POLICY BRIEF

Funding Models to finance Universal Health Coverage

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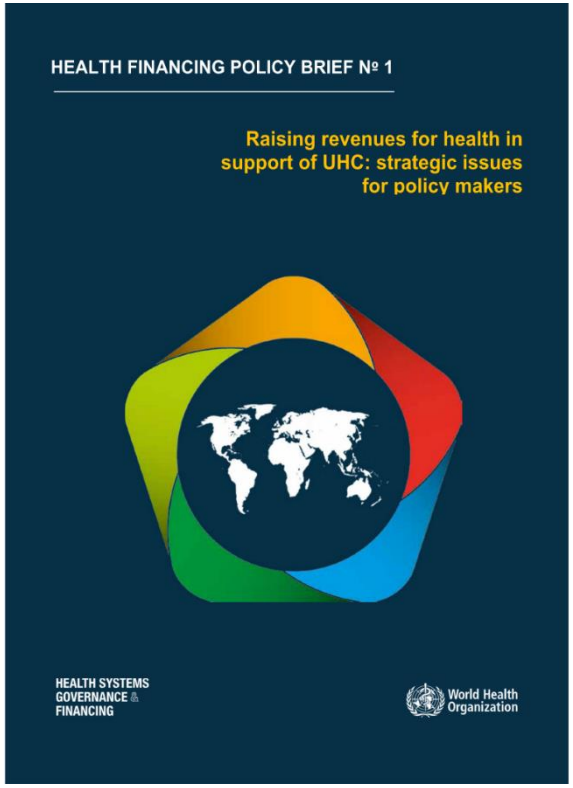
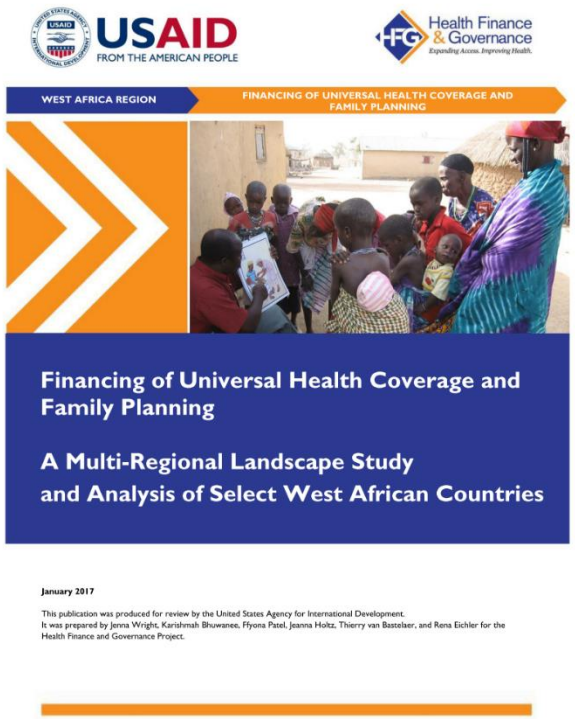
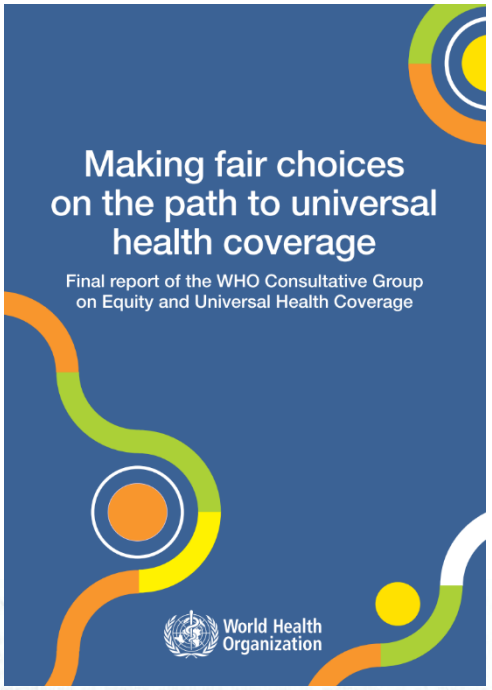
Overview

- Defining UHC
- The issues
- UHC funding models
- What needs to be done and how
- Recommendations (policy asks)







Overview of WHO Health Financing Technical Network

Main Group: WHO Health Financing Technical Network

Members: those interested in health financing policy for UHC, including policy-makers, technical advisors, practitioners, WHO health financing staff, and participants on one of WHO's face-to-face health financing courses and meetings
Purpose: to share information including updates on new materials or events related to WHO's work on health financing policy
URL: http://ezcollab.who.int/hftn
Group e-mail: hftn@ezcollab.org (message goes to all members)

Sub-group: Public
Members: general public
URL: ezcollab.who.int/hftn/public

Sub-groups: Advanced Health Financing Policy Courses
Members: participants on one of WHO's Advanced HF Policy for UHC for LMIC face-to-face courses (HFGlobal2014, 2015 or 2016...etc)
Purpose: sharing of course materials prior to and during the course; establishment of a participant network before, during and after the course; follow up activities such as surveys, webinars, group discussions

Sub-group: WHO Health Financing Colleagues
Members: WHO staff working on health financing issues
Purposes: internal information sharing and networking across WHO offices

Universal Health Coverage (UHC): How Much of a Solution?

Dr.Amit Sengupta

April 2015

CHPA commissioned paper 2016

Rannan-Eliya R. Universal health coverage: the potential contribution of hybrid funding strategies. http://www.chpa.co/Documents/ReportUniversalhealthcoverageareviewofCommonwealthmixedfundingmodels_000.pdf

Empirical evidence suggests some "mixed funding models" of UHC can achieve better health outcomes at lower cost than two widely recognised models

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WHO definition UHC

"all people receiving the health services they need, including health initiatives designed to promote better health (*such as anti-tobacco policies*), prevent illness (*such as vaccinations*), and to provide treatment, rehabilitation, and palliative care (*such as end-of-life 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"

World Health Organisation. *Tracking universal health coverage: first global monitoring report.* 2015. p.viii. http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf

UHC

- The right thing to do
- Promotes social equality, social cohesion and stability
- Achieving UHC = specific SDG target
- Consensus UHC needs predominant public financing
- Lack of consensus how best to do this

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An ideal model

- Sufficient resources (public funding)
- Remove financial risk and barriers
- Promote efficiency and eliminate waste
- Remove inequalities of coverage

Use of expenditure targets

… 15% of government budget to health

… 5-6% of gross GDP

… minimum of 6% of GDP

- YET
  - High degree of UHC with less
    - Sri Lanka 3.5%; Malaysia 4.2%;
  - Limited UHC with more
    - Malawi 11.4%; Sierra Leone 11.1%

Social health insurance: Bismarck Model

- Public insurance scheme that pays for services, usually by private providers
- Insurance contributions from government, employers and individuals
- Government contributions required for those who cannot afford to pay
- Examples: *Germany, Japan, Korea*

Tax-funded system: Beveridge Model

- General revenue taxation pays for bulk of all health care services delivered predominantly, although not exclusively, through a public sector delivery system
- Most, but not all, hospitals and clinics owned by government
- Some doctors are government employees but also private doctors who collect fees from government
- Examples : *United Kingdom, Sweden, New Zealand*

Challenges for LIC

- Limited ability to raise tax revenues or social health insurance contributions

Mixed funding models

- Less researched
- Developed "spontaneously"
- High degree of UHC with public spending of 2-3% GDP
- Health indicators comparable or better than some HIC
- Examples: *Sri Lanka, Malaysia, Hong Kong, Ireland, Australia*

Characteristics of this model

1. Majority funding for health from government & exclusively tax-based
   - *no adoption of social health insurance mechanisms*
2. Public funded package includes
   - substantial funding for hospitals & inpatient treatment
   - services that are genuinely available to the poor through a widely dispersed delivery network
3. Private financing of health care provision is allowed to meet consumer demand for additional 'add on' services
   - doctor of choice, reduced waiting times, enhanced 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

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Comparative health indicators

Key indicators for selected mixed model systems and comparable peers (2013)

	Hong Kong	Ireland	Australia	UK	New Zealand	Germany
Health system type	Mixed	Mixed	Mixed	Beveridge	Beveridge	Bismarck
Infant mortality rate (deaths/1,000 live births)	1.8	3.2	3.4	3.9	5.2	3.2
Life expectancy at birth (years)	84	81	83	81	82	81
Skilled birth attendance (%)	99	100	99	99	97	99
Hospital discharges per 100 people	18	13	17	13	15	25
Doctor consultations per person	11	4	7	5	4	10
Government health spending (%GDP)	2.6	5.5	5.9	7.0	7.6	8.4
Private health spending (% of total health expenditure)	36	32	33	16	17	23

Source: World Health Statistics 2015 (World Health Organization 2015), and Food and Health Bureau, Government of the Hong Kong Special Administrative Region (http://www.fhb.gov.hk) for additional statistics for Hong Kong [accessed 10 May 2016].

Some mixed funding models

Key indicators for selected mixed funding model systems (2013)[18, 19]

	Sri Lanka	Jamaica	Malaysia	Hong Kong
Income category	Lower-middle	Upper-middle	Upper-middle	High
GDP per capita (USD constant 2005)	1,977	4,094	7,052	33,639
Infant mortality rate (deaths/1,000 live births)	8.7	14.4	6.4	1.8
Life expectancy at birth (years)	74.7	75.5	74.6	83.8
Skilled birth attendance (%)	99	99	99	99
Government health spending (%GDP)	1.6	3.4	2.2	2.6
Out-of-pocket health spending (% of total health expenditure)	44	25	36	36

Consumer choice versus clinical outcomes

- Mixed models : focus on maintaining core clinical quality
- Pro-poor : quality publically funded health care at low-cost
- Pro-rich : allowing access to better consumer quality private health care

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The downside

1. Disaffected vocal middle-class who want better consumer quality
2. Poor may opt to use private care and put themselves at financial risk
3. Often poorly regulated private sector of variable clinical quality
4. Health care workers may migrate to private sector putting stress on public system

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What needs to be done?

- All Commonwealth countries need to embrace UHC as the right thing to do.
- Countries need to define 'high priority' health services
  - cost-effectiveness
  - prioritizing health services for the poor
  - providing financial risk protection

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Monitoring and evaluation

- Coverage of 'high priority' health services
- Household expenditures on health as % total household expenditure & income
- % GDP spent on health
  (public/private)
- Health outcomes
  (infant mortality; life expectancy)
- Measures of financial risk protection
  (out of pocket expenditures on inpatient & outpatient care by income group)

POLICY ASKS

In pursuing goal of achieving or improving UHC

- Commonwealth Health Ministers involve other Ministries and civil society stakeholders in decisions to be made about how UHC is to be provided and financed

To inform policy decisions on optimal financing of UHC

Commonwealth Health Ministers request the Commonwealth Secretariat to :

1. Systematically and critically evaluate funding models of Commonwealth countries that have achieved UHC
   - including those Commonwealth countries that use mixed public/private health care models
2. Make recommendations as to how the evidence and the lessons learned can be transferred to other Commonwealth countries as appropriate
3. Report findings to 2018 Commonwealth Health Ministers' meeting

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Thank you

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