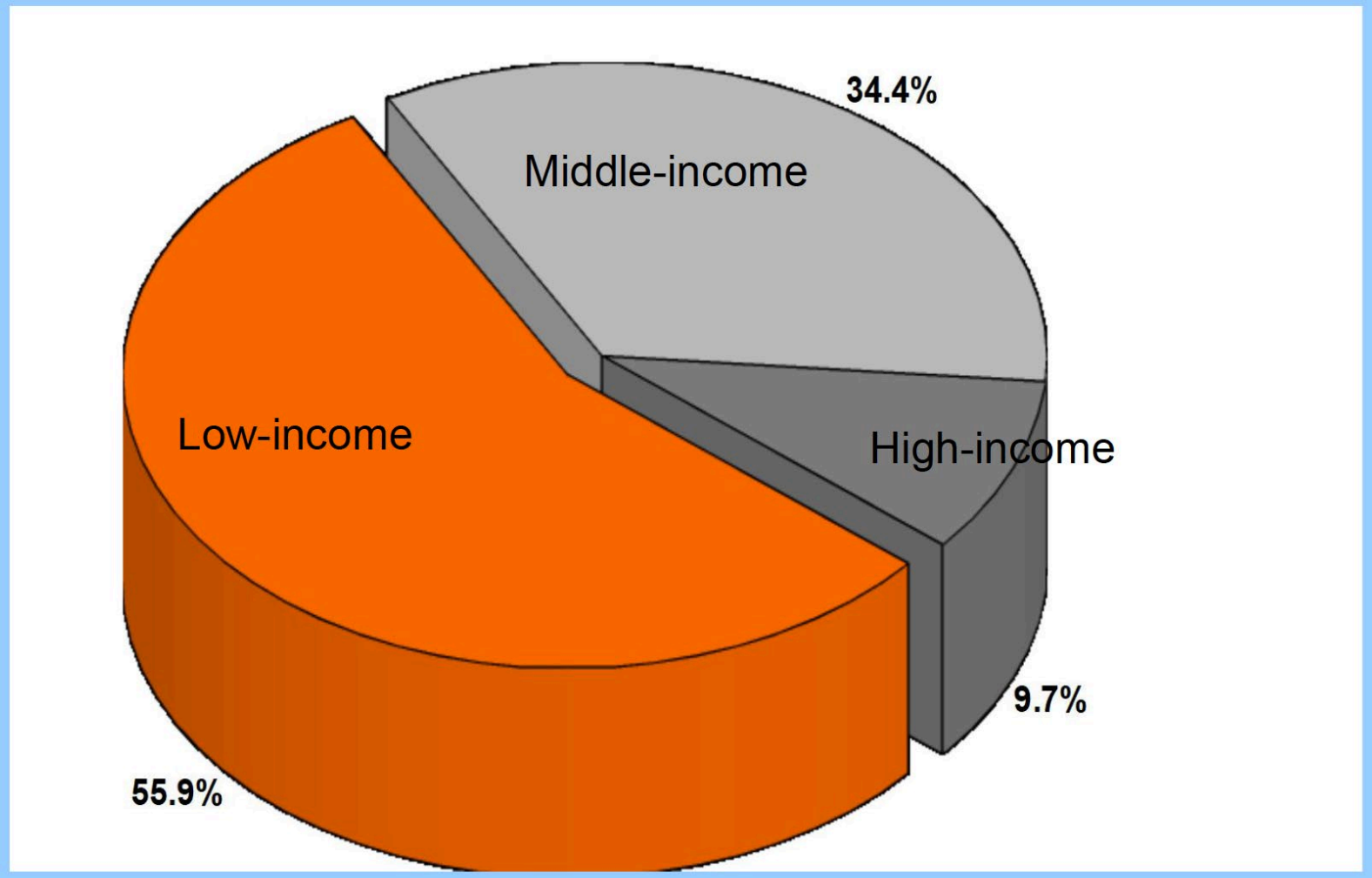




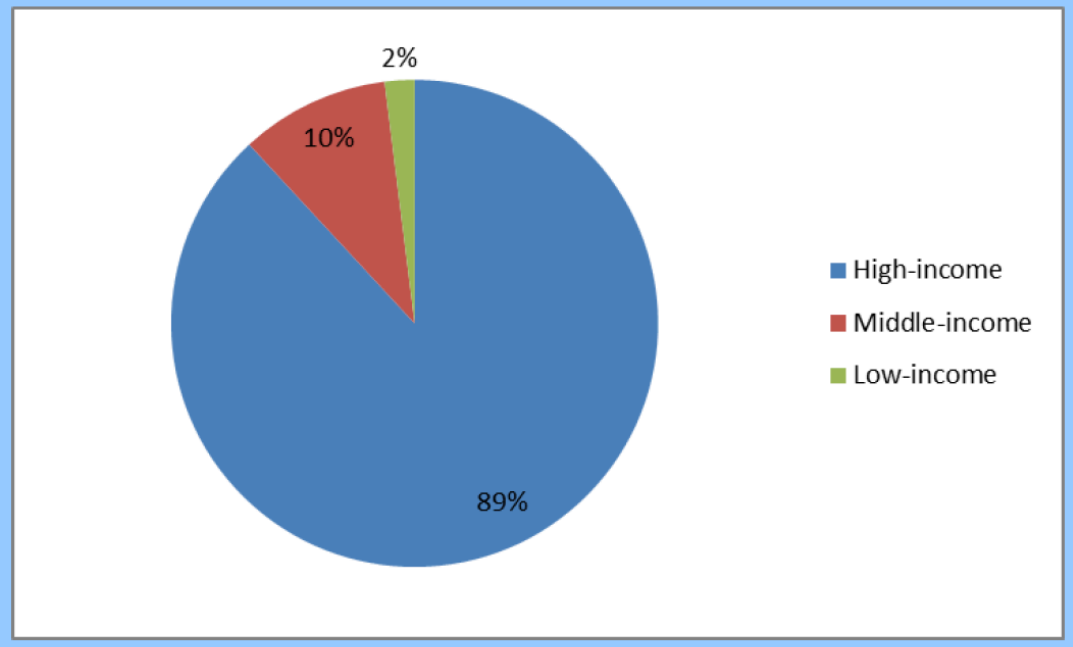
Health Expenditure Patterns

Global inequalities in health spending are large…

LMICs account for 90% of the global disease burden



...but only 12% of global health spending (mid-2000s)

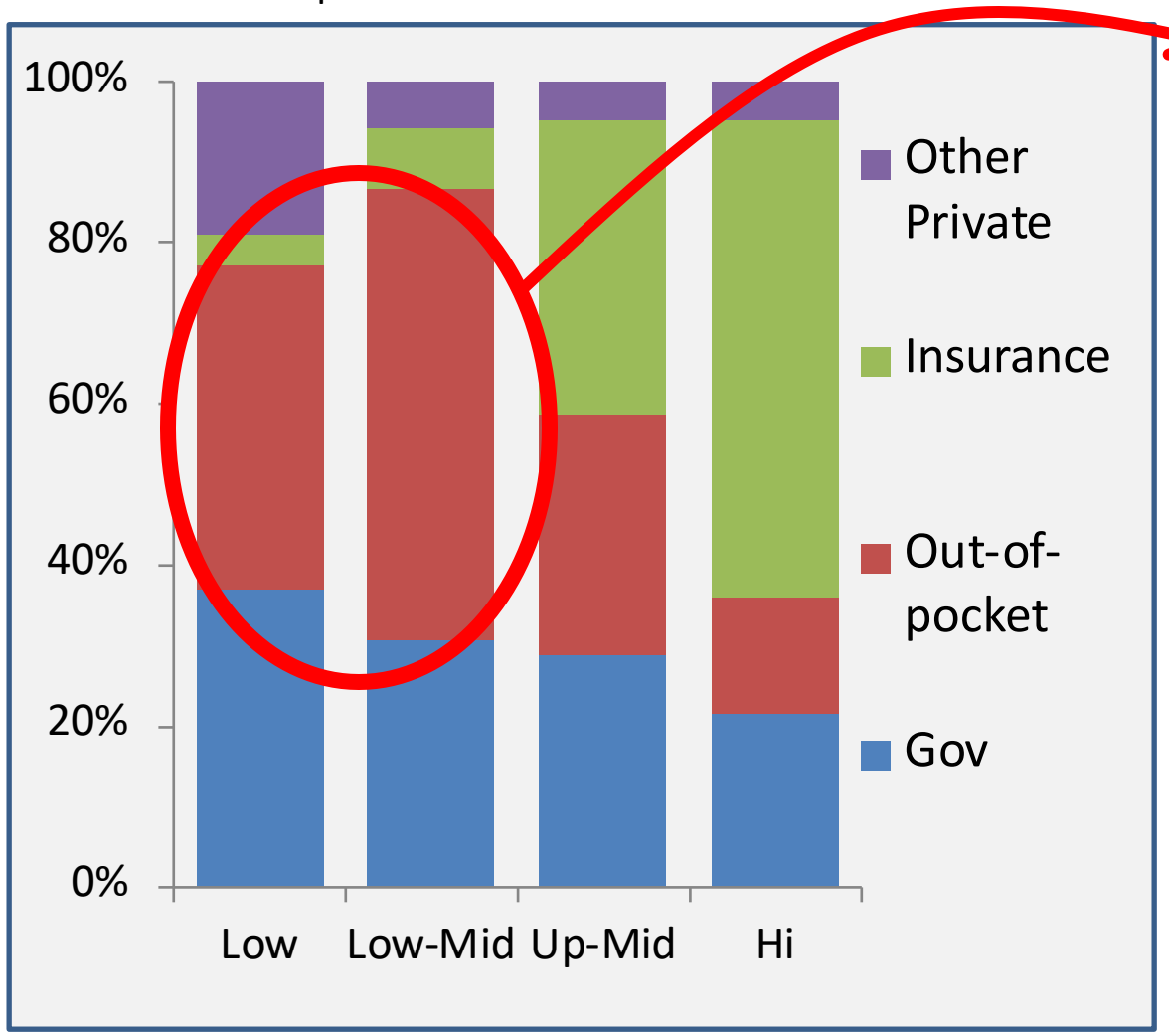


Annual per capita health expenditure*	
Low-income:	$24
Low-middle income:	$91
Upper-middle income:	$342
High-income:	$3810

Who pays for health?

Financing Agents by Income Group (2014)

% Total Health Expenditure



- Low and middle income countries spend less on health per capita and have not yet replaced out of pocket payments with pre-paid contributions
- Each year, an estimated 150 M people face catastrophic health costs because of direct payments, while 100 M are driven below the poverty line, and others avoid seeking care

WHO (2014), Health Expenditure Series.

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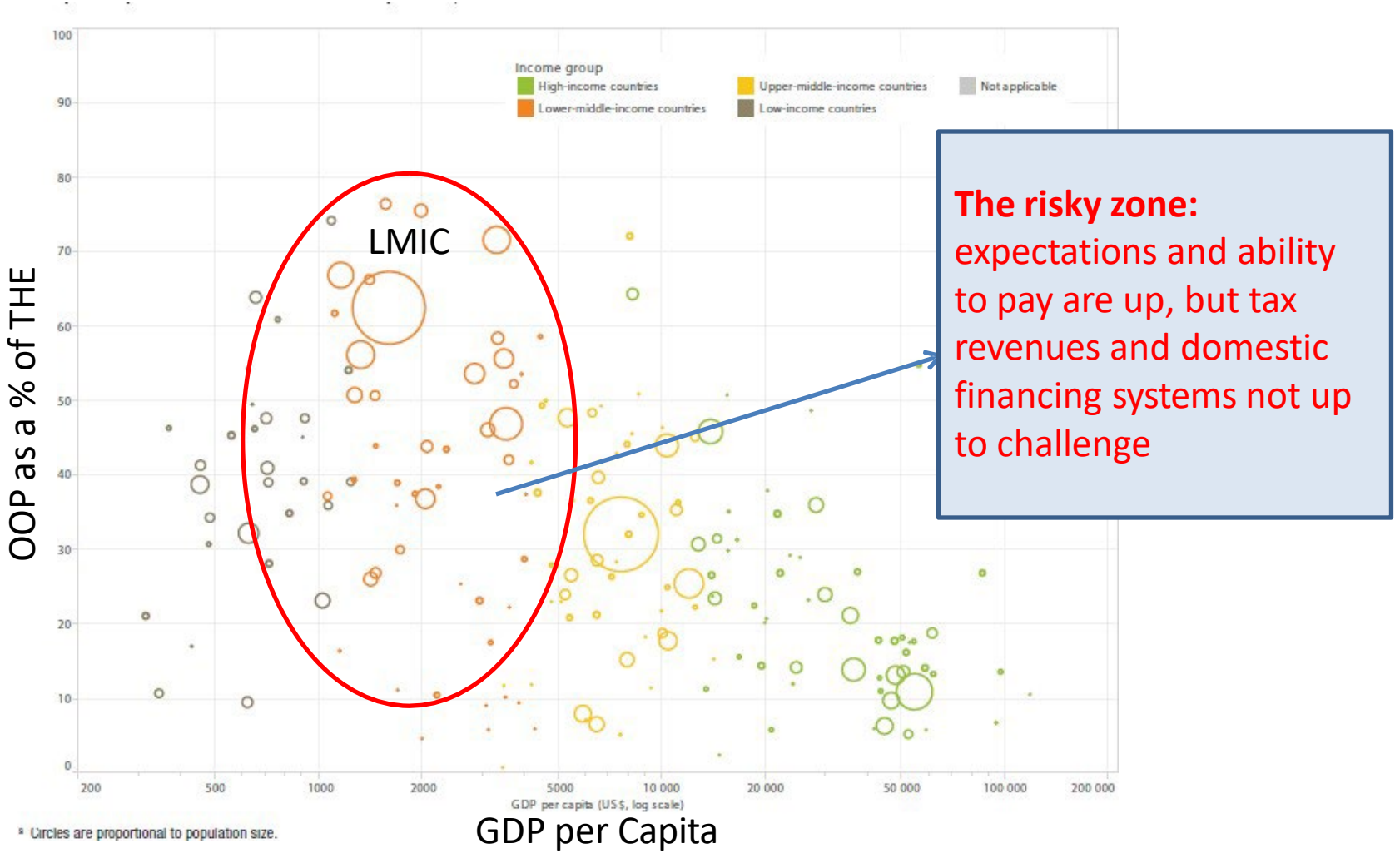
In LMICs, out of pocket spending is increasing

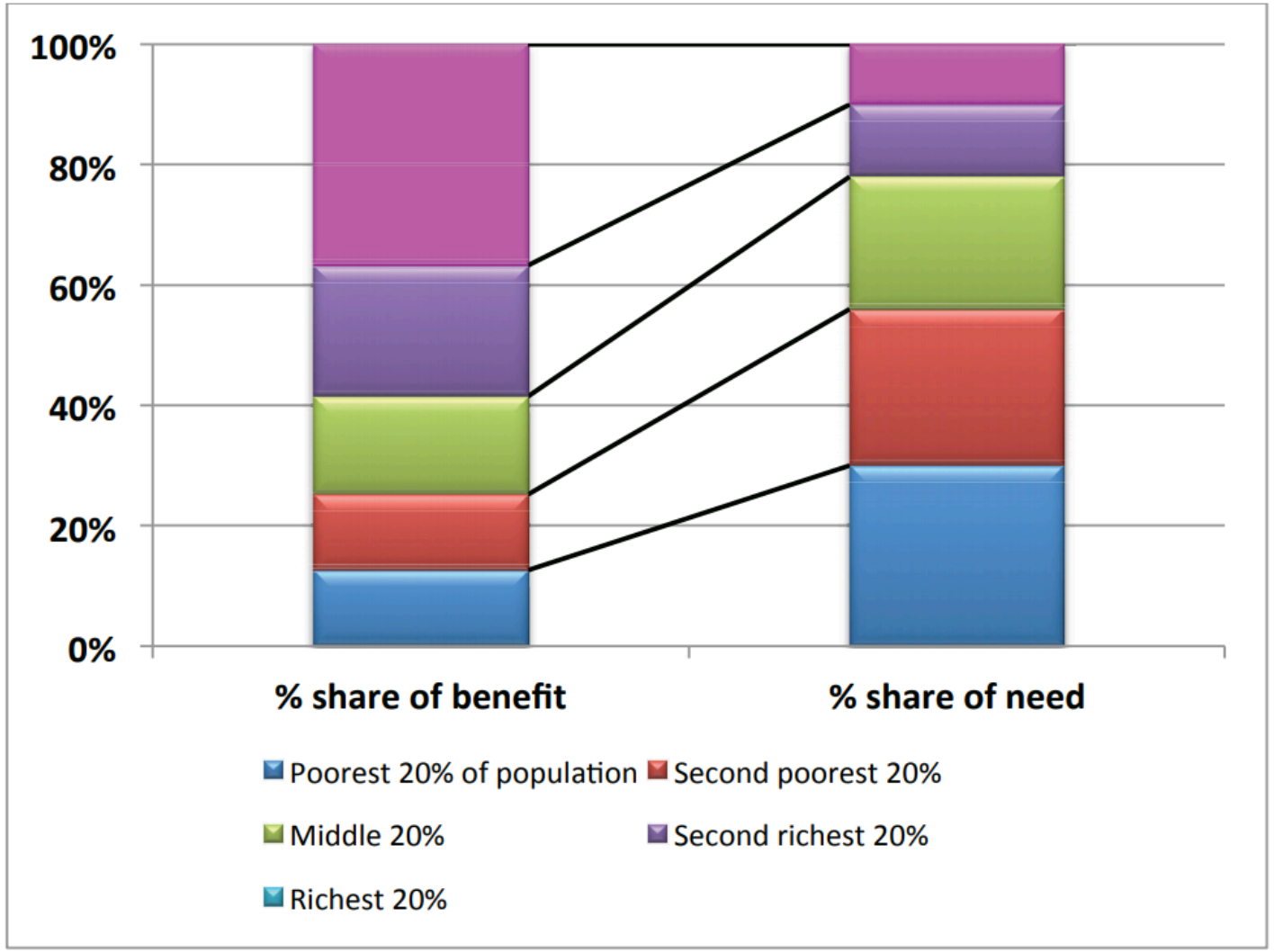


Increases in out of pocket payment are associated with increased catastrophic health spending

World Health Statistics (2017).

But also within countries…

Figure 1: Comparing total benefit incidence with levels of health care need



Source: McIntyre and Ataguba (2012)

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Health Financing functions

- Resource mobilization/Revenue collection
- Risk pooling and financial protection
- Purchasing health services

Health financing refers to the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system…”

Health Financing functions

- Resource mobilization/Revenue collection

Raising sufficient and sustainable revenue to provide essential services and give financial protection

Health Financing functions

- Risk pooling and financial protection

Accumulate revenue so that risk can be shared among the pool. Prepayment of average cost reduces uncertainty. Pooling and prepayment enables redistribution between rich and poor.

Health Financing functions

- Purchasing health services

Refers to the mechanism to “purchase” services from public and private providers.

Health Financing functions

- Guiding principles:

<u>Efficient and equitable</u>

Sources of health financing and implications for SRHR and UHC

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Sources of health financing

- PUBLIC SOURCES
  - Taxation (Indirect and direct)
  - Social Health Insurance
- PRIVATE SOURCES
  - Private insurance
  - Out of pocket/direct payments
- EXTERNAL SOURCES
  - Development assistance – grants and loans

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Key messages

Key messages 1

Global trends in health spending confirm the transformation of the world's funding of health services

- Total health spending is growing faster than gross domestic product, increasing more rapidly in low and middle income countries (close to 6% on average) than in high income countries (4%).
- Health system resources are coming less from households paying out-of-pocket and more through pooled funds, in particular from domestic government sources.
- External funding (aid), represents less than 1% of global health expenditure and is a small and declining proportion of health spending in middle income countries, but it is increasing in low income countries.

Source: WHO. Public Spending on Health

Key messages 2

Public spending on health is central to universal health coverage, but there is no clear trend of increased government priority for health

- Globally, public spending on health increased as country income grew, but low income countries are lagging behind.
- In middle income countries, average per capita public spending on health has doubled since 2000, as these countries progress in their transition to domestic funding.
- Governments in high income countries increased their allocations to health, even after the economic crisis of 2008–2009.

Source: WHO. Public Spending on Health

Key messages 3

Primary health care is a priority for expenditure tracking

- Low and middle income countries devote more than half of health spending to primary health care.
- Public spending accounts for less than 40% of primary health care spending.

Source: WHO. Public Spending on Health

Key messages 4

Allocations across diseases and interventions differ between external and government sources

- Across a set of aid receiving countries, 46% of external funds for health and 20% of public spending on health went to combat HIV/ AIDS, malaria and tuberculosis.
- External funding to combat HIV/AIDS does not have a clear relationship with national prevalence or income level.
- Immunization spending still relies heavily on external sources of funding in most low income countries.

Source: WHO. Public Spending on Health

Key messages 5

Performance of public spending on health can improve

- Service coverage is driven more by income than by the share of public spending in total health spending.
- A larger share of public spending on health in total health spending does not always improve equity in access to health services.
- A health system with higher public spending on health tends to improve financial protection for individuals.

Source: WHO. Public Spending on Health

Key concepts in health financing

Guiding principles for a health financing system more fit to achieve UHC

1. moving towards predominant reliance on **public funding sources**
2. reducing **fragmentation in how funds are pooled** or mitigating the consequences
3. moving towards more **strategic purchasing of health services**, linking provider payments to data on their performance, and to the health needs of the populations they serve
4. aligning coverage policies (benefits and copayments) explicitly with policy objectives.

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Comfort Break

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The Case for UHC

Problem Statement

- Limited resources relative to need
- Impoverishment due to medical expenses
- Lack of access to health services

Sustainable Development Goal 3 : Equitable health outcomes and well-being; Global public health security and resilient societies

Goal 3.8: Achieving *Universal Health Coverage* including

- *Financial risk protection:* Ensure use of services does not expose users to financial hardship
- *Access*: Provide all people with access to quality essential health care services and to safe, effective, quality, affordable medicines and vaccines

UHC is not new but has seen increased momentum under the SDGs

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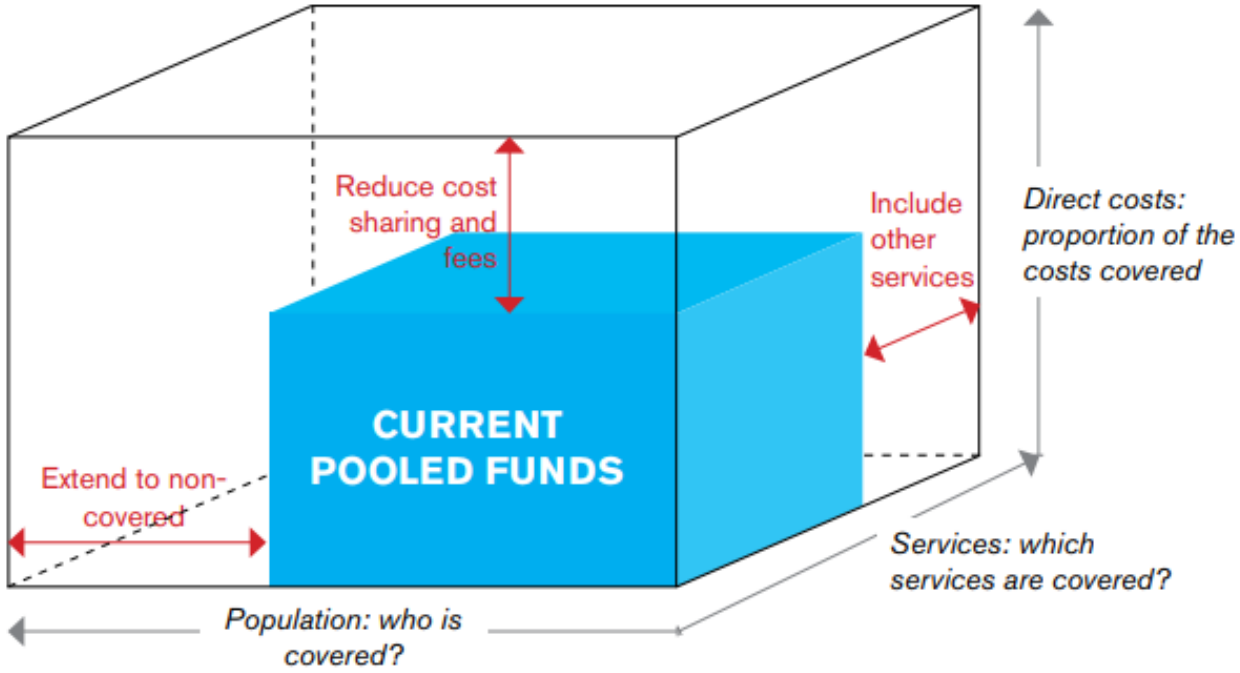
Objectives of Universal Health Coverage

- UHC has three related objectives.
  - The full spectrum of health services should be available according to **need** and their **quality** should be good enough to improve the health of those receiving them.
  - **Financial-risk protection mechanisms** need to be in place to ensure that the cost of using care does not put people at risk of financial hardship.
  - There should be equity of access to health services, whereby the **entire population is covered**, not only those who can pay for services.

What is UHC

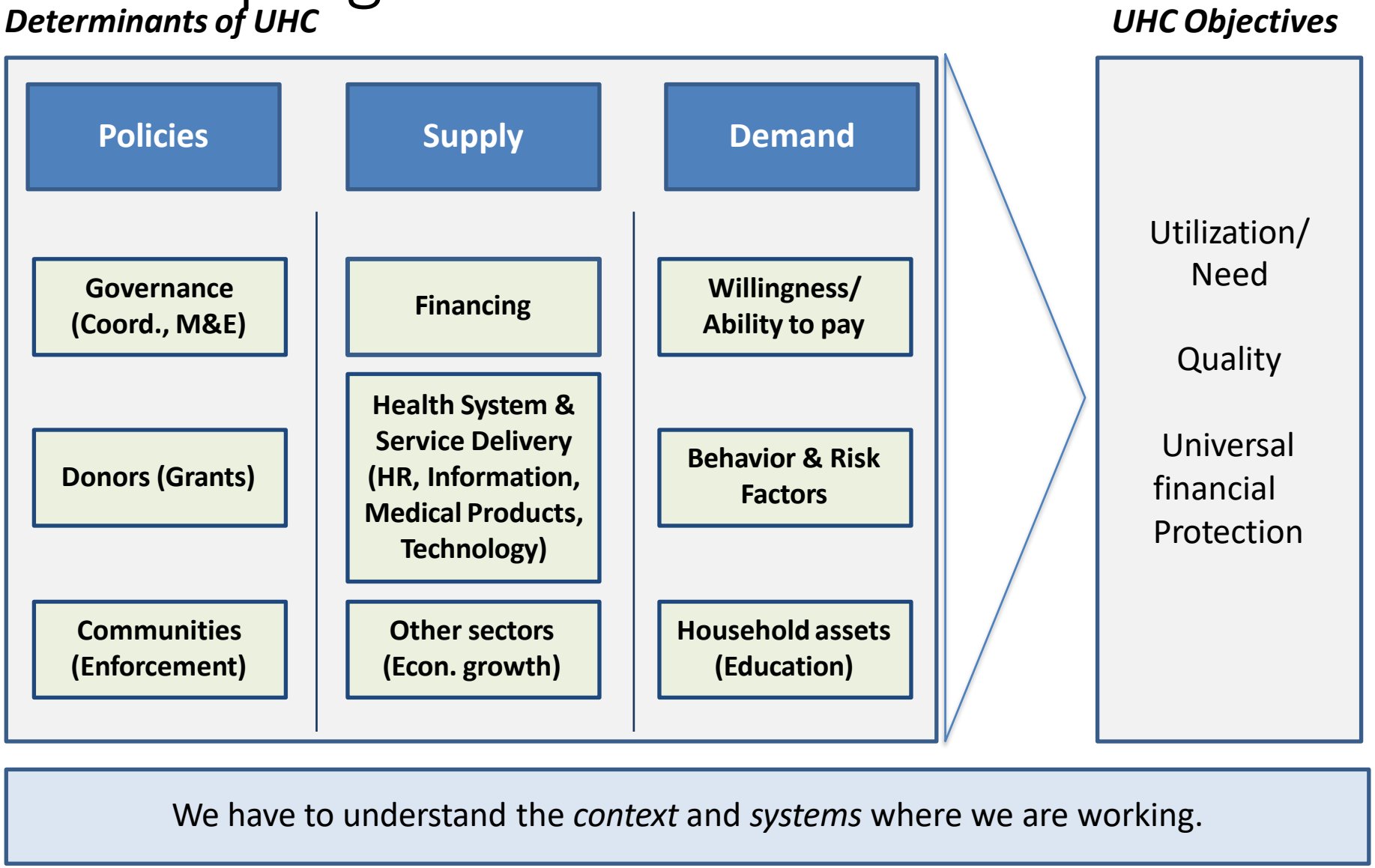
- Three dimensions to UHC
  1. Providing services: Each country needs to define a **comprehensive set of interventions and services** that respond to its critical health issues, and that should be available to the whole population as needed, **financed through the public system.** Countries face the **challenge of prioritizing, phasing in, combining and sequencing interventions** to achieve greatest impact, ensure equity, and find the most rapid and efficient pathway to universal coverage."
  2. Covering populations: "**universal"** means inclusion of all populations, in all circumstances, in all countries. UHC is also about equity; it is about delivering health services according to **need**, and not according to financial power."
  3. Covering costs: Central to universal health coverage is **financial protection** to avoid **out of pocket expenditures** and **catastrophic health expenditures.** Co- financing options to pay for the health system, including through public/private domestic funding, donor grants/development loans. Establishing efficient and equitable mechanisms to **pool funds** to provide financial risk protection related to ill-health, through taxation and health insurance schemes. Strengthening universal and basic forms of health care.

UHC cube



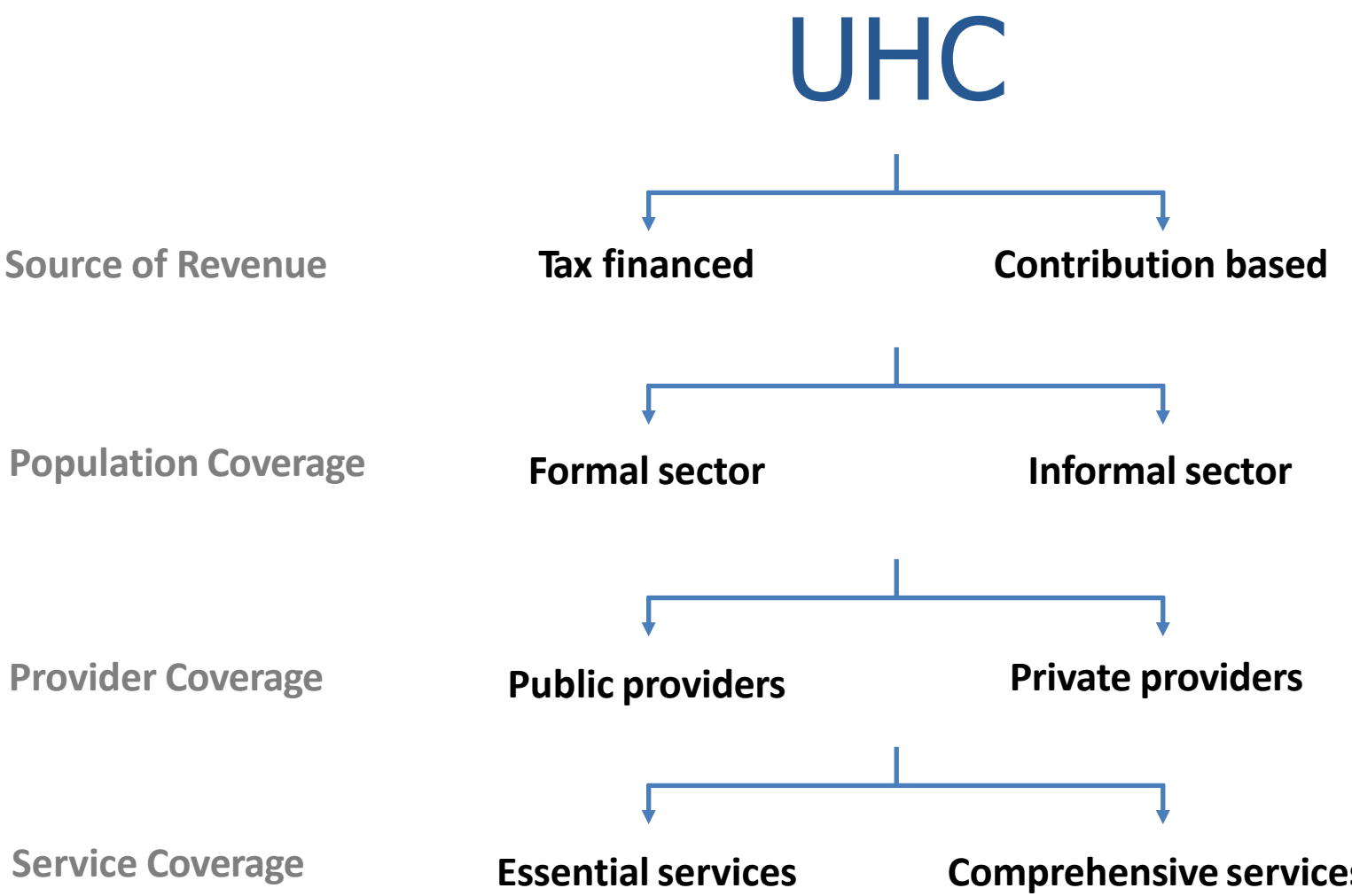
UHC aims to bring better health and protection from poverty; it is the achievement of total population coverage comprehensive set of interventions, and zero out-of-pocket expenses for all interventions.

Financing is just one of many context-specific factors that influence progress towards UHC



Modified from Rich-Poor Differences in Health Care Financing, Preker et. Al., 2004

How do we achieve this objective?



Common features:

Large Pool of Funds

Diverse Health Needs

Quality Assurance

Strategic Purchasing

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What are the primary considerations?

Strategize

UHC Reform

- ❑ Is there political buy-in?
- ❑ Who will be covered under the scheme?
- ❑ What services will be covered?

Design

Financing

- ❑ How will the scheme be financed?
- ❑ What providers will offer services?
- ❑ How will providers be contracted and paid?

Service Delivery

- ❑ How will the entitled population be identified and enrolled?
- ❑ How will providers be monitored and assessed?

Implement

- ❑ What institutions will oversee/administer the scheme?
- ❑ How will data be collected/managed for decision making?
- ❑ How do we strengthen workforce and procurement?
- ❑ How do we measure performance of the scheme?

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There is no one ‘right’ way to finance UHC, but there are key lessons learned

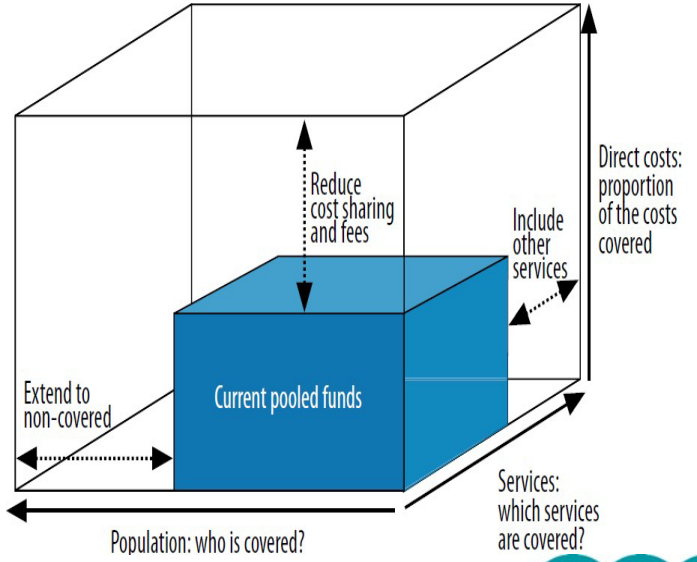
Prioritize Services (Benefits Package): Start with services that can be reliably delivered and financed to the populations at greatest needed, expanding over time

Pre-Payment: Shift from out of pocket payment increasing likelihood of catastrophic health spending to pre-payment (set in an equitable manner)

Re-Distribute Resources (Pooling): Large risk pools and dedicated public funding allow re-distribution between rich and poor, healthy and sick and young and old

Link Payments to Need or Outputs (Strategic Purchasing): Pay providers based on population need or outputs (services, visits, etc.), increasing value for money

Build Strong Institutions: An insurance agency or other institution equipped to manage funds efficiently, equitably and transparently



There is no ‘right’ mechanism to finance UHC

Countries focused on Insurance-based reform

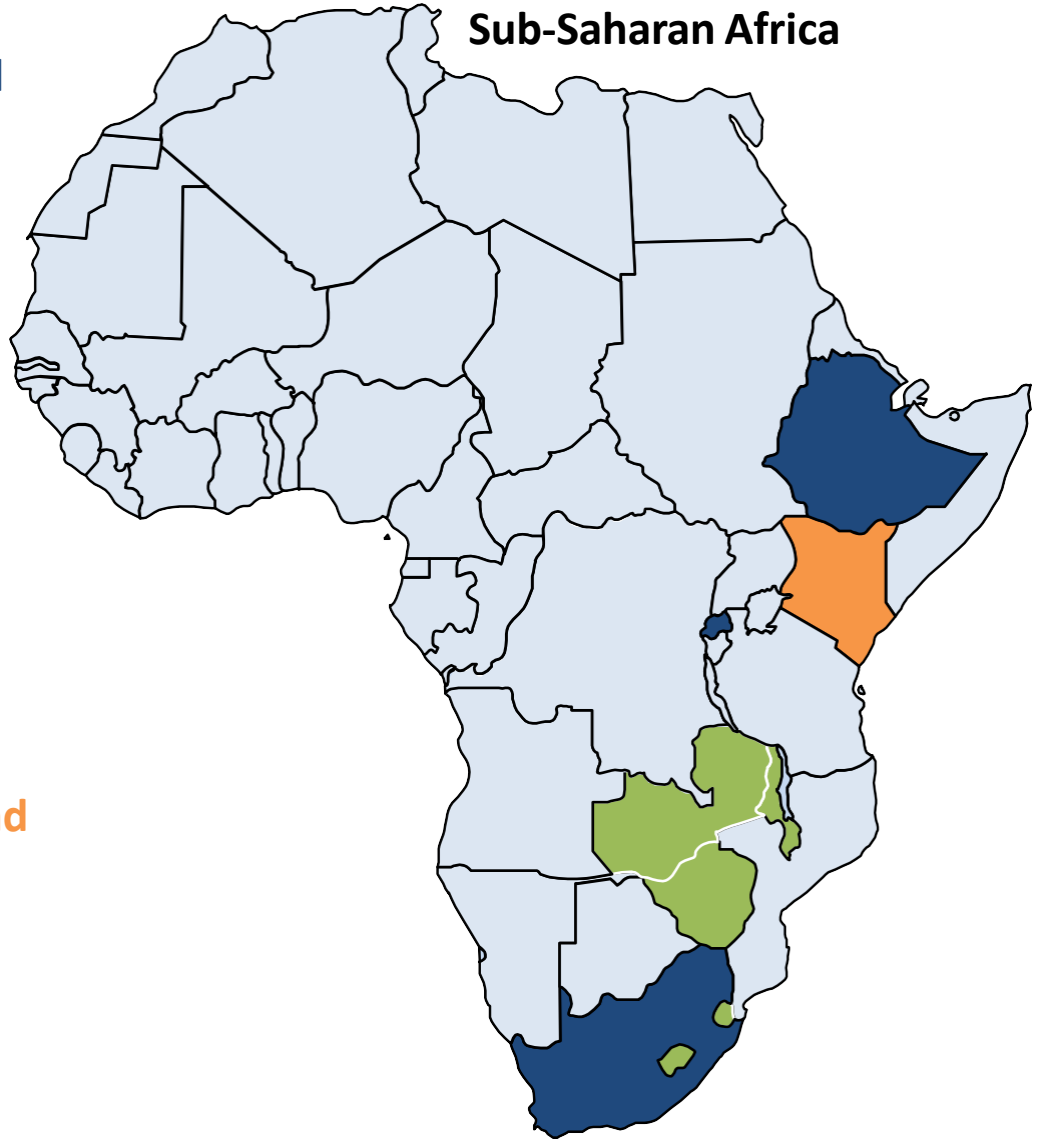
- Ethiopia
- Rwanda
- South Africa

Countries focused on other financing reforms

- Malawi
- Eswatini
- Zambia
- Zimbabwe

Countries exploring both insurance and other financing reforms

- Kenya



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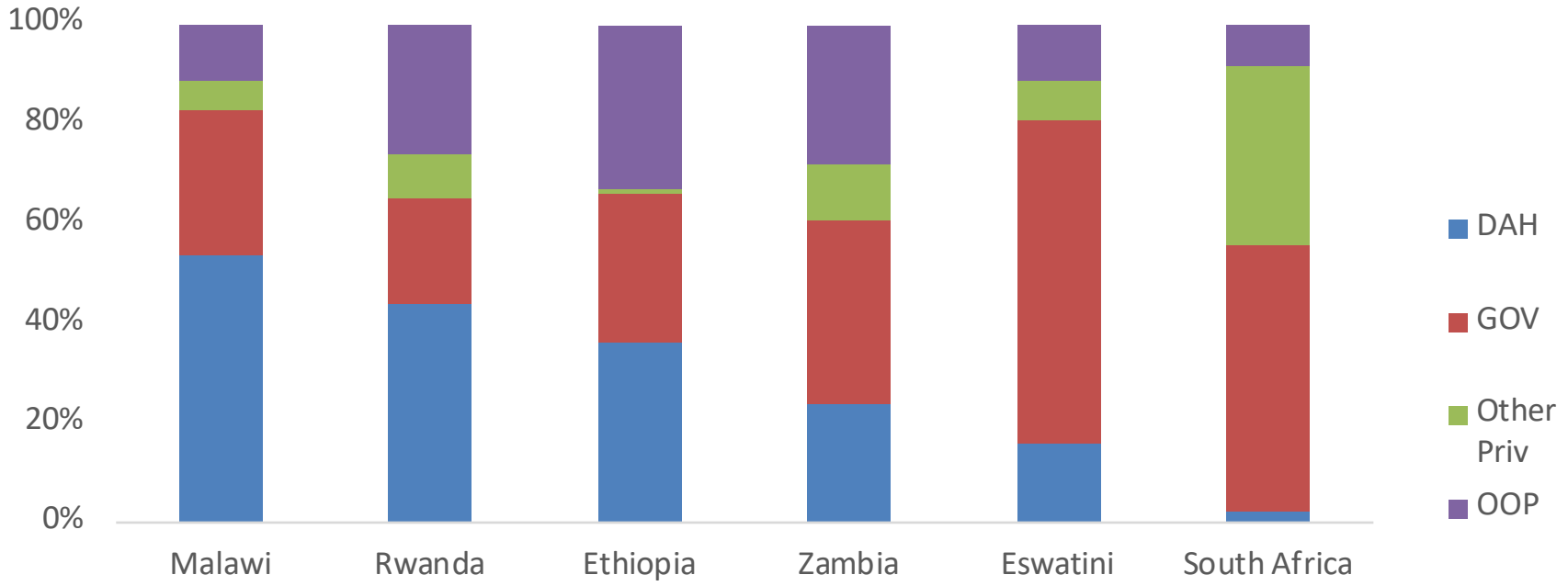
There is no ‘right’ time to finance UHC, but country context will determine pathway

Countries are at different places on the path towards UHC and aid independence



	Malawi	Rwanda	Ethiopia	Zambia	Eswatini	South Africa
$/capita	30	57	28	57	220	430
MMR /100,000	439	210	353	224	452	106

WHO GHED (latest available)

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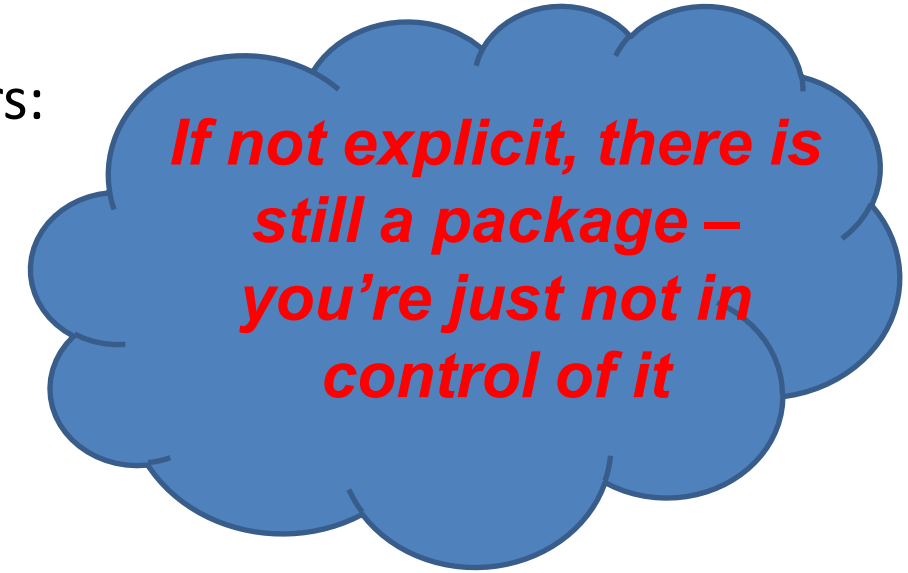
Defining a Health Benefits Package

- A set of services that can be feasibly **financed and provided** under the actual circumstances a given country finds itself. Services are made **explicit** and it is clearly defined who is covered, so that the public can be made aware of **what services are available and for whom**.

- A **realization of the trade-offs** implicit in the UHC cube and a real, **existing** mechanism governments are using to allocate resources

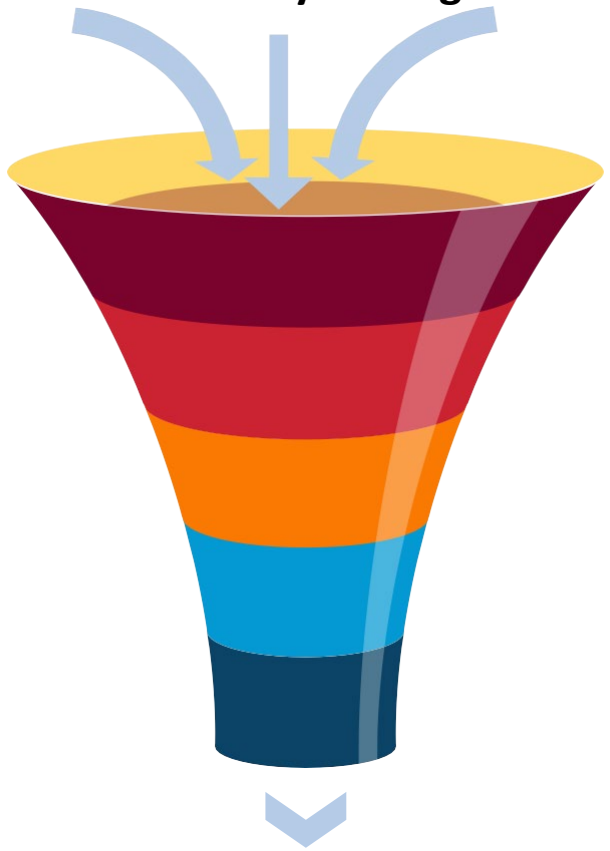
- Can quantify supply side gaps and demand side barriers:
  - Essential services and target subpopulations,
  - Cost at point of service delivery,
  - Gender, SES and Geospatial Equity



Defining a Health Benefits Package

Criteria Selection and Weighting Process

Menu of Priority Setting Criteria



Agreed set of priority setting *criteria* and their *weights*

General Criteria Used to include/exclude services:

- Burden of disease
- Equity
- Cost-effectiveness
- Affordability
- Feasibility (HWF, medical and tech requirements)
- Government and population priorities

1. **Step 1:** Deliberate on menu of criteria (add/subtract)
2. **Step 2:** Individually reflect and rank each criteria
3. **Step 3:** Computing and deliberation of criteria rank
4. **Step 4:** Panelists weight criteria
5. **Step 5:** Computing and deliberation of criteria weights

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Considerations in Integrating vertical programs in UHC prioritization

Fragmented funding complicates resource allocation

- Limited flexibility to adjust how resources are allocated
- Earmarking for donor priorities, vertical
- Hard to coordinate resources behind HIV/SRHR agenda

Monitoring and Evaluation

- Critical need for analysis to inform decision makers
- Technological innovation, challenges to scale

Multiple government institutions and processes

- Setting up transparent processes, good governance structures
- Civil society, other actors can find it difficult to understand and engage with processes

Tension between UHC and what can be financed

- Progressive realization versus rights to health
- Pressure on prioritized package to expand, advocates and interests
- Primary Health Care

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Key Issues for Consideration

UHC Cube

- Population Coverage (women, children, disabled, elderly, key populations)?
- Types of Services offered? Level of integration?
- Naure of co-financing options?
- How to re-structure for allocative efficiencies?
- Increasing domestic resources through innovative financing mechanisms

Current Realities

- HIV as core health issue (expanding treatment coverage- 90-90-90)
- Donor dependency; donor flat lining
- Strained/Weak health systems
- Structural/Social drivers of HIV and poor SRH outcomes
- Political will of governments/repressive legislative and normative environments
- Weaknesses in the SDG framework on Rights to Health issues

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For any queries email georgeg@ukzn.ac.za

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