Universal health coverage: facts and patterns in financing and attainment

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What is 'Universal Health Coverage'?

- **Definition**

    — arrangements that ensure *everyone obtains the health services they need without financial hardship*

- **What does this mean?**
    - *Needed services* – Increasing provision to a level that is deemed acceptable and appropriate for that society
    - *Quality* – Needed services also implies of appropriate quality
    - *Everyone* – Equity in service use
    - *Financial hardship* – Organizing financing and delivery so that no one faces hardship from having to pay for health services

Why ‘Universal Health Coverage’?

- **We often think of UHC as a means to an end**

  Good health

  - With the implication that this a never-ending journey to an unattainable destination, especially for developing countries

- **But for most ordinary people, UHC is more important as an ends in itself**

  — Equity in access to healthcare
  — Financial risk protection

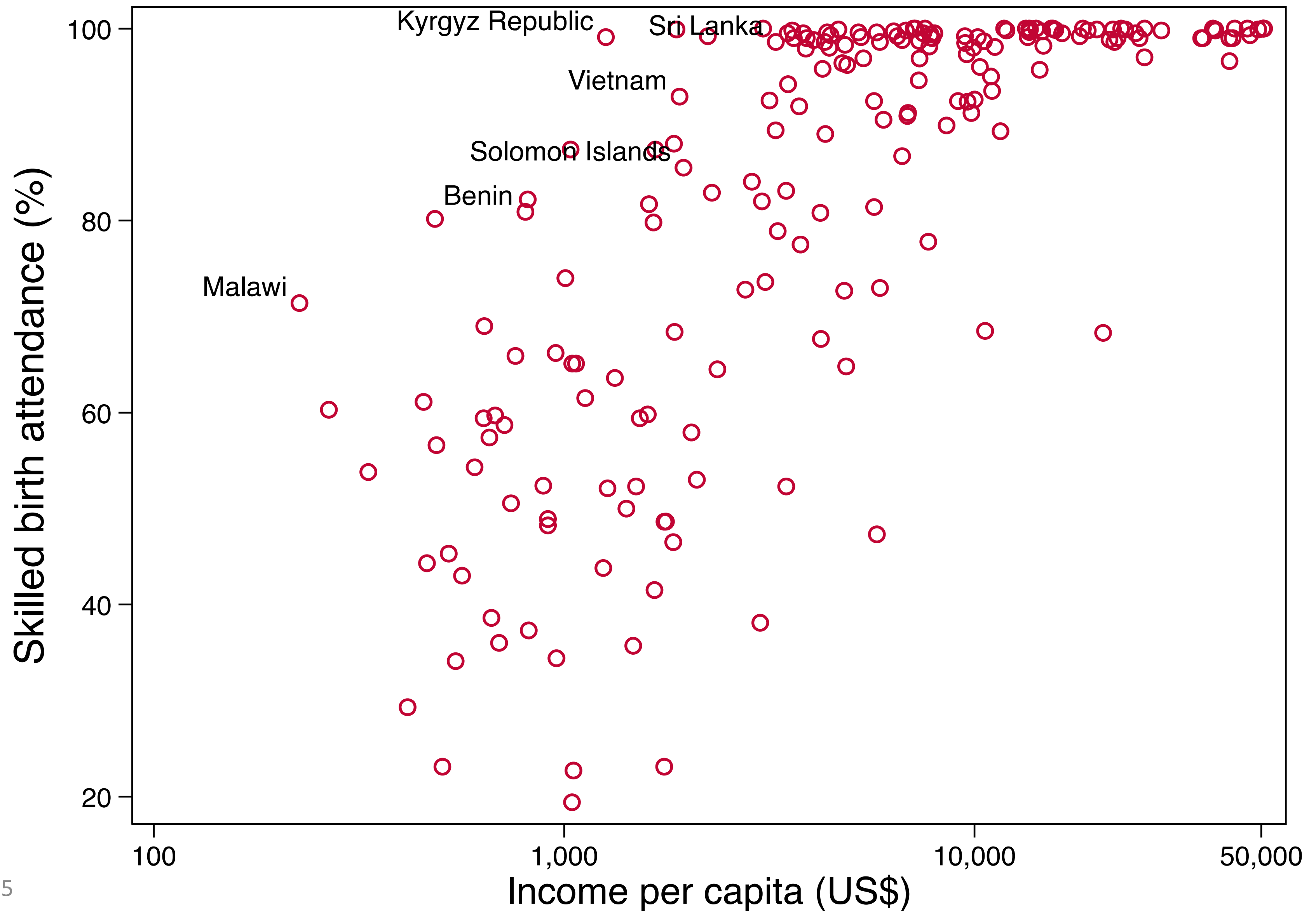
  - Which implies that UHC is achievable even by developing countries

How do countries perform on UHC?

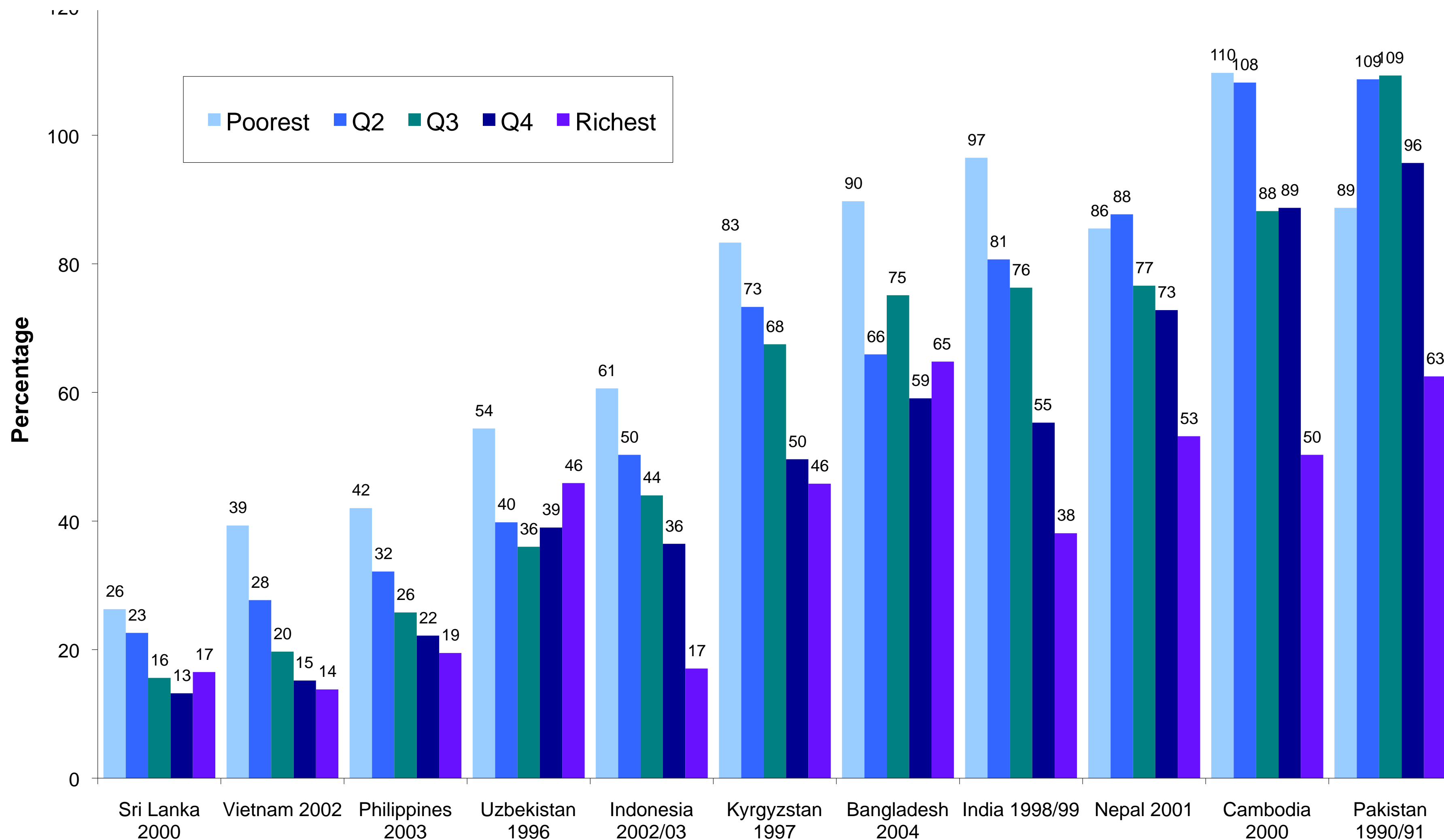
- Generally, richer countries do better
  - Spend more public money on health
  - Better health outcomes
  - Better access to healthcare
  - Lower levels of private and out-of-pocket spending
  - Better risk protection

- But large disparities in performance between and within developing countries indicate potential for most to do better

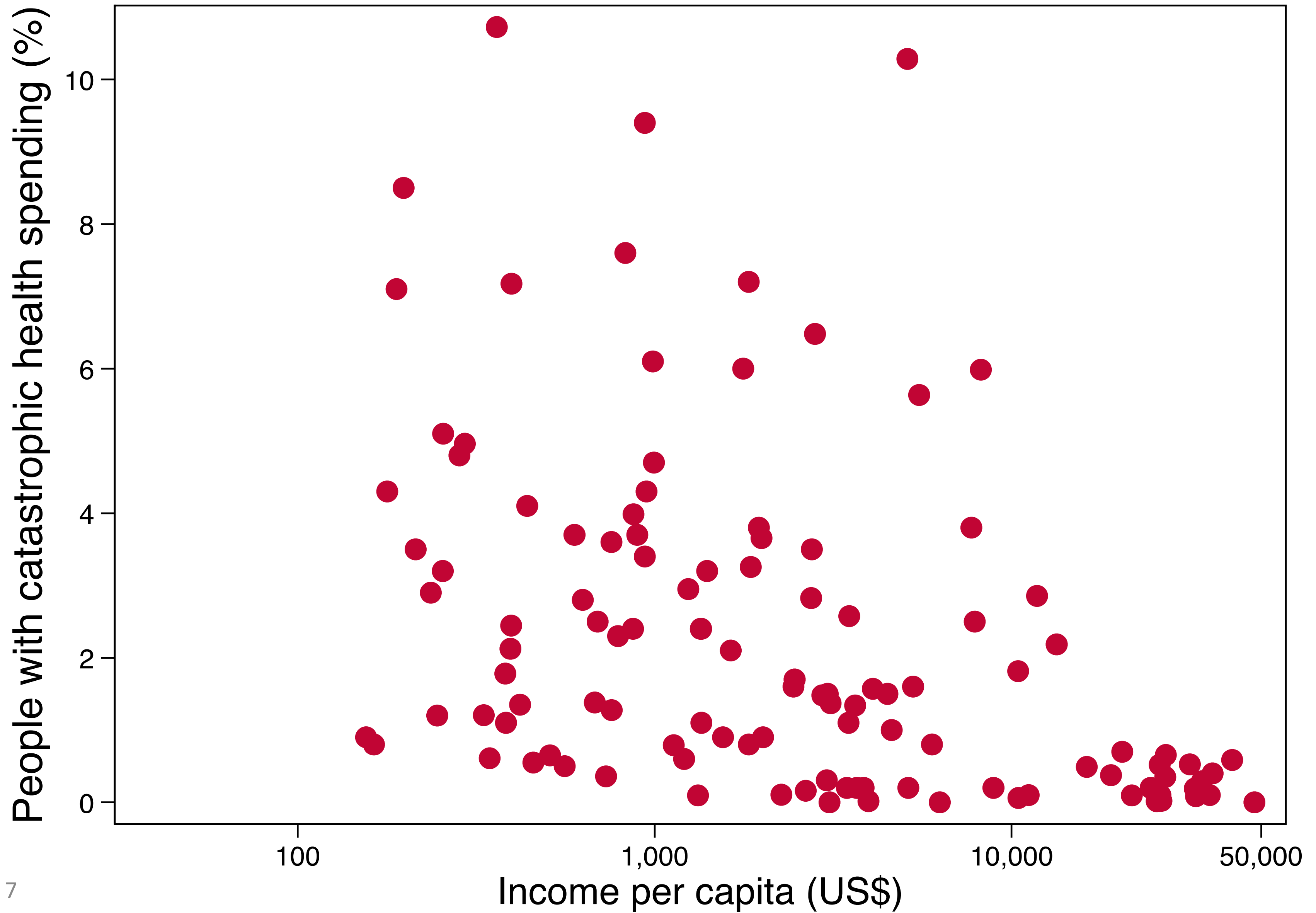
Skilled birth attendance (%) vs. Income



Large disparities in health outcomes within countries indicate potential to do better – child mortality



Households facing catastrophic health spending vs. Income



Is UHC attainable in developing countries?

- **YES**

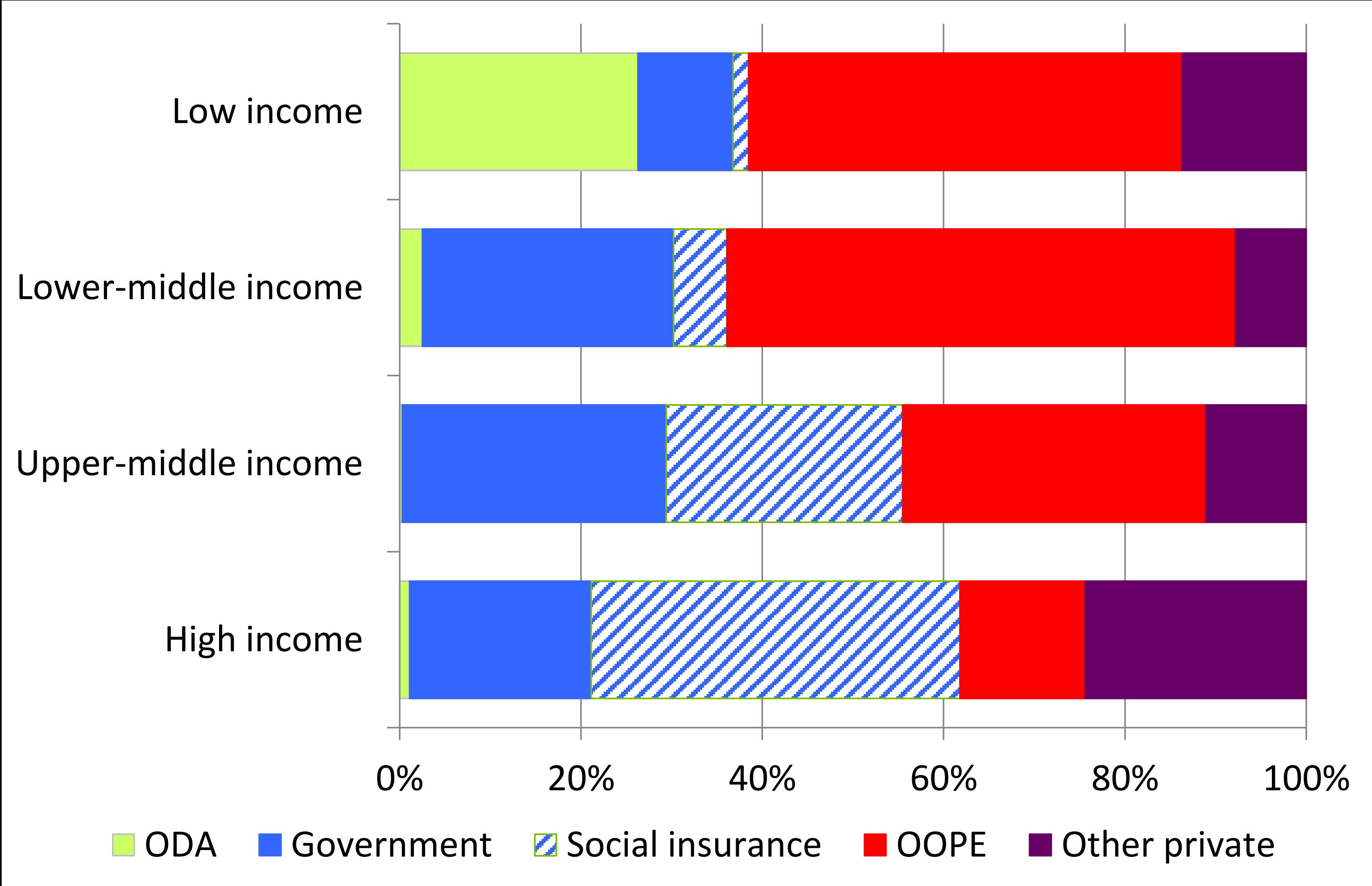
  If UHC = good health outcomes for the level of income, access for everyone to an **appropriate**, **reasonable** and **comprehensive** set of healthcare services, small disparities in access, and decent levels of financial risk protection

  - Kidney transplants would be reasonable in UK, but not in Solomon Islands
  - Statins for medium risk CVD patients would be reasonable in Sri Lanka, but not in Nepal

- Within the Commonwealth, examples include
  - Jamaica, Malaysia, Mauritius, Sri Lanka

How do countries finance UHC?

How countries pay for healthcare



Options for financing

- All countries use a mix of:
  - Out-of-pocket spending, savings accounts, community-based health insurance, private insurance, social insurance, taxation, foreign aid
- No country has achieved UHC through reliance on out-of-pocket spending, community-based health insurance, private insurance, or traditional social health insurance
- All countries achieving UHC rely on **taxation** and sometimes **social health insurance** as well

Two standard routes to UHC

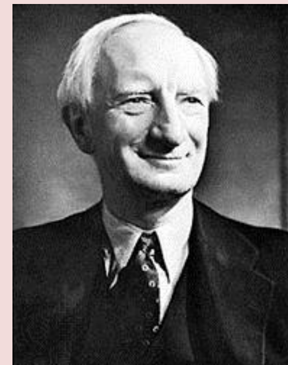
Social health insurance

- Funded by contributions by workers and employers to an insurance fund
- Delivery by private or public providers

The Bismarck model

National health service

- Tax-financed, government delivery system providing all citizens with 80% or more of all healthcare



The Beveridge model

Routes to achieving UHC

– Social Health Insurance (or Bismarck)

- Successful only in upper-middle/high income nations:
  - France, Germany, Japan, Korea
- Traditional SHI never able to achieve UHC. Cannot cover poor and those outside formal sector.
- Modern national health insurance uses government tax money to extend insurance to all citizens
- Route to UHC
  - **Governments spend tax money** to expand coverage, breaking link between contributions and insurance coverage
- Feasibility
  - Ability to overcome opposition from formal sector to funding extension of coverage to non-contributing beneficiaries
  - Political willingness to mobilize additional taxation

Routes to achieving UHC

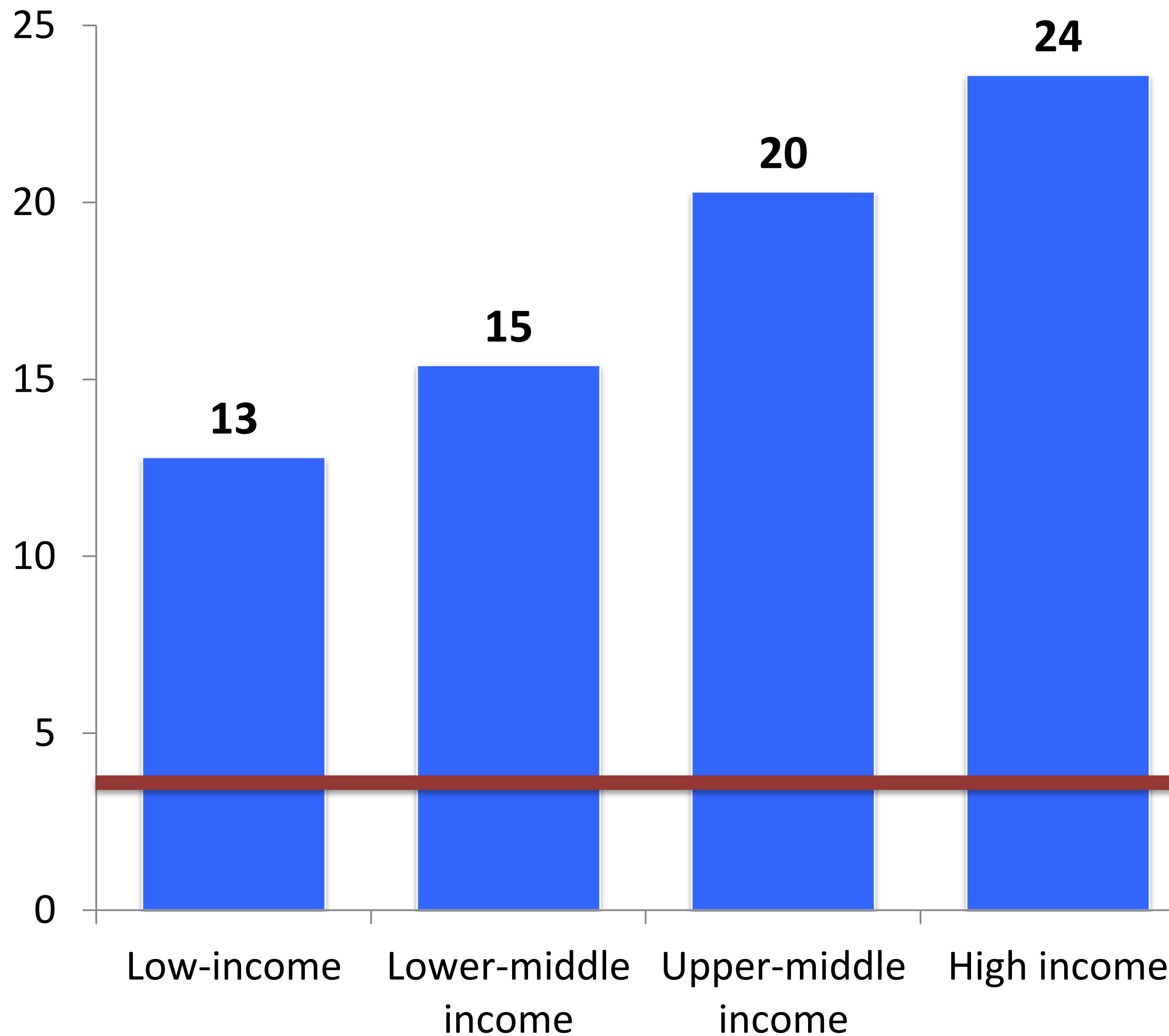
– National Health Service (or Beveridge)

- Successful only in upper-middle and high income nations
  - Cuba, UK, Denmark, New Zealand
- Expansion of government financing and public delivery systems to cover almost all services for all people
- Route to UHC
  - Increase in gov't spending to >3% of GDP to fund >85% of total healthcare costs
  - Reduction/elimination of user fees in public sector
  - Use of gov't budget to cover most outpatient care, including GPs
  - Building delivery network that is accessible to all
- Feasibility
  - Depends on political and economic ability to mobilize additional taxation

How feasible are the standard NHS and NHI models in developing countries?

- Achieving UHC in both approaches requires significant government contributions from taxation to ensure universal coverage
  - In both models, non-poor pay taxes to cover poor
  - In NHS model, non-poor pay taxes to cover themselves, but in NHI model non-poor pay insurance contributions
- Typically, governments need to spend 3-6% of GDP in budgetary spending in either approach

Government tax revenues as share of GDP (%) by level of income (2012)



Minimum tax revenues needed to achieve UHC using NHS or NHI approaches

How feasible are the NHS and NHI models in developing countries?

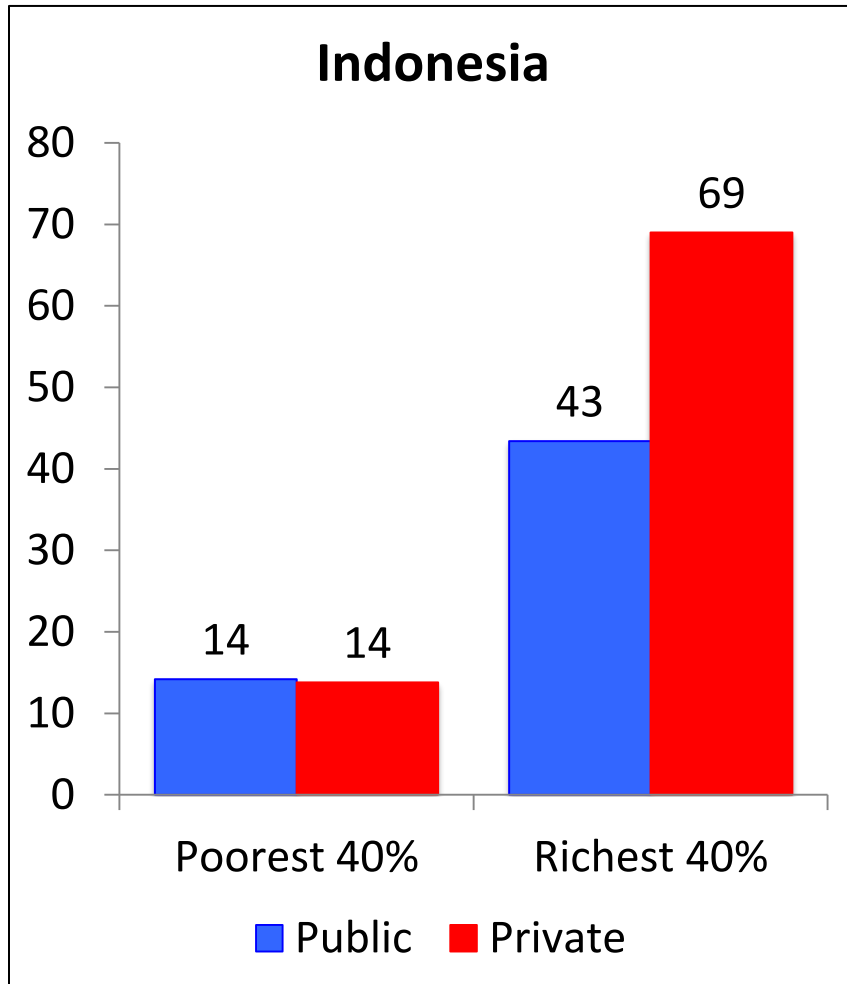
- Governments must spend 3-5% of GDP in tax money, **but reality is that most MOFs cannot afford this!**
- Attempts to implement NHS/NHI models usually result in unequal and deficient coverage
  - Public services are inadequate and end up being captured by rich and urban populations
  - Or SHI coverage remains confined to the formal sector or does not pay for adequate care
- There is no example of UHC through SHI in any low or lower-middle income economy, and almost no case of a true NHS model. So how?

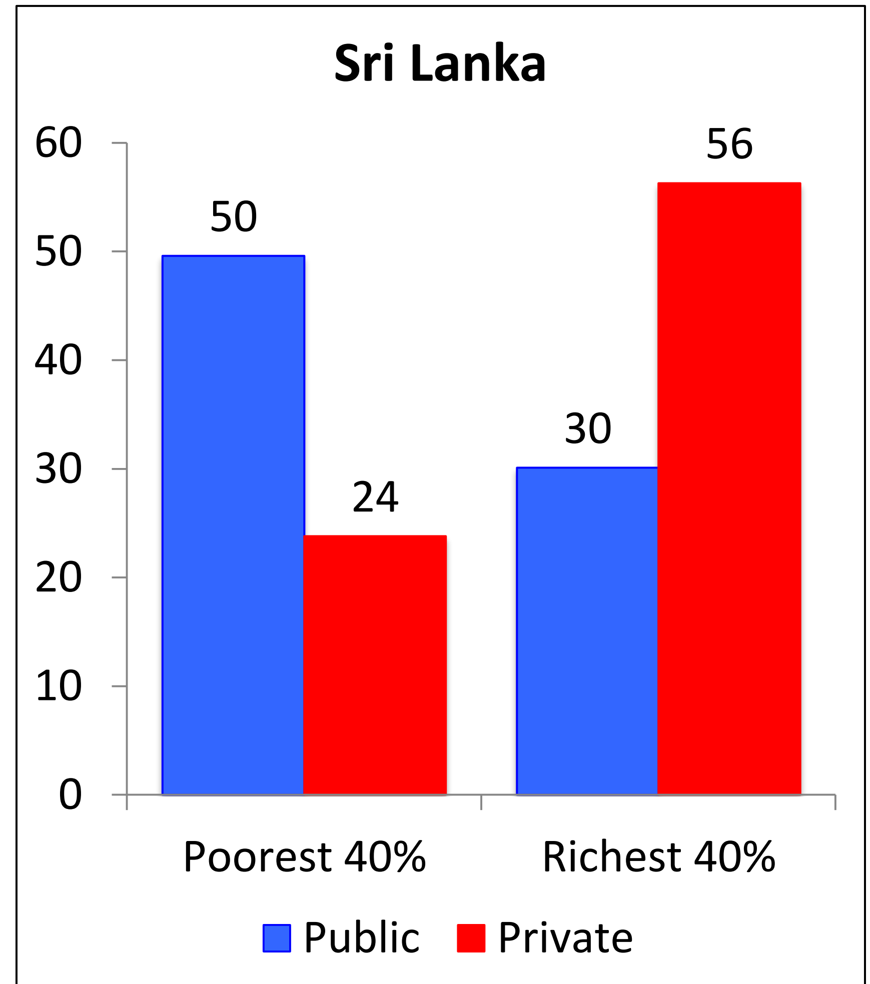
A Third Route to achieving UHC

– Mixed NHS and Private Systems

- Examples
  - Australia, Sri Lanka, Ireland, Jamaica, Malaysia, Mauritius
  - Mostly Commonwealth nations with no history of SHI
- Economic and political constraints prevent full public funding of a NHS, but government faces strong pressure to provide universal coverage
  - Parallel free gov’t services and non-free private services
  - Access of poor to quality public services ensured by removing public sector user fees and good physical access
  - Public services targeted to poor by encouraging non-poor to seek private care for better consumer quality

Targeting of public care in mixed systems that don't or do achieve UHC





Comparison of Mixed Systems vs. Better Known UHC Stars

Country	Public health spending (%GDP)	Skilled birth attendance (%)	IMR	Life expectancy
Sri Lanka	1.4	99	8	74
Malaysia	2.2	99	7	75
Mauritius	2.4	99	12	74
Mexico	3.3	96	12	77
Jamaica	3.4	99	14	73
Thailand	3.7	99	11	74
Brazil	4.7	98	12	74
Ireland	6.0	100	3	81
United Kingdom	7.8	99	4	81
Cuba	8.2	100	5	79

Concluding thoughts

- High income is not a necessary condition for UHC – Developing countries can achieve it too
- Tax money is critical for financing UHC
- The standard NHS and SHI models of UHC are hard to implement in most developing countries
- A mixed public-private model found in many Commonwealth nations provides an alternative and under-rated model for countries with limited tax resources