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Understanding Universal Health Coverage

UHC and Health Financing

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Abt Associates Inc.
In collaboration with:
Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) | Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D) | RTI International | Training Resources Group, Inc. (TRG)

Understanding UHC and HCF

Outline

- What is Universal Health Coverage (UHC)?
- Arguing for UHC - Why are we aiming for UHC?
- What is the link between HealthCare Financing (HCF) and UHC?
- The need for UHC in Nigeria
- Current situation of UHC in Nigeria
- How do we make progress?

What is UHC?

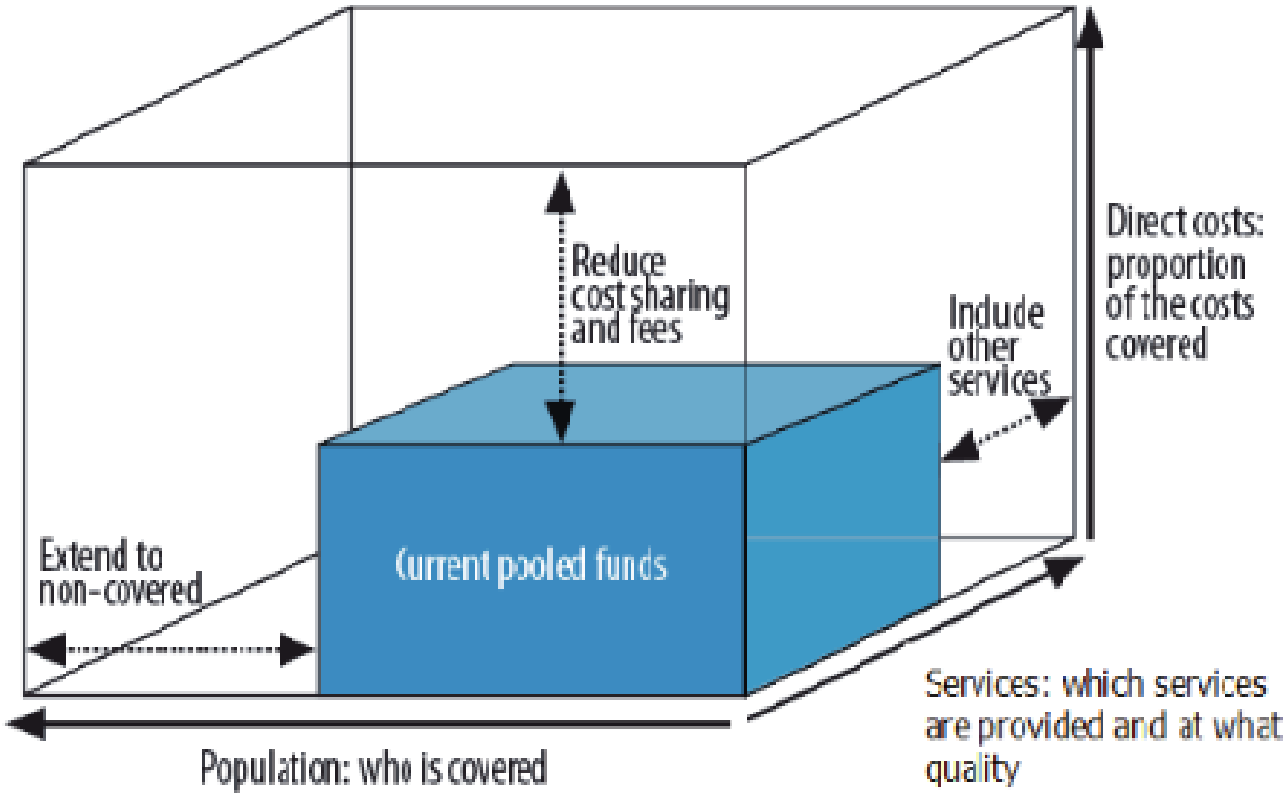
- UHC is a **goal** (aspirational)

All people have access to effective and high-quality health services, without experiencing financial hardship

- **Universal**: All people regardless of race, gender, social status
- **Health services**: curative, health promotion, prevention, rehabilitation, and palliative
- **Quality**: sufficient quality to be effective
- **Financial hardship**: lowering out of pocket costs and the risk of catastrophic health expenditure

Dimensions of Coverage

Three dimensions to consider when moving towards universal coverage

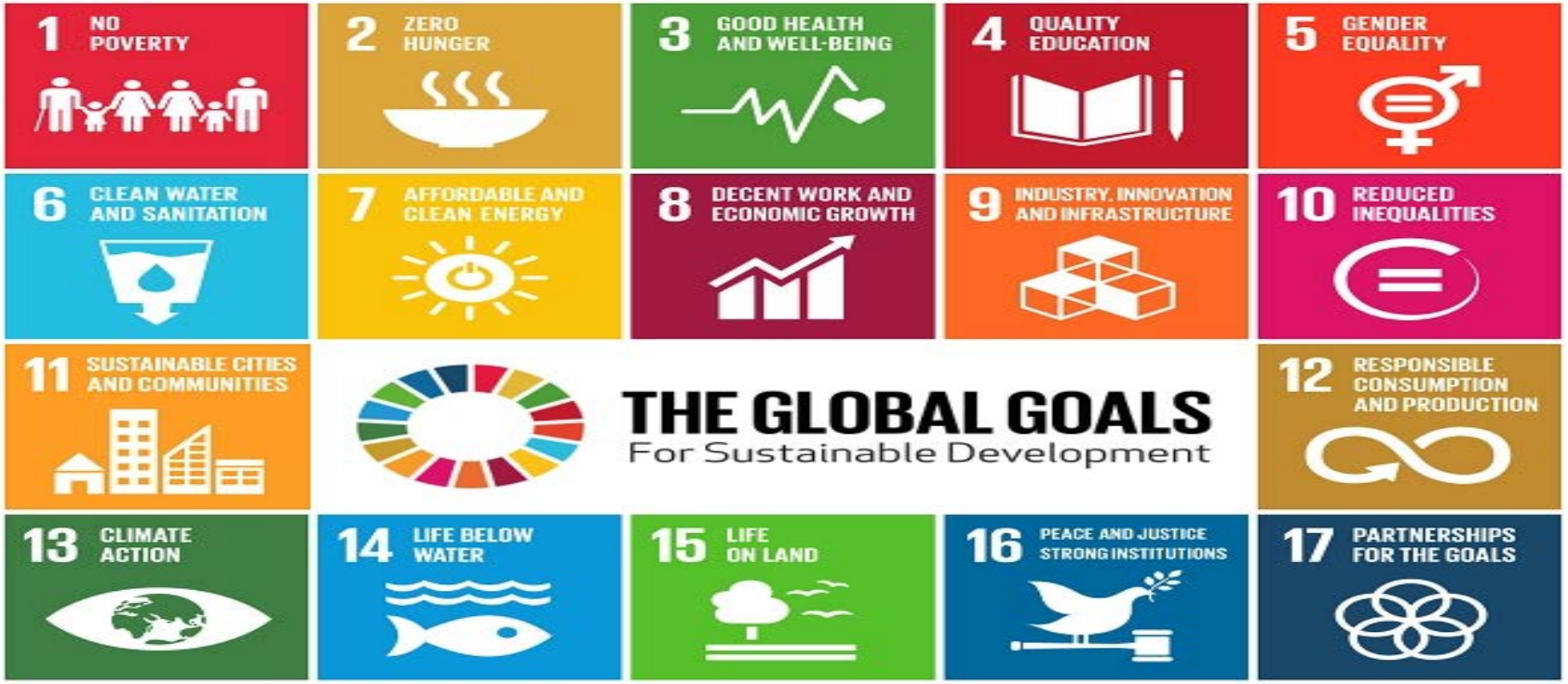


UHC Related Historical Trend

- 1948: Universal declaration of human rights
  - Article 25 states that ***everyone*** *has the right to a standard of living adequate for health, including medical care, and the right to security in the event of sickness or disability*
- 1977: Health for all by the year 2000
  - The World Health Assembly decided on target **health for all** by the 2000 for governments and WHO
- 2012: United Nations General Assembly adopt a resolution calling for countries to toe the path of UHC
- 2014: Presidential Summit on UHC in Nigeria
  - The summit recommends ……..
- 2016: UHC became a global development agenda target - target 8 of SDG 3
- 2017: President Buhari launched PHC Revitalization for UHC initiative

UHC and SDGs

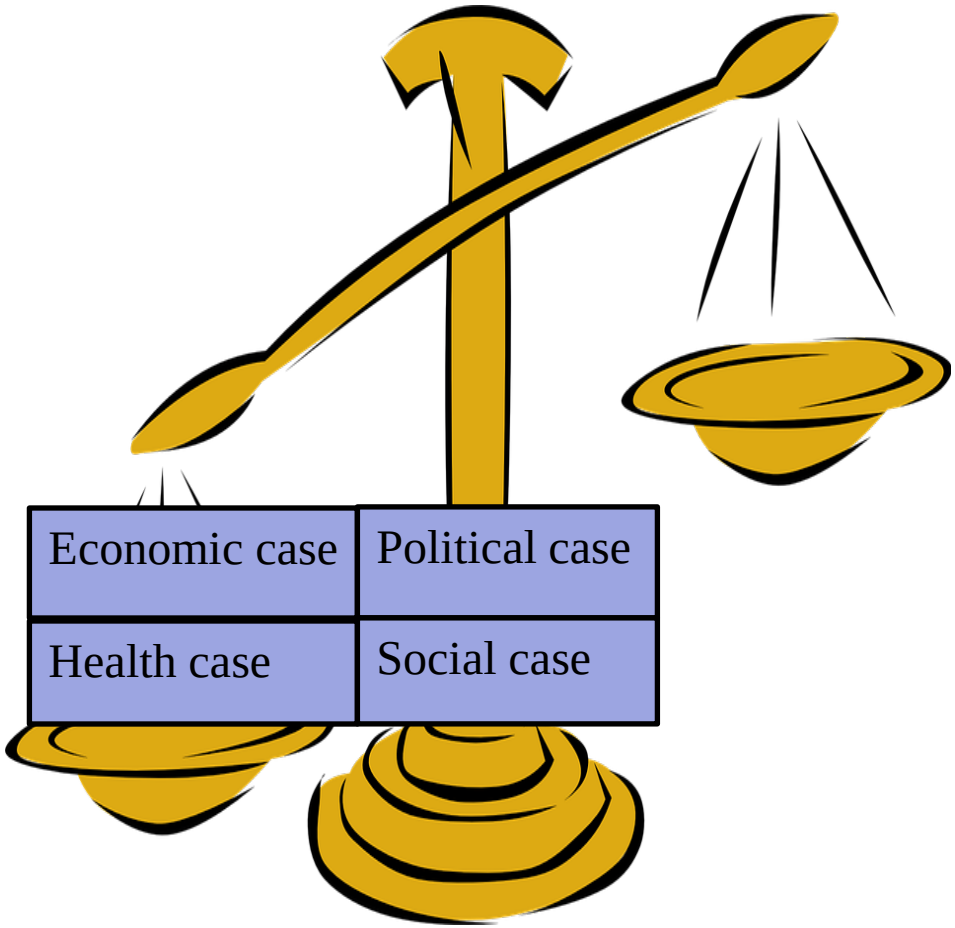
- Goal 3: Ensure healthy lives and promote wellbeing for all at all ages
  - Target 3.8: Achieve UHC

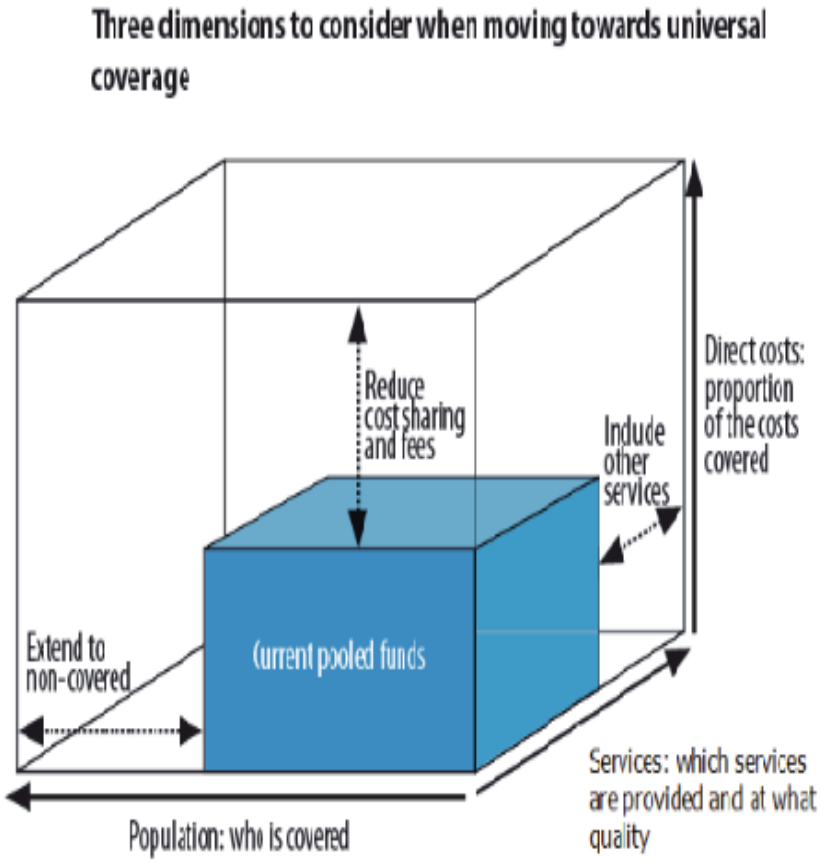


Health Goal is Not in Isolation

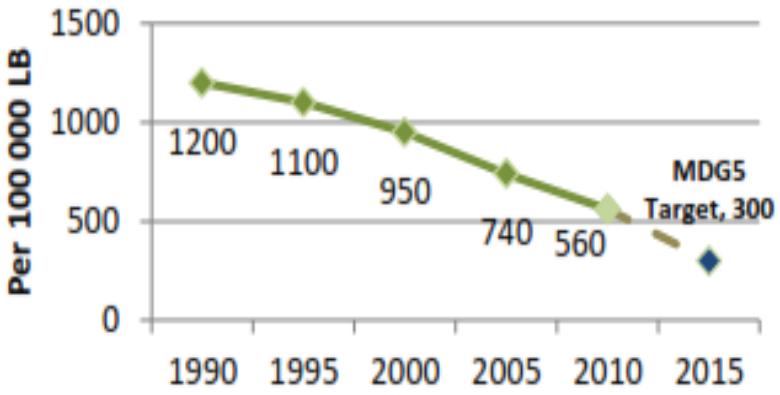
- UHC also supports achievement of other SDGs

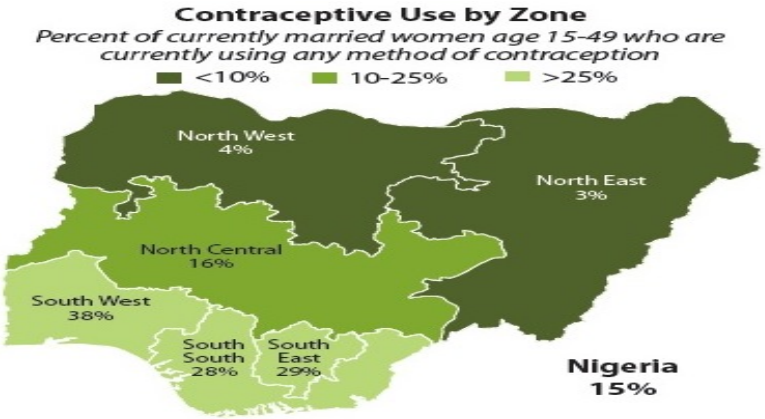
Arguing for UHC - why UHC?

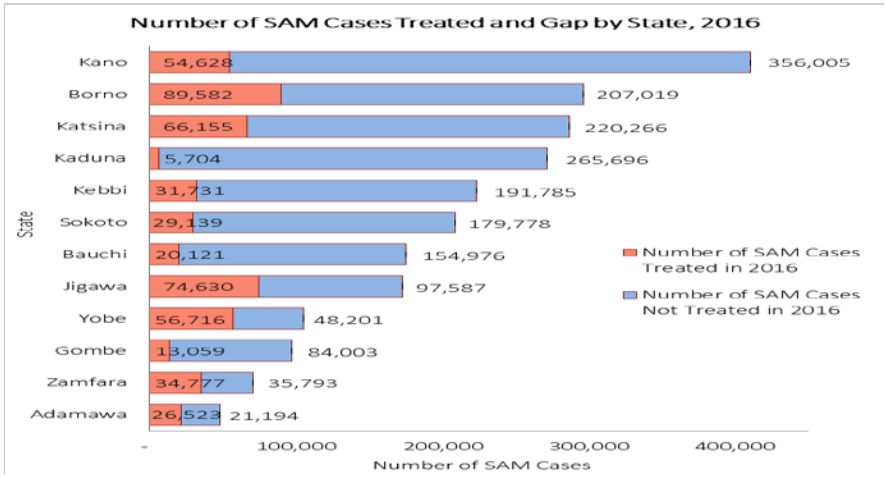


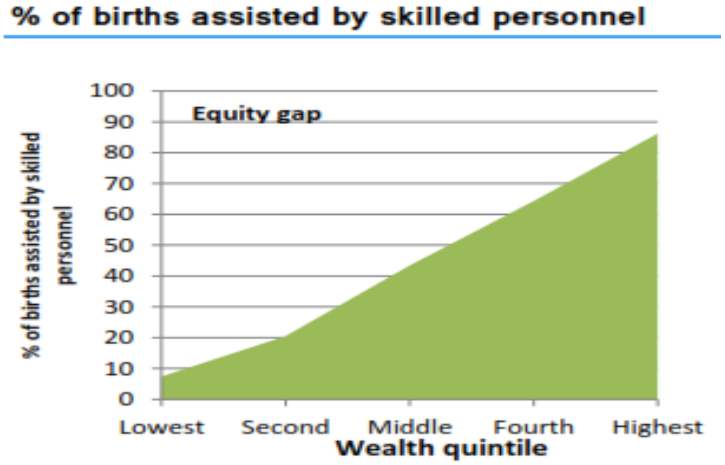


The Health and Nutrition Case for UHC I









Source: Demographic Health Survey (2013)

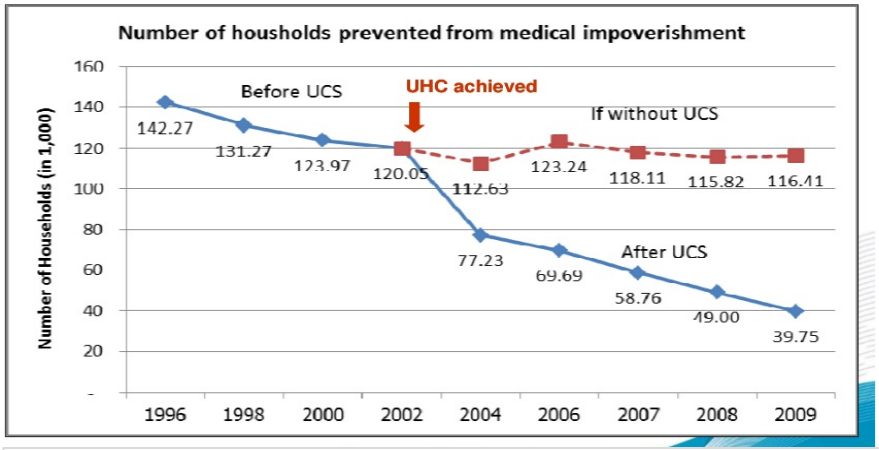
The Health Case for UHC II

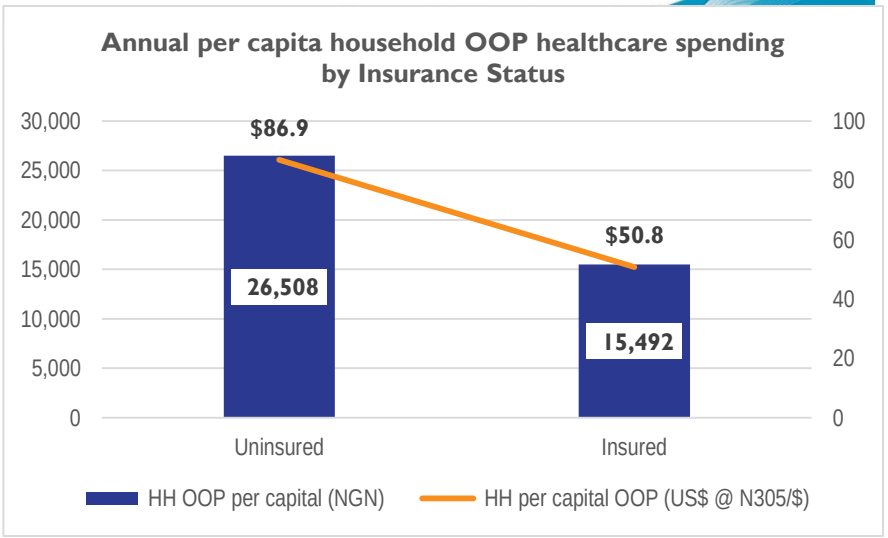
- Poor health outcomes:
  - Low progress in U5 and maternal deaths reduction
  - Health related MDGs not met
- Suboptimal service coverage level
  - Less than a quarter SBA in some geopolitical zones
- Inequity in access to basic health services
  - SBA is 10 times higher among the highest income group
  - Children from lowest income group are 3 times more likely to die before their fifth birthday
- Epidemiological transition
  - Double disease burden and its implications
  - Chronic diseases are more expensive to manage

The Economic Case for UHC

- Poverty reduction
  - Reduced incidence of catastrophic expenditure
  - Improved productivity
- Economic growth
  - 24% of the growth in full income in LMICs between 2000 and 2011 resulted from health improvements
  - One year of added life expectancy increases GDP by 4%
- Employment creation
  - Health sector is large employer of labor – NHS example
  - Improved service affordability means increase service production

UHC is effective for poverty reduction





The Social Case for UHC – Social Protection in Health

- Protection from health risk
  - Epidemiologic surveillance
  - Health promotion
  - Disease prevention
  - Regulation on food and drugs
- Patient protection
  - Availability and quality of care
  - Safety
  - Effectiveness
  - Responsiveness
- Financial protection
  - Protection from catastrophic health expenditure

The political case for UHC

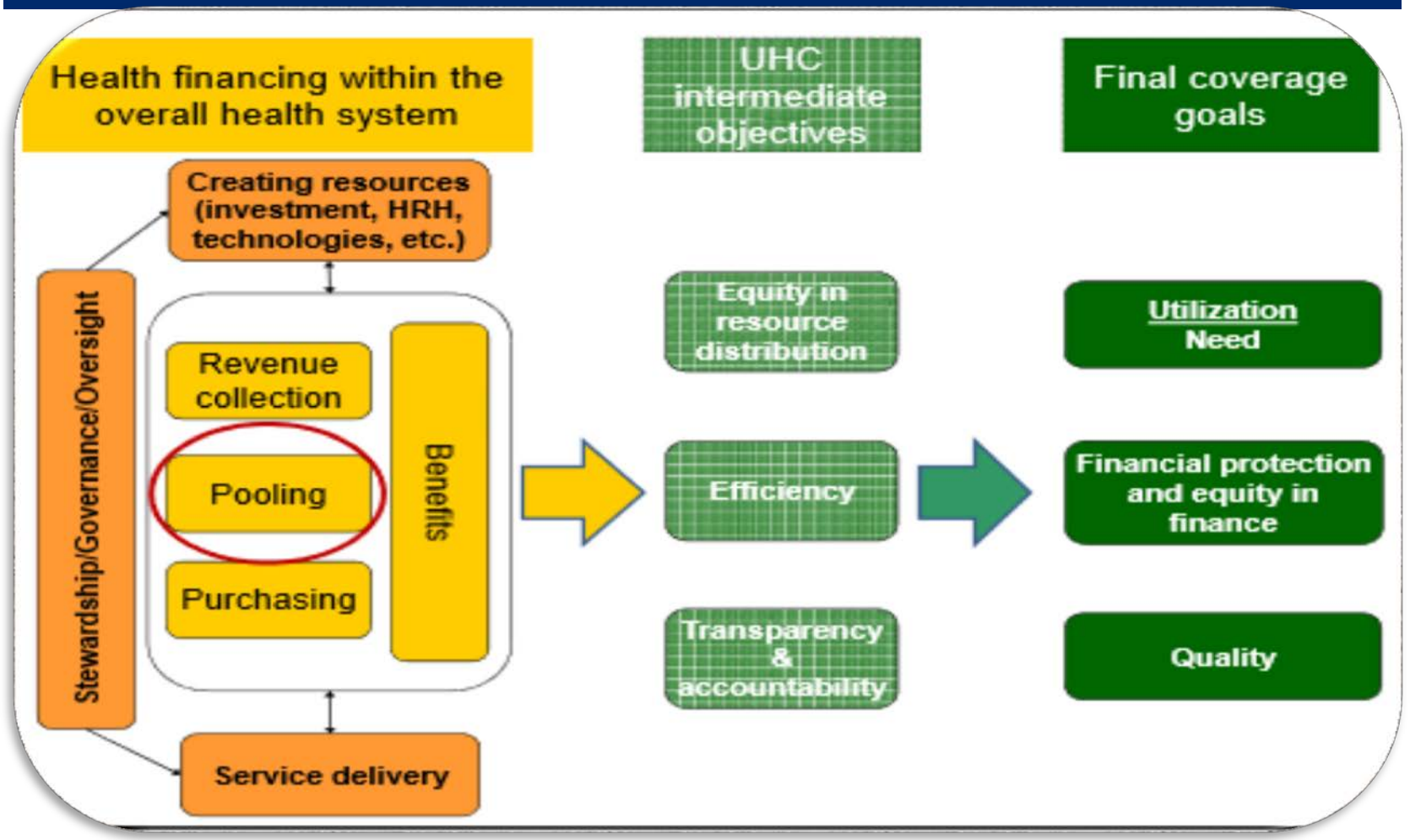
COUNTRY	YEAR	UHC REFORM	POLITICAL TIMING / REASON
United Kingdom	1948	Tax financed National Health Service with universal entitlement to services	Welfare state reforms of new government following the Second World War
Japan	1961	Nationwide universal coverage reforms	Provide popular social benefits to the population
South Korea	1977	National health insurance launched	Flagship social policy of President Park Jung Hee
Brazil	1988	Universal (tax-financed) health services	Quick-win social policy of new democratic government
South Africa	1994	Launch of free (tax-financed) services for pregnant women and children under six	Major social policy of incoming African National Congress Government
Thailand	2001	Universal coverage scheme extends coverage to the entire informal sector	Main plank of the populist platform of incoming government
Zambia	2006	Free health care for people in rural area (extended to urban areas in 2009)	Presidential initiative in the run up to elections
Burundi	2006	Free health care for pregnant women and children	Presidential initiative in response to civil society pressure
USA	2012	National health reforms designed to reduce number of people without health insurance	Major domestic social policy of the President

Measuring UHC: It is a challenge!

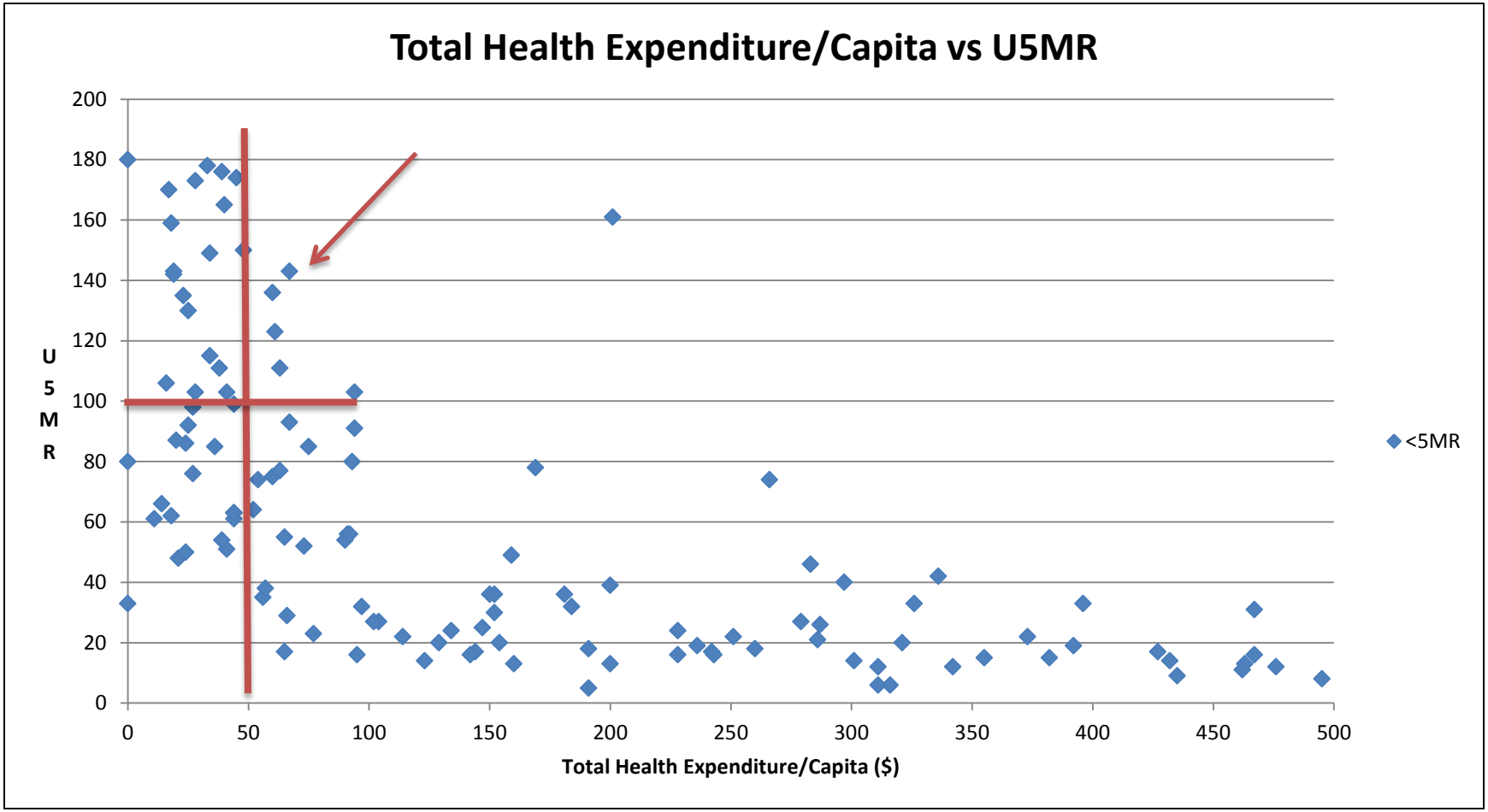
- WHO and World Bank UHC Measurement Framework (2014)
- Population coverage with equity
  - Disaggregate population coverage by gender, wealth quintile, place of residence
- Health service coverage
  - Antenatal care (% pregnant women)
  - Skilled birth attendance (% pregnant women)
  - Immunization (% children)
  - % SAM cases treated
- Financial protection
  - Households experiencing catastrophic health expenditure (%)
  - Households pushed into poverty (%)

How do we finance UHC?

Health Financing and UHC Goals



More Money for Health and More Health for the Money



Can Current Spending Level Buy UHC?

Benchmark	Recommended/Target	Nigeria Values
Government Expenditure per capita	$86 per capita	$31 (2013)(36%)
Budgetary allocation to the Health sector	Target is 15%	4.6% (2016)
% of GDP devoted to healthcare(Govt)	5%	1% (2013)
Household expenditure on Health as a % of Total Health Expenditure	<30%	73% (2013)
Level of Financial risk protection	90%	< than 5% of the pop

Re-Prioritization of Health

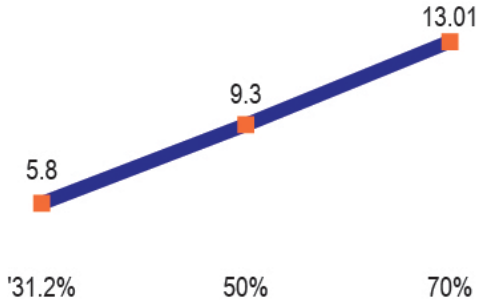
Health Allocation & Performance

- Good at current level - 16.1%
- But budget performance in 2016
  - 31.2% = 5.8b NGN.
- If improved to 70% Performance
  - Additional 7.2b NGN

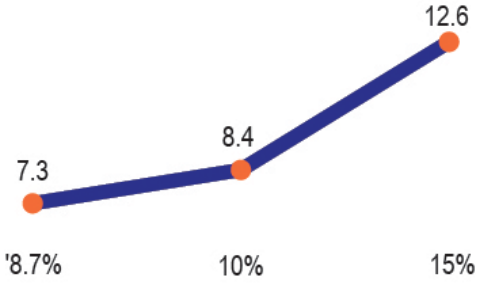
Health Expenditure (HE)

- HE % of Govt expenditure is suboptimal – 8.7%
- At 15%
  - Additional 5.3b NGN
- At 10%
  - Additional 1.1b NGN

Health spending at varying budget allocation performance



Health spending at varying expenditure performance

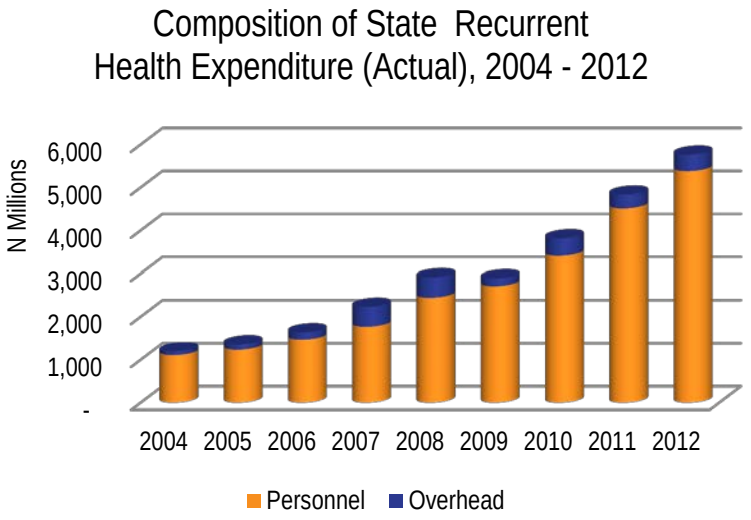


We Need to be More Efficient

Sources of inefficiency

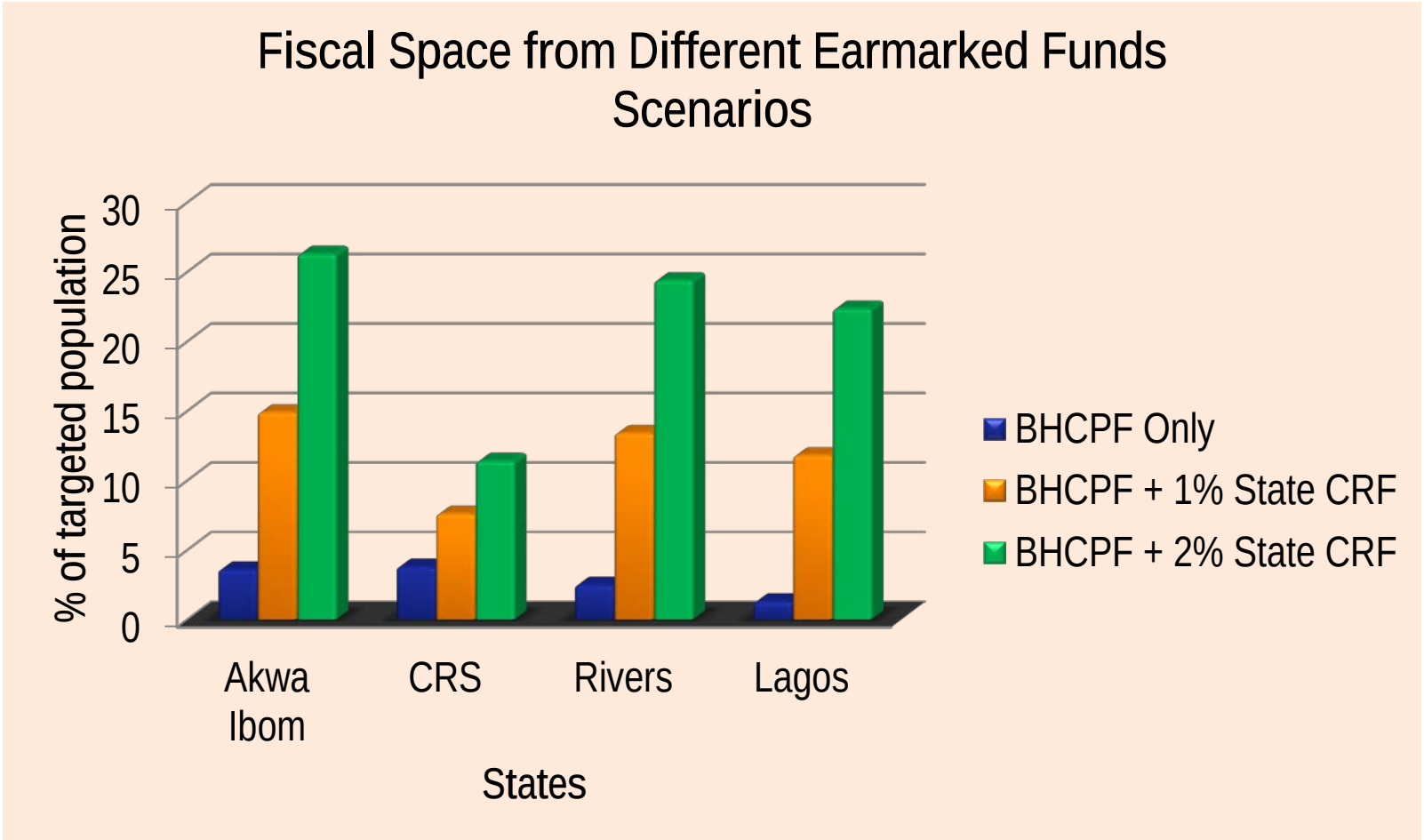
- Organisation of health system
  - Proliferation of 'political' facilities
- Commodity and supply mgt.
  - Generic vs branded drugs
  - Non competitive pricing
  - Avoidable expiries
- Human resource for health
  - Inefficient distribution
  - 'Ghost' workers
  - Absenteeism/moonlighting
- WHO: 20-40% health resources is wasted

Inefficiency in personnel expenditure



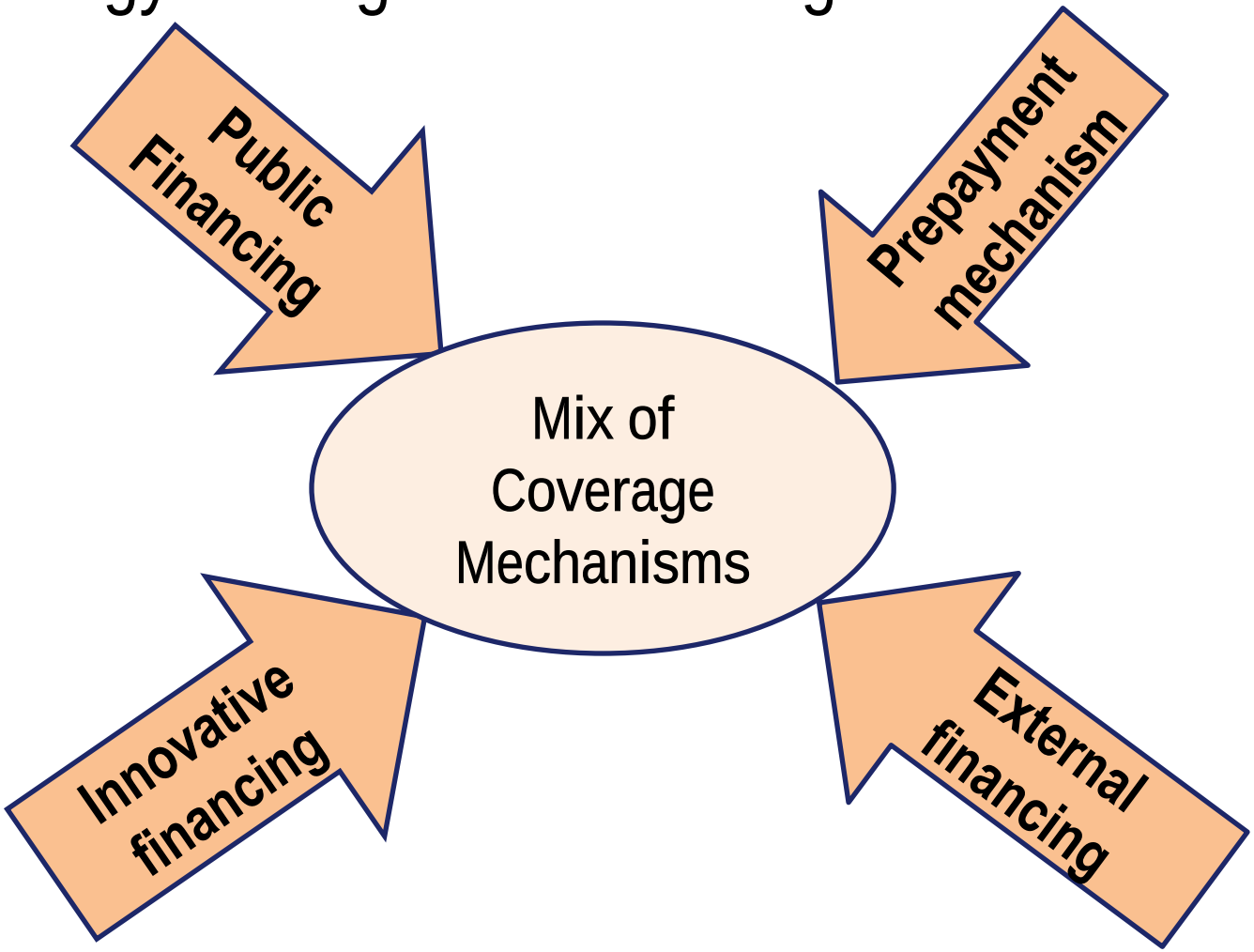
- Wage bill grew in multiple folds despite **embargo on recruitment**
- Number of midwives per 10,0000 pop. fell from 1.8 to 1 during the period

Earmarked funds can provide additional fiscal space



We Need Synergy Among Financing Mechanisms

- Synergy among mix of coverage mechanisms



Financing UHC - The Key Ingredients

- No single UHC recipe but four key ingredients:

1. Promote equitable access by removing financial barriers, especially direct payments;
2. Prepayment must be compulsory
   - Access to care based on needs, payment based on ability
3. Large risk pools are essential
4. Governments need to cover the health costs of people who can not afford to contribute.

Moving Towards UHC - The Key Steps I

- Garner political support for UHC
  - The starting point is political consensus and not technical design
- Diagnosis
  - Fiscal space analysis, governance/political economy assessment, PFM assessment, resource tracking
- Technical design
  - Trajectory of coverage expansion
  - Appropriate mix of financing mechanisms with synergy
  - Health system strengthening plan
- Institutional, policy and legal framework
- Intersectoral collaboration, sectoral coordination, citizen participation and accountability mechanism

Voice of Wisdom and Hope

"Women are not dying of disease we cannot treat …..they are dying because societies have yet to make the decision that their lives are worth saving"

- Mahmoud Fathalla

"The starting point in the journey of Universal Health Coverage is not technical but social and ethical consensus that health is human right"

Julio Frenk

"I am hopeful that our women will no more be dying during childbirth; our children will no more be dying as a result of vaccine preventable diseases or common ailment; access to health care will not be limited because of not having money to pay."

- President Muhammadu Buhari

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