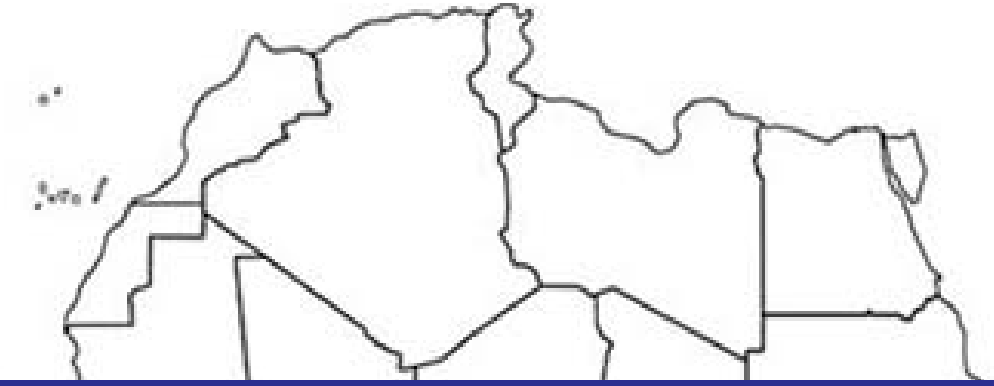

FINANCIAL PROTECTION AND IMPROVED ACCESS TO HEALTH CARE:
PEER-TO-PEER LEARNING WORKSHOP
FINDING SOLUTIONS TO COMMON CHALLENGES

FEBRUARY 15-19, 2016

ACCRA, GHANA

Day II, Session I.

HEALTH SYSTEMS GOVERNANCE & FINANCING

Health Financing for UHC – two sides of the coin

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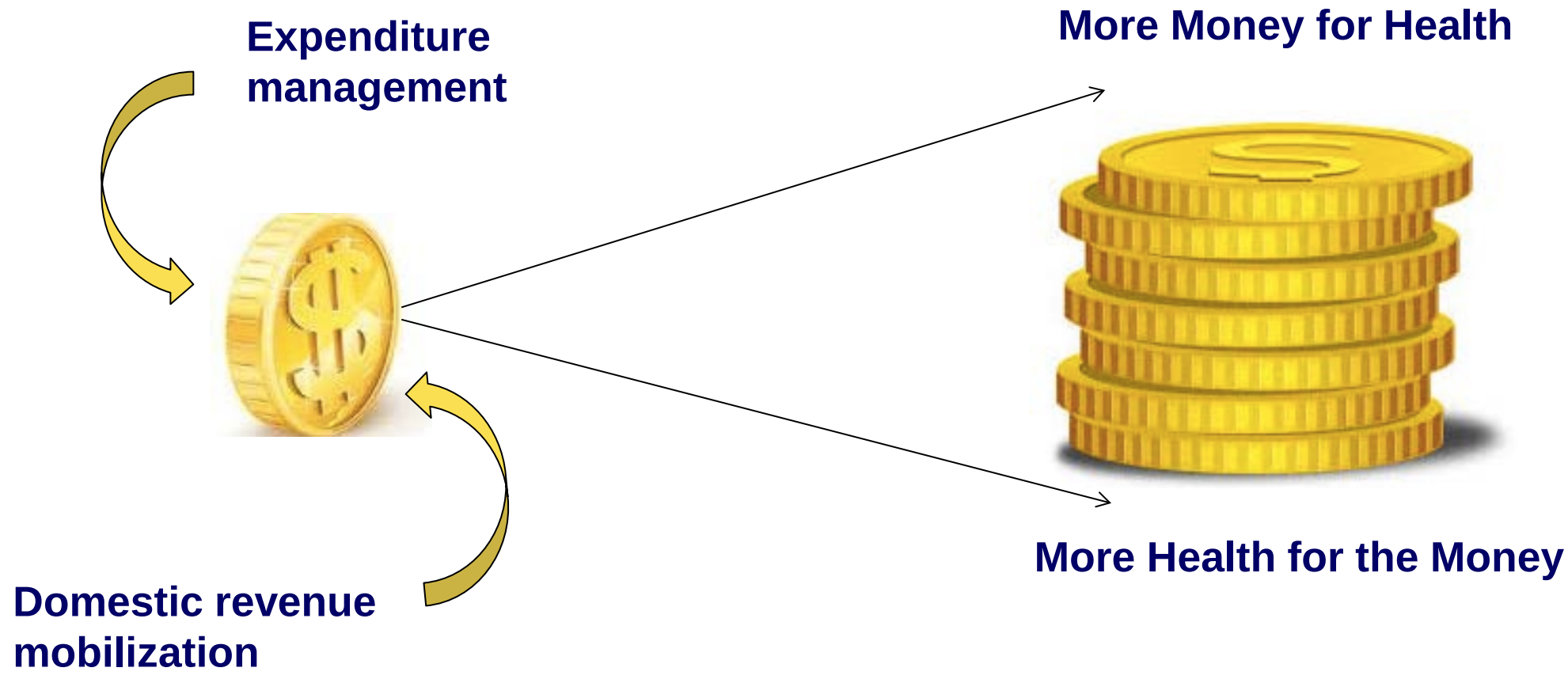
Financial Protection and Improved Access to Health Care
Peer-to-peer learning workshop

15-19 February 2016, Accra, Ghana

World Health Organization

Two sides of the coin: What does it mean?



Main messages up front (and will have more details later in the day)

- Given what we know about health financing, it is essential to move towards predominant reliance on compulsory (public) revenue raising mechanisms
  - For LMICs, this means general budget revenues
  - Many ideas for new sources, but don't lose sight of big picture
- But you can't just spend your way to UHC
  - Efficiency key to get results while managing expenditure growth
- So moving towards strategic purchasing is essential
  - But many barriers – notably public finance management (PFM) rules - to using budget funds to "buy services"
- Need more effective engagement of Health with Finance authorities on both level of funding & rules governing use

UHC AND HEALTH FINANCING: CORE CONCEPTS

Concept of UHC embodies specific aims (UHC goals)

- Equity in service use (reduce gap between need and utilization);
- Quality (sufficient to make a difference); and
- Financial protection
- From aspiration to practical policy orientation
  - moving towards Universal Coverage, i.e. improvements on these goals
  - Globally relevant (all countries have room for improvement)

What UHC brings to public policy on health coverage

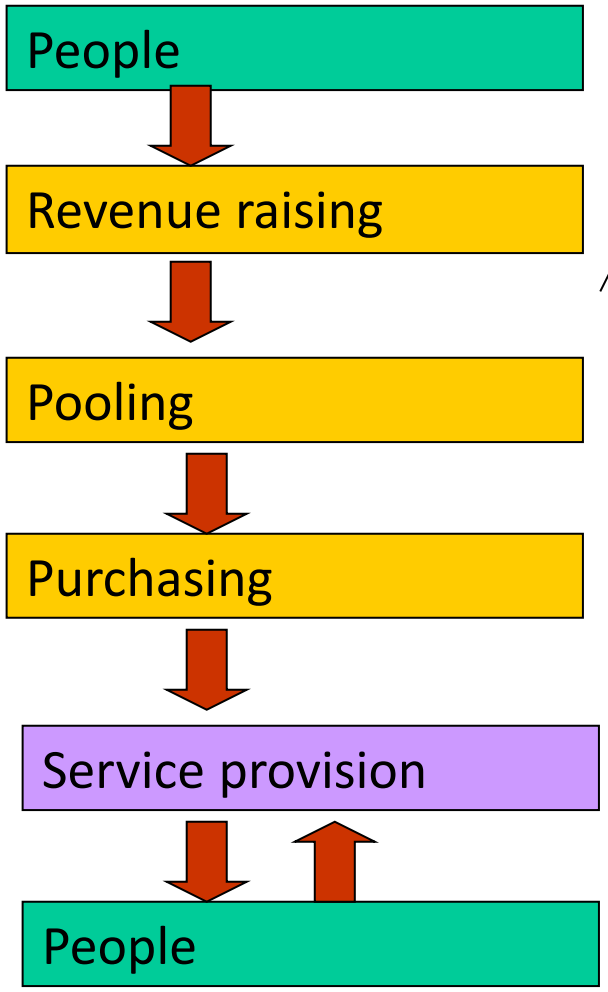
- Coverage as a “right” (of citizenship, residence) rather than as a condition of employment
  - Copying European historical experience (starting with the formal sector) is not appropriate
  - Critically important implications for choices on revenue sources and the basis for entitlement

- **Unit of Analysis**: system, not scheme
  - Effects of a “scheme” or a “program” is not of interest per se; what matters is the effect on UHC goals considered at level of the entire system and population
  - Also relevant to efficiency considerations

More concretely, towards UHC in national health financing strategies

- Transform UHC objectives into “problems”
  - How is our system under-performing on these objectives? What are specific manifestations of these problems in our country?
  - Why? Need to get to causes that are actionable by reform
- A health financing strategy: what can we do in the next 5-10 years to address the causes of our priority problems and lay the foundation for future development?
- A health financing strategy should be about solving problems, not “picking a model”

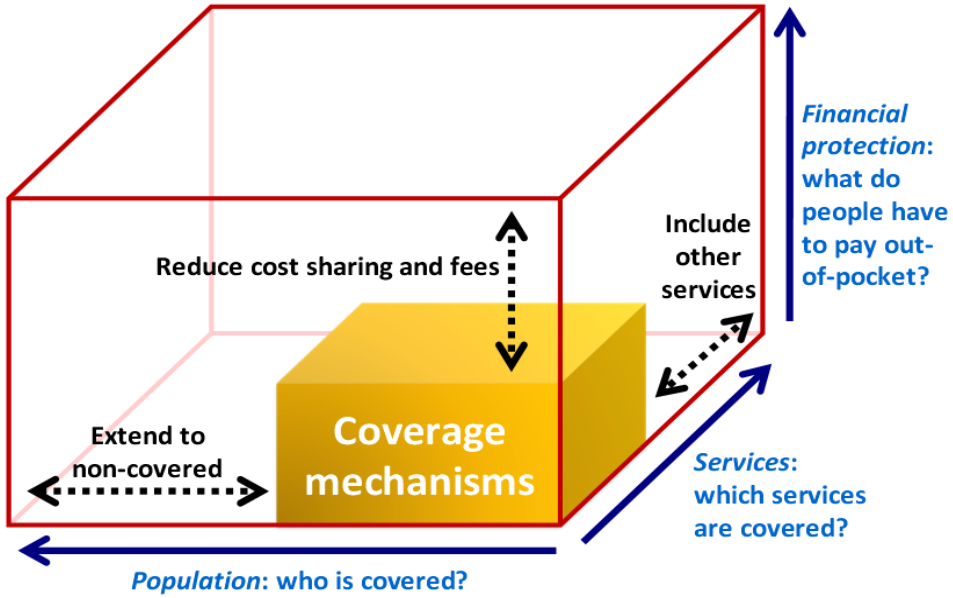
What health financing policy needs to address



and also this:

Reforms to improve how the health financing system performs

This



Priorities and tradeoffs with regard to population, service, and cost coverage

UHC AND HEALTH FINANCING: WHAT WE WANT FROM REVENUE RAISING

The facts of (health financing) life

- Move towards predominant reliance on compulsory (i.e. public) funding sources
  - "Compulsion" refers to revenue source (i.e. some form of taxation) and basis for entitlement (mandatory/automatic)
- You won't get there thru voluntary health insurance (VHI)
  - Adverse selection: part of the "physics" of health financing policy
  - Issue is compulsory vs voluntary, not vs private (ownership of VHI – commercial, government or "community" – doesn't matter)
  - More to come on this later in the week

More bad news: the taxation challenge for low and middle income countries

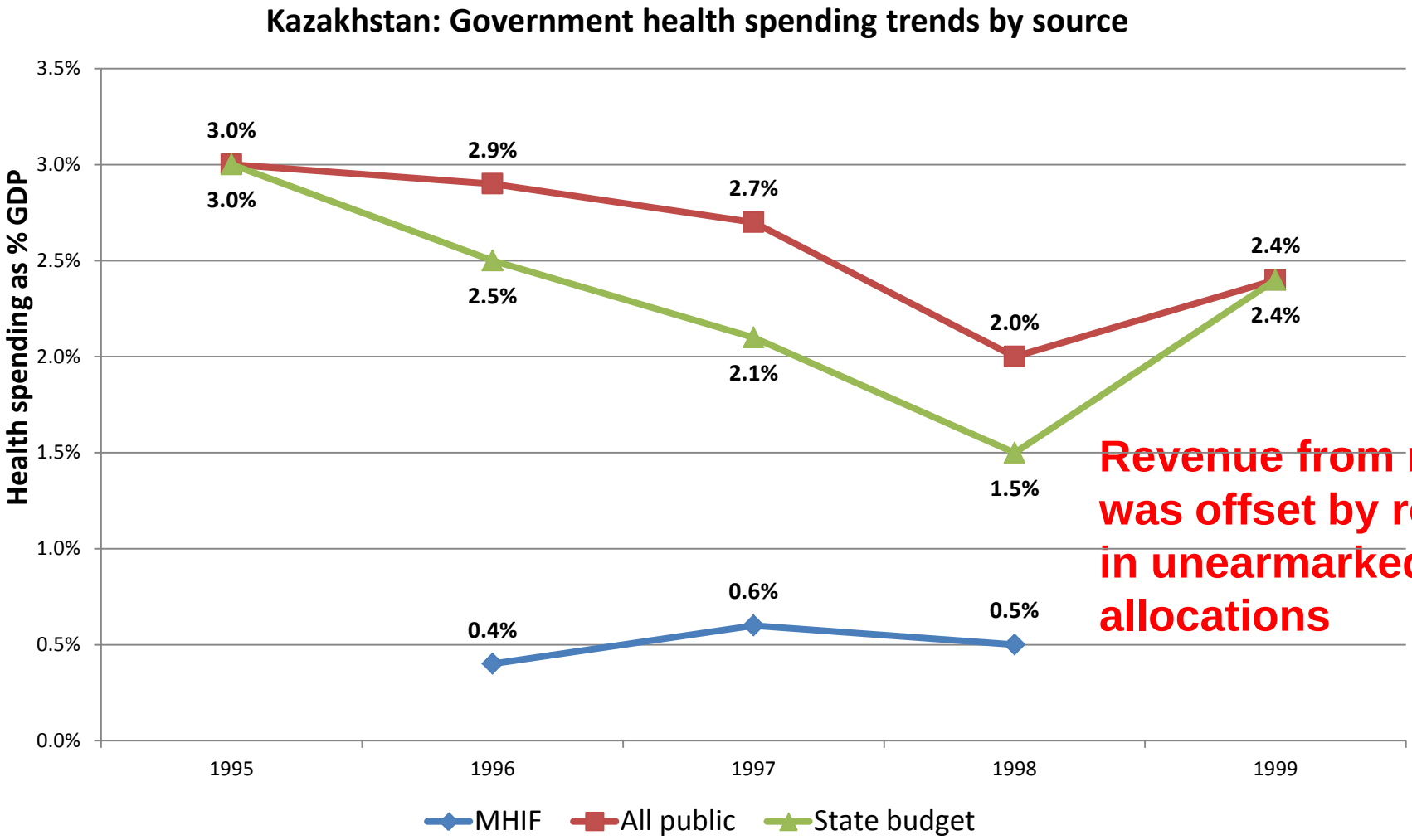
- LMICs tend to suffer from poor tax collection
  - Challenge of rural and informally employed
- Implications for health spending:
  - More private; more out-of-pocket; more regressive

2013 estimates

Country income group	Total government spending as % GDP	Private as % of total health spending
Low	25%	59%
Lower-mid	29%	51%
Upper-mid	35%	40%
High	42%	30%

Source: WHO Global Health Expenditure Database, countries w/ population > 600,000

What about new taxes? Will they always raise more money for the system? ("it depends")



Revenue from new tax was offset by reduction in unearmarked allocations

Example shows another truth: it's a political as well as fiscal issue

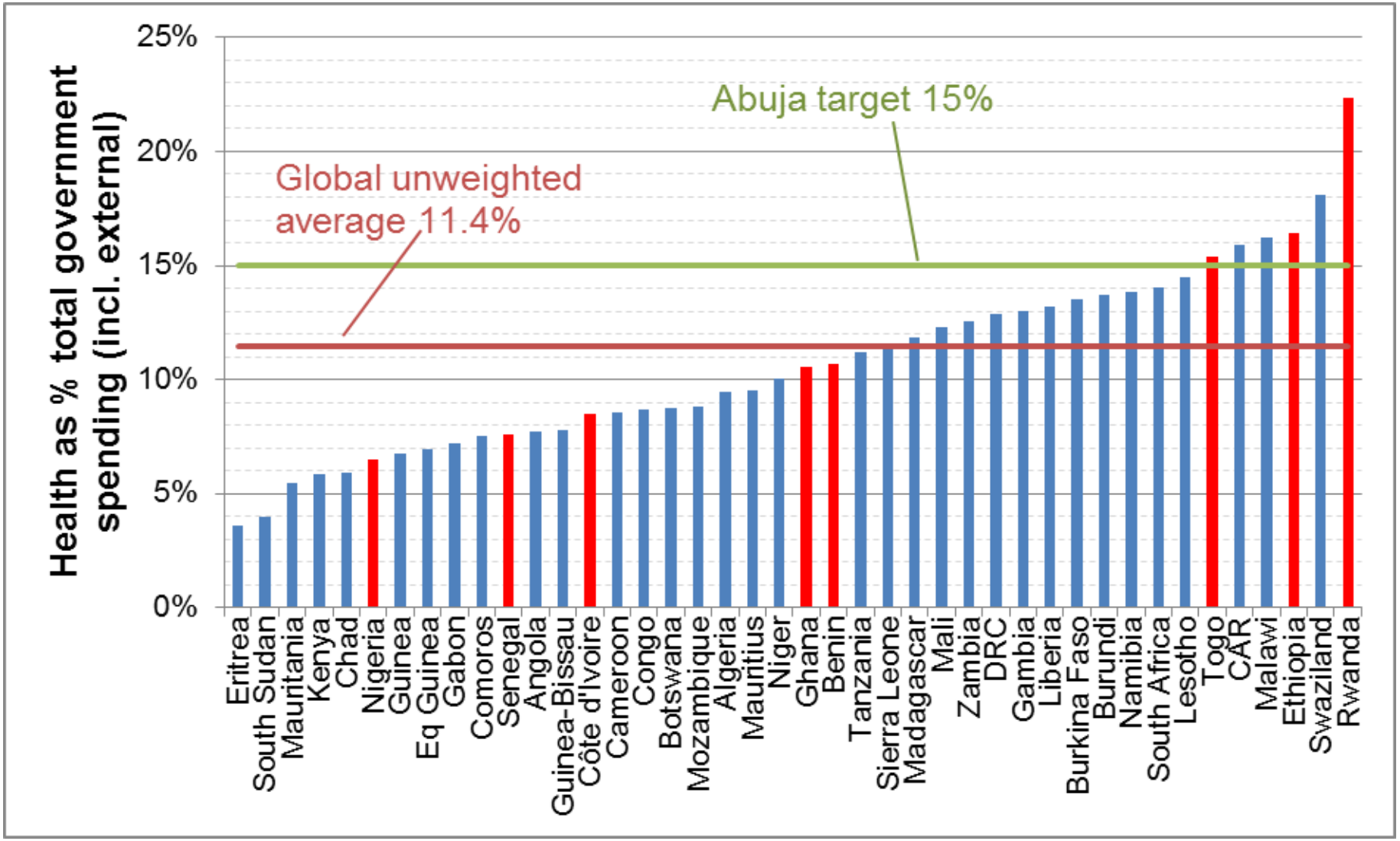
$$\frac{\text{Gov't health spending}}{\text{GDP}} = \frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}}$$

Government health spending as share of the economy

Fiscal capacity

Public policy priorities

What matters is the overall share, not just revenues from one earmarked tax



Source: WHO health expenditure estimates for 2013

So for revenue raising

Public funding matters; VHI won't get you there

Fiscal context matters, the FfD-3 tax agenda is critical for UHC

Don't be too fascinated by any single source or tax, even if "innovative"

Priorities matter: huge cross-country variation, despite Abuja

But remember: you can't just spend your way to UHC (other side of the coin)

UHC and health financing: one slide for what we want in pooling arrangements

- Aim: maximize redistributional capacity of prepaid funds
- For this, pools should be
  - Large(r)
  - (more) Diverse
  - With compulsory or automatic participation
- So fragmentation is the major problem
  - Source of inequity (unequal benefits by scheme), typically favoring the better off and better-organized
  - Source of inefficiency – duplication of functional responsibilities across schemes and programs
  - In other words, more prepayment, fewer prepayment schemes

UHC AND HEALTH FINANCING: STRATEGIC PURCHASING FOR SUSTAINABLE PROGRESS

If UHC was just about how much you spend…

- Then our USAID colleagues would be able to point to their own (and my own) country as having achieved more UHC (whatever that means) than any other in the world
- It turns out that you can't just spend your way to UHC

To sustain progress, need to ensure efficiency and accountability for results

- "Strategic purchasing" as a critical strategy for this
  - linking the allocation of resources to providers to ***information*** on their performance and/or the health needs of those they serve
  - Manage overall expenditure growth (no open-ended promises)
- Ideally, systems should pay for services, and design incentives for efficient use of resources
- But most funding has to come from general budgets, and most public budgets can only pay for buildings and inputs
  - Highlights importance of aligning Public Finance Management (PFM) mechanisms with output-based provider payment in the health sector (coming later this morning)

So UHC ≠ getting people enrolled in an insurance scheme: China in the 2000s

- Massively increased public spending to bring insurance coverage to well over 90% of population
- But relied on fee-for-service payment with high cost sharing, with no gains in financial protection
  - Good for doctors and hospitals, not good for patients or those trying to manage insurance budgets
  - As a result, more public money was just more “fuel on the fire”
- Contrasts greatly with experience of Thailand (more later)
  - Also brought scheme affiliation to near 100%
  - Payment systems ensure system functions within a budget

CONCLUDING COMMENTS

More coins are needed, but success depends on how we use it and manage its growth

- More money and resources are not enough to make **sustainable** progress towards universal health coverage (UHC)
  - If funds cannot be directed to priority populations, programs, and services

  AND
  - If funds are not used efficiently

  AND
  - If there are no limits on the financial liability of the purchaser

Implications for African health and finance dialog on UHC – the path to sustainability

- Moving towards greater reliance on public funding will mean general government budget revenues in particular
- Key challenge is to use these revenues effectively; hard to do in many rigid public finance systems
- This requires intensive and effective dialog between health and public finance authorities on level of budgets…
- …and the ability to transform these revenues into services and drive efficiency gains…
- …while at the same time ensuring accountability for the use of these scarce public funds

Set priorities and don't get distracted

- Without a strong, effective purchasing function, more revenues won't help very much – building and institutionalizing this foundation is the top priority
- It's not about filling a funding gap based on international norms, or magical "innovative" new sources
- And you can't "align donor funding" until the architecture and engineering of your domestic system is in order
  - First and foremost, key is your domestic health financing system (including financing and system arrangements for health programs as well)

The path to UHC runs from domestic budget revenues to PFM arrangements