2018 Commonwealth Civil Society Policy Forum

Universal health coverage: holding countries to account

POLICY BRIEF
Universal health coverage and sustainable financing

Civil Society across the Commonwealth, supported by the Commonwealth Foundation, host an annual policy forum addressing the theme of the annual Commonwealth Health Ministers' meeting (CHMM) which is held each year in Geneva on the eve of the World Health Assembly. Through the policy forum, Commonwealth civil society comes together to discuss, debate, and develop a consensus position or set of positions and recommendations and/or a declaration for action on the policy issues under discussion.

These positions or requests for action are then presented by civil society to Commonwealth Health Ministers at their meeting. The 2018 Commonwealth Civil Society Policy Forum addressed the following issues:

- UHC and sustainable financing;
- UHC and a sufficient health workforce;
- UHC and access to quality essential medicines and vaccines.

Eminent speakers addressed these three issues and recommendations were developed which were shared with civil society across the Commonwealth through an online survey to gain input into and consensus about the proposed recommendations and action to be presented to Commonwealth Health Ministers at their meeting. This policy brief addresses Universal Health Coverage and Sustainable Financing.

The recommendations presented to Commonwealth Health Ministers can be found at the conclusion of the Policy Brief. Nurses and midwives are encouraged to refer these recommendations to their government for action.

DEFINING UHC

The World Health Organisation (WHO) defines universal health coverage as "all people receiving the health services they need, including health initiatives designed to promote better health, prevent illness, and to provide treatment, rehabilitation, and palliative care of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship".[1]

The WHO go on to note that a significant number of countries, at all levels of development, are embracing the goal of UHC as the right thing to do for their citizens. UHC, the WHO say, is a powerful social equalizer and contributes to social cohesion and stability. Supporting the right to health and ending extreme poverty can both be pursued through UHC. The WHO also note that UHC is a critical component of the new Sustainable Development Goals (SDGs) which include a specific health goal: "Ensure healthy lives and promote wellbeing for all at all ages".

Within this health goal, there is a specific target for UHC:

"Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[2]

WHAT ARE THE ISSUES?

Universal Health Coverage requires countries to ensure that all people have equitable access to needed quality health care services without experiencing financial risk, such as excessive out of pocket expenses. The 2010 World Health Report, put forward a number messages central to achieving UHC:

- raising sufficient resources for health,
- removing financial risk and barriers to access,
- promoting efficiency and eliminating waste,
- addressing inequalities in coverage.[3]

There is consensus in the literature that achieving UHC requires a predominant reliance on compulsory or public funding for health services which is central to ensuring access to health services whilst also protecting individuals and families from potentially impoverishing levels of out of pocket expenses. Whilst private financing plays a role in all health systems, the WHO state that evidence clearly shows that it is public financing which drives improvements in health system performance on UHC.[4,5]

No country has attained UHC by relying on voluntary contributions to insurance schemes regardless of whether they are run by non-government, commercial or government entities.[6]

Kutzin maintains that while public funding can come from general government revenues or compulsory social health insurance contributions (eg income and payroll taxes), the allocation of general government revenues is essential, especially for poorer countries where large segments of the population may not be in salaried employment and not subject to the collection of income or payroll taxes. This position is reinforced by the WHO, commenting that there will be a proportion of the population too poor to contribute through income taxes or insurance premiums and will need subsidisation from pooled funds, generally government revenue.[7]

The answer to the question "how much public spending is enough", Kutzin notes, is not straightforward and there is no single or simple answer.[8]

A number of health expenditure targets exist but there is no agreed formula. These include targets based on absolute spending amounts and those based on spending relative to a denominator such as GDP or total government spending and there are wide variations between targets.

To add to the confusion, targets and estimates are not always explicit in stating whether they are referring to public expenditure on health as a percentage of GDP or total spending on health as a percentage of GDP.

The 2010 WHO World Health Report comments that "those countries whose entire populations have access to a set of services usually have relatively high levels of pooled funds in the order of 5-6% of gross GDP".[9]

Many countries however have achieved a high degree of UHC with less than 6% of GDP (Sri Lanka 3.5%; Malaysia 4.2%; and Jamaica 5.4%).[10] Conversely many Commonwealth countries already spend much more than 6% of GDP without achieving UHC. [11]

Although there is no agreed formula, it is clear that many households forgo care or face financial risk from out of pocket expenses or payment at time of service in those countries that rely predominantly on private sources of health care. It is also apparent that even at low levels of public spending, countries can make significant steps toward UHC.

UHC FUNDING MODELS

The two most commonly reported UHC financing systems are:[12]

(a) Social health insurance (or the Bismarck Model): Insurance contributions from government, employers and individuals are used to finance a public insurance scheme that pays for services, usually by private providers (examples include *Germany, Japan and Korea*). Kutzin notes however that countries that have initiated financing reforms with a health insurance scheme solely for particular groups such as the formal workforce, are focusing attention and resources on already advantaged and well organized groups, which tends to exacerbate rather than redress inequalities.[13] Government contributions are still required for those who are not covered by the social health insurance or who cannot afford to pay.

(b) Tax-funded systems (or the Beveridge Model): General revenue taxation is used to pay for the bulk of all health care services delivered predominantly, although not exclusively, through a public sector delivery system (examples include *United Kingdom, Sweden and New Zealand*). In this model, most, but not all hospitals and clinics are owned by the government: some doctors are government employees however there are also private doctors who collect their fees from the government and private hospitals and clinics.

These models, or their variations, face challenges however requiring at least 3% of GDP and often more. In developing countries this may be difficult to achieve because of the limited capacity of low-income countries to raise taxation funding or social insurance contributions to implement either Beveridge or Bismarck approaches to achieve UHC.

(c) Less researched is a mixed model of public and private health care provision which appears to achieve UHC at a surprisingly low proportion of GDP.[14] This model combines public provision of a universal package of health services for all, both rich and poor, with private health care provision meeting consumer demand for 'add on' services, such as reduced waiting times, doctor of choice, and enhanced amenities such as private rooms and choice of food. Examples include: Jamaica and many of its English-speaking Caribbean neighbours, Sri Lanka, Malaysia, Hong Kong, Ireland and Australia. Sri Lanka and Malaysia have achieved a high degree of UHC with public spending of 2.0% and 2.3% GDP and have health indicators comparable or better than some high income countries.[15]

In all cases of these mixed models reviewed, governments focused on maximizing universal or equitable access to a universal package of services for both rich and poor, and reducing exposure to financial risk, whilst minimizing government spending. Limited public funding benefits the poor more than the rich, not by means testing, but by differences in consumer quality.

WHAT NEEDS TO BE DONE AND HOW?

A significant number of countries are embracing the goal of UHC as the right thing to do for their citizens. UHC promotes social equality, social cohesion, and stability. Achieving UHC is also one of the health goals of the Sustainable Development Goals.

UHC that provides equitable access to needed health services for the entire population without exposing them to financial hardship is a priority for civil society across the Commonwealth. Commonwealth Health Ministers need to involve all sectors of government and civil society stakeholders in their countries in decisions about how UHC is to be provided and financed.

In addition, steps need to be put in place to define 'high priority' health services based on cost-effectiveness; prioritizing health services for the poor; and providing financial risk protection.

Monitoring indicators could include coverage of these 'high priority' health services; household expenditures on heath as a share of total household expenditure and income; % of GDP spent on health (public/private); health outcomes such as infant mortality and life expectancy; and measures of financial risk protection, such as out of pocket expenditures on inpatient and outpatient care by income group.

Achieving and funding UHC is a significant challenge for countries, particularly low-income countries. Although calls to increase the overall proportion of GDP allocated to UHC should be supported, it is also important that quality core clinical care is provided in the most cost-effective manner if UHC is to be achieved.[16]

Empirical evidence suggests that amongst low and middle-income economies, mixed public/private health care models as described earlier have performed well in terms of health outcomes and have generally achieved this at a lower cost than the better-known UHC models, Beveridge and Bismarck.

The Commonwealth is in a unique position to examine the financing models of Commonwealth countries who have achieved, or mostly achieved UHC, to identify key characteristics and share these within the Commonwealth.

UHC SURVEY

Number of returns:	70
Europe:	16 (23%)
Asia:	15 (21%)
Pacific:	3 (4%)
Africa:	23 (33%)
International:	4 (6%)
Caribbean and Americas:	8 (11%)
Not stated:	1 (1%)
Female:	35 (50%)
Male:	33 (47%)
No response:	2 (3%)

RECOMMENDATIONS

1. By 2020, all Commonwealth governments have developed national UHC plans, with community-inclusive multi-stakeholder input. Publicly funded 'high priority' health services in terms of outcome and cost-effectiveness should be clearly defined and publicly communicated.
   Survey responses
   YES: 60 (86%)
   YES with revision: 8 (11%)
   NO: 2 (3%)

2. That Commonwealth governments include in their UHC plans strategies for access to safe, effective, quality and affordable essential medicines and vaccines for their citizens.
   Survey responses
   YES: 64 (91%)
   YES with revision: 6 (9%)

3. By 2020, all Commonwealth governments have developed mechanisms to monitor their UHC plans by, but not limited to, the following measures:
   - usage of 'high priority' health services by income group and area of residence,
   - household expenditure on health as % total household expenditure and income,
   - % GDP spent on health (public/private),
   - health outcomes,
   - measures of financial risk such as out of pocket expenditures on both inpatient and outpatient care by income group.

   Survey responses
   YES: 62 (88%)
   YES with revision: 6 (9%)
   NO: 2 (3%)

REFERENCES

1. World Health Organisation. *Tracking universal health coverage: first global monitoring report.* 2015. p.viii: http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf).
2. United Nations. *Sustainable Development Goals. Goal 3 2015:* http://www.un.org/sustainabledevelopment/health/#7e9fb9b0ec8c8e6e6).
3. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010: http://www.who.int/whr/2010/en/).
4. Jowett, J. and Kutzin, J. *Raising revenues for health in support of UHC: strategic issues for policy makers.* WHO Health Financing Policy Brief No.1 2015 p.2: http://apps.who.int/iris/bitstream/10665/192280/1/WHO_HIS_HGF_PolicyBrief_15.1_eng.pdf.
5. Jowett M, Brunal MP, Flores G, Cylus J. 2016. *Spending targets for health: no magic number*. WHO Health Financing Working Paper No.1 p.3: http://www.who.int/health_financing/documents/no-magic-number/en/).
6. Kutzin, J. *Anything goes on the path to universal health coverage?* 2012. Bulletin of the World Health Organization 90:867-868: http://www.who.int/bulletin/volumes/90/11/12-113654/en/).
7. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010 p.xiv: http://www.who.int/whr/2010/en/).
8. Kutzin, J. *Anything goes on the path to universal health coverage? No.* 2012. Bulletin of the World Health Organization 90:867-868: http://www.who.int/bulletin/volumes/90/11/12-113654/en/.
9. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010 p.xv: http://www.who.int/whr/2010/en/.
10. World Bank. *Health expenditure % GDP*: http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.XPD.TOTL.ZS&country.
11. Jowett M, Brunal MP, Flores G, Cylus J. *Spending targets for health: no magic number*. Geneva: WHO; 2016 (WHO/HIS/HGF/HFWorkingPaper/16.1; Health Financing Working Paper No.1. p.3): http://www.who.int/health_financing/documents/no-magic-number/en/.
12. Rannan-Eliya, R., Amarasinghe, S. and Nilamudeen, A. *Universal health coverage: the potential contribution of hybrid funding strategies*. 2016. Institute of Health Policy Sri Lanka: http://www.chpa.co.
13. Kutzin, J. *Anything goes on the path to universal health coverage? No.* 2012. Bulletin of the World Health Organization 90:867-868. http://www.who.int/bulletin/volumes/90/11/12-113654/en/.
14. Rannan-Eliya, R., Amarasinghe, S. and Nilamudeen, A. *Universal health coverage: the potential contribution of hybrid funding strategies*. 2016. Institute of Health Policy Sri Lanka: http://www.chpa.co.
15. World Bank. *Health expenditure, public, % of GDP*. http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.XPD.PUBL.ZS&country.
16. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010 p.xvi:
17. http://www.who.int/whr/2010/en/World Bank. *Health expenditure, public, % of GDP*. http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.XPD.PUBL.ZS&country.
18. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010 p.xvi: http://www.who.int/whr/2010/en/