

Health Financing for Universal Coverage

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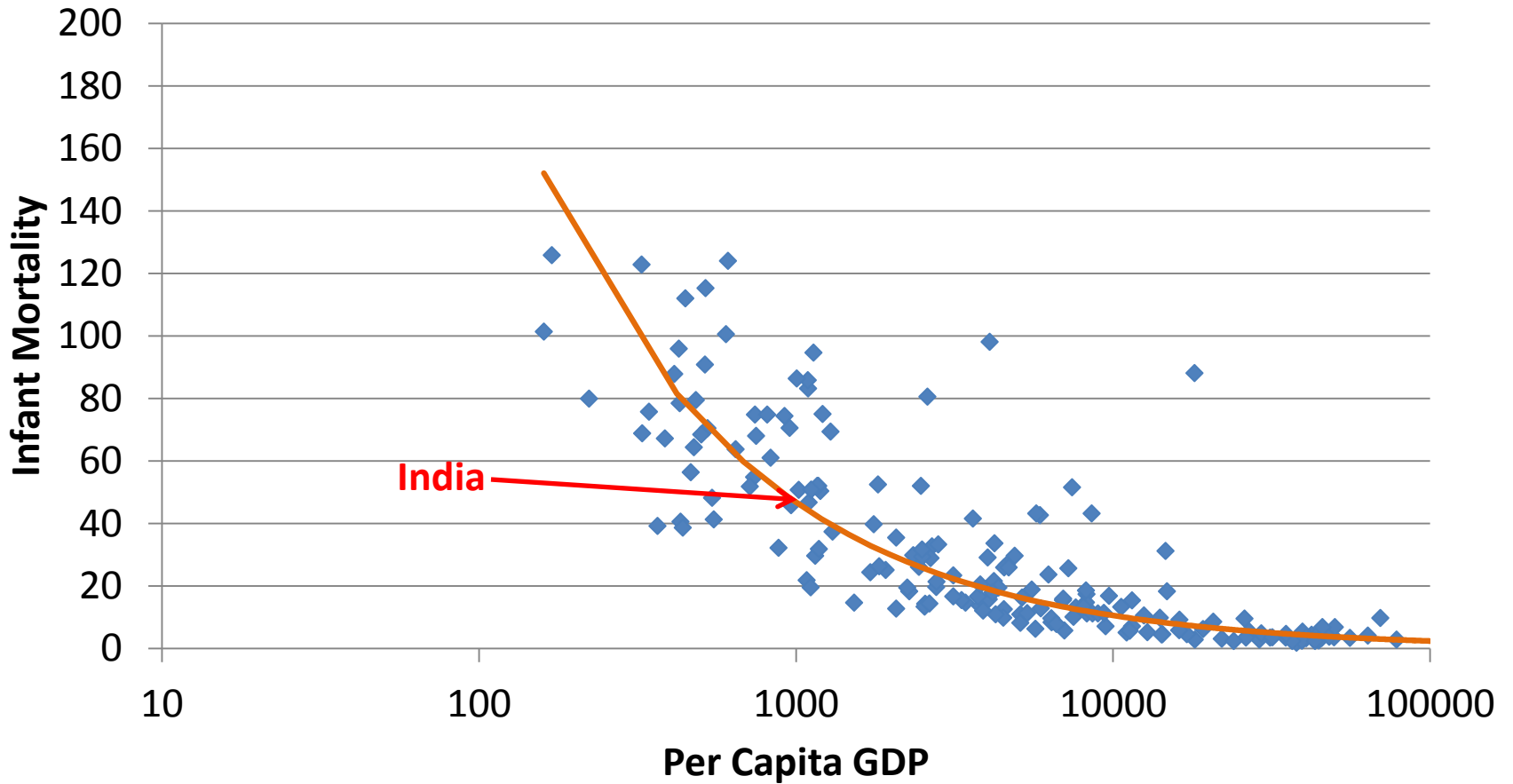
**Presented at the
National Institute of Health and Family Welfare, New Delhi
1 November 2013**

Why focus on health financing?

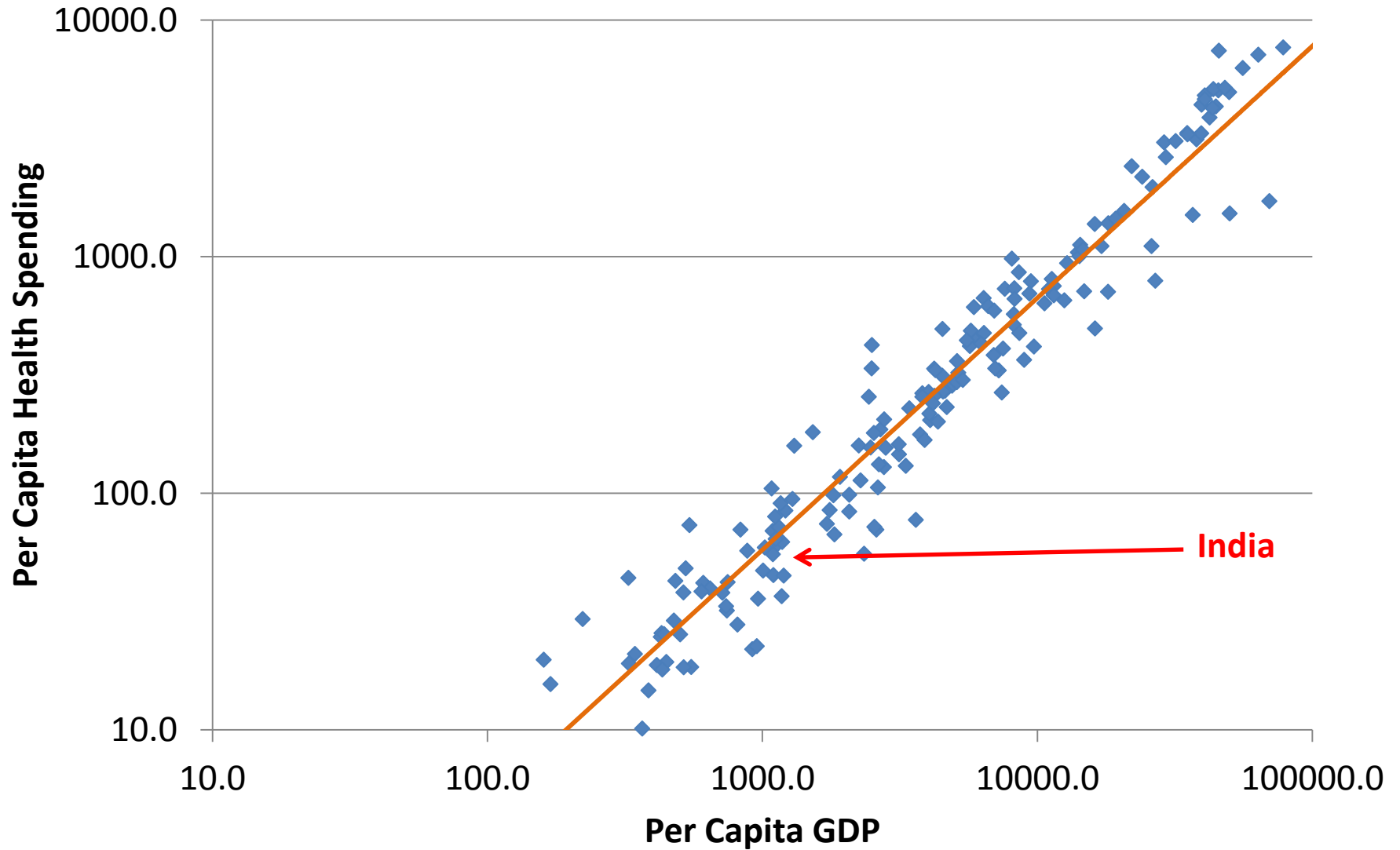
- While GDP growth and health outcomes are related, the link comes via a higher level of health spending
- Higher GDP growth rate enable countries to allocate more to health, which in turn impacts on health outcomes
 - But wide variation across countries
 - Higher GDP does not always lead to higher allocations to health
- Similarly, higher allocations to health can lead to varied outcomes
- India has low GDP per capita, low per capita health spending and poor health outcomes
 - There are countries that are spending more on health even with India's level of per capita GDP
 - It is possible to improve health outcomes even with this level of health spending

Infant Mortality and per capita GDP

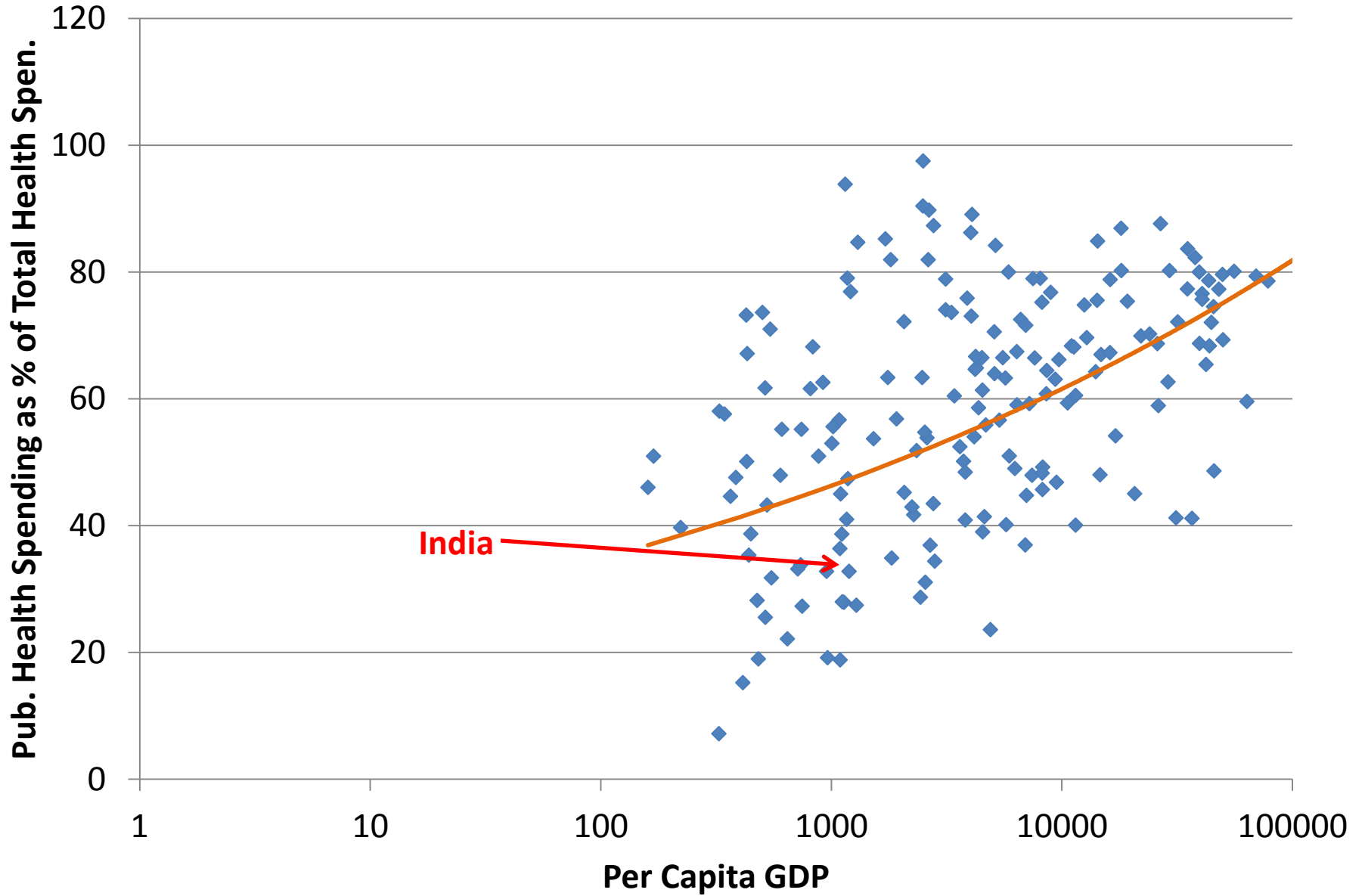
Infant mortality Vs GDP Per Capita



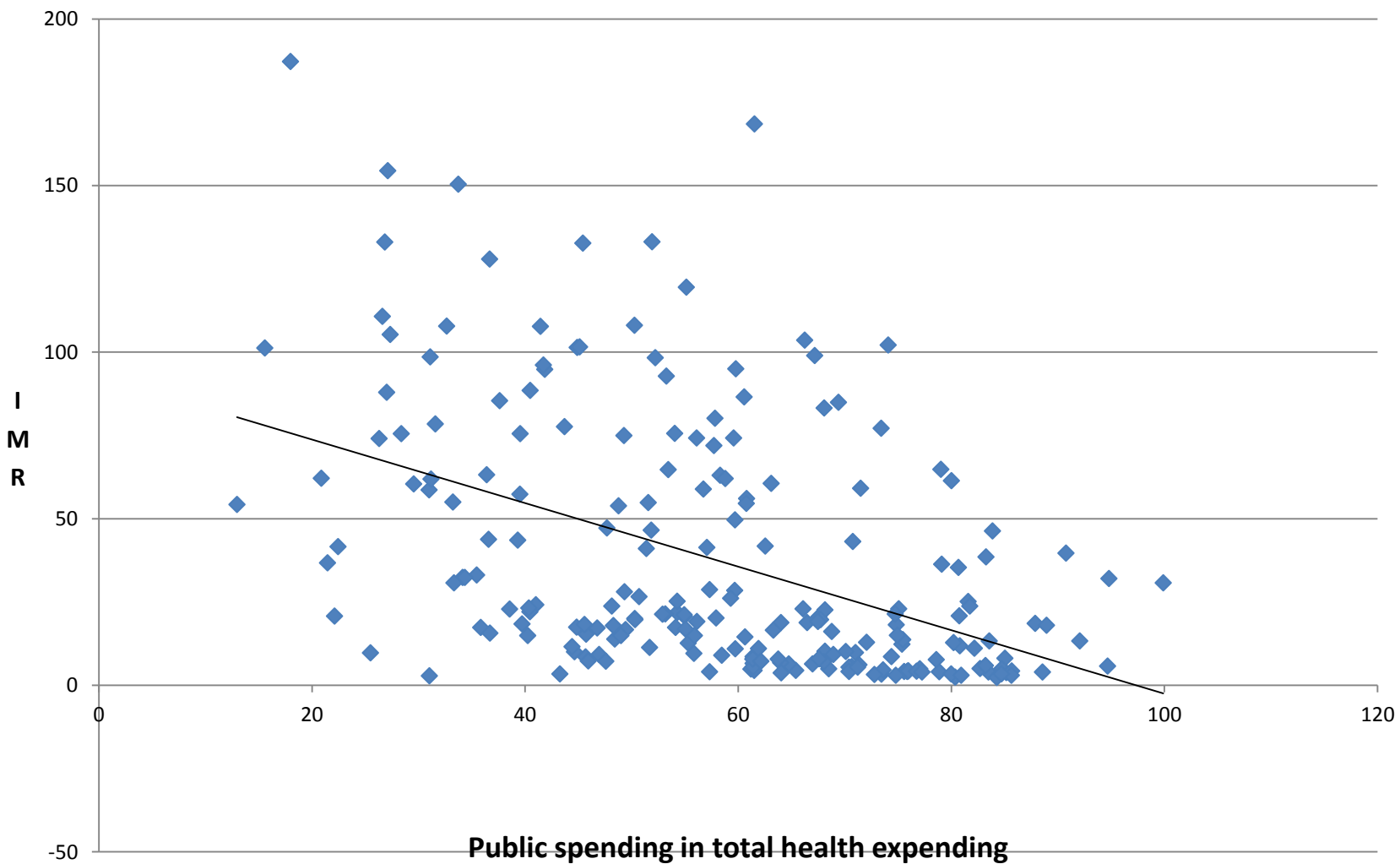
Per capita health spending and GDP per capita



Public share of total health spending and GDP



Public spending & health outcome across countries, 2011



Definition of health care financing

- Health financing system is, therefore, more than merely an approach to mobilize funds for health care
- WHO definition of health financing:
 - Health financing is 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.”
- The purpose of health financing is to make **funding available**, as well as to set the right **financial incentives to providers**, to ensure that all individuals have **access** to effective public health and personal health care” (WHO 2000).

Three functions of health financing

- Revenue Collection
- Pooling
- Purchasing

Health Financing Functions and Objectives (Scheiber 2007)

Functions

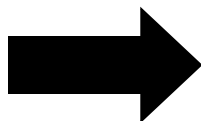
Objectives

Revenue
Collection



raise *sufficient* and *sustainable* revenues in an *efficient* and *equitable* manner

Pooling



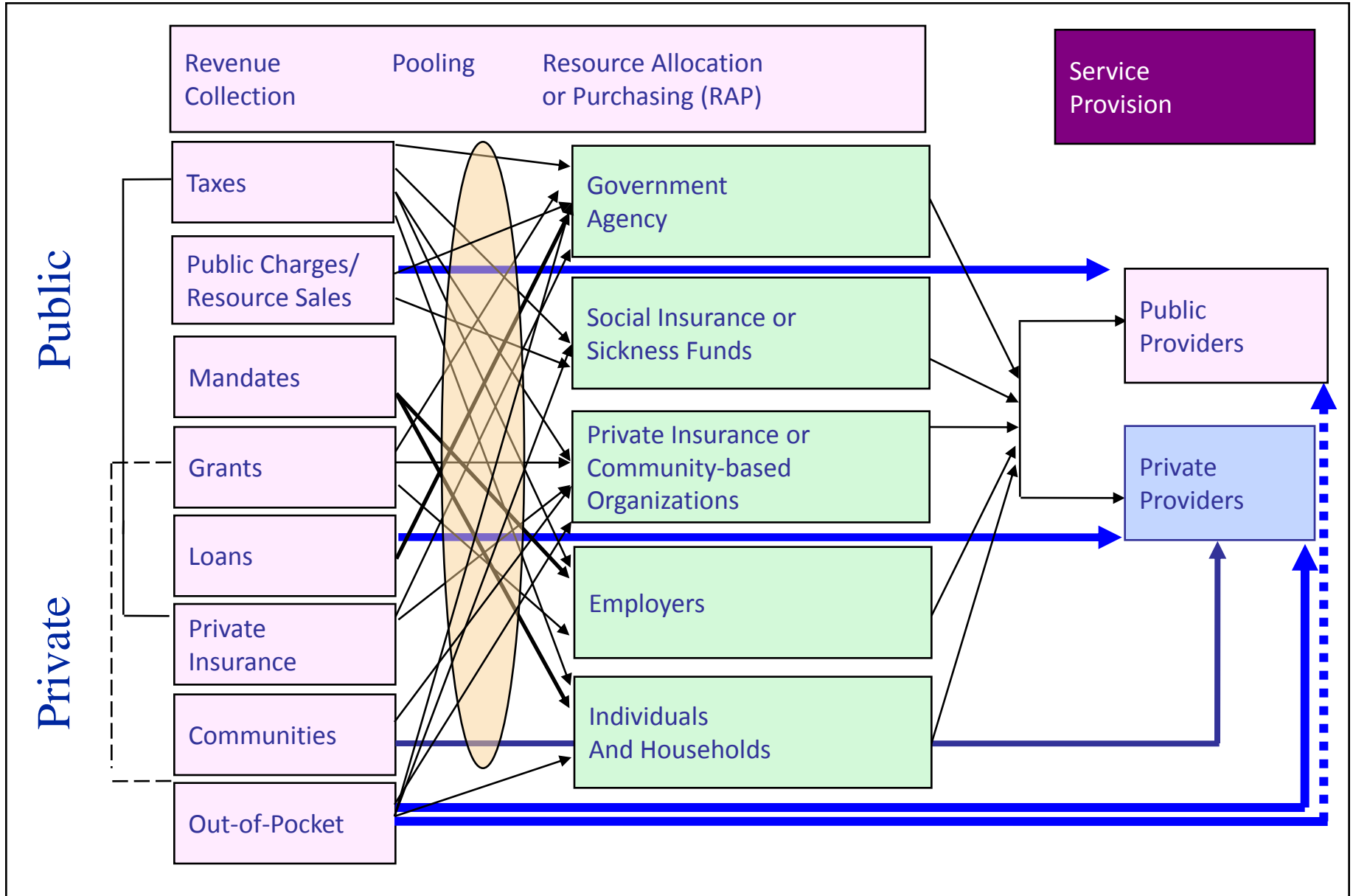
manage these revenues to *equitably* and *efficiently* pool health risks

Purchasing



assure the purchase of health services in an *allocatively* and *technically efficient* manner

Financing Needs to Deal with Revenue Collection, Risk Pooling, Management and Payment (Schieber 2007)



Pooling

- Pooling is the accumulation and management of financial resources to ensure that the financial risk of having to pay for health care is borne by all members of the pool and not by the individuals who fall ill.
- The main purpose of pooling is to spread the financial risk associated with the need to use health services.

Operationally....

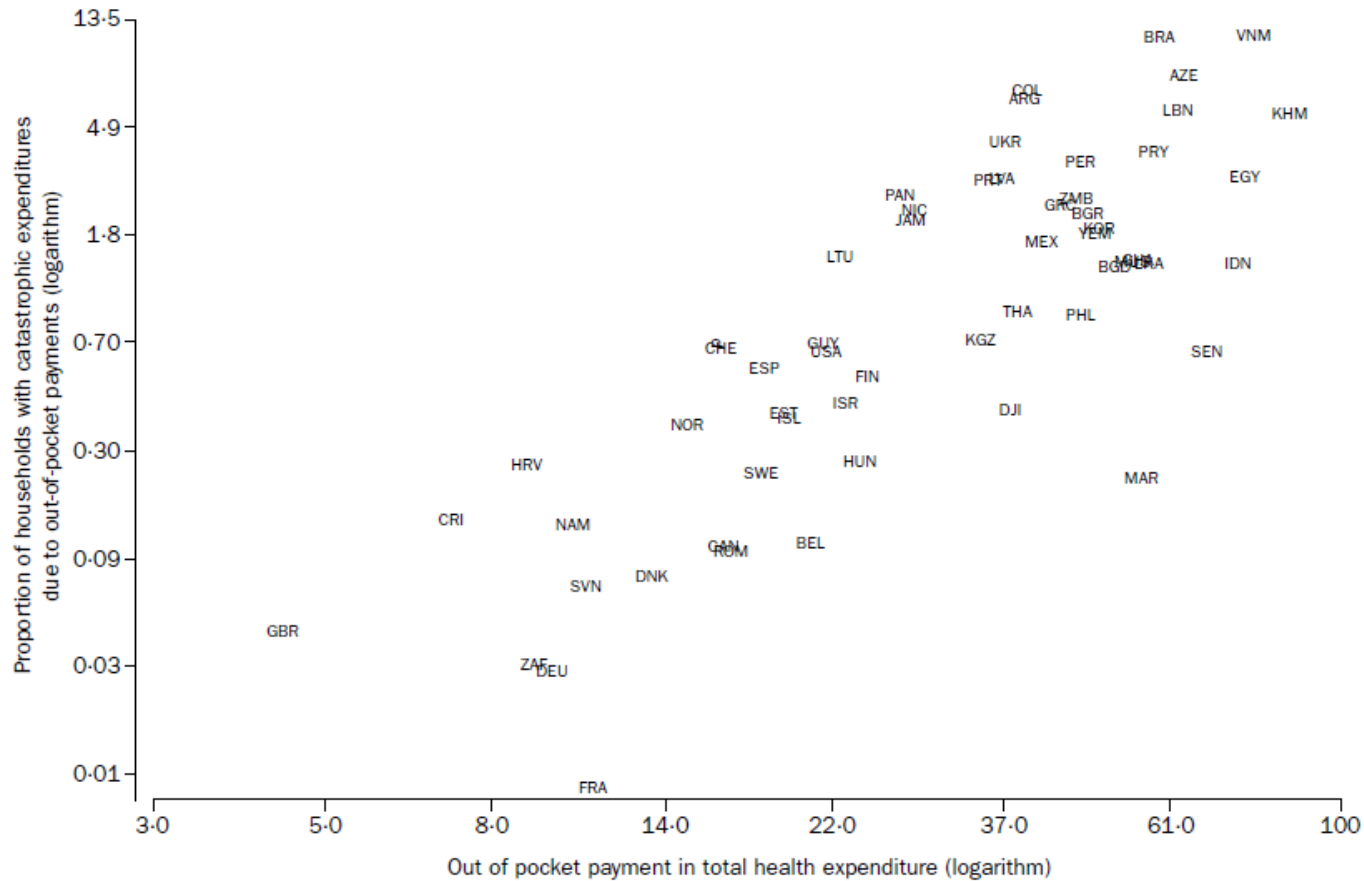
Three critical areas of health financing (WHO 2010)

- How is a health system to be financed?
 - To raise sufficient resources for health: many countries do not have enough fiscal space to raise additional resources
- How can people be protected from the financial consequences of ill-health and paying for health services?
 - Reduce heavy reliance on OOP
 - Contain rising costs
- How can optimum use of resources be ensured?
 - Reduce and eliminate inefficient and inequitable use of resources

Financial barriers

- Countries with high out-of-pocket expenses have inefficient and insufficient pooling of resources
- Inability to access health services, catastrophic expenditure and impoverishment are strongly associated with the extent to which countries rely on out-of-pocket payments as a means of financing their health systems.
- Direct payment at the point of service is inequitable, restricts access to health care and can lead to economic burden
- Concept of *catastrophic expenditure*: a high OOP payments budget share has been used as an indicator of catastrophic impact
- High out-of-pocket health spending has been seen to be poverty-inducing

Correlation of household with catastrophic health expenditure and out-of-pocket payments



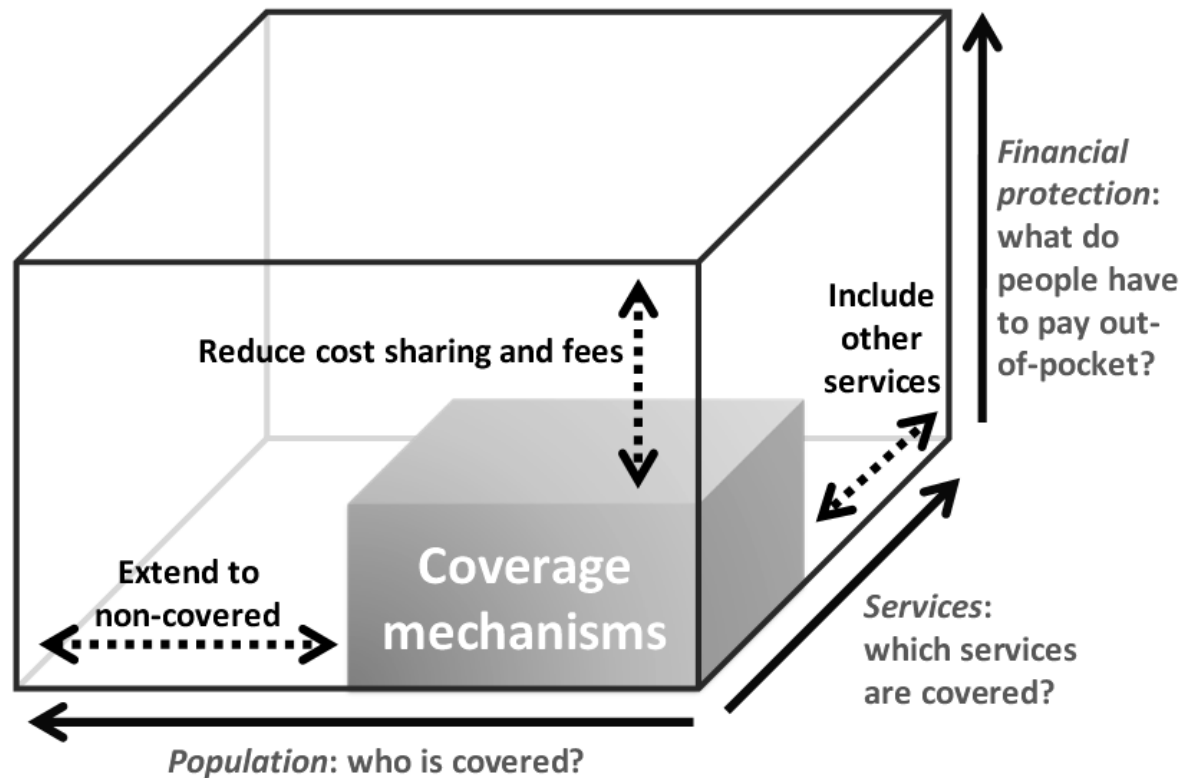
Proportion of households with catastrophic expenditures vs share of out-of-pocket payment in total health expenditures
 Log-log plot is used because the relation not linear. See table 1 for definitions of country codes.

Universal coverage

- A question facing all countries is how their health financing systems can achieve or maintain universal coverage of health services and reduce high reliance on OOPS.
- In 2005 the Member States of WHO adopted a resolution encouraging countries to develop health financing systems aimed at providing universal coverage.
 - This was defined as securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost.
- Universal coverage incorporates two additional dimensions in addition to financial risk protection: the extent of population coverage (e.g. who is covered) and the extent of health service coverage (e.g. what is covered).
- The reduction in the incidence of financial hardship associated with direct payments is a key indicator of progress toward universal coverage.

Three dimensions of universal coverage, WHO: who, what and how much is covered

Towards universal coverage



Structure of international healthcare systems (Hohman 2006)

- There is a “public versus private” continuum in terms of the financing and delivery of healthcare (Sanders 2002).
- Most systems tend to predominantly embrace a “national health service model,” “entrepreneurial model,” or “mandated insurance model.”
- **National health service:** universal coverage is publicly financed through taxation. Healthcare delivery occurs via mostly public mechanisms; hospitals are publicly owned, and medical services are primarily delivered by government-salaried physicians (Sanders 2002). (UK, Spain, Sri Lanka, Bhutan)
- **Entrepreneurial model** of healthcare (USA): people voluntarily purchase employment-based or individual insurance, and the healthcare delivery mechanisms (providers and healthcare facilities) exist largely in the private sector. Financing can come from both private and public sources (Sanders 2002).
- **Mandated insurance model:** between these two models in which compulsory universal coverage is publicly financed and health care is delivered by both public and private entities . Within this category, systems can be further classified as following a ***national health insurance/single-payer model*** (Canada and Sweden) or a ***multi-payer health insurance model*** that relies on sickness funds to provide universal health coverage (Germany and France).

How to move towards universal health coverage?

- Countries are at different stages vis-à-vis UHC
- Health sector reforms critical
- Many low and middle-income countries made significant progress in developing their financial systems towards UHC
 - Ex. Chile, Colombia, Cuba, Rwanda, Sri Lanka, Thailand, Brazil
 - These countries have expanded various forms of prepayment and pooling to increase financial risk protection, particularly for the poor
- 27 OECD countries cover all their citizens with a set of interventions from pooled funds, while Mexico and Turkey are moving towards such a system
- Paths and speed towards UHC have been and continues to be varied
 - All countries face increasing demand for better services, different diseases and a growing list of expensive medical technologies and medicines making health costs rise continually.

Health financing transition

- Total health spending is rising in countries in response to increasing incomes, fuelled by advances in technology
- It has been argued that (Svedoff et al 2012) health financing transition—a shift toward higher health spending and a higher pooled share of health spending— is occurring in countries that are rolling out UHC successfully
 - Need to channel this rising spending through pooling
 - Also need to step up government investment

Out-of-pocket spending & public financing for health

- One core indicator of UHC is out-of-pocket spending (OOPS) by households
- Whatever the route to achieve UHC, a country with increased health coverage would be bound to show a decline in OOPS.
- Thus, one would expect OOPS to have a close relationship with government spending on health as well. A recent paper using global data (Gupta and Chowdhury 2013) presents evidence to suggest that higher is government spending , lower is OOPS.

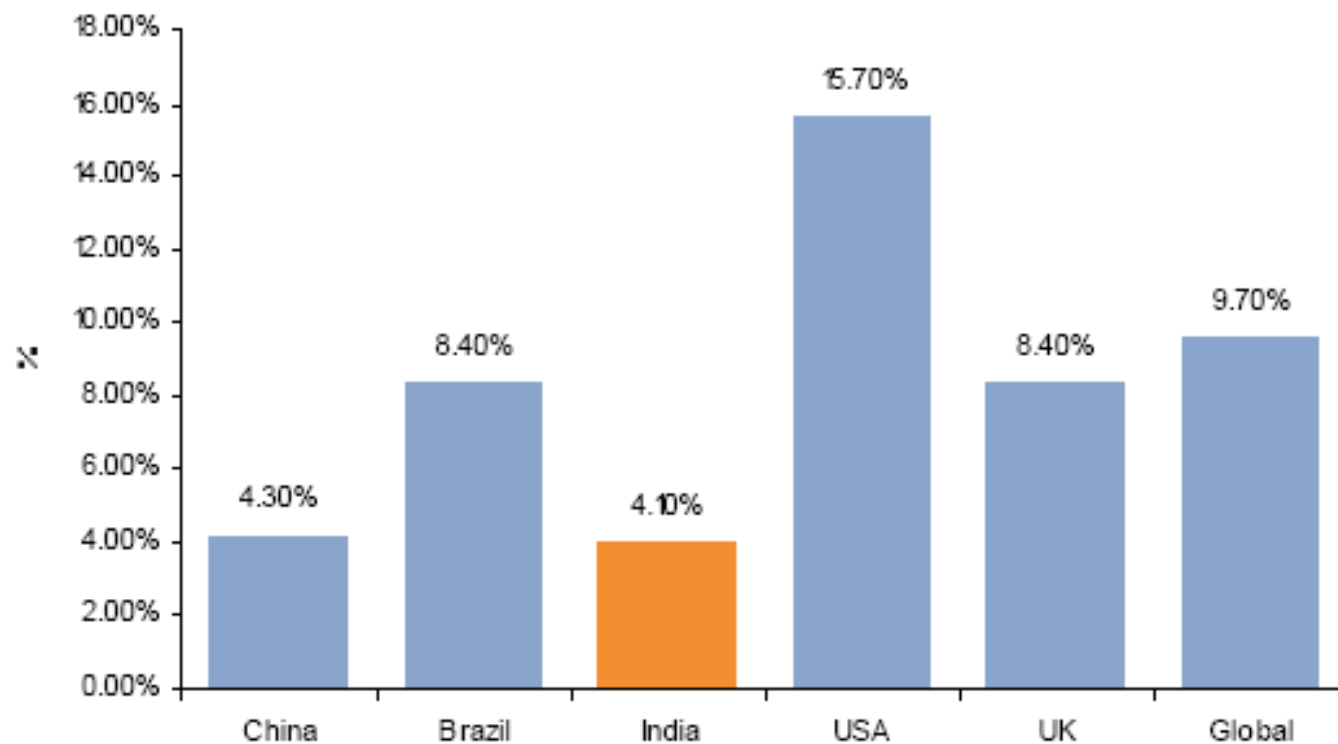
India case study: prospects of UHC

- High OOPS
- Large public health infrastructure with issues of efficiency and funding
- Rapidly expanding private health sector
- Fragmented health coverage system, with private health insurance covering about 5% of the population, large publicly funded health system with concerns around efficiency; small SHI, significant coverage for government organized sector raising serious issues around equity in financing, many CBHI programmes, some public-private partnerships to extend health coverage
- Some increase in government health spending in the last decade, but still low
- Health a state subject and complex federal structure and centre-state dynamics

Issues for Approach to the 12th Five Year Plan (Planning Commission, April 2011) & Draft Approach Paper for the Twelfth Five Year Plan 2012-2017

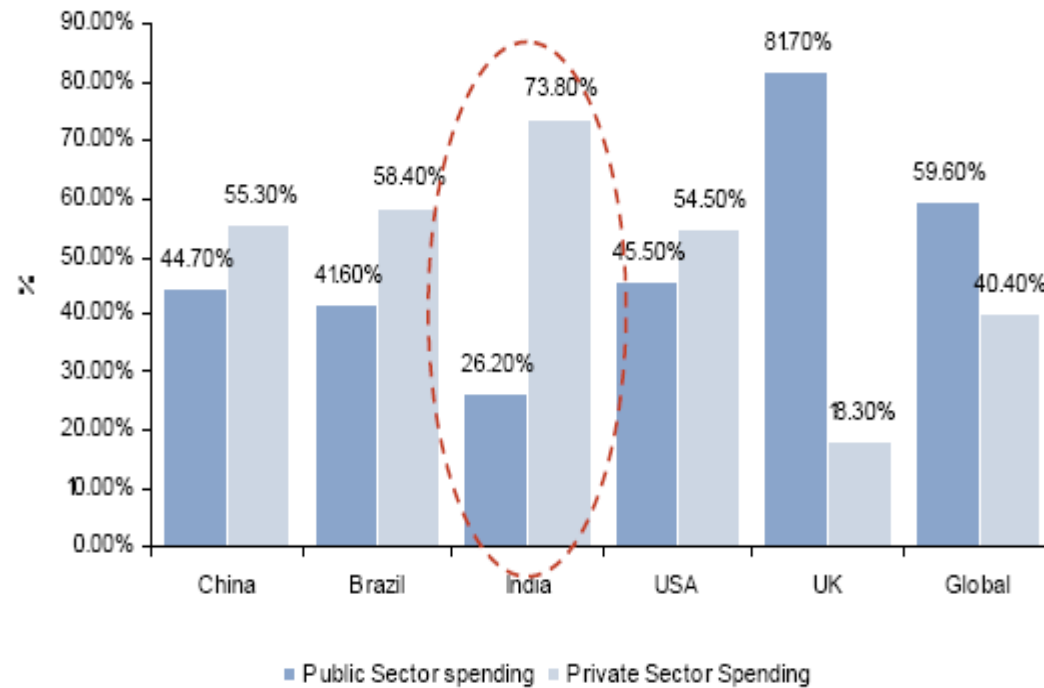
- Better health is not only about curative care, but about better prevention
 - Clean drinking water, sanitation and better nutrition, childcare, etc.
 - **Convergence of schemes across Ministries is needed**
- Desperate **shortage of medical personnel**. Need targeted approach to increase seats in medical colleges, nursing colleges and other licensed health professionals
- ...critical imbalance in the healthcare system, which stemmed from deficiencies in the **public sector's capacity to deliver basic healthcare**.
- **Unregulated** and widely varied rapidly growing **private sector**
- Improve quality of NRHM services vs. quantity of NRHM infrastructure.
- Role of PPP in secondary and tertiary healthcare must be expanded
- **Health insurance cover should be expanded to all disadvantaged groups**
- Focus on women and children; ICDS needs to be revamped

Spending as a % of GDP



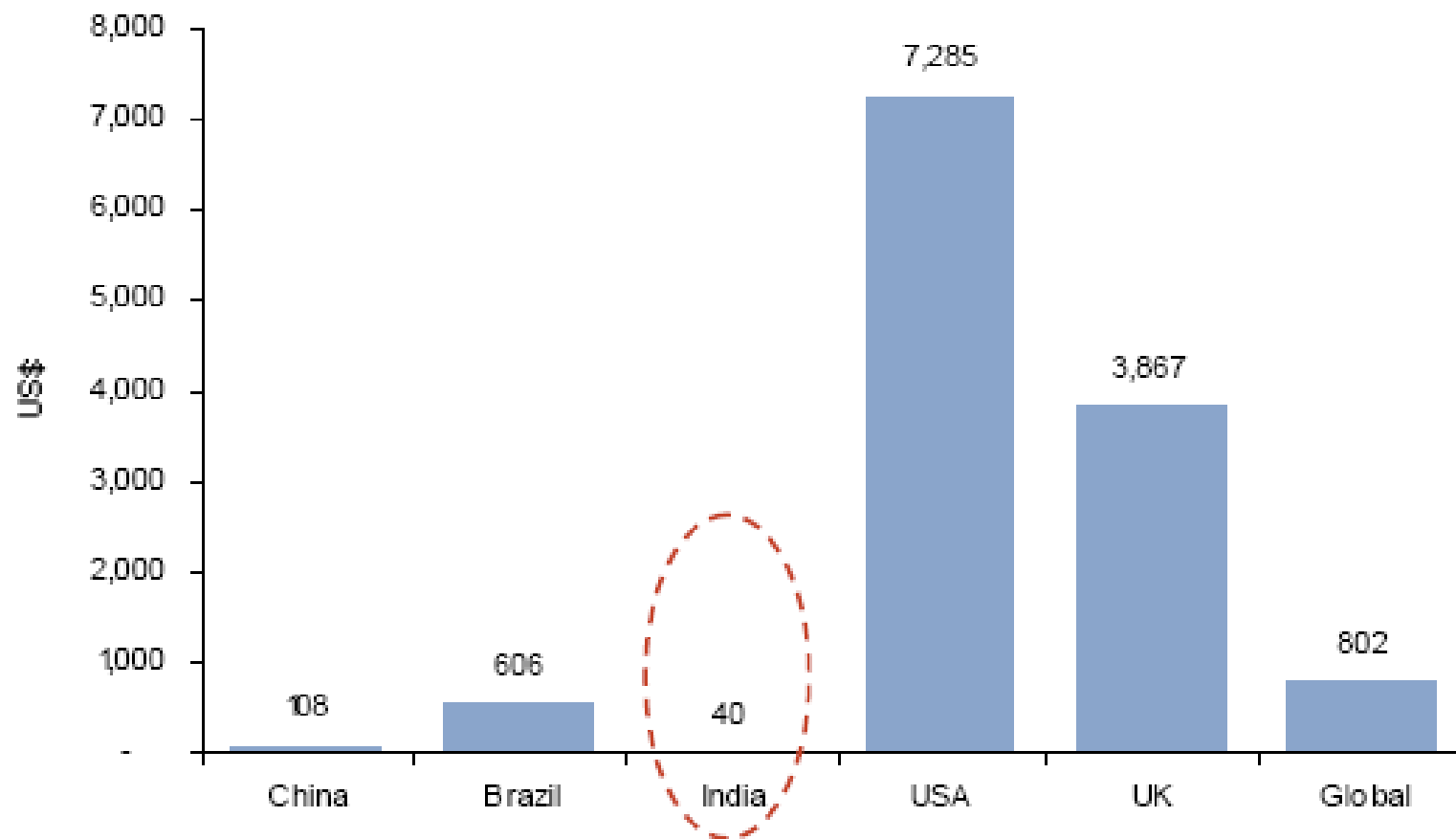
Source: WHO World Health Statistics 2010

Comparison of Healthcare Spend



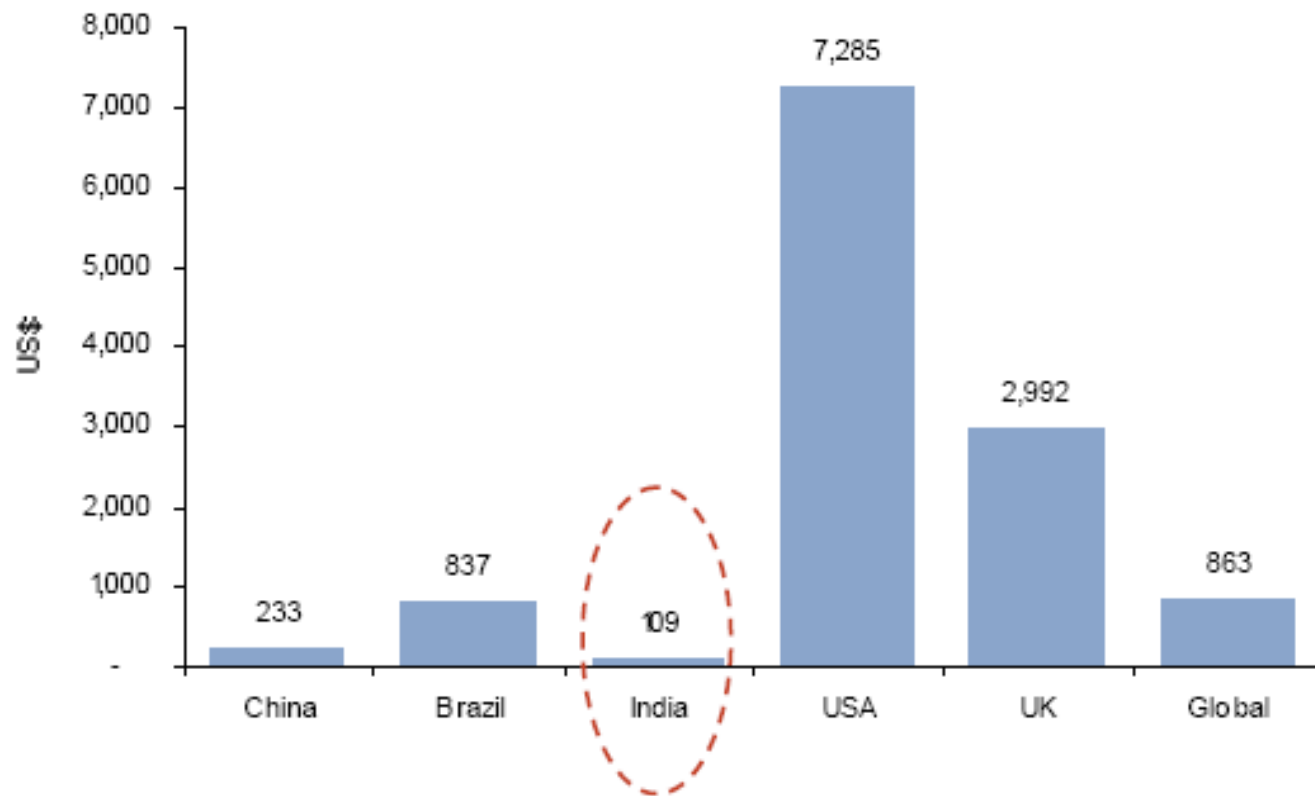
Source: WHO World Health Statistics 2010

Per Capita Spending (US\$)



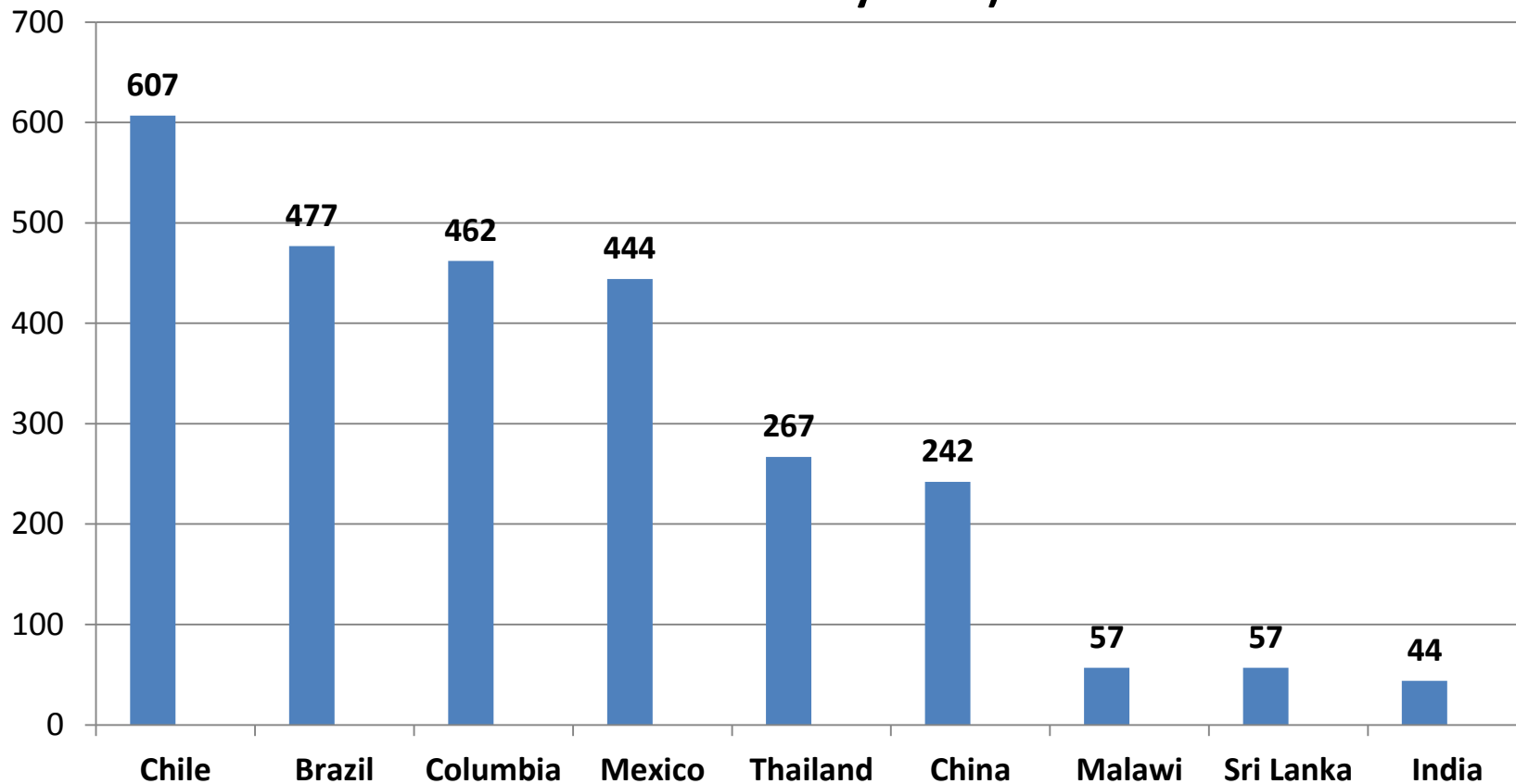
Source: WHO World Health Statistics 2010

Per Capita Spending (PPP)

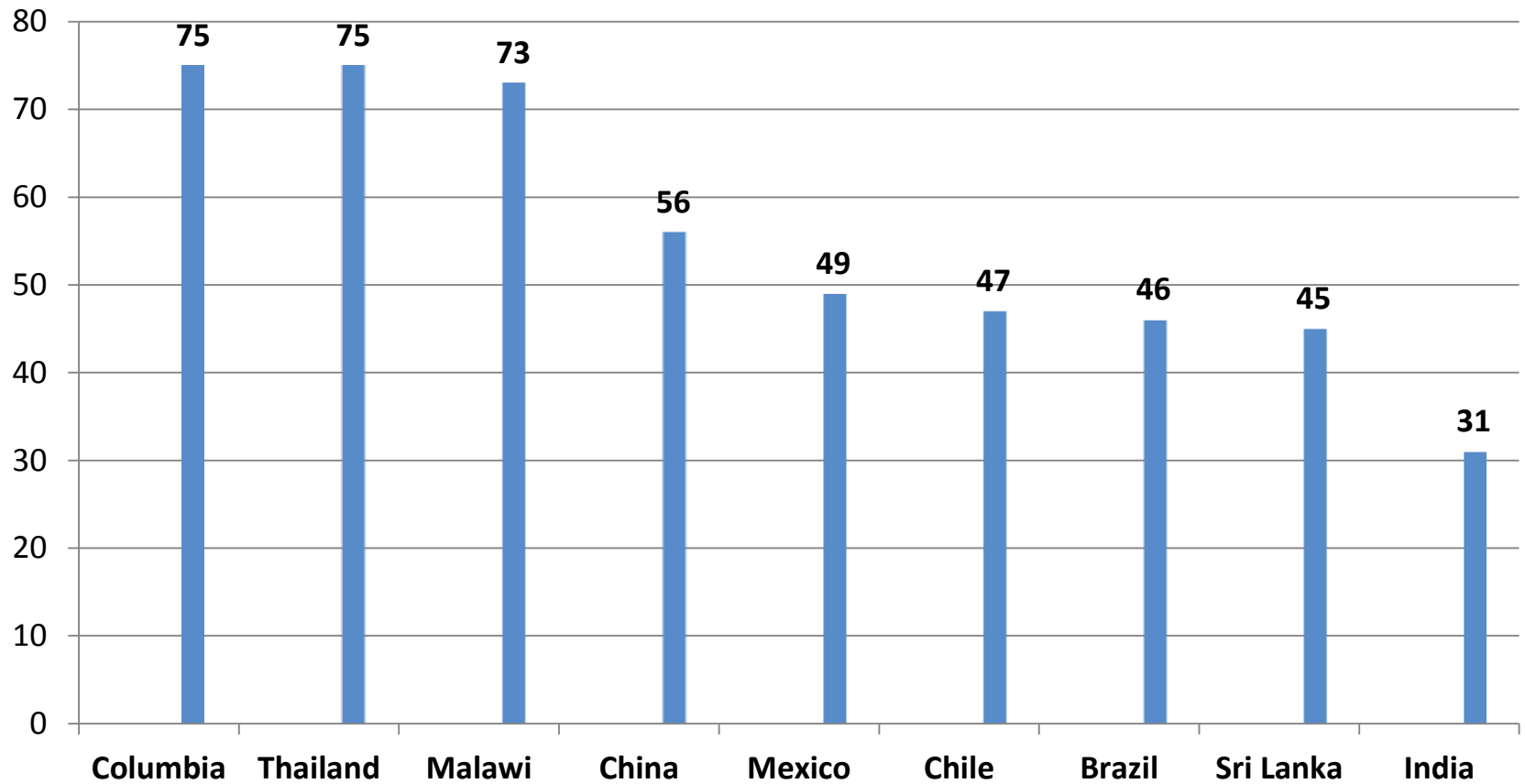


Source: WHO World Health Statistics 2010

Per capita public spending in PPP (NCU/US\$) in 2011 (Gupta and Chowdhury 2013)



Share of public spending in total spending, 2011 (Gupta & Chowdhury 2013)



Some recent analysis of health financing

- Bhat et al 2004
- ERF 2006
- Berman et al 2008
- Rao et al 2012

Most of the recent studies concluded that public spending is too low.

Funding for Health in Eleventh Plan: Core and Broad Health Components (Planning Commission, 12th Plan Document)

(Figures in Crore)

Year	Centre Core Health	States Core Health	% GDP Core Health			% GDP (Broad Health)		
			Centre	State	Total	Centre	State	Total
X Plan	47,077	1,07,046	0.29%	0.65%	0.94%	0.56%	1.18%	1.74%
2007–08	16,055	30,536	0.32%	0.61%	0.93%	0.71%	1.17%	1.89%
2008–09	19,604	36,346	0.35%	0.65%	0.99%	0.75%	1.22%	1.98%
2009–10	25,652	44,748	0.40%	0.69%	1.09%	0.78%	1.24%	2.02%
2010–11	27,466	55,955	0.36%	0.73%	1.09%	0.75%	1.27%	2.02%
2011–12	30,587	62,343	0.34%	0.70%	1.04%	0.74%	1.19%	1.94%
XI Plan	1,19,364	2,29,928	0.35%	0.68%	1.04%	0.75%	1.22%	1.97%

Note: Core health includes health care expenditure of central ministries (MoHFW, Labour on RSBY and so on) on health; Broad health includes Drinking Water and Sanitation, Mid-Day Meal and ICDS (Plan and non-Plan).

Financing UHC in India....

- The High-Level Expert Group (HLEG/Planning Commission) recommended an increase in public funding of health to a minimum of 2.5 % of GDP during the 12th Five-Year Plan (2012–17) and a minimum of 3 percent by 2022
- Other estimates indicate that a fully evolved programme of UHC might require a much higher level of public funding of around 4 percent of GDP (Prinja et al 2012).
- Funding has also been identified as a key constraint by Planning Commission's the Steering Committee on Health for the 12th Five Year Plan which states that the "The health care system in the country suffers from inadequate funding" (Planning Commission 2012).
- "Since expenditure on health by the State Governments is about twice the expenditure by the Centre, the overall targets for public sector health expenditure can only be achieved if, along with the Centre, State Governments expand their health budgets appropriately" (Planning Commission 2012)

Financing UHC in India....

- For 12th Plan the projections envisage increasing total public funding, plan and non-plan, on core health from 1.04 per cent of GDP in 2011–12 to 1.87 per cent of GDP by the end of the Twelfth Plan
- This implies an increase of three times the Eleventh Plan levels, and an increase of about 34 percent annually over this period.
- With the incentive measures proposed, it is estimated that States' total funding on health will also increase to three times the Eleventh Plan levels involving a similar annual increase.
- The share between the Centre and the State may remain the same at 33:67 ratio though the Steering Committee does mention a 15:85 ratio.

High level expert group on Universal Health Coverage (UHC) headed by Dr. Srinath Reddy and set up by Planning Commission

- The HLEG has adopted the following working definition of UHC:

Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, **to affordable, accountable, appropriate health services of assured quality** (promotive, preventive, curative and rehabilitative) **as well as public health services addressing the wider determinants of health** delivered to individuals and populations, with **the government being the guarantor and enabler**, although not necessarily the only provider, of health and related services.

HLEG

UNIVERSAL HEALTH COVERAGE BY 2022: THE VISION

ENTITLEMENT

Universal health entitlement to every citizen



NATIONAL HEALTH PACKAGE

Guaranteed access to an essential health package (including cashless in-patient and out-patient care provided free-of-cost)

- Primary care
- Secondary care
- Tertiary care



CHOICE OF FACILITIES

People are free to choose between

- Public sector facilities; and
- Contracted-in private providers

High level expert group on UHC....

- Financing the proposed scheme will require public expenditure on health to be stepped up from around 1.2 per cent of gross domestic product (GDP) now to 2.5 per cent by 2017 and to 3 per cent of GDP by 2022. “Increased public expenditures, in our estimate, will lead to a sharp decline in the proportion of private out-of-pocket spending on health from 73 per cent at present to 33 per cent by 2022,”
- Introduction of specific purpose transfers to equalise the levels of per capita public spending on health across different States
- Low public spending on drugs and non-availability of free medicines in government health care facilities major deterrent to accessing public sector health facilities. Recommends increasing public spending on procuring drugs and medicines
- Use general taxation as the principal source of health care financing – complemented by additional mandatory deductions for health care from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary.
- No sector-specific taxes for financing.

Some concerns.....

- Might take a very long time to implement all its aspects
 - No phased timeline indicated
 - Actual costs of all the components that envisage major changes not calculated, so not clear what the price tag is of this change, either in total or in parts
- Need a proper mapping exercise in the country
 - How much are we currently spending on health cover?
 - On whom?
 - How optimal is the current resource allocation?
- How to consolidate schemes? Who takes the decision? Which ministries should lead? What happens during the transition phase? How many schemes? How to improve efficiency of current public health infrastructure?

Some concerns....

- Each such recommendation calls for major reforms in the administrative, legal and delivery systems.
- The issue of private sector remains unclear. What kind of legislative reforms are required? How can the private sector be properly incentivized? What happens to the existing heterogeneous mix of private players? What impact will they have on prices and quality?
- How can the government raise the standard of service delivery in the government sector?
 - At present quality issues plague the public health care delivery. Can this package be delivered w/o making significant and far-reaching changes in the entire public health sector mechanism?
- If revamping the public health care delivery system is a critical prerequisite, need to work out the costs of such an exercise
 - What role will states play?
- Human resources would remain a critical area of concern: currently, the incentive structure is such that even with massive pay revisions, government doctors are leaving for the private sector. Not clear how the issue of incentives will be addressed in the current recommendations.

Pooling: political decision?

- Currently, the per capita public health spending is around Rs 950 (2011-12) whereas the per capita expenditure on CGHS beneficiaries is Rs. 3600
 - The current system raises serious equity concerns about public health spending.
- Under the circumstances, consolidation of funds would raise important political and administrative issues.
- Can estimates of costs of UHC be calculated without first taking a decision on the extent of pooling?
- In any case, how realistic is it to raise public spending by about 6 times?

Recent analysis (Berman et al 2010)

- Realizing the goal of 2-3% of GDP (public spending) would require that states on aggregate would need to increase spending on average by 22-38% per year to attain this target.
- States have not been able to fully utilize additional funding provided by the central government, slowing NRHM implementation.
- Achieving this target is unlikely, both because of the fiscal implications of such large increases as well as the difficulties in actually spending rapidly increased budgets.

Recent evidence on UHC (Stuckler et al 2010)

This paper poses some key questions:

- Why do some countries have UHC and others do not?
- What are the social, economic and political preconditions for UHC to be a realistic goal?
- How have countries in the past achieved UHC, and does their experience offer lessons that apply to low and middle income countries?

Key issues raised by the analysis (Stuckler et al)

- UHC is a legal & political - rather than a technical - issue
- Mere coverage not enough to ensure access to a range of health care services
- Empirical evidence suggests that political commitment, higher tax revenues & greater democracy are associated with a higher share of GDP going to public health spending
- Higher share of private expenditure may crowd out public expenditure, thus reducing scope of rapid expansion of UHC

Good practices in health financing (Gottret et al, World Bank, 2008)

Study selected 9 countries on the basis of (a) Improvements in health care coverage, (b) Applicability and pertinence for other low- and middle-income countries, (c) Large-scale initiatives, (d) Availability of information and data. Also 2nd tier selection criterion included health indicators and outcomes on the one hand and relation of expenditures to outcomes on the other.

The study indicated the following General “Enabling” Conditions that comprised several common institutional, societal, policy, and implementation characteristics.

- *Economic, institutional, and societal factors:* ex: strong economic growth, political stability, well educated population
- *Policy factors:* financial resources committed to health, including private financing; commitment to equity and solidarity; health coverage and financing mandates; consolidation of risk pools; recognized limits to decentralization; focus on primary care.
- *Implementation factors:* carefully sequenced health service delivery and provider payment reforms; good information systems and evidence-based decision making; strong stakeholder support; efficiency gains and co-payments used as financing mechanisms; and flexibility and mid-course corrections.

Colombia example

- Before 1993, “the health care system in Colombia was characterized by atomized risk pools, low efficiency, failure of public subsidies to reach the poor, large out-of-pocket expenditures, and significant inequality” (Glassman et al 2009)
 - Similar to many countries in SEAR
- The 1993 reforms was the beginning of a period of intense experimentation & adjustments, with the result that health coverage increased dramatically and the poor benefitted the most.
- Public spending, including social security, accounts for more than 80 percent of total health spending, while out of-pocket spending is among the lowest in the world.

Key features in Colombian experience with UHC

- Middle income country
- Broad tax base
- Political will and legal framework; democracy
- Simultaneous efforts to reform the public health care system as well as financing
- Switching from supply-side to demand-side subsidies
- Consolidation of financing and setting up the national equalization fund
- Existence of a separate ministry (ministry of social protection)

South East Asia region

- Two successful examples: Thailand and Sri Lanka
- Thailand showed strong political/legal commitment & continuous evaluation of incremental reforms to move towards a more unified financing system
 - it set up a new, completely revamped, general revenue funded program with no copayments for the poor, elderly, children, and disabled.
- In Sri Lanka, while health spending is not very high, it has been able to improve efficiency substantially in the public health system
 - Sri Lanka covers its entire population through general revenues with low reliance on private spending, especially for the poor
 - However, with changing disease burden, increasing costs, the country is in requires to step up health spending

Whither UHC?

- Choices have to be made regarding which path to follow: SHI which includes pre-payment mechanisms or wholly tax-based health system
 - Many examples in Asia of publicly-funded target system catering to the poor and using private providers/insurers
 - Well functioning health infrastructure with a proper referral system might also be able to achieve the same outcomes.
 - Pooling, especially of pre-payment funds very important:
 - can the current structures be really dismantled? Can funds be pooled across fragmented systems? CGHS, Railways, RSBY etc? PSU?
 - Pool at national or state level? How?
- Consolidation of all resources is a complex technical and political process. In Chile it has taken 10 years to years for such reforms to take place (it has separated the insurance and financial administration from public provision of health care services and created the National Health Fund)
- Provider incentive has proved to be a very thorny issue in health reforms. Need to understand this in the context of a rapidly growing private health and hospital sector
- Regulation would remain a key issue, especially in a federal set up with health being a state subject
- Accountability in the government sector

These questions can be addressed if.....

- Adequate time for planning and collecting evidence
- Much wider consultations with multiple stakeholders takes place
- Different parts of government work together
 - Health and Family Welfare, Labour, Drugs and Pharmaceuticals, Finance
 - State governments
 - Private sector: providers, insurance companies
- Research, planning and M&E an integral part of UHC: need evidence-based reforms in a gradual fashion
- Major changes in administrative and legal structures a prerequisite for a successful path towards UHC
 - Politically hard decisions need to be made if effective pooling has to be the core of UHC
- The UHC approach is too important a step with far reaching implications about the health system:
 - Phased roll out, evidence-based incremental changes