Universal Health Coverage

Investing in health: an economic imperative for sustainable development

Report of the Commonwealth Civil Society Forum

Saturday, 16 May 2015

Commonwealth Foundation

McKinsey&Company

INTRODUCTION

In conjunction with the Commonwealth Health Ministers meeting (CHMM) and the World Health Assembly in May 2015, the CHPA in partnership with the Commonwealth Foundation and McKinsey and Company hosted a Commonwealth Civil Society Forum. The Forum was titled: *Investing in health: an economic imperative for sustainable development* and was held 16 May 2015, the day prior to the CHMM. The main focus of the Forum was how universal health coverage should be financed and what services should be provided. The Forum consisted of a number of keynote presentations followed by a discussion between speakers and participants moderated by Dr Nicolaus Henke from McKinsey and Company.

The specific objectives of the Forum were:

a. To host Commonwealth Civil Society Forum in May 2015 to present the 'convergence' concept; to discuss universal health coverage and what it actually means; to discuss ways of financing universal health coverage; and make recommendations to Commonwealth Health Ministers for further action.

b. To present recommendations from the CCSF to Commonwealth Health Ministers at the CHMM and outline requested action.

c. To provide ongoing advocacy through CHPA members and partners to encourage mobilisation of resources from national and donor governments to ensure the rapid implementation of universal health coverage and 'convergence interventions' throughout the Commonwealth.

The Forum explored the financing of universal health coverage and asked Commonwealth Health Ministers to define their own set of high priority 'convergence interventions' and to universally implement these with public financing from national budgets with contributions, if necessary, from the international community.

BACKGROUND

Good health is the fundamental foundation on which democracy and development is built. Unless populations are healthy they cannot participate in education and employment or contribute to the economic wellbeing of their country. Additionally, an unhealthy population places an economic burden on their country. Recent reports however suggest the exciting possibility of achieving dramatic gains in global health by 2035 through a convergence around the management of infections; child and maternal mortality; major reductions in the incidence and consequences of NCDs and injuries; and the promise of universal health coverage. Research by the Lancet Commission[1] found that the returns on investing in health are impressive. For example, reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries as measured in their national income accounts and with the right investments, the stark differences in infections and maternal and child death rates between countries of differing income levels could be brought to an end within a generation through investment in evidence-based, low cost interventions.

Sternberg et al[2] costed health systems strengthening and six investment packages for maternal and newborn health, child health, immunisation, family planning, HIV and AIDS, and malaria with nutrition as a cross-cutting theme. They used simulation modelling to estimate the health and socio-economic returns of these investments. Increasing health expenditure by just $5 per person per year up to 2035 in 74 high-burden countries could yield up to nine times that value in economic and social benefits. These returns include greater gross domestic product (GDP) growth through improved productivity, and prevention of the needless deaths of 147 million children, 32 million stillbirths, and 5 million women by 2035.

Commonwealth Health Ministers have acknowledged the need to ensure that all Commonwealth citizens have equitable access to quality and affordable essential health services, without enduring financial hardship, in a manner that is sustainable for the long-term. Challenges exist and it is clear that to achieve universal health coverage and convergence it will require additional resources from both national and donor governments. Yet the economic advantages of investing in primary health care and preventing ill health; immunisation; NCDs (including mental health); maternal and child health; the health workforce; and essential medicines will be considerable for Commonwealth countries. Increased official development assistance for such interventions provides the opportunity for faster implementation of these interventions post-2015.

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[1] Jamieson, Global health 2035: a world converging within a generation *The Lancet*, Volume 382, Issue 9908, Pages 1898-1955, 7 December 2013 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext

[2] Sternberg, K. 2014. Advancing social and economic development by investing in women's and children's health: a new global investment framework. *The Lancet* Volume 383 Issue 9909 pp 1333-1354 (Available from: http://www.thelancet.com).

The evidence-base is now very much stronger and there is a clear understanding about which interventions are most cost-effective and what the costs and benefits of these interventions are. Prompted by the 20th anniversary of the World Bank's *World Health Report* 1993, the Lancet commissioned a report titled *Global health 2035: a world converging within a generation*. Four conclusions were reached:

1. There is a very large payoff from investing in health.
2. Convergence is achievable within our lifetime.
3. Scale-up of low-cost packages of interventions can enable major progress in NCDs and injuries within a generation.
4. Progressive universalism is an efficient way to achieve health and financial protection.

Convergence is the concept that, with the right investments, the stark differences in infections and maternal, and child death rates between countries of differing income levels could be brought to an end within our lifetime. The Lancet article notes "*efficiency and equity considerations have led high-income countries, and many middle-income countries, to offer health services, including preventive health interventions, to all households with minimum or no payment at the time of use*." It goes on to state that "*the first type of progressive universalism involves initial rapid movement toward publicly financed coverage of the entire population for a defined set of interventions*."

Taking this principle, the Forum aimed to highlight the following points:

- high priority, evidenced-based, cost-effective, health interventions exist; and
- research has demonstrated that implementation of these interventions would result in a 'convergence' of health outcomes between developed and developing countries within a generation.

Mr Vijay Krishnarayan
Director
The Commonwealth Foundation

Participants were welcomed to the Forum by Mr Vijay Krishnarayan, Director of the Commonwealth Foundation who emphasised the importance of universal health coverage which gave access to all citizens to essential health care at a price they could afford without tipping them into poverty. Mr Krishnarayan emphasised the important role of health in enabling participation of citizens in democratic processes and stressed the critical role of civil society across the Commonwealth in Good health is the fundamental foundation on which democracy and development is built. Unless populations are healthy they cannot participate in education and employment or contribute to the economic wellbeing of their country. Mr Krishnarayan shared with participants the activities of the Commonwealth Foundation in promoting participative governance between civil society and governments across the Commonwealth.

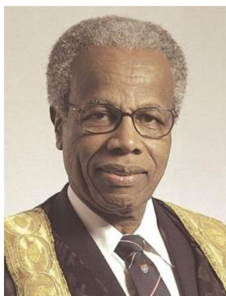
Five speakers presented different aspects of investing in health to achieve universal health coverage arguing that it was an economic imperative for Commonwealth countries.

Dr Nicolaus Henke
McKinsey and Company
Opportunities to enable universal health coverage

Dr Henke said that investing in health is fundamental to economic and social development. He cited four health system objectives that were important for economic development:

- Good health outcomes which lead to higher labor productivity; higher quality of life and living standards; and political and social stability.
- Financial protection which is the protection of individuals from health shocks and impoverishment as a consequence, thus supporting consumer demand and economic growth.
- Responsiveness which is patient satisfaction; meeting people's expectations; and ensuring support from society for the health system.
- Country competitiveness which supports attracting talent, capital, and direct investments to the country; keeps labor costs and tax loads at a globally competitive level; contributes to fiscal and macroeconomic performance; and results in a more productive workforce, especially through more working hours.

The four common challenges for countries, Dr Henke said, were identifying the country specific social determinants of health; developing the best financing model for the country; ensuring a supportive workforce and infrastructure; and coping with NCDs and ageing populations.



Sir George Alleyne
United Nations Secretary-General's Special Envoy for HIV and AIDS in the Caribbean region
Universal Health Coverage: what works, what it costs and who pays

Sir George said that research has demonstrated that developing countries could achieve a similar health status as developed countries by 2035 by adopting a number of simple cost effective strategies which would improve the health and therefore the economic productivity of their populations. Sir George said there were four key global health messages:

1. There is an enormous payoff from improvements in health.
2. Fiscal policies are a powerful and underused lever for curbing non-communicable diseases and injuries.
3. Progressive pathways to universal health coverage are an efficient way to achieve health and financial protection.
4. A ‘grand convergence’ in health is achievable within our lifetime.

Ms Jill Iliffe
Secretary, Commonwealth Health Professions Alliance
Universal health coverage: but what of universal health care

Ms Iliffe noted the WHO definition of universal health coverage (UHC) as “all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services” while recognising that no government is able to provide every service that every person needs at any given time. Ms Iliffe expressed concern that the focus of the universal health coverage debate appears to have shifted from how and what services are to be provided to how services are to be financed. Ms Iliffe said that in developing a budget in any context, the first step is to work out what you want the budget to cover; how you finance it is the second step however the discussion around universal health coverage is all about the sustainable financing of health systems. What is less discussed is what care is being financed, to whom, by whom, and at what quality.

Ms Iliffe commented that the development of health systems in most low and middle income countries has been, and still is, considerably influenced by external agencies, donors and ‘experts’ and it cannot be said that this influence has always been in the best interests of the various countries or their populations. Countries which rely heavily on donor aid to meet essential services are captured by the priorities of the donor rather than the needs of the community. Providing quality health care to meet the health needs of countries must be an essential component of the financing debate.

K M Gopakumar
Third World Network
Challenges for access to medicines within universal health coverage

Mr Gopakumar emphasised that universal health coverage means publicly financed and publicly provided comprehensive health care services. Access to medicines, Mr Gopakumar said, is part of the right to health. The key components of access to medicines are:

- Sustainable financing,
- Public procurement and distribution resulting in availability at affordable pricing and including local production and public health oriented patent and intellectual property laws,
- Rational use,
- Appropriate drug regulatory framework.

Mr Gopakumar said that access to medicines constitutes a major part of health care expenditure and out of pocket expenditure for individuals often precipitating them into poverty as a consequence.

Mr Gopakumar went on the discuss what he considers the negative impact of the TRIPS Agreement (the Agreement on Trade-Related Aspects of Intellectual Property Rights, an international agreement administered by the World Trade Organization that sets down minimum standards for many forms of intellectual property regulation) especially for low and middle income countries which includes compromised access to medicines; multiple challenges for the effective use of the TRIPS flexibilities; and the incapacity of countries to fulfill human rights obligations especially the right to health and the right to enjoy the progress of science and technology. Mr Gopakumar recommended the suspension of the TRIPS Agreement for developing countries and the removal of unwanted regulatory barriers to ensure competition and access of bio-therapeutic products.

Dr Ravindra Rannan-Eliya
Director, Institute for Health Policy, Sri Lanka
Universal health coverage: facts and patterns in financing and attainment

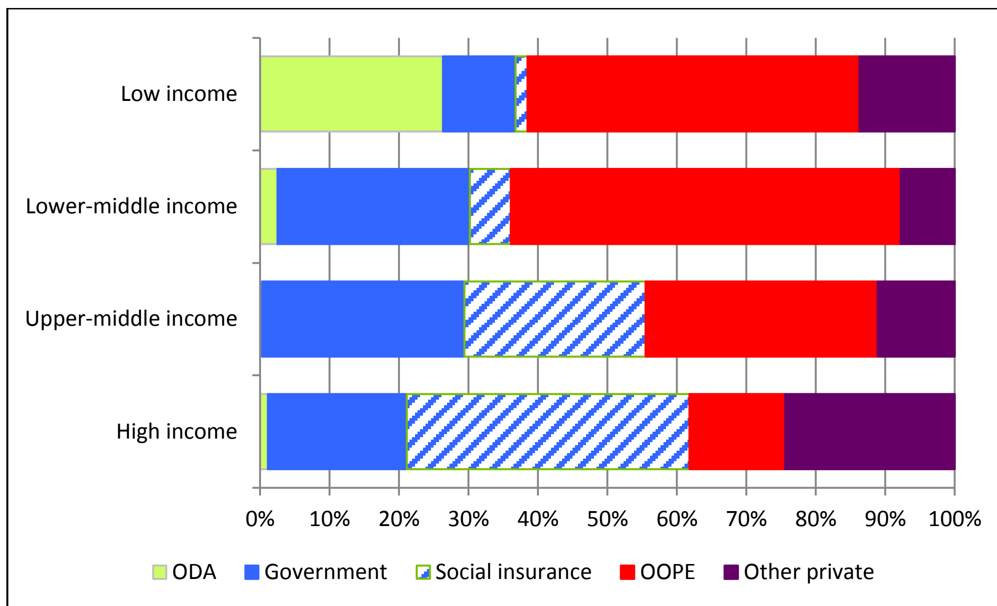
Dr Rannan-Eliya defined universal health coverage as ensuring that everyone obtains the health services they need without financial hardship and maintained that UHC was attainable for developing countries.

Dr Rannan-Eliya said that in looking at UHC financing options:

- all countries use a mix of out of pocket spending, savings accounts, community-based health insurance, private insurance, social insurance, taxation, or 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, and that
- all countries achieving UHC rely on taxation and sometimes social health insurance as well.

Dr Rannan-Eliya shared a diagram showing health financing by income level of country (see diagram 1).

DIAGRAM 1: Health financing by income level of country



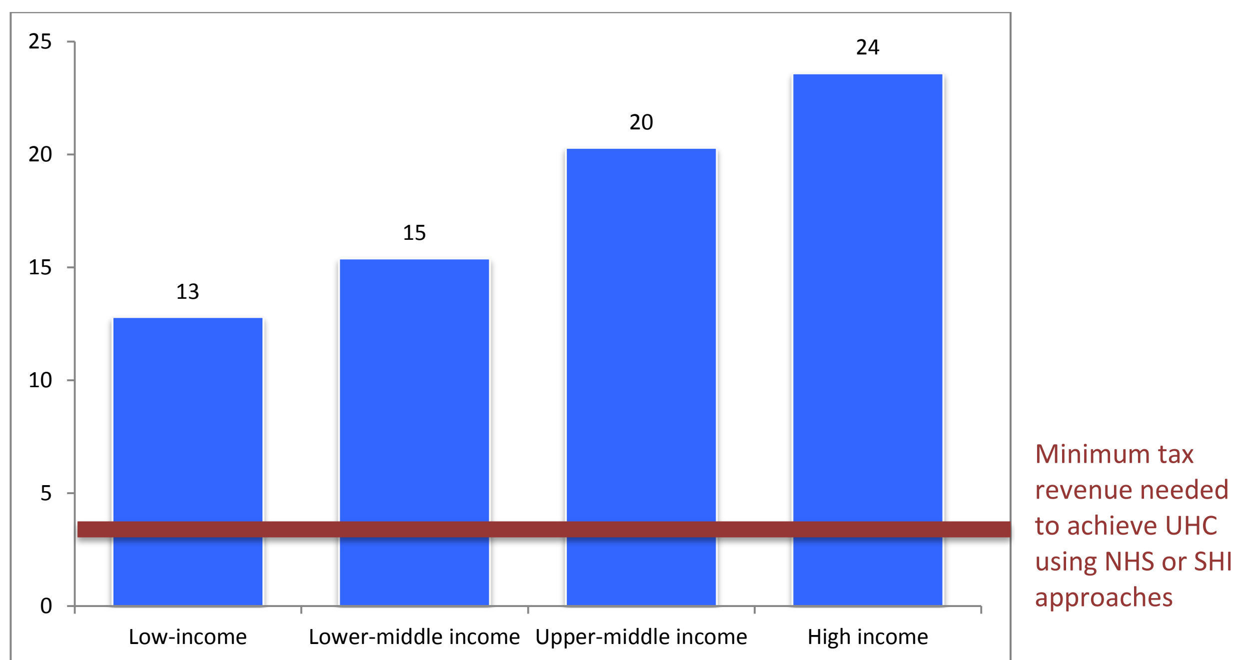
ODA (overseas development assistance) OOPE (out of pocket expenses)

Dr Rannan-Eliya said that there were two standard routes to achieving UHC: the Bismark model of social health insurance funded by contributions from workers and employers into an insurance fund and delivered by public or private providers (France, Germany, Japan, Korea); and the Beveridge model of a tax-financed, government delivered system providing all citizens with 80% or more of their health care (Cuba, United Kingdom, Denmark, New Zealand).

One of the difficulties with the Bismark model is that it excludes non-contributing citizens and UHC can only be achieved if governments extend coverage using taxation revenue. The model only becomes feasible if there is political willingness to use taxation revenue to extend coverage and a lack of opposition from contributing members of society to coverage being extended to non-contributing members. Achievement of UHC using the Beveridge model is only feasible if there is the political will and economic capacity in a country to mobilise taxation revenue to fund a public deliver system that provided almost all health services for all people (an increase in government spending on health to >3% of GDP to fund >85% of total health care costs including most outpatient care; reduction or elimination of user fees in the public sector; and a publicly funded delivery network accessible to all).

Dr Rannan-Eliya said that both models require significant government contribution from taxation to ensure universal coverage, typically between 3-6% of GDP. In both models, the non-poor pay taxes to cover the poor. In reality, Dr Rannan-Eliya said, most low or low-middle income countries cannot afford to spend 3-6% of their GDP on health and attempts to implement NHS or SHI models usually result in unequal or deficient coverage with inadequate public services captured by rich and urban populations or SHI coverage confined to only those who can afford to pay.

DIAGRAM 2: Government tax revenue as share of GDP (%) by level of income (2012)



There is however a third way, Dr Rannan-Eliya said, for low and low-middle income countries to achieve UHC using a mix of public and private systems successfully implemented in countries such as Australia, Sri Lanka, Ireland, Jamaica, Malaysia, and Mauritius, where economic and political constraints prevent full public funding of a NHS but where the government faces strong pressure to provide universal coverage. The outcome is a parallel free government service and a non-free private service. Access by the poor to quality public services are ensured by removing public sector user fees and providing good physical access. Public services target the poor by encouraging the non-poor to seek private care. Outcomes are comparable to the NHS model as shown in the table below.

DIAGRAM 3: Comparison of selected outcomes between Mixed model and NHS model

Country	Public health spending (%GDP)	Skilled birth attendance (%)	Life expectancy
Sri Lanka	1.4	99	74
Malaysia	2.2	99	75
Mauritius	2.4	99	74
Jamaica	3.4	99	73
Ireland	6.0	100	81
United Kingdom	7.8	99	81
Cuba	8.2	100	79

Dr Rannan-Eliya concluded by saying that high income is not a necessary condition for UHC - developing countries can also achieve UHC; however taxation revenue is critical for financing UHC. While 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.

Discussion

A number of messages and themes were emphasised during the presentations and the panel discussion that followed the various presentations:

- Investing in health is fundamental to economic and social development.
- High income is not a necessary condition for achieving universal health coverage (UHC).
- Public health systems are more efficient because they ensure economies of scale and lower transaction costs. Public health systems also perform tasks not directly linked to care such as disease surveillance.
- Health products, including medicines and vaccines, should be available at affordable prices. This will require new regulatory frameworks.
- Funds will always be limited but the evidence suggests that public funding should provide priority interventions for all and user fees for these interventions should be removed.
- No country has achieved UHC through reliance on out-of-pocket spending, community-based health insurance, private insurance, or traditional social health insurance (SHI). All countries achieving UHC rely on taxation and sometimes social health insurance as well. Therefore tax money is critical for financing UHC.
- The standard NHS and SHI models of UHC are hard to implement in most developing countries and a mixed public-private model found in many Commonwealth countries provides an alternative and under-rated model for countries with limited tax resources.
- Some low income countries will still have significant funding gaps and external resources will be required.

Conclusion

There is growing evidence to show that each country needs to establish a mechanism to define its own set of priority services for UHC and then to universally implement these interventions with public financing from national budgets. In many cases the extra resources will come from economic growth and increased tax allocations to health. However for some countries it needs to be recognised that financial contributions will still be required from the international community. The Commonwealth has some unique strengths and one of these is highlighted by some very successful 'mixed public-private models of UHC'. This model needs to be studied, shared and promoted amongst all Commonwealth countries and also more widely within the global community.

A report of the Forum with the key points made by the speakers and emanating from the discussion was presented to Commonwealth Health Ministers at their meeting Sunday 17 May by Dr Tony Nelson, Secretary of the CHPA (see appendix 1).

APPENDIX 1

Commonwealth Association for Health and Disability
Commonwealth Association for Paediatric Gastroenterology and Nutrition
Commonwealth Dental Association
Commonwealth HIV and AIDS Action Group
Commonwealth Medical Association
Commonwealth Nurses and Midwives Federation
Commonwealth Pharmacists Association

Commonwealth Health Ministers Meeting
Geneva, Switzerland, 17th May 2015
Theme: *Universal Health Coverage, with an emphasis on ageing and good health.*

Item VI: Report from Commonwealth Civil Society Forum

"Universal Health Coverage: Investing in Health - an economic imperative for sustainable development"

Professor Edmund Anthony Severn Nelson
Commonwealth Health Professions Alliance
Department of Paediatrics, The Chinese University of Hong Kong

ABSTRACT

The Forum, organised by the Commonwealth Health Professions Alliance and supported by the Commonwealth Foundation and McKinsey and Company, noted that investing in health is fundamental to economic and social development. However financing and regulatory frameworks are important challenges for implementing Universal Health Coverage (UHC). Public health systems offer economies of scale and lower transaction costs and all countries achieving UHC rely primarily on taxation. Although high income is not a prerequisite for achieving UHC, some low income countries will still require support from external resources. The two standard routes to achieving UHC usually discussed are: 1) Social health insurance and 2) National Health Service (NHS). However a "Hybrid NHS and Private System model" has been successfully used by several developing Commonwealth countries (Sri Lanka, Jamaica, Malaysia). This under-rated model offers a third way that is seldom addressed in international fora. These successful "mixed Commonwealth models of UHC" need to be studied, shared and promoted more widely.

REPORT

In July 2014, the Commonwealth Health Professions Alliance represented by 5 of its 7 member associations, together with the support of the Commonwealth Foundation, organised a roundtable with High Commissioners at Marlborough House. The theme of the roundtable was "*Investing in health: an economic imperative for sustainable development*". This was the impetus for the Commonwealth Civil Society Forum held on 16 May 2015.

The Forum was organised by the CHPA and supported by the Commonwealth Foundation and McKinsey and Company. Introductory comments noted challenges to implementing UHC such as social determinants, financing, workforce and infrastructure, NCDs and aging. The Forum explored different funding models and discussed the importance of public financing.

Sir George Alleyne spoke about "Investing in health: what works, what it costs and who pays?" Sir George co-authored the seminal Lancet commissioned report on "Global health 2035: a world converging within a generation" which showed that the right health investments produce remarkable returns ~ both in terms of economic growth but also in terms of health gains. Progressive universalism (reducing user fees, expanding services, increasing coverage) is proposed as a path to achieving UHC.

Mr Gopakumar from the Third World Network addressed the difficult issue of "access to medicines in relation to UHC" showing the need for public financing and public procurement, availability at affordable prices, rational use, and appropriate trade and R&D regulatory frameworks. This emphasises the need for a policy space to ensure access to affordable medicines.

Dr Ravi Rannan-Eliya, the Director of the Institute for Health Policy in Sri Lanka, spoke about different ways to fund UHC, sharing some unique successes from within the Commonwealth. The two standard routes to UHC usually discussed are: 1) Social health insurance (SHI) or the "The Bismarck model" and 2) National Health Service (NHS) or "The Beveridge model". Most Commonwealth countries have no history of SHI and many lack the tax resources to fund a full NHS system. However a third route to achieving UHC is a "Hybrid NHS and Private System model" that several developing Commonwealth countries, such as Sri Lanka, Jamaica and Malaysia have successfully used to provide an acceptable level of UHC within a limited public budget. This approach is seldom addressed in international fora and deserves greater attention and investigation by the Commonwealth community.

A number of messages and themes were emphasised during the presentations and the panel discussion that followed.

- Investing in health is fundamental to economic and social development.
- High income is not a necessary condition for UHC.
- Public health systems are more efficient because they ensure economies of scale and lower transaction costs. Public health systems also perform tasks not directly linked to care such as disease surveillance.

- Health products, including medicines and vaccines, should be available at affordable prices. This will require new regulatory frameworks.
- Funds will always be limited but the evidence suggests that public funding should provide priority interventions for all and user fees for these interventions should be removed.
- 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. Therefore tax money is critical for financing UHC.
- The standard NHS and SHI models of UHC are hard to implement in most developing countries and a mixed public-private model found in many Commonwealth countries provides an alternative and under-rated model for countries with limited tax resources.
- Some low income countries will still have significant funding gaps and external resources will be required.

In conclusion there is growing evidence to show that each country needs to establish a mechanism to define its own set of priority services for UHC and then to universally implement these interventions with public financing from national budgets. In many cases the extra resources will come from economic growth and increased tax allocations to health. However for some countries it needs to be recognised that contributions will be required from the international community.

The Commonwealth has some unique strengths and one of these is highlighted by some very successful "mixed public-private models of UHC". We need to study, share and promote these models amongst all Commonwealth countries and also more widely within the global community.