Universal Health Coverage
Learning from Global Experience

Dr. Nata Menabde
WHO Representative to India
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.

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Where best to intervene?

- **Upstream**
  - Work and societal organization (hierarchy, status, stress, biologic pathways)
  - Social determinants (education, housing, nutrition, etc)
  - Health promotion and disease prevention (lifestyles, environment, etc)
  - Alma Ata Primary Health Care (understanding causes, teamwork, etc)

- **Downstream**
  - Acute Medical Care (symptoms, immediate causes, etc)
Where *best* to intervene?

<table>
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<tr>
<th>Diabetes</th>
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<td>Empowerment and gender equity?</td>
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<td>Taxing of sugar-heavy foods?</td>
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<td>Teams fostering healthy eating habits?</td>
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<td>Early diagnosis of diabetes and good follow up?</td>
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<td>Effective quality care of a diabetic coma, etc.?</td>
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## Where *best* to intervene?

<table>
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<th>Cerebro-Vascular Disease</th>
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<td>Good global governance &amp; market responsibility?</td>
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<td>Work with food industry to reduce salt and fat?</td>
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<td>Community-based fostering of physical exercise?</td>
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<td>Early diagnosis of High Blood Pressure?</td>
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<td>Quality care provided to an episode of stroke?</td>
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People should be *protected* from having to choose between financial ruin and loss of health

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).
BRICS: Percentage of Total Pharmaceutical Expenditure of Total Health Expenditure Over Time
India: Total Pharmaceutical Health Expenditure

Year


millions (Indian Rupees)

0 1000000 2000000 3000000 4000000 5000000 6000000 7000000 8000000 9000000 10000000 11000000 12000000 13000000 14000000

2001 2002 2003 2004 2005 2006 2007 2008 2009 2010
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.
Towards universal coverage

Reduce cost sharing and fees

Include other services

Financial protection: what do people have to pay out-of-pocket?

Services: which services are covered?

Population: who is covered?

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
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.”
Thank you