Universal Health Coverage
Advancing the Agenda and Addressing the Challenges, 11 April 2012, New Delhi

Universal Health Coverage Learning from Global Experience

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Two main building blocks:

- General aspects of *Universal Coverage*;
- India; the *need* for and the *opportunities* regarding universal coverage.

Concept:

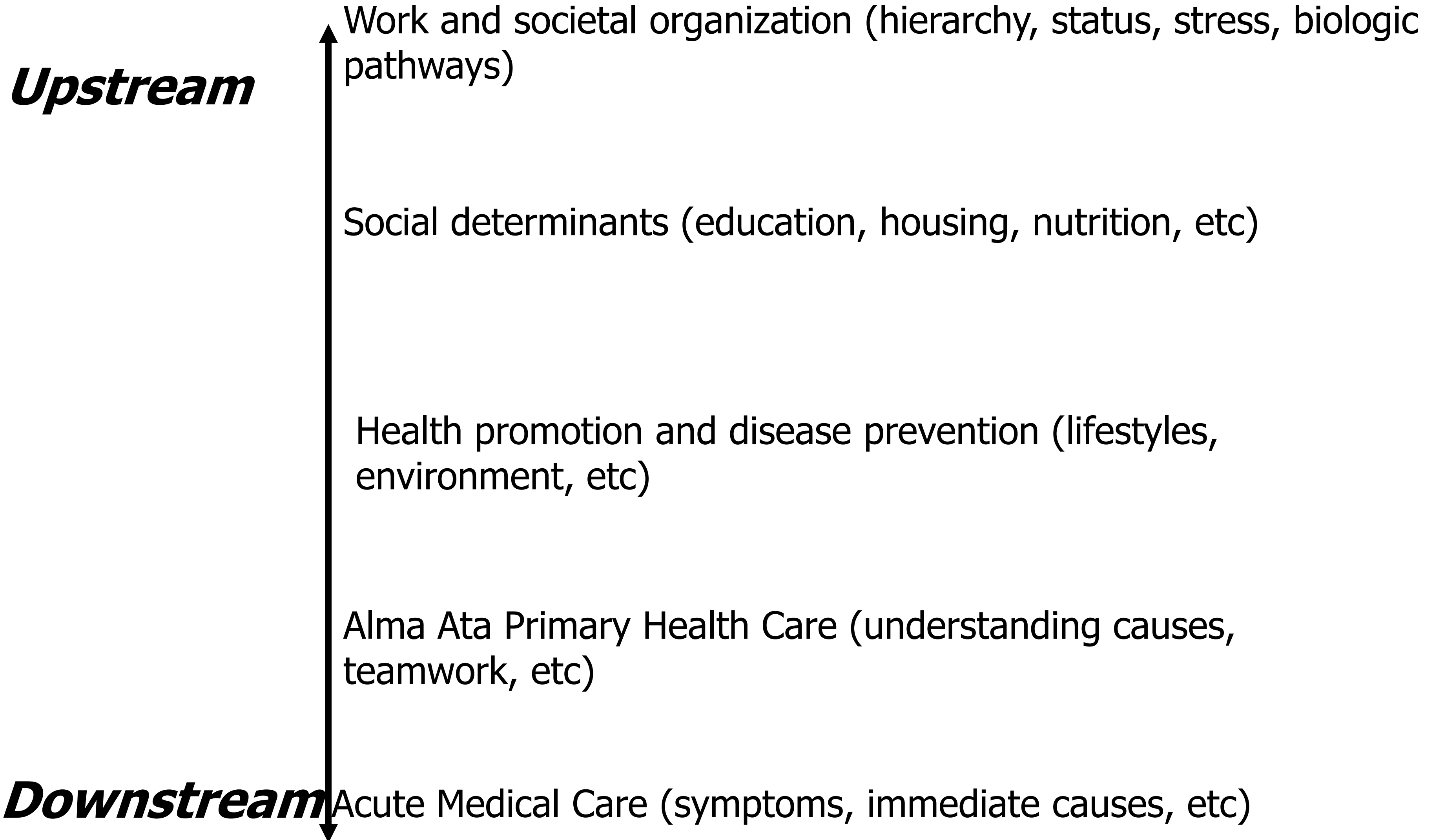
Half of life expectancy depends on “the circumstances in which people grow, live, work, and age” –e.g. education, housing, food and employment*.

Another half depends on services aimed at individuals and populations **.

Ensuring the financing for those health services by all (“universal coverage”) is crucial.

* Closing the gap in a generation; Health equity through action on the social determinants of health. Geneva, World Health Organization, 2008 http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf, accessed 2 March 2012
** *Figueras J, Lessof S, McKee M, Duran A and Menabde N, Health systems, health, wealth and societal well-being: an introduction in* McKee M and Figueras J, 2011, Health Systems: Health, Wealth, Society and Well-being, Open University Press, Maidenhead Berkshire, England, *pp1-19*

Where best to intervene?



Where *best* to intervene?

Diabetes
Empowerment and gender equity?
Taxing of sugar-heavy foods?
Teams fostering healthy eating habits?
Early diagnosis of diabetes and good follow up?
Effective quality care of a diabetic coma, etc.?

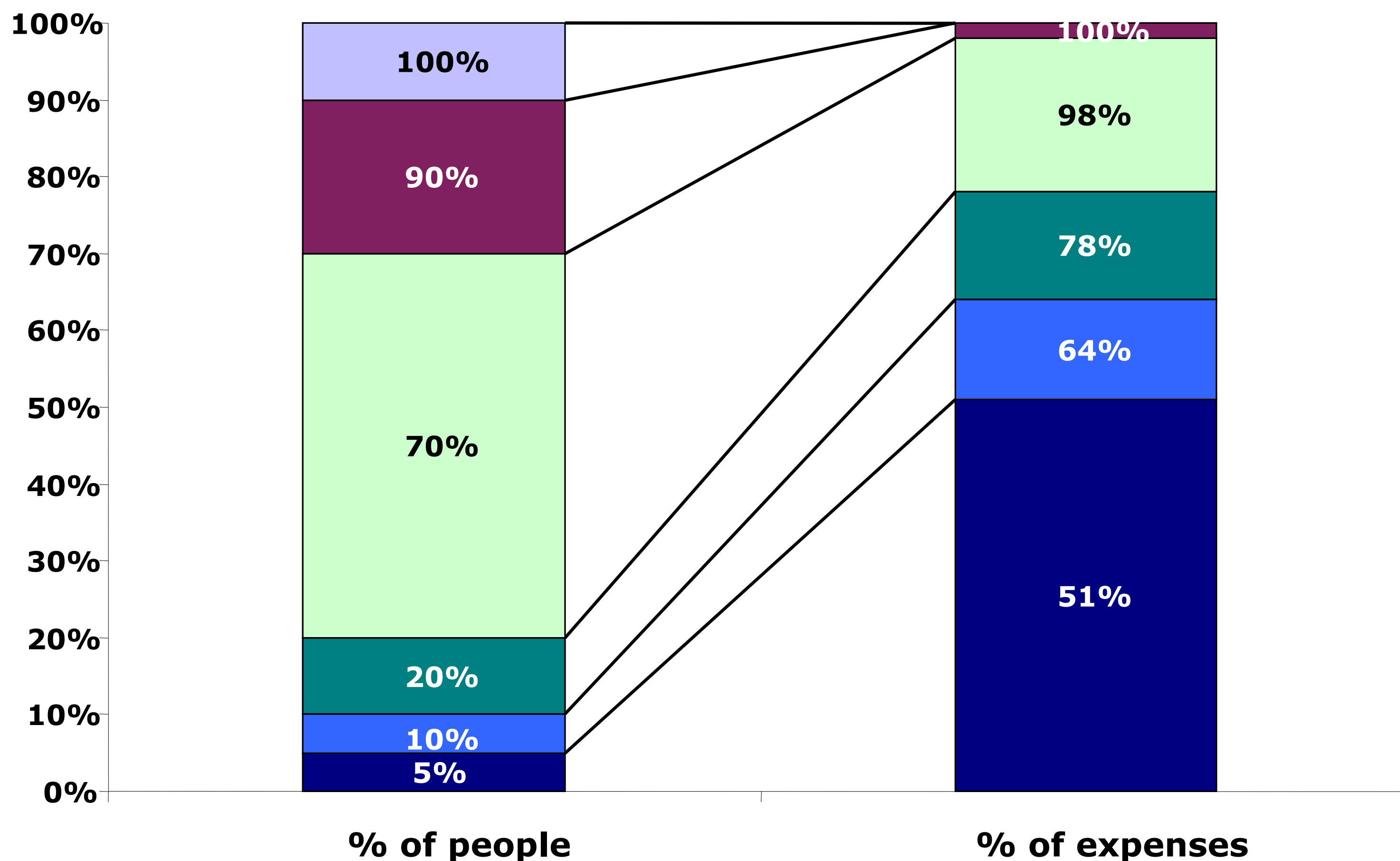
Where *best* to intervene?

Cerebro-Vascular Disease
Good global governance & market responsibility?
Work with food industry to reduce salt and fat?
Community-based fostering of physical exercise?
Early diagnosis of High Blood Pressure?
Quality care provided to an episode of stroke?

People should be *protected* from having to choose between financial ruin and loss of health

WHO, The World Health Report 2000, p.24

Concentration of total health expenditures, France 2008



Institut de Recherche et Documentation en Économie de la Santé IRDES, 2010, EPAS (*Echantillon Permanent d'assurés sociaux* – National Panel for insured population) from CNAMTS (*Caisse national d'assurance maladie des travailleurs salariés*, National Health Insurance Scheme for salaried employee). Exploitation: Julien Mousquès (mousques@irdes.fr) for IRDES (www.irdes.fr). Sample size: 79.035 individuals. Field: only for consumers (at least one consumption of health care or services within 2008)

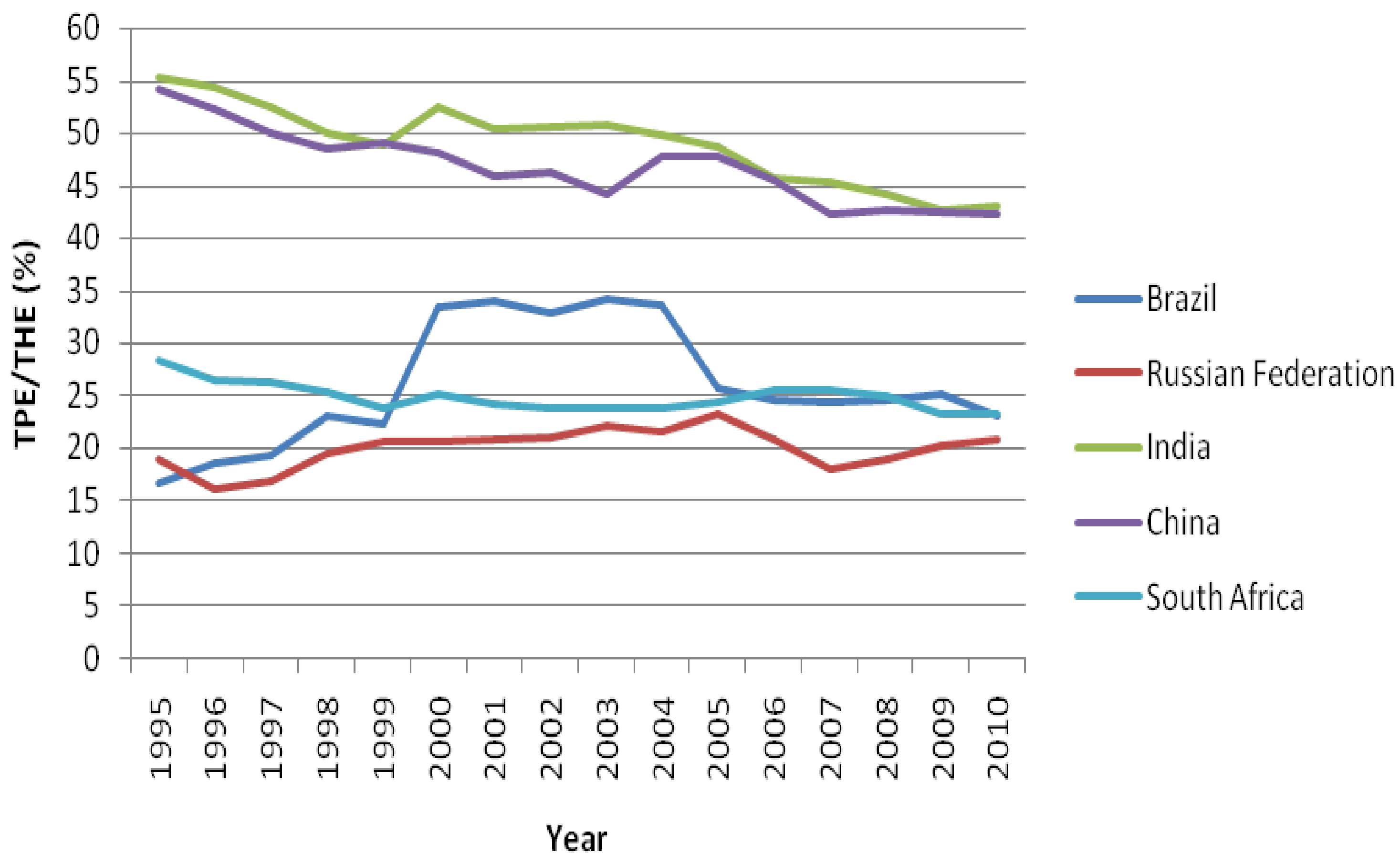
Each year, paying for their health care:

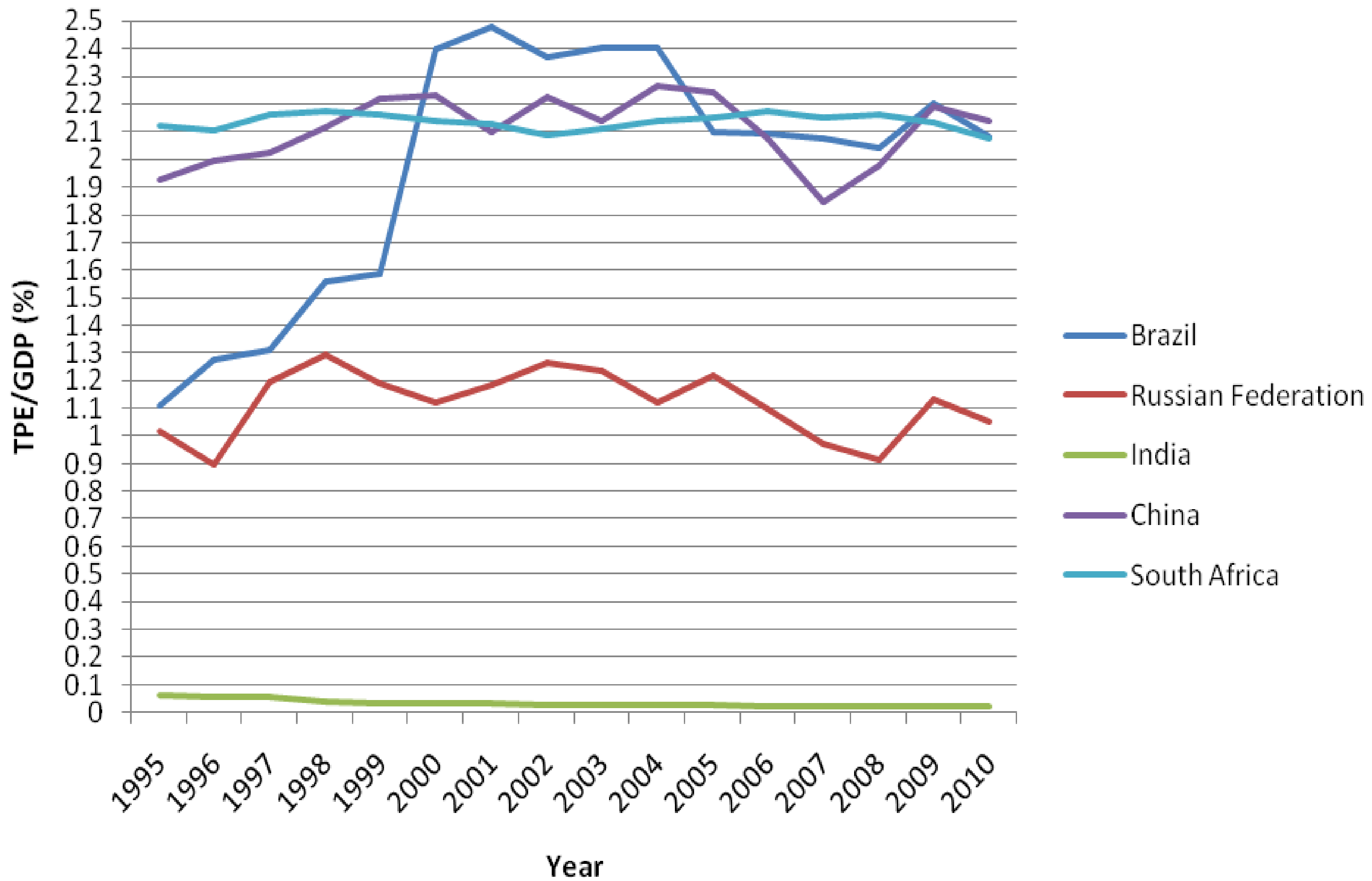
11% of the population suffers financial hardship in some countries

Globally, 150 million people suffer catastrophe annually and 100 are pushed below poverty line;

More than half the world's population lacks social protection; 1 in 5 has social security protection (middle-income from 20% to 60%; sub-Saharan Africa and southern Asia only 5-10% of people).

The World Health Report 2010, Health Systems Financing; the Path to Universal Coverage, WHO Geneva, page x


BRICS: Percentage of Total Pharmaceutical Expenditure of Total Health Expenditure Over Time
TPE/THE (%)
60
55
50
45
40
35
30
25
20
15
10
5
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
Year
Brazil
Russian Federation
India
China
South Africa


BRICS: Total Pharmaceutical Expenditure of Gross Domestic Product (GDP) (%)
TPE/GDP (%)
2.5
2.4
2.3
2.2
2.1
2
1.9
1.8
1.7
1.6
1.5
1.4
1.3
1.2
1.1
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
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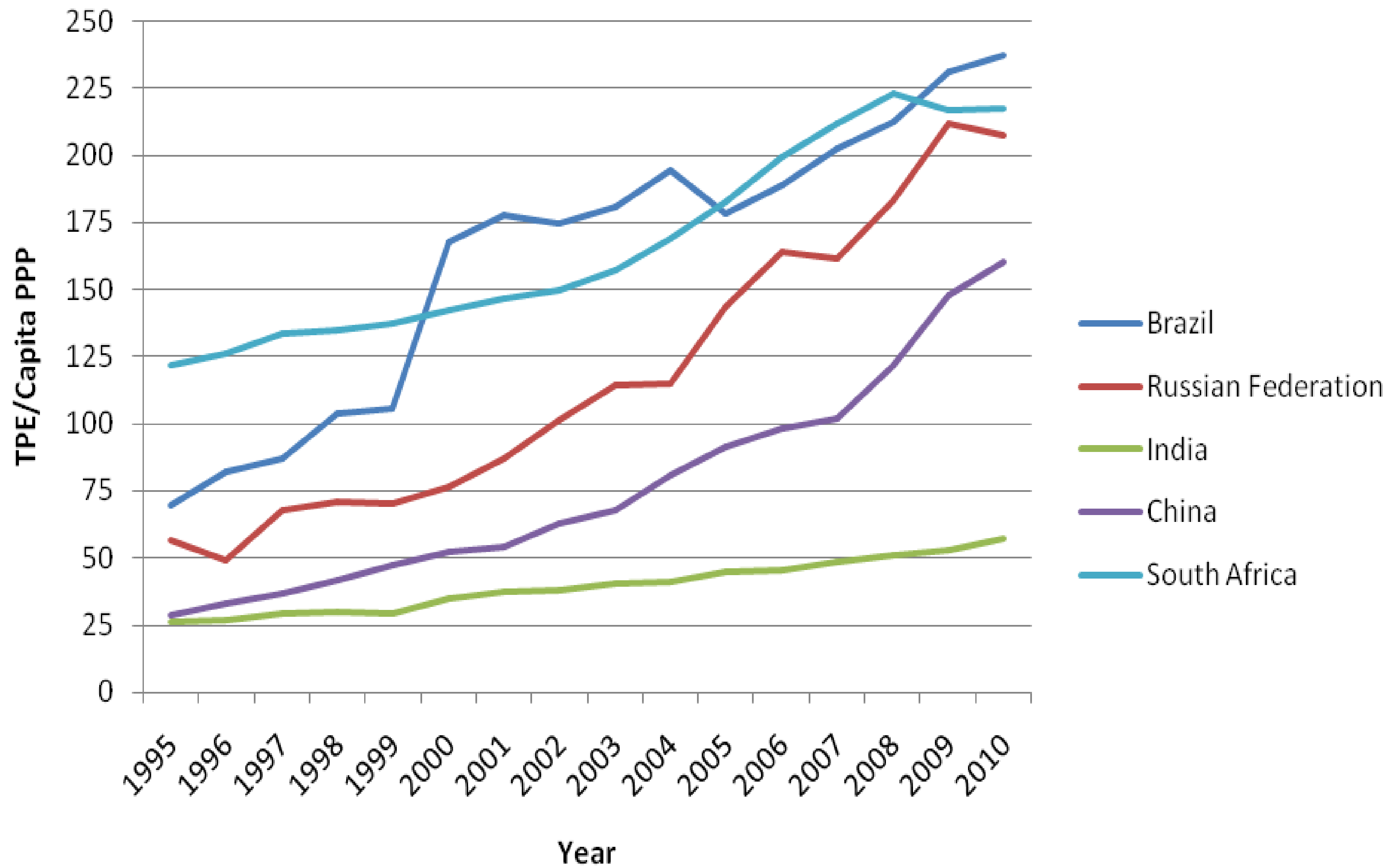
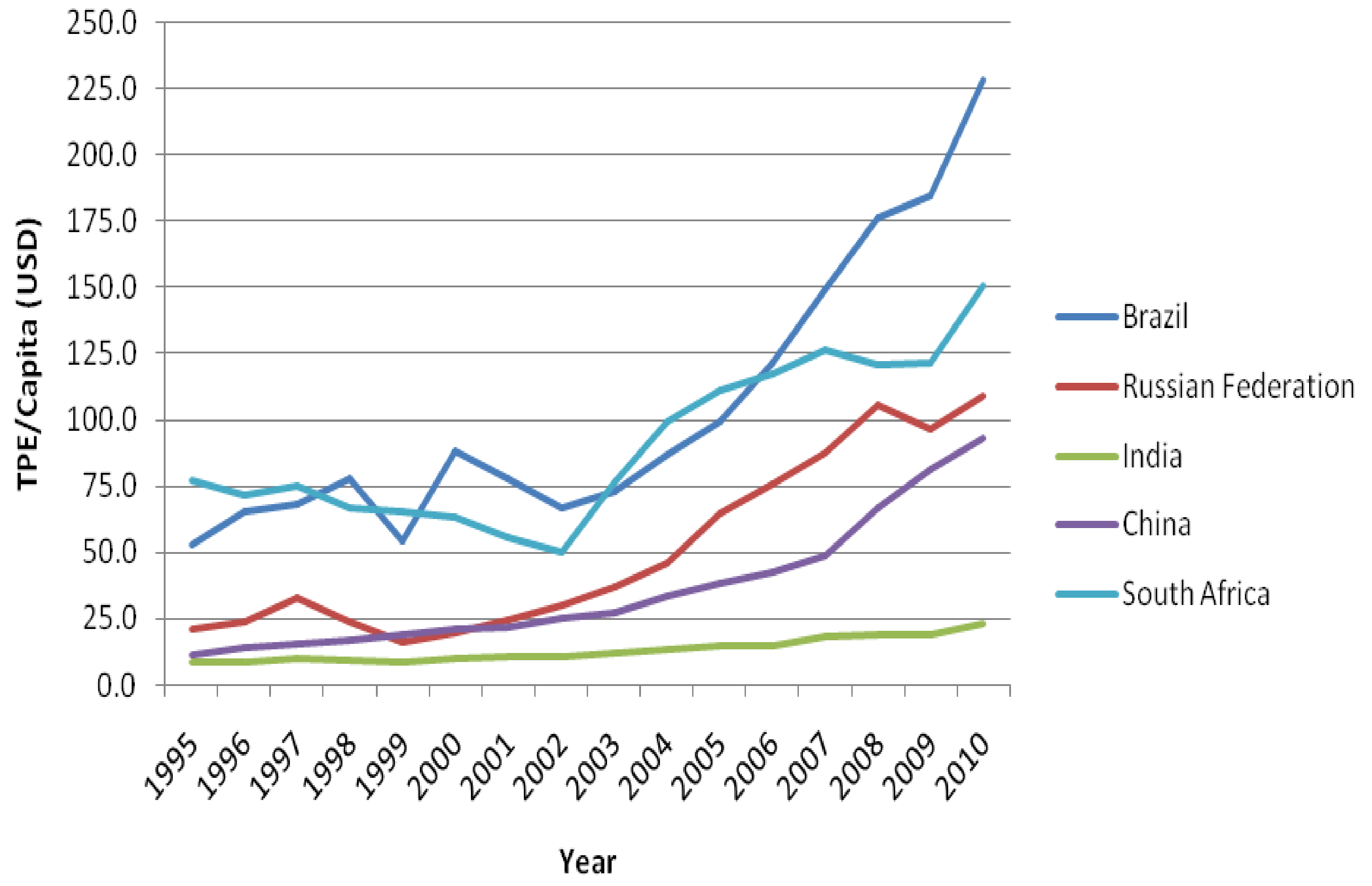
2009
2010
Year
Brazil
Russian Federation
India
China
South Africa


BRICS: Total Pharmaceutical Expenditure Per Capita PPP
TPE/Capita PPP
250
225
200
175
150
125
100
75
50
25
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
Year
Brazil
Russian Federation
India
China
South Africa



BRICS: Total Pharmaceutical Expenditure Per Capita USD
TPE/Capita (USD)
250.0
225.0
200.0
175.0
150.0
125.0
100.0
75.0
50.0
25.0
0.0
1995
1996
1997
1998
1999
2000
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2002
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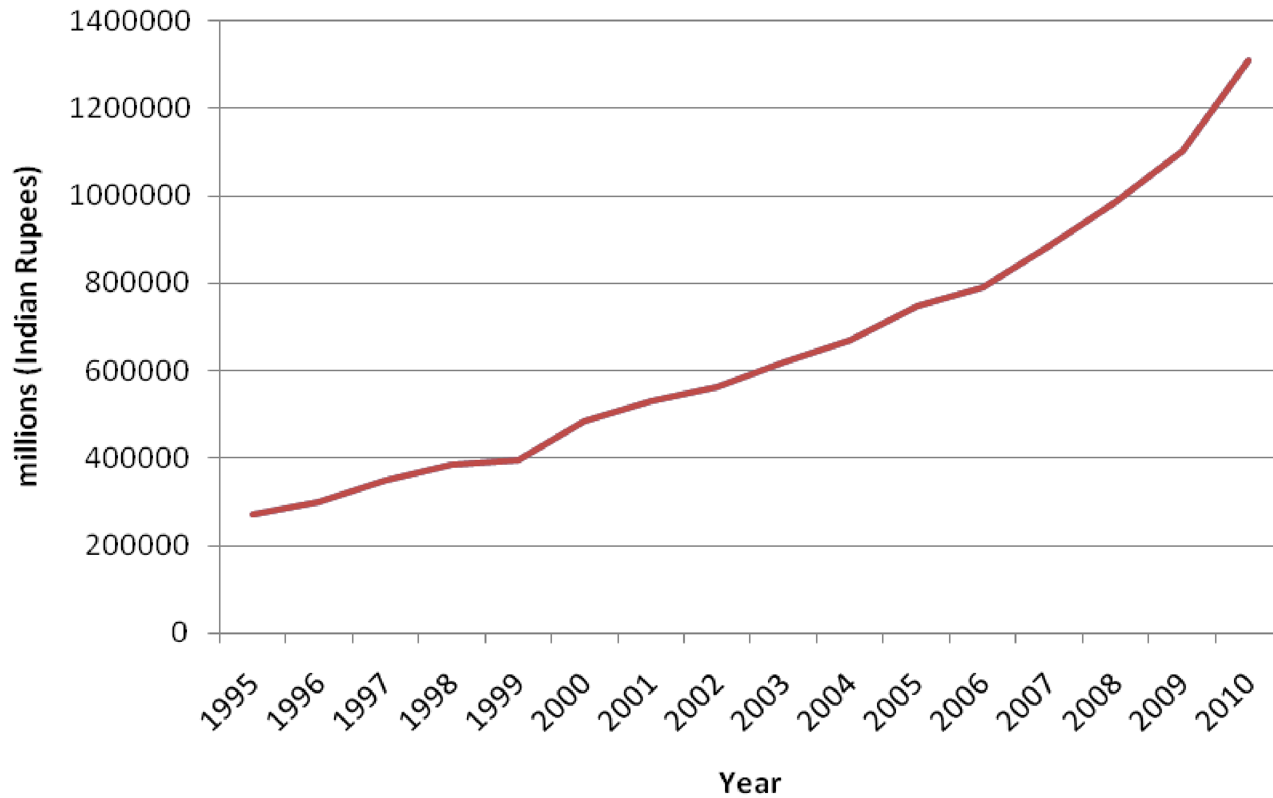
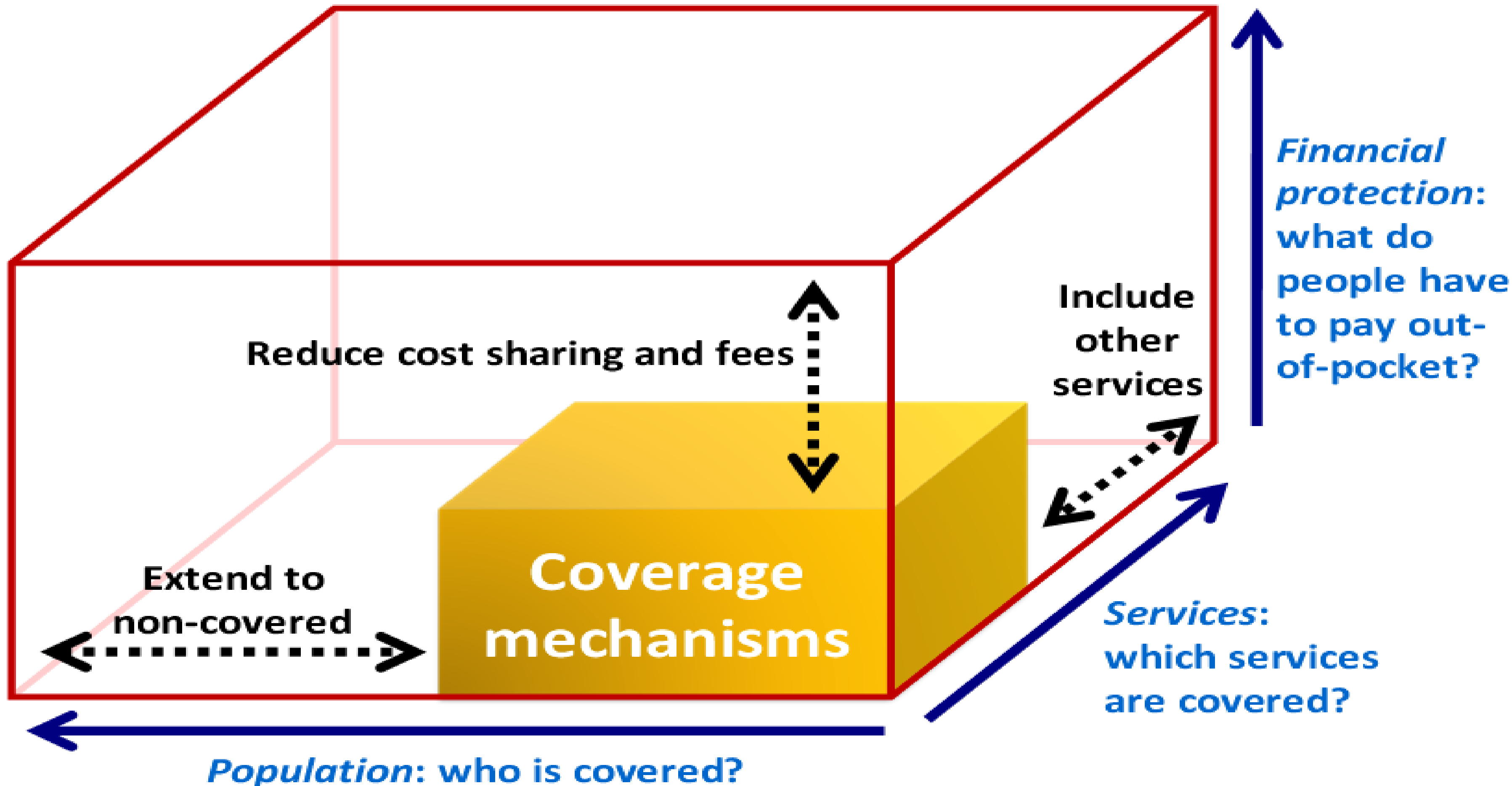
2006
2007
2008
2009
2010
Year
Brazil
Russian Federation
India
China
South Africa


India: Total Pharmaceutical Health Expenditure
millions (Indian Rupees)
1400000
1200000
1000000
800000
600000
400000
200000
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
Year

Policy decisions help explain much of the difference in coverage, both between and inside countries. *Political will*, rather than *national wealth,* is the critical pre-requisite for moving towards universal coverage.

The World Health Report 2010, Health Systems Financing; the Path to Universal Coverage, WHO Geneva, page x-xii

Towards universal coverage



World Health Organization, 2010, Health Financing, Towards Universal Coverage, WHR 2010, WHO, Geneva, p xv

Three core technical issues:

a. Raise *sufficient funds* (US$ 60 per capita by 2015);

b. Reduce *direct payments* to finance health services (below 15-20% of THE)

c. Improve *efficiency and equity* in the use of resources (current waste: 20-40%).

Sufficient funds:

1. Efficiency of revenue collection,
2. Re-prioritize government budgets
3. Do innovative financing
4. Use development assistance wisely

Rely less on direct payments:

Encourage pre-payment & risk-pooling

Three broad lessons from country experience:

(a) a proportion will need to be subsidized;

(b) contributions need to be compulsory,

(c) Not too small pools protecting too few people

Improve efficiency and equity:

(a) instead of expensive brands - use cheaper, effective medicines -use medicines more appropriately;

(b) improve quality control of medicines;

(c) get the most out of technologies & health services;

(d) motivate health workers;

(e) improve hospital efficiency;

(f) get care right the first time/ reduce medical errors;

(g) eliminate waste and corruption;

(h) critically assess what services are needed; and

(i) improve methods of payment to service providers, including strategic purchasing.

International experience (1 of 5)

Brazil, Chile, China, Mexico, Rwanda, Thailand: three areas of problem.

Gabon, innovative levy on mobile phone use.

Cambodia, health equity fund covering the poor.

Indonesia, tax system revamped

Lebanon improved its primary care network.

International experience (2 of 5)

Nobody covers 100% of people for 100% of the services available and for 100% of the cost.

Took a century or more to achieve in much of Western Europe.

International experience (3 of 5)

Much more difficult to achieve than to advocate.

Free public services may be captured by the rich,

The poor could gain little if last in the queue

Davidson R Gwatkin, Alex Ergo Universal health coverage: friend or foe of health equity? Published Online November 16, 2010 DOI:10.1016/S0140-6736(10)62058-2)

International experience (4 of 5)

Removing financial barriers is not enough. Need:

(a) conditional cash transfers;

(b) vouchers and refunds to cover transport, microcredit schemes, etc.

International experience (5 of 5)

Governments need to:

- mind trade offs between equity and efficiency.

- ensure population-based services focusing on prevention and promotion.

- ensure that all providers operate appropriately and attend patients'•needs.

Three main reasons for UC in India

- Pending & emerging health agenda items
- Re-position as economic powerhouse, and
- Exhaustion of previous arrangements

Three developments indicate *ample opportunities* for providing UC:

- political will to change;

- economic resources available and

- knowledge and skills in the country.

A message of cautious optimism

- It is needed
- It is feasible
- There is political will
- Necessary knowledge and skills exist
- IT WILL BE DONE!

”(…)Three overarching goals by 2020:

(i) Ensure reach and quality of services to all;

(ii) Reduce financial burden on individuals; and

(iii) Empower people to hold the health-care system accountable ”.

K Srinath Reddy, Vikram Patel, Prabhat Jha, Vinod K Paul, A K Shiva Kumar, Lalit Dandona, for The Lancet *India Group for Universal Healthcare,* Towards achievement of universal health care in India by 2020: a call to action Published Online January 12, 2011 DOI:10.1016/S0140- 6736(10)61960-5

[Heath System Video]

Thank you