UNIVERSAL HEALTH COVERAGE: the potential contribution of hybrid funding strategies

A review of Commonwealth Mixed Public-Private Funding Models

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Executive Summary

Introduction

Commonwealth nations together with the other members of the global community have committed to a shared goal of universal health coverage (UHC) by 2030. This requires countries to move toward ensuring that all people have equitable access to needed quality health care services without experiencing financial risk.

To achieve this, countries need to mobilize sufficient public financing in the form of tax-financing or social health insurance. A key reason for this is to minimize out-of-pocket spending so as to reduce the exposure to financial risk. Two pathways to do this and achieve UHC are usually cited and offered to developing countries.

The Beveridge model involves using general revenue taxation to pay for the bulk of all health care services, usually, but not necessarily, delivered by a public sector delivery system.

The alternative Bismarck model involves using contributory social health insurance to finance a public scheme that pays for services by usually private providers. It provides benefits only to those who contribute, and coverage is limited to formal sector workers from whom mandatory deductions for insurance can be collected. In the second half of the 20th Century, many countries modified this prototype by using general revenue taxation to extend coverage beyond the formal sector to the whole population, often on a non-contributory basis.

Whether countries adopt the Beveridge or Bismarck models, in practice they need to mobilize at least 3% of GDP or more in either tax-financing or social health insurance or both. This is a minimum level of public financing, equivalent to what it cost the UK to establish the British NHS in 1948.

Most developing countries that are held up as UHC success stories have in fact had to mobilize even more, including Thailand (4%) and Brazil (4%). The problem is that these levels of public financing are in practice not realistic in the poorest developing countries.

Taxation and social health insurance compete for the same sources of money. The capacity of developing countries to raise money through either mechanism is inherently less than rich ones, owing to their smaller formal sectors and weaker administrative capacities.

Low-income developing countries mobilize in taxes only 13% of GDP, which means that the poorest countries would need to allocate a quarter or more of their government budgets to health in order to implement either the Beveridge or Bismarck approaches. This is not realistic, and not surprisingly no low or lower-middle income nation has been able to achieve UHC through either the Beveridge or Bismarck models.

The hybrid or mixed public-private financing model

Despite necessary realism or pessimism about whether the Beveridge or Bismarck models offer viable routes to UHC in developing countries with limited money, there is evidence that a few developing countries (and also advanced economies) have been able to progress substantially toward UHC, despite modest levels of government spending and using approaches that do not fit either the Beveridge or Bismarck models. These cases include Jamaica, Sri Lanka, Malaysia, Hong Kong, Ireland and Australia. All of these are either members of the Commonwealth, or have close links with Commonwealth nations. Their experiences have been given scant attention in the global discussion, and they are rarely cited as potential role models for UHC.

Yet, the evidence shows that they tend to out-perform in overall health outcomes, achieve high levels of equitable access to health care and good financial protection, whilst spending less than their peers. Although these health systems come from all parts of the world and all stages of economic development, we show that they share many common features, indicating that they represent an unrecognized third approach to financing progress toward UHC.

In all the cases reviewed in this study, governments have focused on maximizing universal or equal access to services for both rich and poor, and reducing exposure to financial risk, whilst minimizing government spending. Government financing has been exclusively tax-based, with no adoption of social health insurance mechanisms. All experts agree that universal health coverage will never be achieved without the significant contribution of public funds.

In all the cases, government funding is used to pay for a universal package of services available at zero or minimal cost on an equal basis to both rich and poor.

In Jamaica, Sri Lanka, Malaysia and Hong Kong, governments have funded a public delivery system, whilst Australia and Ireland also use public funding to pay for access to private doctors and hospitals. The publicly funded package in each case includes substantial funding for hospitals and inpatient treatment, ensuring that the poor are not exposed to significant financial risk. Governments have also taken steps to ensure that the publicly funded set of services is genuinely available to the poor by building a widely dispersed delivery network where necessary.

Despite the strong emphasis on public funding, the need to minimize government spending has meant that all the governments have been unable to increase spending to emulate either the Beveridge or Bismarck models. Instead they have had to allow private financing and provision to fill the gap.

However, unlike most developing countries, where under-funded public systems benefit the rich more than the poor, these health systems have managed to ensure that their limited public funding benefits the poor more than the rich. This has generally been achieved not by explicit targeting or means testing, but by using differences in consumer quality to encourage the non-poor to voluntarily seek out and pay for private care.

Richer patients desire greater doctor choice, shorter waiting times and better amenities in their hospitals and clinics. In these hybrid systems, the government has generally skimped on providing these aspects of service, whilst focusing on maintaining the availability of the core clinical components of care.

Consequently, richer patients have gone to the private sector to obtain these, allowing the limited amount of public funding to pay for comprehensive services, albeit with lower consumer quality, for the poor. Whilst the rich end up using more private services than the poor, the pro-poor reach of the public scheme in each case has ensured reasonable equity in overall access to medical care.

Implications

For the global community

This short review has identified a number of health systems at all levels of economic development that have adopted a common approach to financing and delivering health care that differs significantly from the standard Beveridge and Bismarck models. In all these systems, governments spend much less on health care than their peers. Yet, we have noted that they generally out-perform their peers in terms of access to health care and ultimate population health outcomes.

The challenge of achieving UHC – equitable access to quality health care combined with financial risk protection – has been accepted by the global community as a shared goal over the next two decades. In order for this goal to be realized, developing countries need realistic options to expand coverage. Realism requires finding strategies that are compatible with the limited fiscal capacity that is an inevitable corollary of being a developing nation. The evidence indicates that the standard Beveridge and Bismarck models are not fiscally feasible in most developing nations. They both require substantial spending of tax monies that poor countries cannot realistically afford. The global community and developing countries in particular need additional options that help extend coverage without breaking the bank.

There is sufficient evidence to indicate that the hybrid systems we have detailed have found one answer to this challenge of improving coverage with limited fiscal resources. However, they have generally not been the object of the intensive global search for solutions but they are worth further analysis.

The leading international organizations – the World Bank, WHO and other bilateral development agencies, as well as countless independent initiatives and academic investigations, have paid little attention to these examples. There is little awareness of what they have achieved, or how they have done this. Given the enormity of the challenges facing poor countries as they strive toward UHC the time has come for a proper look at these experiences to identify what has been critical and what can be learnt and transferred.

For the Commonwealth

Almost all the cases identified have their roots in the Commonwealth, and are either members of the Commonwealth or have strong links with Commonwealth nations.

This is not a coincidence. It stems from a fortuitous combination of common institutional legacies and shared policy discourses.

We have noted that the global community has tended to ignore these experiences, despite their great relevance to contemporary development challenges. This has been a loss not only to the global community as a whole, but also Commonwealth nations.

The large majority of Commonwealth nations still face the challenge of how to move toward UHC whilst still economically developing and managing with limited fiscal resources. Yet, it is unfortunately true that most of these Commonwealth nations know more about the success stories outside the Commonwealth than the hidden success stories within the Commonwealth. This represents a loss not only for the Commonwealth as a whole, but also a failure to realize the benefits that flow from a shared history and common sets of values.

Given the past failure of the global community to look more closely at these success stories in the Commonwealth, we urge Commonwealth nations to:

- look more closely themselves at this experience within the Commonwealth, and
- work with and encourage others to take more seriously these experiences.

Practical actions include fostering a systematic program of investigation to understand and document these hybrid systems better, and creating mechanisms to share understanding of the critical elements of these systems with other Commonwealth nations.

Recommendations

The challenge of achieving UHC – equitable access to quality healthcare combined with financial risk protection – has been accepted by the global community as a shared goal over the next two decades.

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There is sufficient evidence to indicate that the hybrid systems we have detailed have found one answer to this challenge of improving coverage with limited fiscal resources. We recommend that the Commonwealth and the wider global community:

Recommendation 1
Give more serious attention and prominence to the experience of these hybrid health systems as potential role models for achieving UHC in developing countries.

Recommendation 2
Support efforts to systematically document and assess these experiences in order to identify lessons that can be transferred to other countries.

Recommendation 3
Support the sharing of these experiences between Commonwealth nations as part of the Commonwealth's shared heritage.

Key indicators for selected mixed model systems and comparable peers (2013)

	Hong Kong	Ireland	Australia	UK	New Zealand	Germany
Health system type	Mixed	Mixed	Mixed	Beveridge	Beveridge	Bismarck
Infant mortality rate (deaths/1,000 live births)	1.8	3.2	3.4	3.9	5.2	3.2
Life expectancy at birth (years)	84	81	83	81	82	81
Skilled birth attendance (%)	99	100	99	99	97	99
Hospital discharges per 100 people	18	13	17	13	15	25
Doctor consultations per person	11	4	7	5	4	10
Government health spending (%GDP)	2.6	5.5	5.9	7.0	7.6	8.4
Private health spending (% of total health expenditure)	36	32	33	16	17	23

Source: World Health Statistics 2015 (World Health Organization 2015), and Food and Health Bureau, Government of the Hong Kong Special Administrative Region (http://www.fhb.gov.hk) for additional statistics for Hong Kong [accessed 10 May 2016].

Key indicators for selected mixed funding model systems (2013)[18, 19]

	Sri Lanka	Jamaica	Malaysia	Hong Kong
Income category	Lower-middle	Upper-middle	Upper-middle	High
GDP per capita (USD constant 2005)	1,977	4,094	7,052	33,639
Infant mortality rate (deaths/1,000 live births)	8.7	14.4	6.4	1.8
Life expectancy at birth (years)	74.7	75.5	74.6	83.8
Skilled birth attendance (%)	99	99	99	99
Government health spending (%GDP)	1.6	3.4	2.2	2.6
Out-of-pocket health spending (% of total health expenditure)	44	25	36	36

This report was prepared by Ravindra Rannan-Eliya, Sarasi Amarasinghe, and Amaani Nilamudeen from the Institute for Health Policy Sri Lanka for the Commonwealth Health Professions Alliance (http://www.chpa.co) on the occasion of the 2016 Commonwealth Health Ministers' meeting where the goal of universal health coverage (UHC) was the focus of discussion. The report highlights a funding model to achieve UHC which has been successfully implemented by a number of Commonwealth countries and recommends further examination of this 'hybrid' model for wider adoption. The study was funded by the Commonwealth Foundation.