Global movements towards universal health coverage and Thailand's influence

World Health Organization

What is Universal Health Coverage?

World Health Assembly Resolution 58.33, 2005 urged countries to develop their health financing systems to:

- ☑ **Ensure all people have access to needed health services**
- ☑ **Without the risk of financial ruin linked to paying for care**

Defined this as achieving Universal Coverage

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Current situation

World is still a long way from universal coverage

- **Access** to health services (prevention, promotion, treatment, rehabilitation) too low
- 150 million suffer financial catastrophe each year, while 100 million are pushed into poverty
- Many determining factors – but unless domestic health financing systems function properly, it is difficult to get very close to universal coverage

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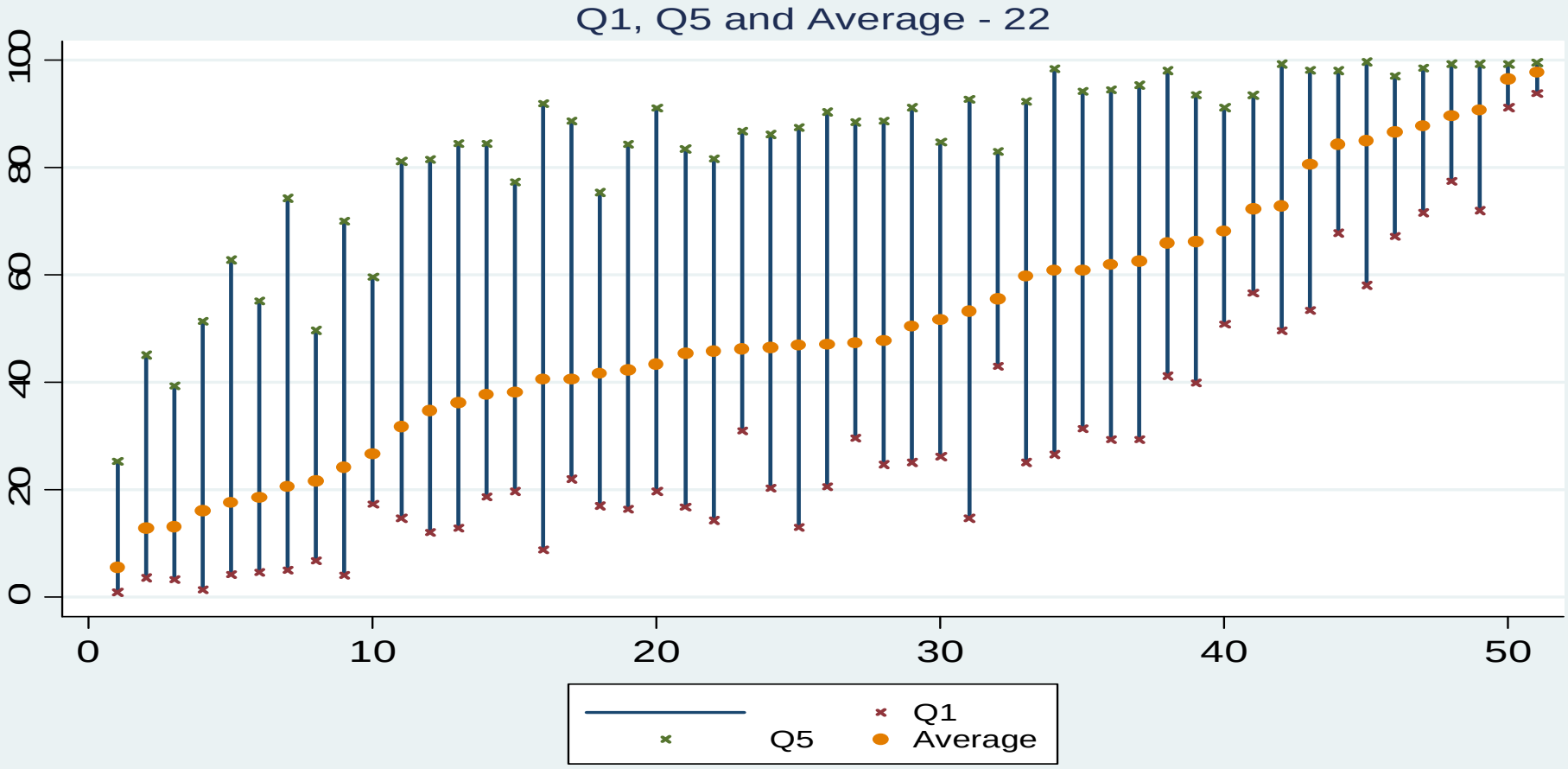
Millions miss out on needed health services

Percentage of births by medically trained persons



Source: Latest available DHS for each country (excl. CIS countries)

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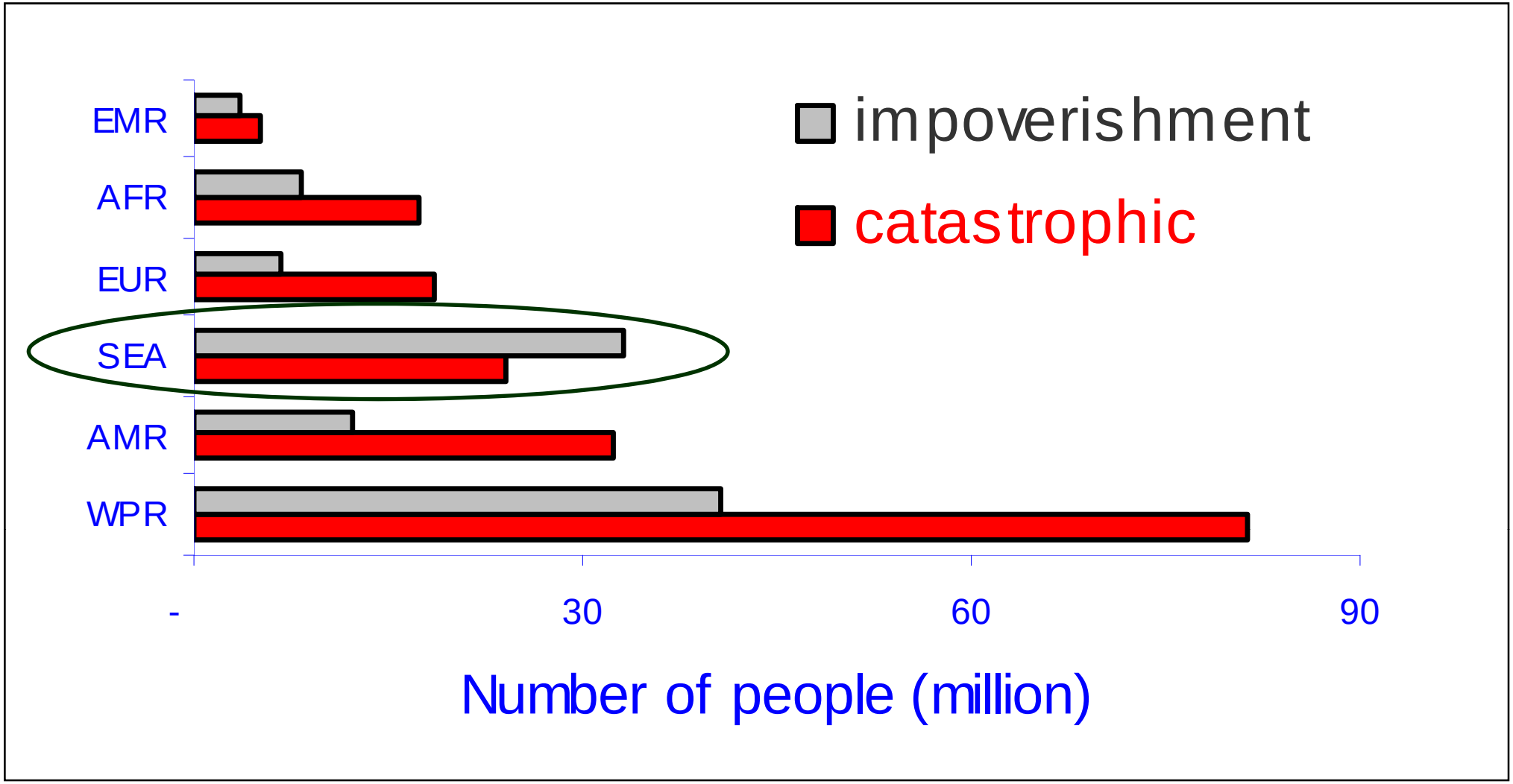
Millions suffer financially when they use health services



Source: WHO (Ke Xu) estimates from household survey data

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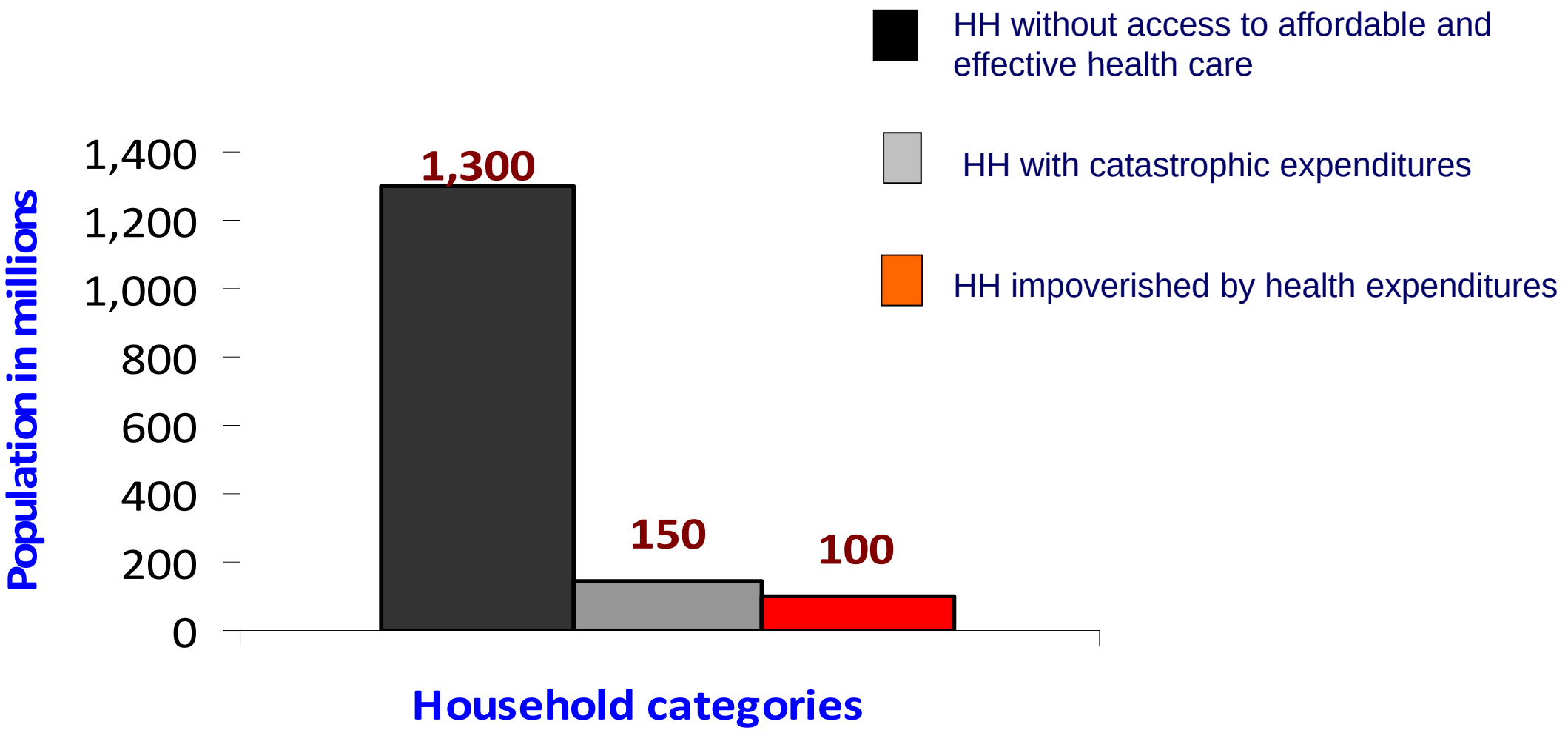
Millions are pushed into poverty by using health services



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Health-related poverty

1/3 of new annual household poverty is due to costs to access care

Consultation
+
Diagnostics
+
Medicines
+
Transport
+
Loss in wages

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Trends

General government expenditure on health (GGHE)

	2000	2009
– Low*	36.2%	39.3%
– Low Middle	54.5%	57.1%
– Upper middle	58.9%	61.5%
– High	70.7%	72.3%
World*	56.8%	59.3%

* for 2000: Less Afghanistan, DPR Korea,
for 2009: Less DPR Korea, Somalia, Zimbabwe

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Trends

Out of pocket expenditure (OOPs)

	2000	2009
– Low*	51.3%	47.2%
– Low Middle	39.6%	36.3%
– Upper middle	32.7%	30.0%
– High	21.7%	21.1%
World*	35.0%	32.2%

* for 2000: Less Afghanistan, DPR Korea,
for 2009: Less DPR Korea, Somalia, Zimbabwe

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Cause

1. **Exclusion linked to factors outside the health system** – inequalities in income and education and social exclusion

2. **Weak health systems:** Insufficient health workers, medicines and health technologies. Ineffective service delivery. Poor information systems, weak government leadership.

3. **Health financing systems that do not function.**

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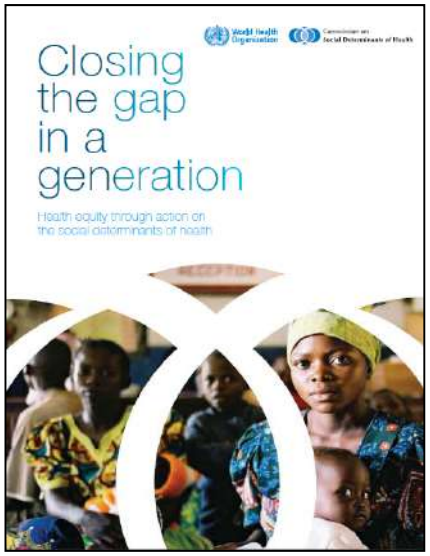
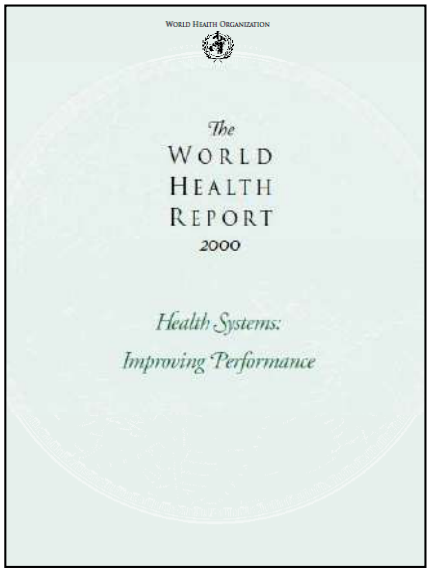
2008

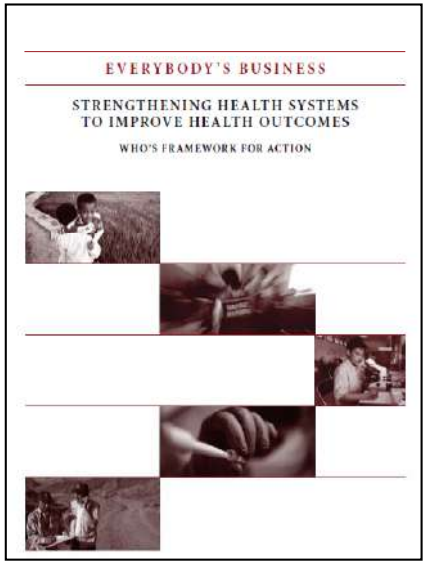


1. **Exclusion**

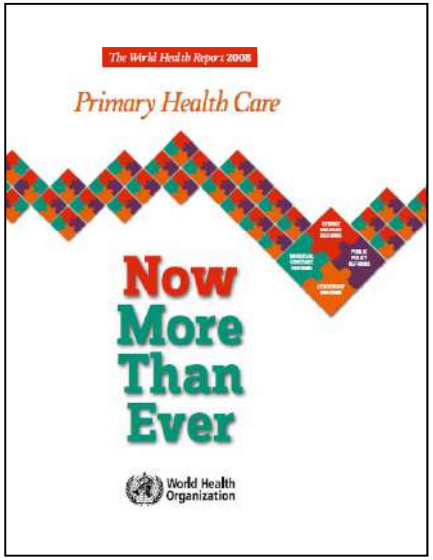
2000



2007



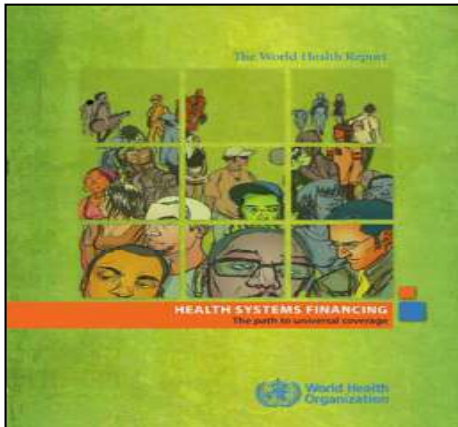
2008



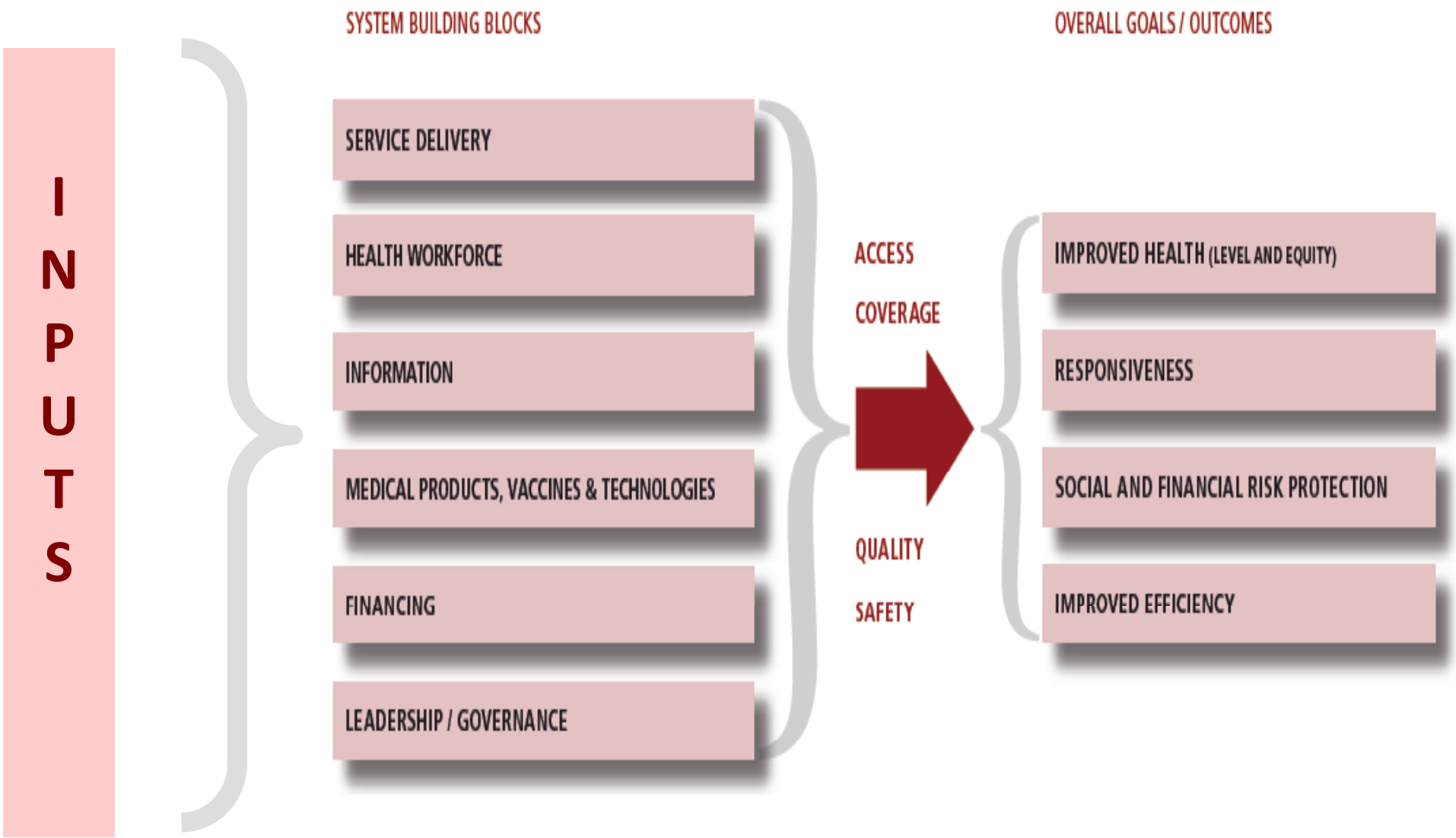
2. **Weak health systems**

3. **Health financing systems that do not function**

2010



WHO Framework for Assessing Health Systems



Many interacting solutions but health financing is key

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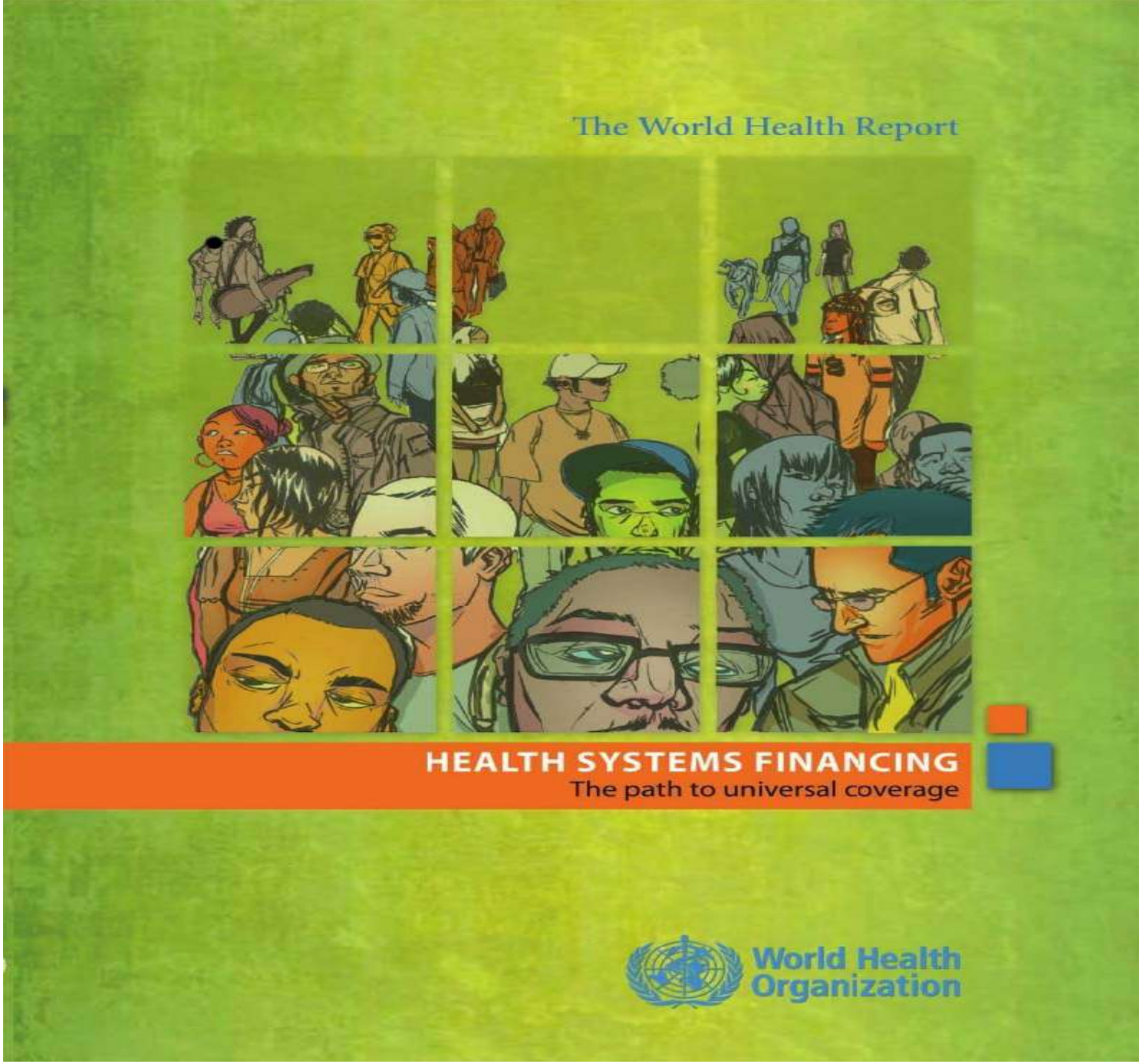
The World Health Report 2010



www.who.int/whr/2010

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WHR 2010 Conclusions: Domestic Financing

Every country can do something to advance towards universal coverage or maintain the gains they have made, through:

1. Raising more funds for health

2. Reducing financial barriers to access; increasing financial risk protection

3. Improving efficiency and equity

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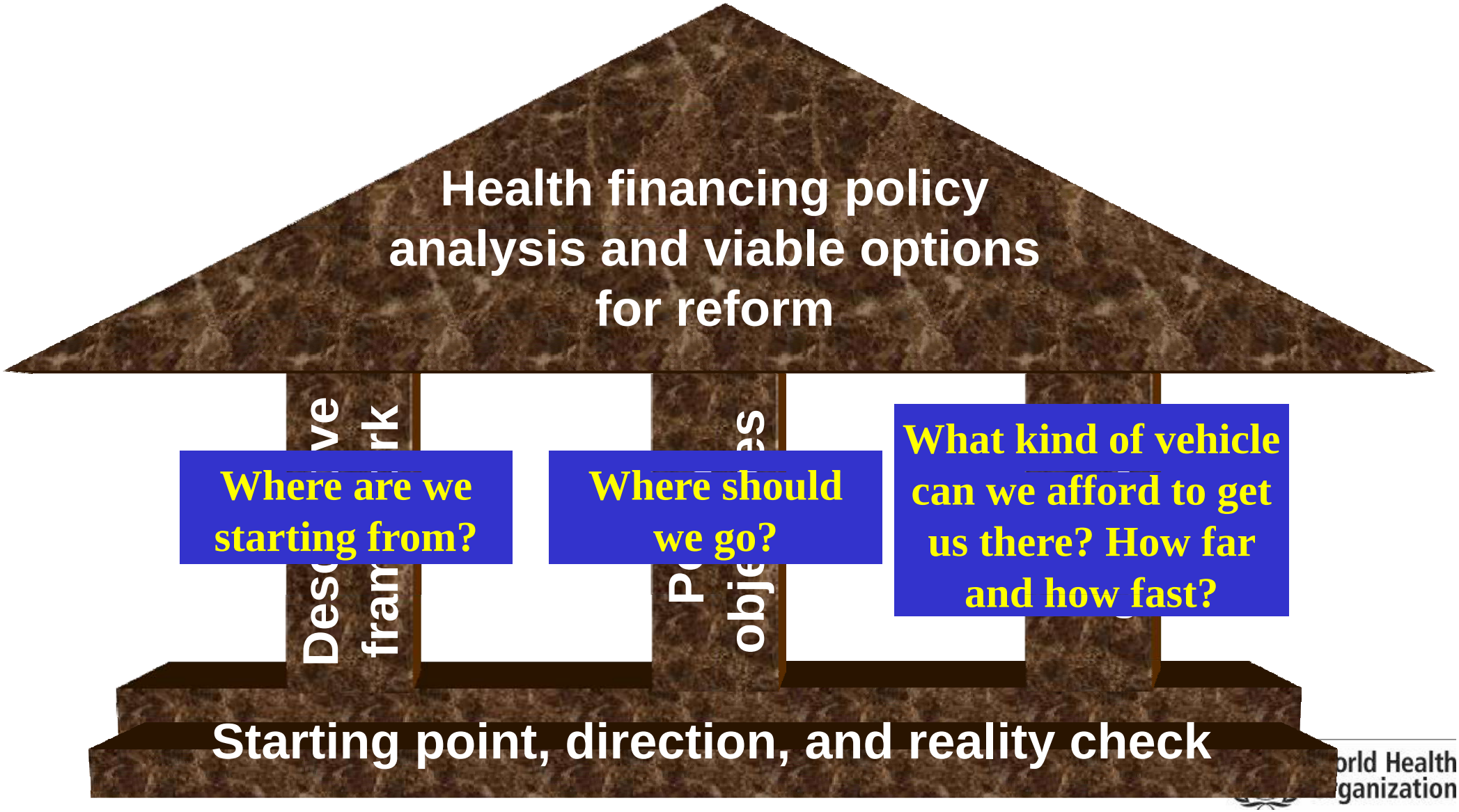
Three pillars for approaching health financing policy



Success requires good thinkers as well as good analysis and good policies

- The "good examples" are from countries that invested in their analytic capacity
- Important to analyze while implementing and use information to adapt over time (no amount of planning will get it perfect the first time)
- Need to develop capacity to adapt to changing circumstances and new challenges

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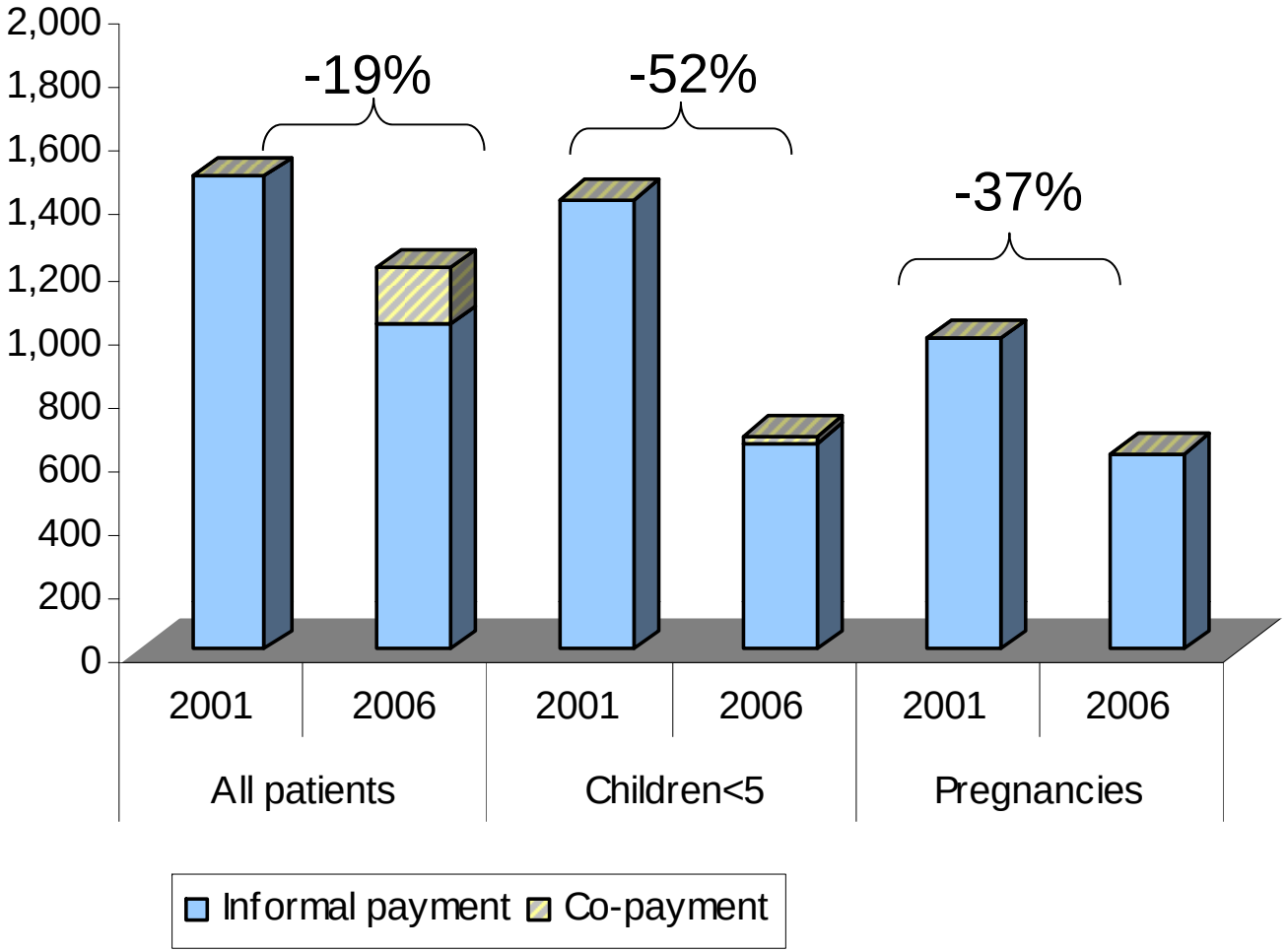
In Kyrgyzstan, such analysis was the basis for comprehensive reforms that reduced out-of-pocket and informal payments



Net reduction in real terms by:

→ 19% in total patient payments

→ 52% for children

→ 37% for pregnancies

Source: Melitta Jakab/WHO, and the Kyrgyz Health Policy Analysis Center, based on analyses of household survey data

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WHR 2010 Conclusions: Domestic Financing

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1. Raise sufficient Funds: Domestic Options

Increase budget allocations

(45 governments devote < 8% of their spending to health; 14 devote < 5%)

Find new or diversified sources of funds

- **"Sin" taxes, particularly on tobacco and alcohol:** a 50% increase in tobacco tax in 22 low income countries would bring an additional US$1.42 billion – allowing government health expenditure to increase by 25%.
- **Sales taxes:** Ghana funded its national health insurance partly by increasing the value-added tax (VAT) by 2.5%
- **A currency transaction levy would be feasible in many countries -** India could raise US$ 370 million per year from a very small levy (0.005%).
- **Solidarity levies -** Gabon raised $30 million for health in 2009 partly by imposing a 1.5% levy on companies handling remittances from abroad

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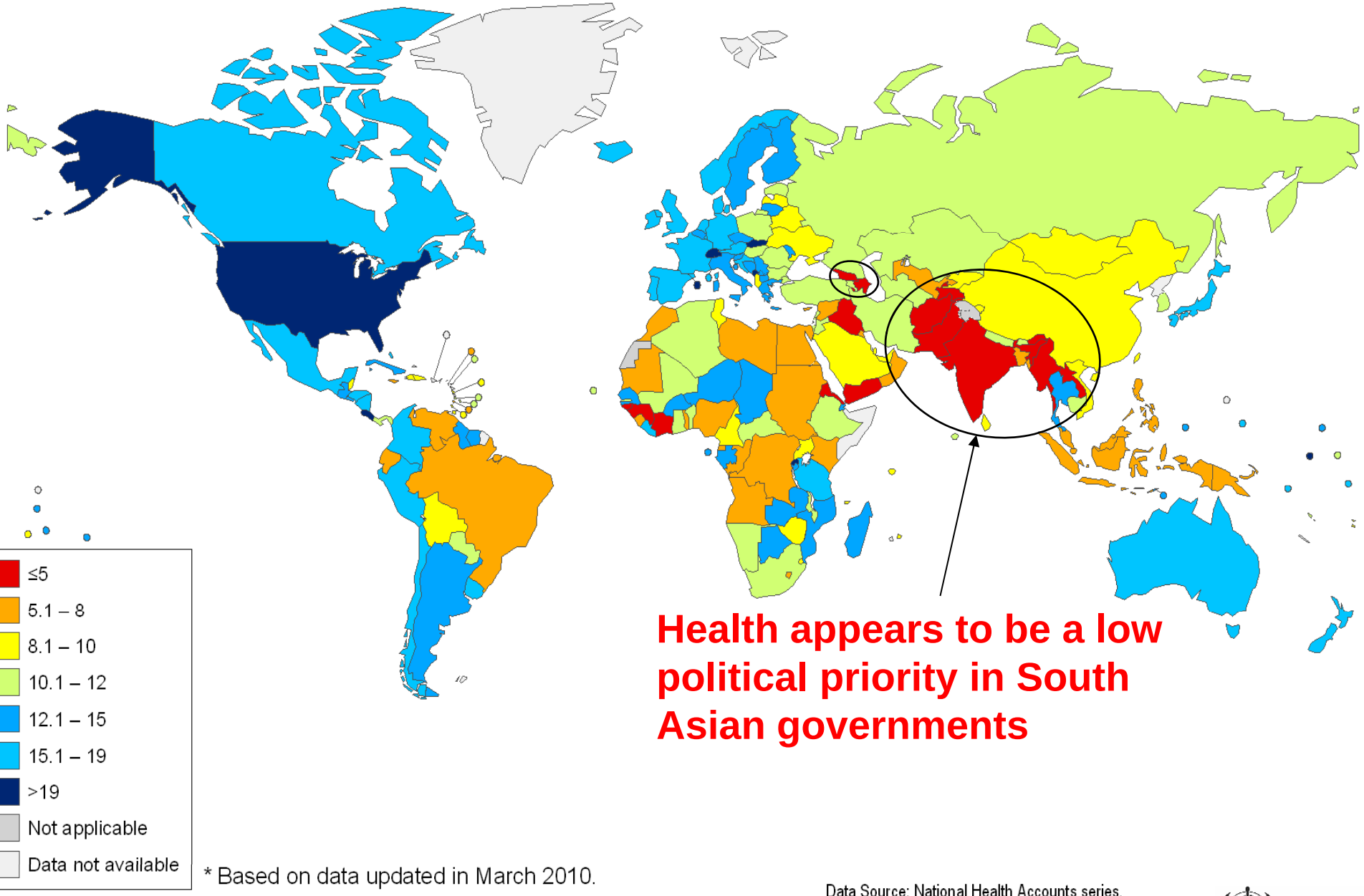
Government expenditure on health, 2007 *
(share of the total government expenditure, %)



* Based on data updated in March 2010.

Data Source: National Health Accounts series, World Health Organization
Map Production: Public Health Information and Geographic Information Systems (GIS)
World Health Organization

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2. Reduce barriers; ensure financial risk protection

- Reduce out of pocket payments at the point of service
- Increase "prepayment" through health insurance and/or taxes with pooling
- Community and micro insurance not usually financially sustainable - pools too small
- Universal coverage difficult without making compulsory contributions (through taxes and/or insurance)
- Major advances can be made even in low- and middle-income countries
  (Brazil, Chile, China, Colombia, Costa Rica, Ghana, Kyrgyzstan, Mexico, Republic of Moldova, Rwanda, Thailand, Turkey and Sierra Leone)
- There will always be poor who cannot contribute and must be subsidized from pooled funds – generally from tax revenues

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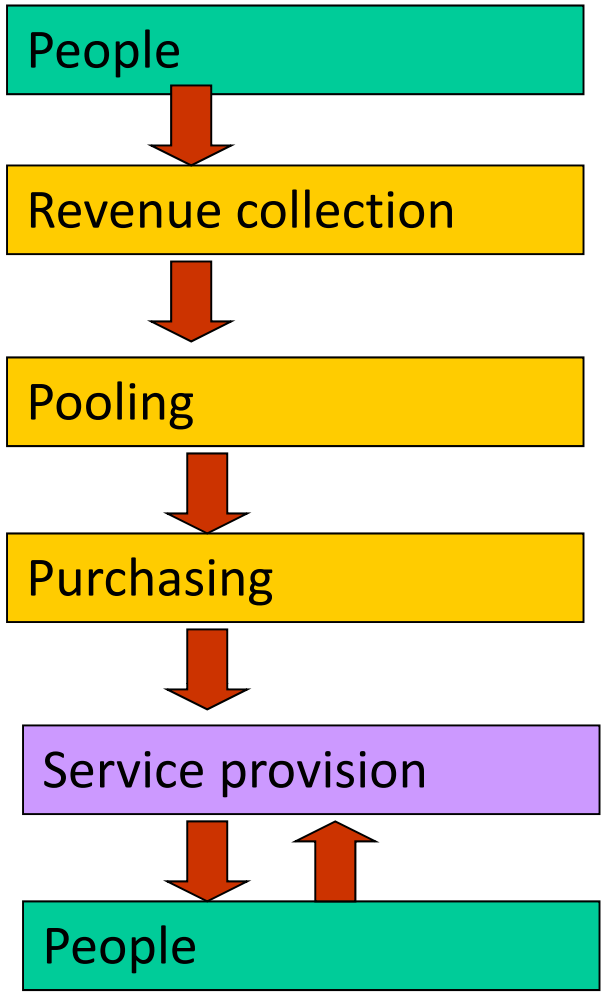
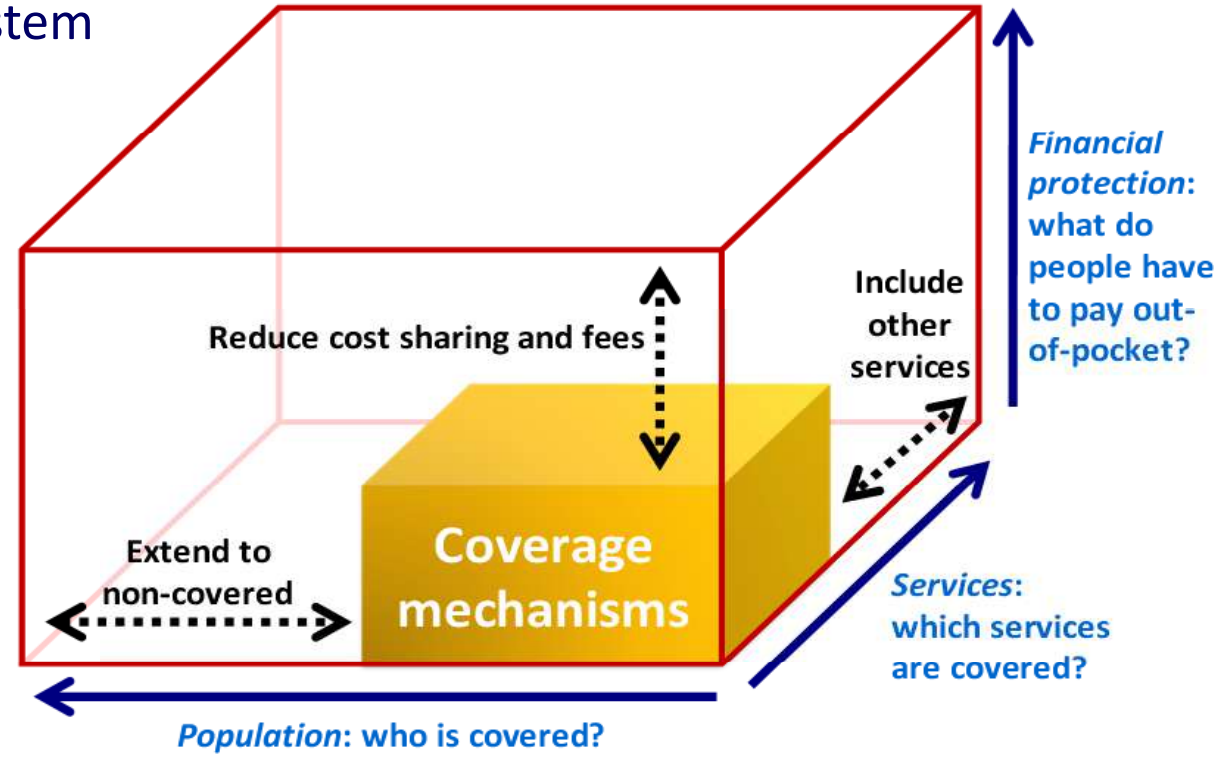
What kinds of choices need to be made?



and also this:

Reforms to improve how the health financing system performs

This



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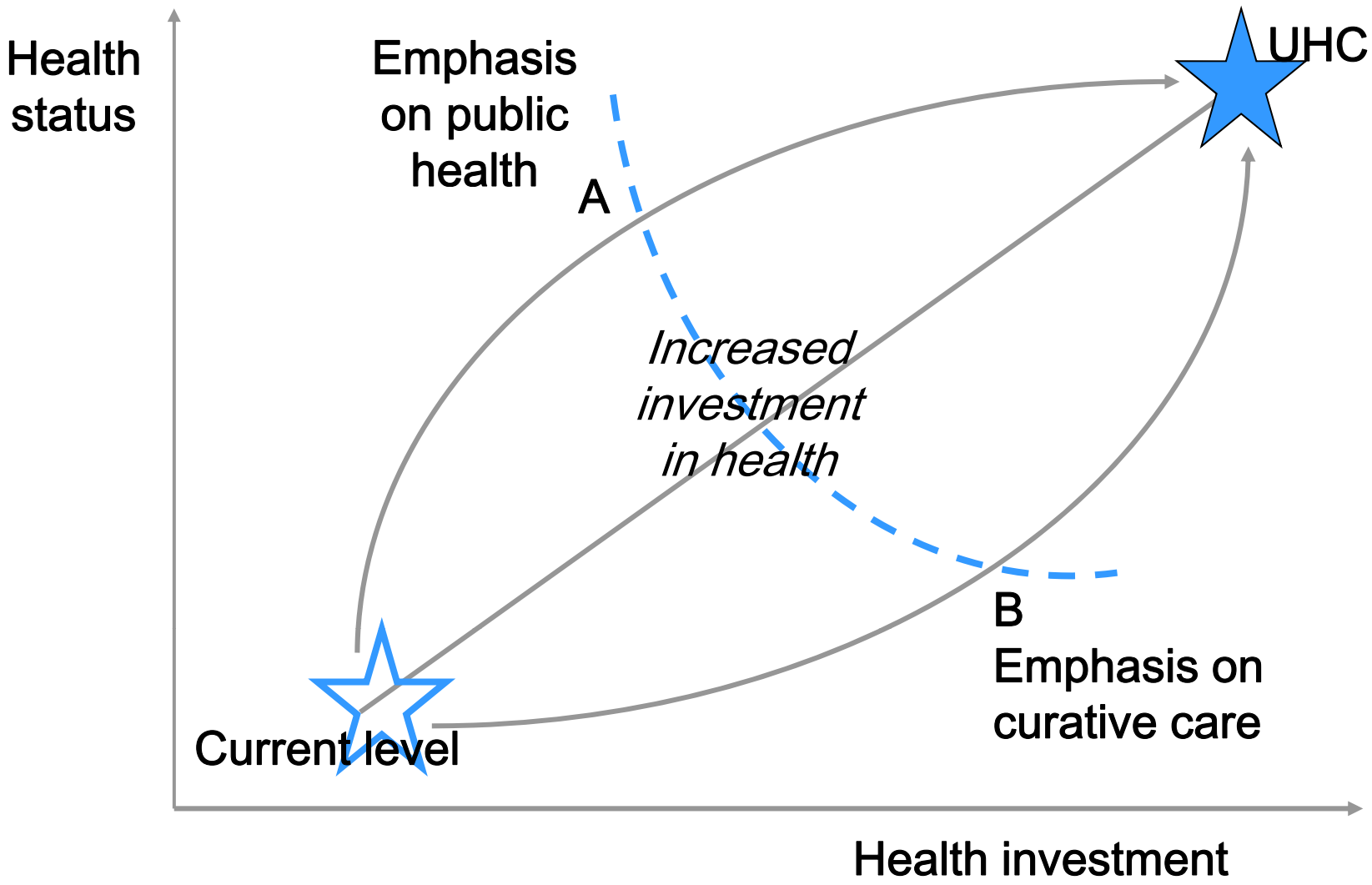
Policy choices



Source; Peter Berman 2012

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3. Reduce inefficiencies & inequities

Common causes

Medicines and health technologies

- Spending too much
- Inappropriate use
- Ineffective use
- Leakage and wastage

Hospital inefficiency particularly over-capacity

Health workforce

- De-motivated
- Wrong skills in the wrong places

Inappropriate mix of prevention, promotion, treatment and rehabilitation, or between levels of care

Reducing inefficiencies could free up 20-40% of available resources for health

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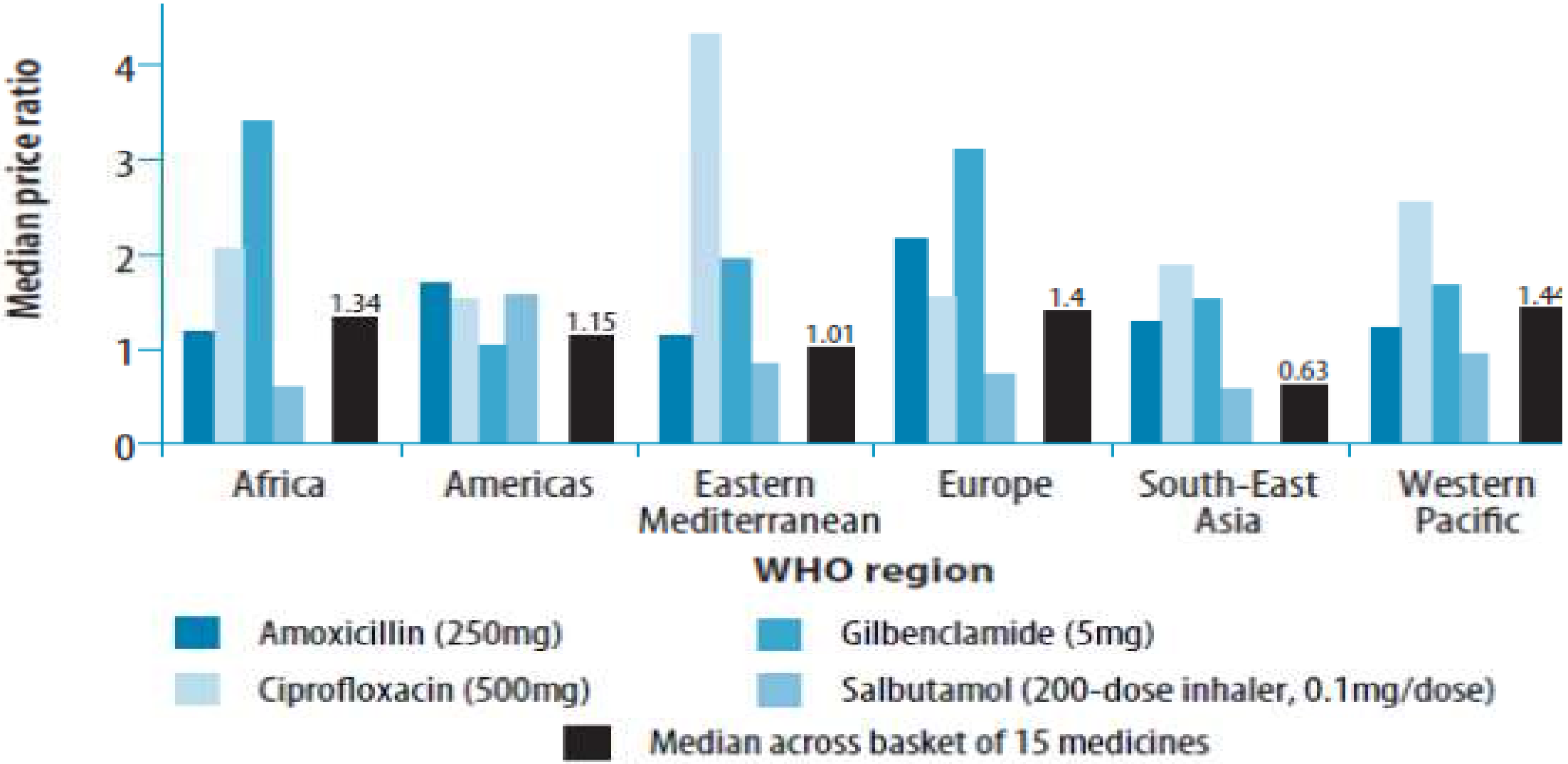
Common cause of inefficiency: Paying too much for medicines

Median price ratios of public sector procurement prices for generic medicines by WHO Region



Reduce Inequities

Protect the poor and vulnerable

In addition to prepaid and pooled resources, other options are:

Free or subsidized services (e.g. through exemptions or vouchers) for poor populations or specific health conditions (i.e. child or maternal care) e.g. Sierra Leone.

Subsidized or free enrolment in health insurance –e.g. Mexico, Thailand

Cash payments to cover transport costs and other costs of obtaining care, usually preventive

What can the international community do?

Global solidarity with improved global efficiency

- **Keep current promises:** Current funding gap in low income countries would reduce substantially if donor promises kept.
- **Innovative international financing**
  e.g. Millennium Foundation
- **Get more efficient at the global level**

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Global solidarity with improved efficiency

- **Reduce the costs imposed on countries to access external funding**

  Rwanda has to report on 890 different health indicators to the various donors, almost 600 for HIV and malaria alone. Vietnam had 400 aid missions to review health projects in 2009.

- **Actively support countries to implement <u>domestic</u> health financing strategies**, and consistent health plans, to move more quickly towards universal coverage.

- **Buy into these plans;** channel funds to build domestic financing capacities and institutions (e.g. fund Sector Wide Approaches, General Budget Support, health insurance systems) rather than bypassing weak systems

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WHA Resolution 64.9 (2011)
Sustainable Health Financing Structures and Universal Coverage

Requested WHO to (paraphrased):

- Report to UN Secretary General the importance of UC → UNGA
- Work closely with all partners
- Prepare a plan of action to help Member States
- Track progress towards UC
- Facilitate sharing of experiences

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Progress on global advocacy

1. ***Objective:*** *get UHC into the post MDG goals, objectives and targets for both coverage and financial risk protection*

2. ***Opportunities:***
   - *Mexico ministerial meeting on UC (April 2012)*
   - *WHA (May 2012)*
   - *Rio + 20 (June 2012)*
   - *G20 (June 2012)*
   - *Health and foreign policy initiative (Sep 2012)*
   - *HSR Symposium on UHC – Oct/Nov 2012*
   - *UNGA*
   - *NGO alliance on UHC (end 2012)*
   - *WB annual meetings*
   - *Regional meetings*

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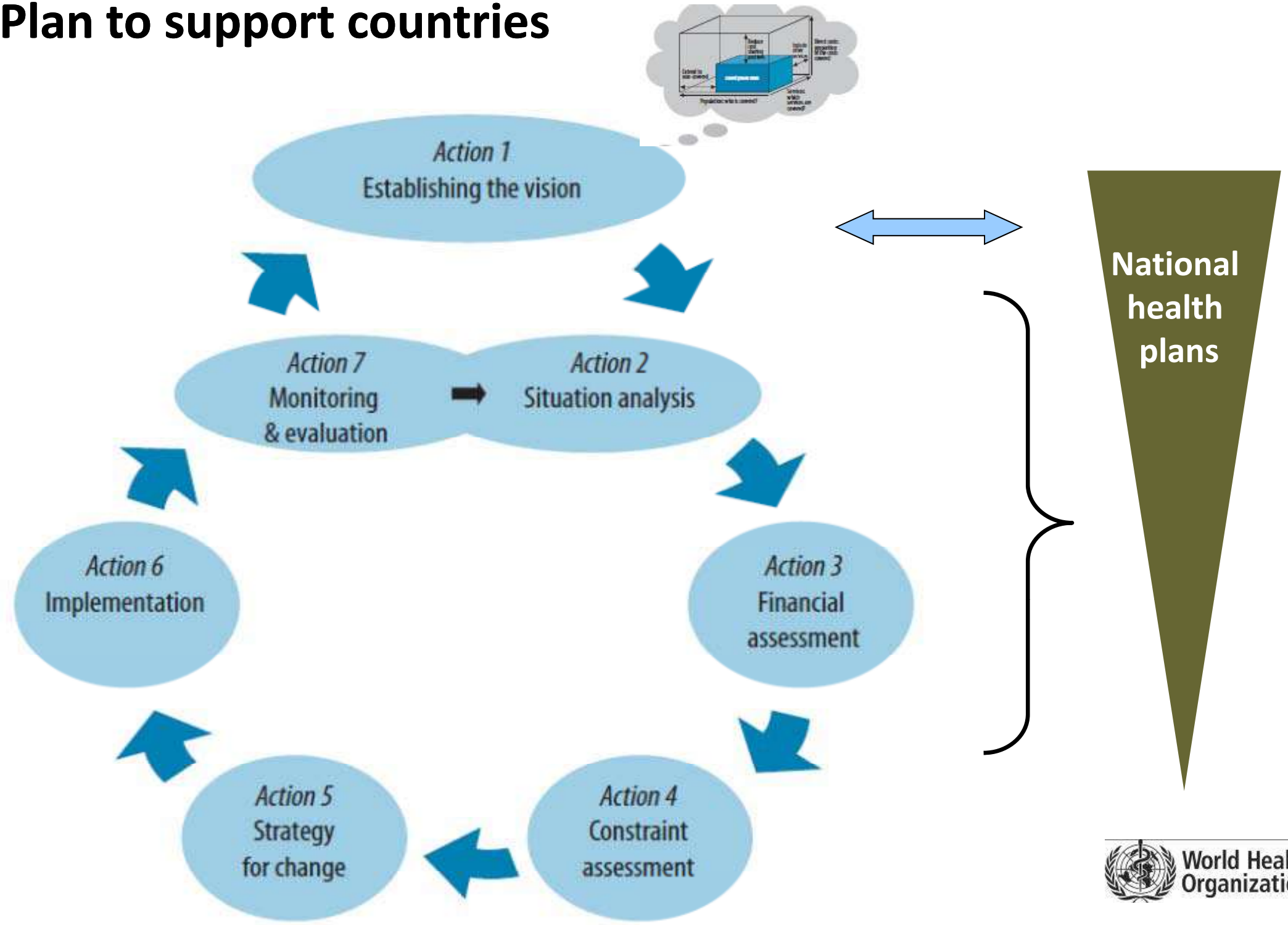
Plan to support countries



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Thailand's global influence: legendary with many lessons to share

- Prioritized health system development - built on a strong foundation of primary health care
- Strong evidence generation and use
- General government revenues for the informal sector
- Centralizing pooling for 47 million people – very enabling
- Purchaser-provider split with shift to capitation scheme
- Low cost

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Other lessons and key challenges in Thailand

- Imbalance: most spending on curative care; only 5% on health promotion and disease prevention
- Distribution of human resources for health - problematic
- Uneven access for remote areas of Thailand and migrant workers,

Thailand's global influence

- Growing number of countries have moved in same direction
  - Recognize that contributory approaches will not achieve UC when large informal sector
  - Channel general government funding from direct budgeting of supply to "purchaser-side subsidies"
    - India, Ghana, Rwanda, Colombia, and Mexico (and South Africa)
    - Eastern European and ex Soviet Union countries, similar to Kyrgyzstan approach initiated in 2001
    - Now Moldova and Lithuania.
- Kind and generous host to many study tours, workshops, conferences (PMAC); very generous in sharing knowledge & experience
- Used as an example in many, many workshops/documents
  - WHO/WB institute/Harvard University Global Flagship" seminar
  - WHO/EURO Barcelona course

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Dr Margaret Chan
Director General, WHO

Address to the 61st World Health Assembly. Geneva: World Health Organization, 2008

"When I took office at the start of last year, I called for a return to primary health care as an approach to strengthen health systems.

My commitment has deepened.

If we want to reach the health-related goals, we must return to the values, principles, and approaches of primary health care."

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Weak Health Systems

Strong Health Systems Based on Strong Primary Health Care!