Universal Health Coverage (UHC): Myths and Challenges

Insight Thursday, ADB
Nov 10 2016

Soonman KWON, Ph.D.
Technical Advisor (Health)
ADB

1. Financial Protection for UHC

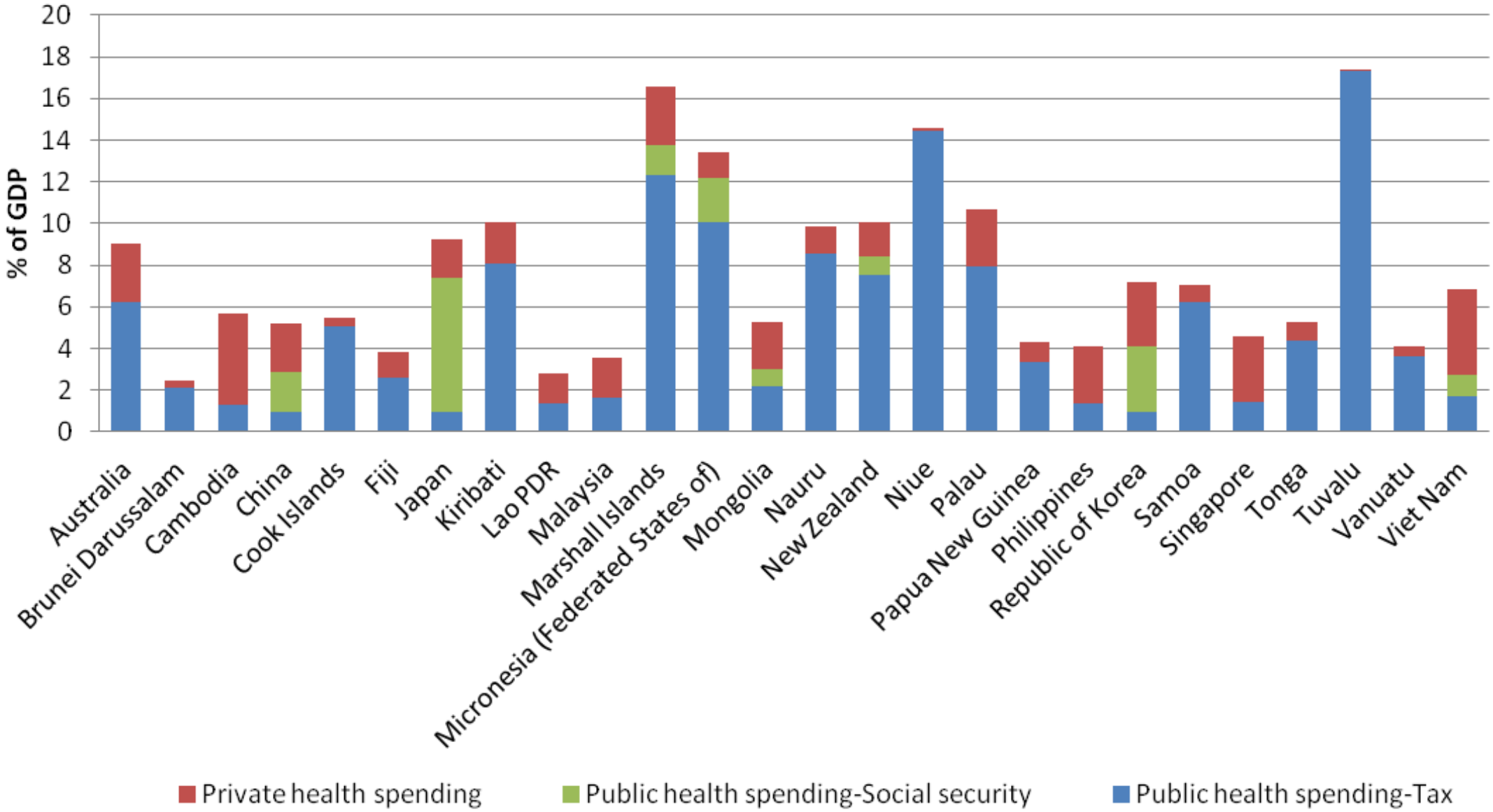
GOAL: Access to quality health care without financial hardship

-> Maximize the role of public pre-paid financing, e.g., tax and SHI (Social Health insurance), and minimize out-of-pocket (OOP) payment at the point of service

Evidence in Asia: Huge OOP pay results in
Catastrophic payment for health care,
Impoverishment due to illness, and Unmet need

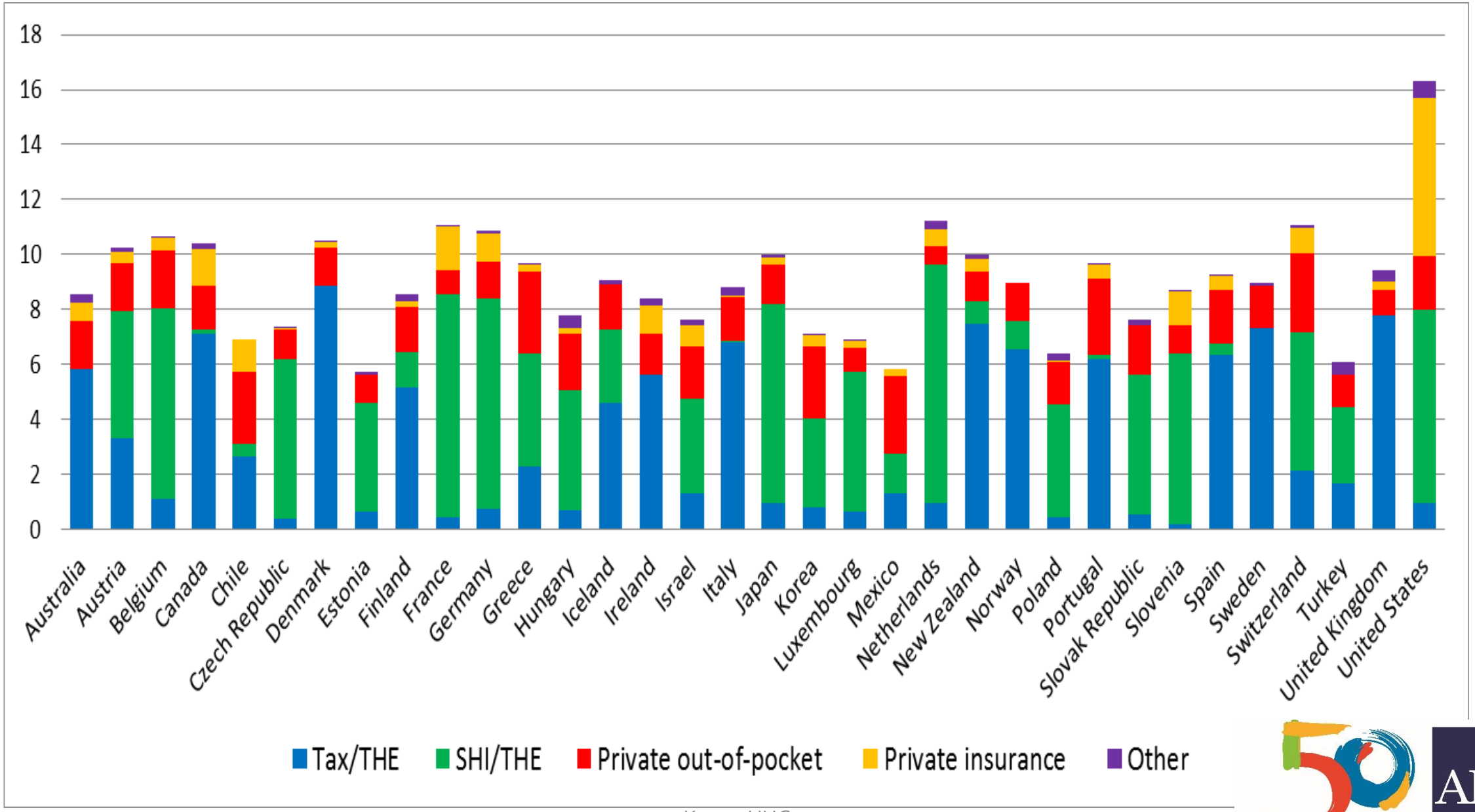
Progress toward UHC Should
- Pay attention not only population coverage
but also *benefit/cost coverage*
- Protection of vulnerable population: equity matters

Financing Mix and Health Expenditure as a % of GDP



Source: WHO, 2013

Health Expenditure as % of GDP, 2011 (OECD)



Source: OECD Health Statistics (2013), World Bank data (2014)

2. How to ensure more People have Access to Health Care?: Population Coverage

- Mandatory public financing
  - Principle of social solidarity
  - Income-based contribution is not possible in voluntary financing

- Political mobilization and commitment: role of subsidy
  e.g., People's Republic of China (PRC), Thailand

- Unique ID and ICT as infrastructure:
  targeting, enrollment management (India)

- Social marketing, health care literacy

3. Where the Money Comes from?: Funding

- Putting various sources of public revenue in a big pool for effective purchasing of health care for people

- Mandatory contribution: Japan, Korea, Taipei,China
- Earmarked consumption tax (Ghana), earmarked non-wage income tax (France, Taipei,China)
- General revenue: Subsidy for the informal sector in PRC, Thailand

4. Which Services to Provide?: Service Coverage

- Purchase continuum of care (integrated service delivery)
  - need good referrals, quality primary care

- Cannot cover every service
  - Need priority setting for essential services, How?
  - Essential service (benefit) package is still loosely defined, and the process to determine it is not transparent in most countries

- Should institutionalize a formal process based on
  - Evidence: economic evaluation, reduce political manipulation
  - Social value judgement: citizen participation,
    high-level (e.g., tri-partite) committees

5. Purchasing, Service Delivery and Providers

- How to maximize purchasing power of health financing agency
- Single pool rather than multiple pools
- Capacity and incentive for the purchasing agency

- Should Revitalize **Primary Care**
- Gatekeeping for efficiency
- Front-line providers in health security issues, e.g., infectious disease
- Focal point for the continuum of care for older people
- Prevention and promotion for NCDs:
  e.g., physical exercise, health education,
  community-based intervention

6. Challenges of Population Ageing

Universal access to health care for all people, regardless of age

- Health in the entire life course

Extend the benefit package of existing schemes and essential medicines list to cover NCD (Non-Communicable Disease)s and services for older people

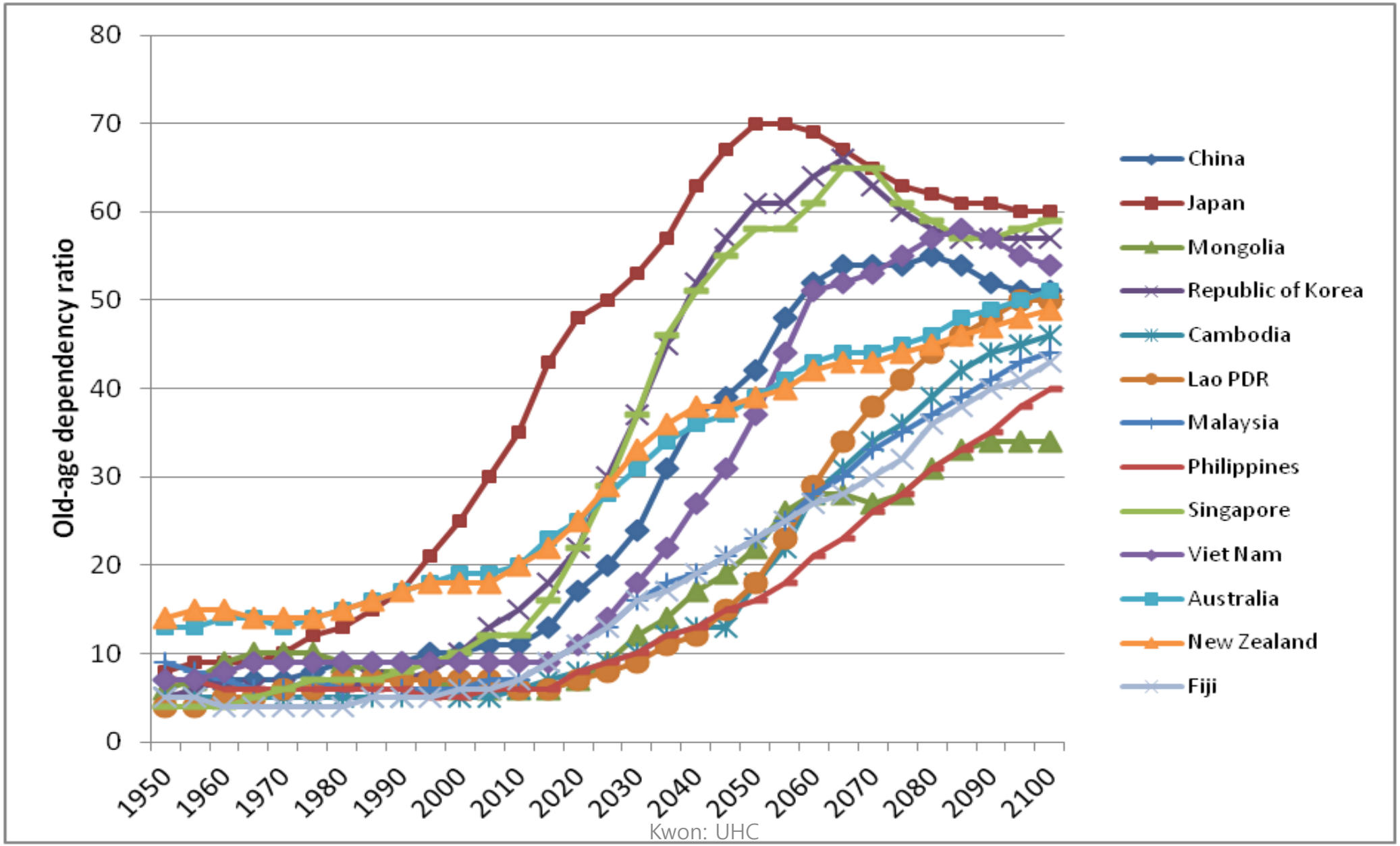
Larger number of (older) people after retirement:

Financing that relies on formal labor market faces challenges

Continuum of care: Coordination between health care and long-term care

-> overcome discontinuity and fragmentation among service providers (HC, LTC, rehabilitation, community care, etc.)

Old-Age Dependency (65+/(20-64))



Kwon: UHC

Further Thoughts: Role of ADB

- Integrated Delivery System: With weak primary care system, UHC (with reduced financial barrier to health care) may distort the system toward hospital-based care with cost escalation (low financial sustainability)

  -> Strong public health centers and referral hospitals/systems

- Investment in Health: increases labor productivity, investment in education, and capital accumulation

  -> Political will, prioritization and role of MoF

- Multi-sectoral approach: education, environment, water, sanitation, urban design, etc.