# FINANCING UNIVERSAL HEALTH COVERAGE

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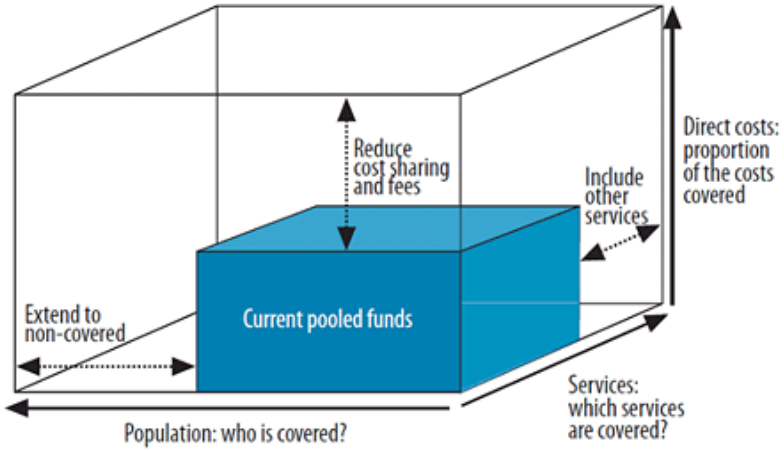
ADB–ADBI Regional Inception Workshop: Strategies for Financing Social Protection to Achieve SDGs in DMCs
17-18 May 2018, ADBI Tokyo, Japan

# Universal Health Coverage

- **Provide all people with access to needed health services** (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective;

- Ensure that the **use of these services does not expose the user to financial hardship**;

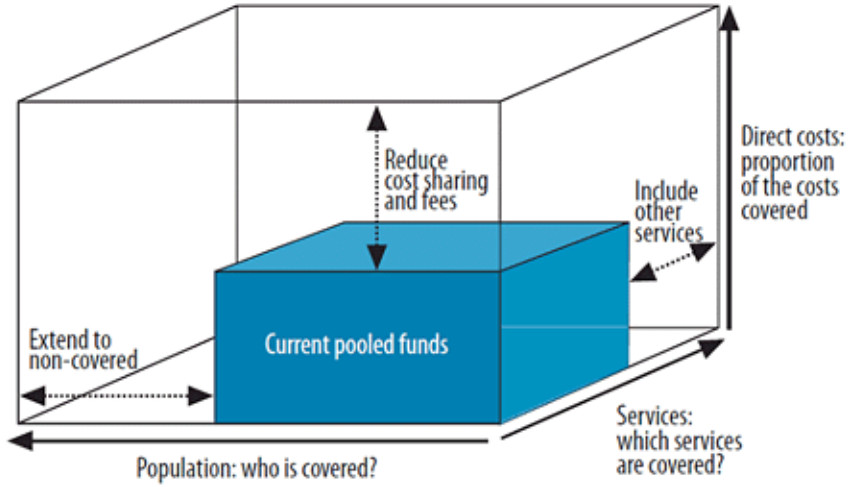



Three dimensions to consider when moving towards universal coverage

- **State has the central role** in securing funding for healthcare, regulating the quality and range of services, and ensuring access to health services

# Measuring UHC

**What health services should be included?**

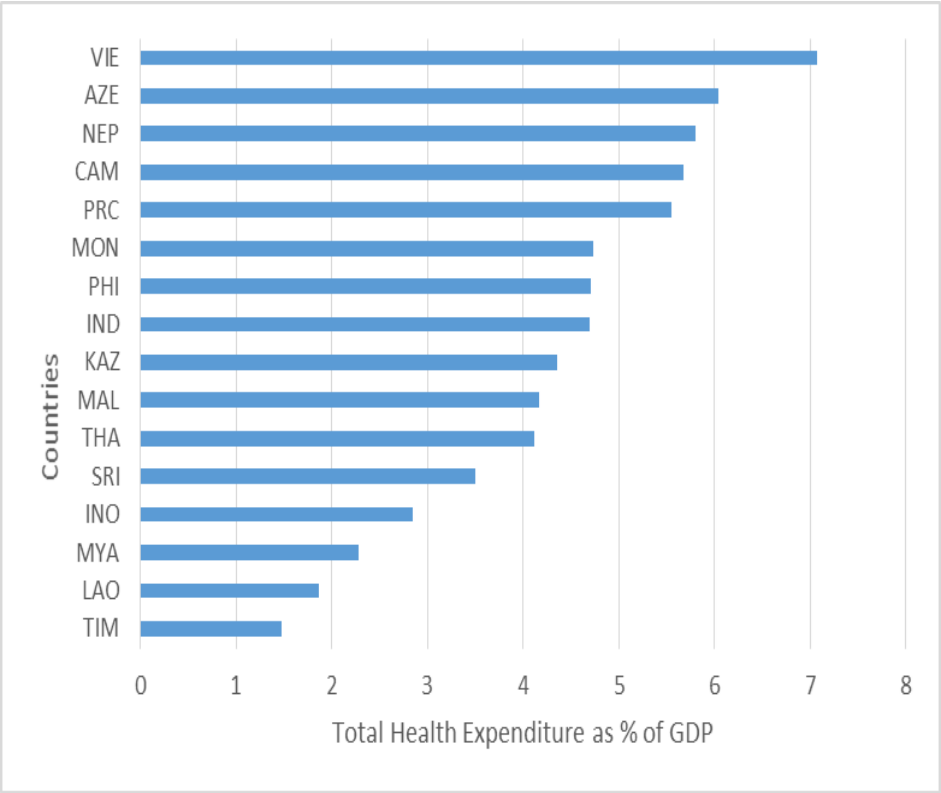



Three dimensions to consider when moving towards universal coverage

**How much should be covered?**

**Who should be financially protected?**

# Measuring UHC: Financial Risk Protection

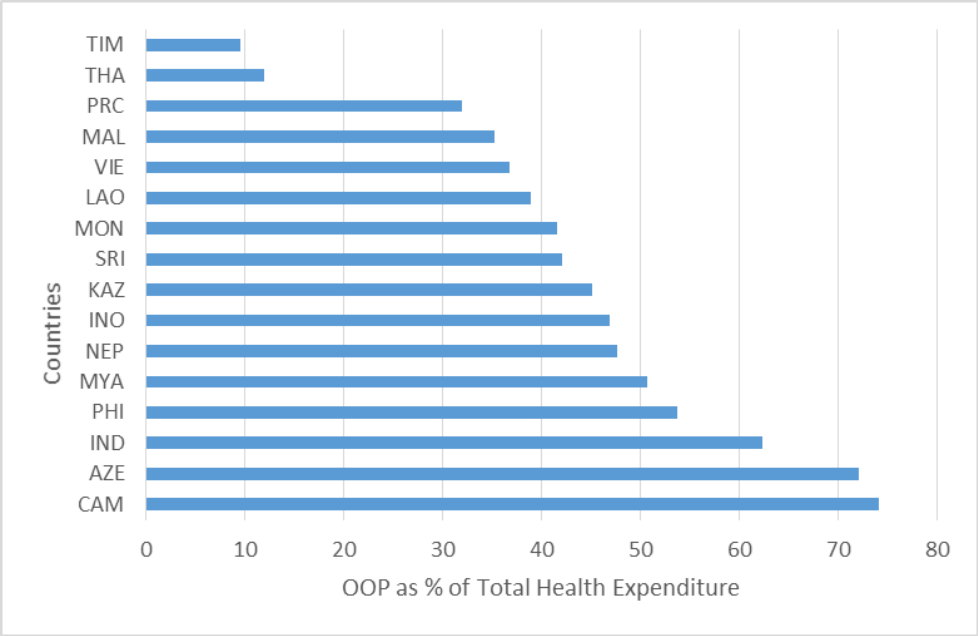



*WHO Global Health Observatory, 2014*

Using health spending indices from the 16 focus countries, **health spending as % of GDP ranges from 1.5% - 7%.**

***Does higher spending for health as % of GDP result directly to better financial risk protection?***

# Level of OOP spending in selected countries in Asia and the Pacific




Source: WHO Global Health Observatory, 2014

In **Viet Nam,** OOP remains high (36.76%) despite its health spending reaching up to 7% of its GDP.

**Thailand** on the other hand, managed to reduce its OOP **to <20% while managing a health spending at 4% of its GDP.**

# Measuring UHC: Financial Risk Protection

**Less OOP payments is protective of Catastrophic health spending and thr Risk of impoverishment**

Ways to improve **Financial Risk Protection**:

**Increase government spending (Direct Service Provision)**

**Pool financial resources under a National Health Insurance (NHI) (Third party payer)**

***Important Consideration: Payment system efficiency / effectiveness***

# Measuring UHC: Health Service Coverage

| Country | Skilled Birth Attendance | Antenatal Care Services - at least four visits (%) | Married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%) | DTP3 coverage (%) | Estimated ART coverage among people with HIV (%) | Tuberculosis Treatment Coverage (%) | Population using improved drinking-water sources (%); Urban and Rural total | Population using improved sanitation facilities (%); Urban and Rural Total |
|---|---|---|---|---|---|---|---|---|
| | *Latest Available Year* | *Latest Available Year* | *Latest Available year* | 2016 | 2016 | 2015 | 2015 | 2015 |
| Azerbaijan | 99.9 | 66.1 | 21.5 | 97 | 30 (22-40) | 81 (67-98) | 87 | 89.3 |
| Cambodia | 89 | 75.6 | 56.4 | 90 | 80 (70-92) | 59 (42-92) | 75.5 | 42.4 |
| India | 81.1 | 49.7 | 63.9 | 88 | 49 (40-61) | 59 (36-110) | 94.1 | 39.6 |
| Indonesia | 87.4 | 83.5 | 78.8 | 79 | 13 (11-15) | 32 (23-50) | 87.4 | 60.8 |
| Kazakhstan | 100 | 87 | 79.6 | 82 | 31 (27-37) | 89 (81-99) | 92.9 | 97.5 |
| Lao, People Democratic Republic | 40.1 | 36.9 | 61.3 | 82 | 41 (36-47) | 37 (26-57) | 75.7 | 70.9 |
| Malaysia | 99 | - | - | 98 | 37 (34-41) | 87 (75-100) | 98.2 | 96 |
| Mongolia | 98.9 | 89.6 | 68.3 | 99 | 33 (31-39) | 37 (23-72) | 64.4 | 59.7 |
| Myanmar | 60.2 | 73.4 | 58.5 | 90 | 55 (48-63) | 70 (54-96) | 80.6 | 79.6 |
| Nepal | 55.6 | 59.5 | 56 | 87 | 40 (35-47) | 75 (66-85) | 91.6 | 45.8 |
| People's Republic of China | 99.9 | - | 96.6 | 99 | - | 87 (75-100) | 95.5 | 76.5 |
| Philippines | 72.8 | 84.3 | 51.5 | 86 | 32 (29-35) | 85 (74-99) | 91.8 | 73.9 |
| Sri-Lanka | 98.6 | 92.5 | 69.4 | 99 | 27 (18-39) | 69 (52-96) | 95.6 | 95.1 |
| Thailand | 99.6 | 93.4 | 89.2 | 99 | 69 (60-79) | 53 (35-89) | 97.8 | 93 |
| Timor-Leste | 29.3 | 55.1 | 38.3 | 85 | - | 57 (40-87) | 71.9 | 40.6 |
| Viet Nam | 93.8 | 73.6 | 69.7 | 96 | 47 (41-53) | 79 (65-98) | 97.6 | 78 |

Source: WHO Global Health Observatory; Accessed October 16, 2017

# Estimating Financing Gap

**National health expenditure** is still a critical yardstick for estimating the resource requirements to close national health protection gaps.

However, **Increasing the share of total health spending to GDP is not the only approach** to move towards UHC.

**Investments in health still need to increase** as none of the 16 countries approach the global average of the share of total health spending to GDP at **9.9% in 2014** (World Health Organization, 2017)

# Estimating Financing Gap

Financially addressing the health protection gap is not simply a matter of increasing the share of total health spending to GDP.

**China, Vietnam, Nepal, Azerbaijan and Cambodia** have health spending that is >5% of their GDP.

Despite this, **Cambodia and Azerbaijan** still has highest OOP share in their total health spending.

**Needs to reduce OOP and to increase pooled funding and spending**

# Estimating Financing Gap

## ASSUMPTIONS

- An initial determination of financing needs among the 16 countries is not expected to provide definitive estimates of the funding gap as it will be unable to fully consider different UHC paths among them.

- The assumptions did *not* take the global average of 9.9% of THE in GDP and an OOP of less than 20%

  - 9.9% is too high, as the highest share of THE in GDP among the 16 countries is Viet Nam's 7%.

  - Although Viet Nam is not accepted internationally as having reached UHC, the Republic of Korea, at 7%, has reached

  - **This combination of the highest current share and a country example of achieving UHC at that share is the basis for taking 7% as the minimum needed to finance UHC.**

# Estimating Financing Gap

## ASSUMPTIONS

- However, an assumption of 7% of GDP to reach UHC is not fully appropriate, as seen in Cambodia and Azerbaijan.'
  - need to ensure that this spending is pooled and there are parallel efforts to reduce OOP spending as THE increases.
  - An ideal target for OOP spending would be the 12% of Thailand
    - **However, a higher level of OOP spending of 40% will be used, a rate that the Republic of Korea, Malaysia, and Sri Lanka have kept, while being acknowledged as having UHC or something close to it.**
- **Using 7% of GDP with 40% OOP spending as minimum threshold spending for UHC translates to prepaid or pooled health spending of 4% THE in GDP**

# Estimating Financing Gap

## Calculations

- Current (actual) pooling per capita calculated as the residual of OOP spending. *Pooling includes SHI expenditure as well as that of tax-financed systems.*
- The target pooling (cost coverage) is here normatively set at 60% of target expenditure (7% of GDP).
- **The resource gap per capita is then calculated as the difference between actual and target pooling.**
- Multiplying this by population, we arrive at the total amount of the health protection gap.
- **The total costs for the 16 countries are estimated at around $600 billion (PPP), or 1.7% of their GDP**

# Moving beyond the estimates

**Countries need to boost financing** BUT this should come with stronger regulations to effectively reduce OOP and inequalities in access to health care services.

**Strategic Purchasing** will make use of the government money to purchase health services more effectively (Overcome inefficiencies)

# SDG Health Price Tag

The Lancet Global Health

- Estimates the costs and benefits of progressively expanding health services in order to reach 16 SDG health targets
  - 67 LMIC, 75% of the world's population
- Prevent 97 million premature deaths and add as much as 8.4 years of life expectancy
- 85% of these costs can be met with domestic resources, although as many as 32 of the world's poorest countries will face an annual gap of up to US$ 54 billion and will need external assistance.
  - 75% for health systems investments such as employing more health workers; building and operating new clinics, hospitals and laboratories; and buying medical equipment
  - Remaining costs are for medicines, vaccines, syringes and other commodities used to prevent or treat specific diseases, and for activities such as training, health campaigns and outreach to vulnerable communities.

# SDG Health Price Tag

The Lancet Global Health

## Ambitious Scenario

- Attain the health targets in the SDGs by 2030
- New investments from an initial US$ 134 billion annually to $371 billion, or $58 per person
  - +23 million health workers,
  - +415 000 new health facilities (91% primary health care centers)
- Prevent 97M premature deaths
- Boost health spending as a proportion of GDP from an average of 5.6% to 7.5%.

## Progress Scenario

- Countries get two thirds or more of the way to the targets
- New investments from an initial US$ 104 billion a year to $274 billion, or $41 per person
  - +14 million new health worker
  - +378 000 new health facilities (93% primary health care centers)
- Prevent 71M premature deaths
- Boost health spending as a proportion of GDP to an average of 6.5%.