HEALTH SYSTEMS
GOVERNANCE &
FINANCING

Financing for Universal Health Coverage: informing the finance-health dialog

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Financing Healthcare in Africa: challenges and opportunities
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Main messages up front

- Principles from experience: health financing for UHC
  - Move towards predominant reliance on compulsory (public) revenue raising mechanisms
  - Reduce fragmentation in pooling (not today)
  - Strategic purchasing to sustain progress by driving efficiency gains and linking budgets to services and populations
- For LMICs, as in Africa
  - General budget revenue is main source; must use it well
- Therefore, effective engagement of Health with Finance authorities essential on both level of budget funding and rules governing use
  - Which is why we are here

1. UHC AND HEALTH FINANCING: CONCEPTS AND POLICY IMPLICATIONS

Universal Health Coverage

- Enable all people to use the health services that they need (including prevention, promotion, treatment, palliation and rehabilitation) of sufficient quality to be effective;
- Ensure that the use of these services does not expose the user to financial hardship“

  – World Health Report 2010, p.6

Definition embodies specific aims (UHC goals)

- Equity in service use (reduce gap between need and utilization);
- Quality (sufficient to make a difference); and
- Financial protection…
- …for all

- Utopian and unattainable??

For relevance, think of UHC as a direction, not a destination

- No country fully achieves all the coverage objectives
  - And harder for poorer countries
- But all countries want to
  - Reduce the gap between need and utilization
  - Improve quality
  - Improve financial protection
- Thus, "moving towards Universal Coverage" is something that every country can do
  - Practical orientation for policy reforms
  - Relevant to countries of all income levels

What UHC brings to public policy on health coverage

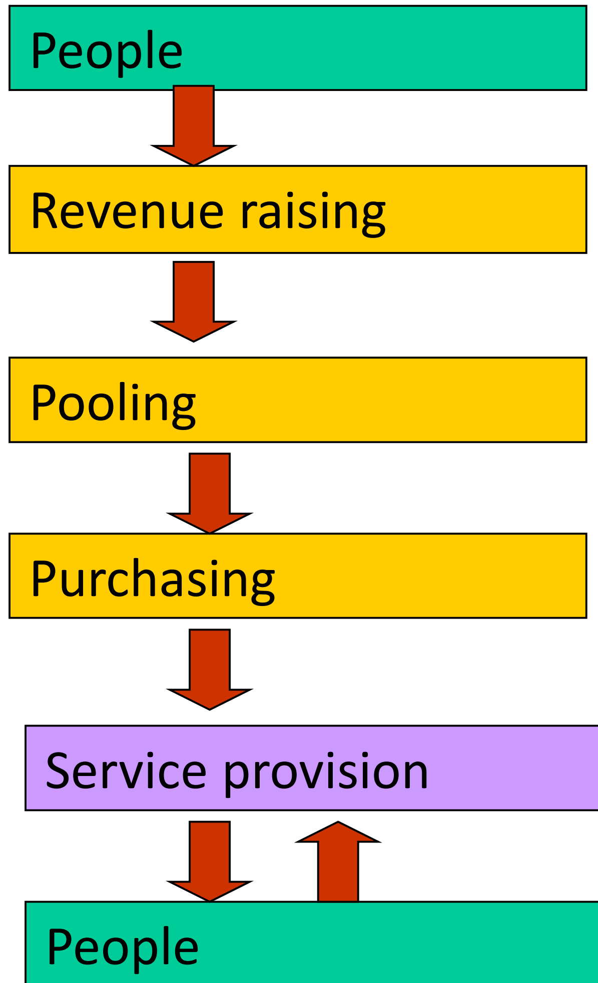
- Coverage as a "right" (of citizenship, residence) rather than as a condition of employment
  - Copying European historical experience (starting with the formal sector) is not appropriate
  - Critically important implications for choices on revenue sources and the basis for entitlement

- Unit of Analysis: system, not scheme
  - Effects of a "scheme" or a "program" is not of interest per se; what matters is the effect on UHC goals considered at level of the entire system and population

More concretely for national health financing strategies

- Transform UHC objectives into “problems”
  - How is our system under-performing on these objectives? What are specific manifestations of these problems in our country?
  - Why? (why, why, why?) – get to causes actionable by reform
- Strategy: what can we do in the next 5-10 years to address priority problems and lay the foundation for future development?
- A health financing strategy should be about solving problems, not “picking a model”

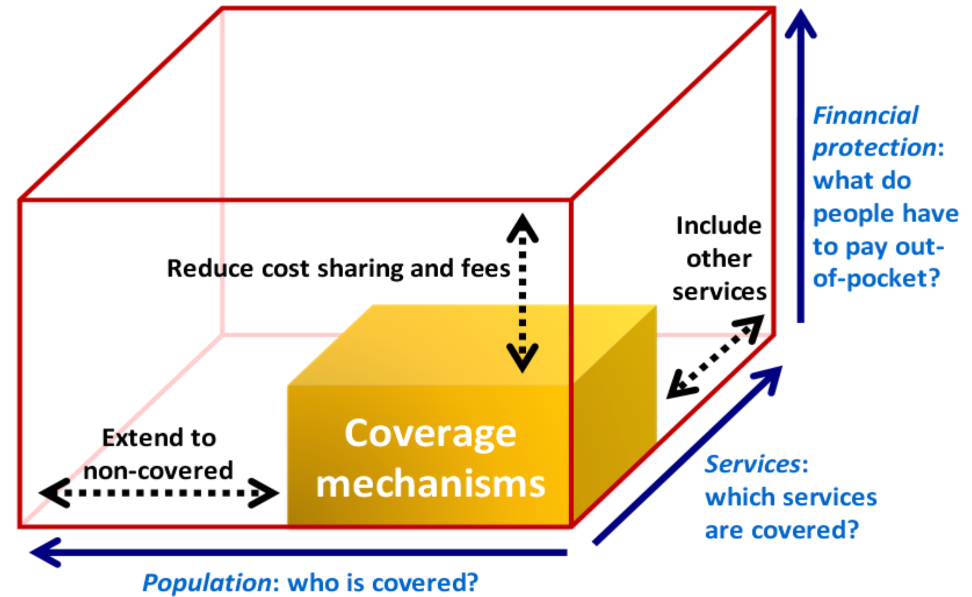
What must health financing policy address?



and also this:

Reforms to improve how the health financing system performs

This



Priorities and tradeoffs with regard to population, service, and cost coverage

2. KEY LESSONS FROM HEALTH FINANCING REFORM EXPERIENCE

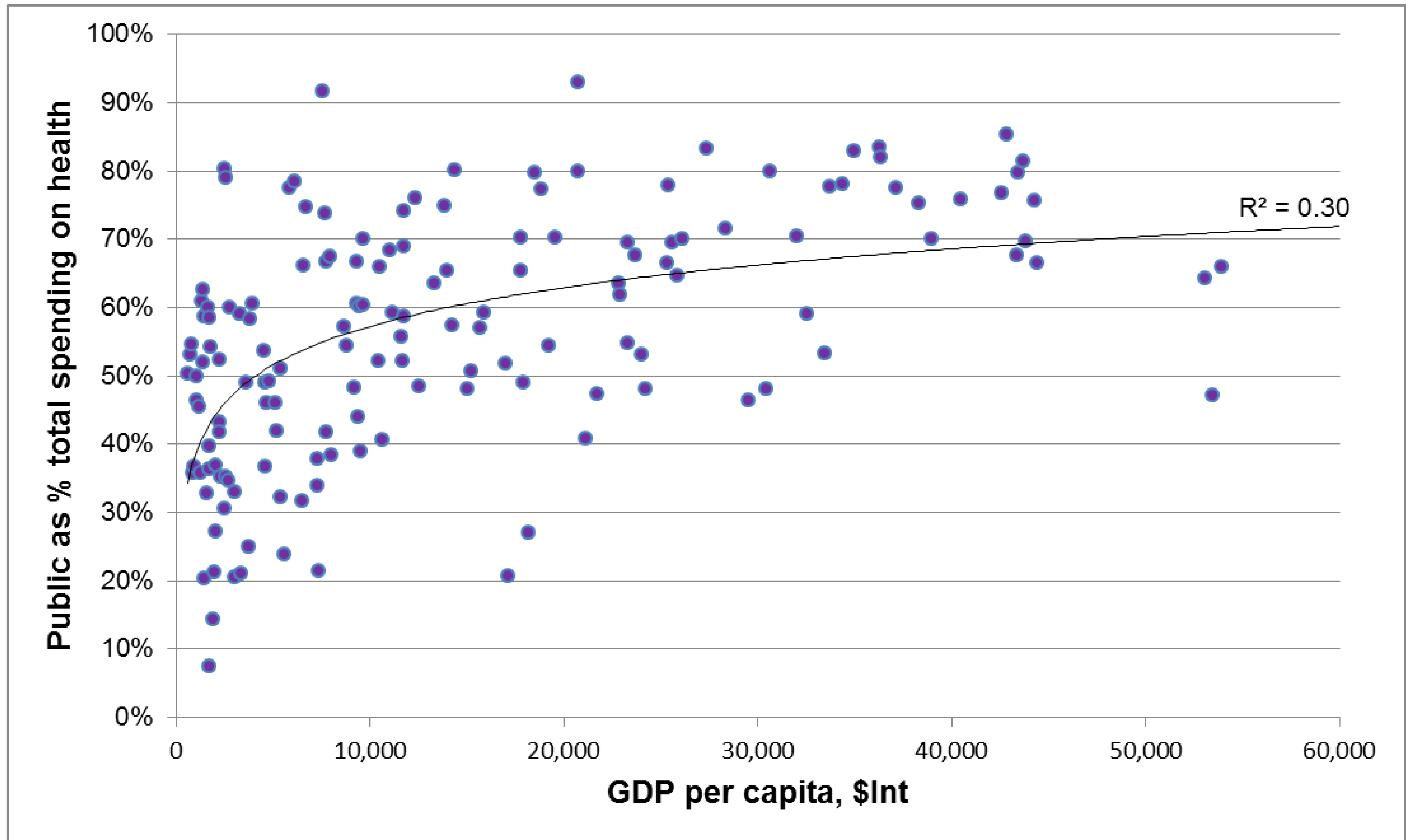
WHO diplomacy: “The path to UHC should be home-grown” (but…)

- Even though broad UHC “goals” are shared by all countries…
  - Specific manifestations of problems vary, so how the goals should be operationalized will vary as well
  - Every country already has a health financing system, so starting point for each country is unique
  - Mix of fiscal and other contextual factors also unique
- …this should not be interpreted to mean that “anything goes” – we have learned a few things over past 30 years
  - Some “do’s” and “don’ts” in health financing policy
  - Can serve as “signposts” for reform, to know if you’re going in the right (or wrong) direction

Three broad principles to guide health financing reform(ers)

- Move towards predominant reliance on compulsory (i.e. public) funding sources
  - Relying principally on voluntary prepayment does not work
  - Issue is compulsory vs voluntary, not public vs private
- Reduce fragmentation to enhance redistributional capacity (more prepayment, fewer prepayment schemes) [no time in this presentation]
- Towards strategic purchasing to align funding and incentives with promised services, promote efficiency and accountability, and sustain progress

Facts on funding: as countries get richer, they rely more on public sources…



Source: WHO estimates for 2013, countries with population > 600,000

…because poorer countries have a harder time raising tax revenues

- Lower income countries tend to suffer from poor tax collection
  - Challenge of rural and informally employed
- Implications for health spending:
  - More private; more out-of-pocket; more regressive

2013 data

Country income group	Total government spending as % GDP	Private as % of total health spending
Low	25%	59%
Lower-mid	29%	51%
Upper-mid	35%	40%
High	42%	30%

Source: WHO Global Health Expenditure Database, countries w/ population > 600,000

So for low- and middle-income countries

- Major challenge to mobilize tax revenues to move towards predominant reliance on compulsory sources
- The main domestic source of public funding must be general budget revenues
  - with indirect taxes often as the main source
- Hence, the importance of effective dialogue with MOF on the level of funding, the budget process, etc.
- The Addis Ababa Action Agenda matters (for UHC)
  - Improve domestic tax systems, reduce illicit flows

But you can't just spend your way to UHC

- Contrasting experience of China and Thailand in 2000s
- Both greatly increased public spending and affiliation in health insurance programs
- Thailand managed overall expenditure growth through coherent policies on benefit design and purchasing
- China relied on fee-for-service payment with high cost sharing, with no gains in financial protection
  - Good for doctors and hospitals, not good for patients or those trying to manage insurance budgets

To sustain progress, need to ensure efficiency and accountability for results

- "Strategic purchasing" as a critical strategy for this
  - linking the allocation of resources to providers to information on their performance and/or the health needs of those they serve
- Ideally, systems should pay for services, and design incentives for efficient use of resources
- But most public finance systems can only pay for buildings and inputs
  - Highlights importance of aligning Public Finance Management (PFM) mechanisms with output-based provider payment in the health sector

A good example from Burundi

- 2006: President declares free maternal child services
- Initial large increase in utilization, as desired
  - But loss of fee revenues led to rapid depletion of inputs, complaints from health workers about increased workload, and then informal payments
- Policy response: strategic purchasing (in form of RBF)
  - National pool of donor funds (now a line in national budget)
  - Payment linked to benefit: facility-level indicators on services for under-five's and pregnant women
  - Provider autonomy over use of funds
  - Reform associated with some dramatic improvements in MCH outcomes

Strategic purchasing and PFM arrangements

- To address limited funding, MOH develops priorities through its strategies and plans
  - Prioritizes services (e.g. RMNCH, HIV, NCDs, etc.) and/or populations (e.g. poor)
- Key issue for public finance systems: is it possible to match public revenues for health to the defined priorities, or is system constrained to use line-item budgets?
- The problem of line-item budgeting & expenditure control
  - Payment does not match priority services & populations
  - Result: priorities merely "declarative", breaking trust with population because no means to connect payment to promises

Separation of functions needed to support and institutionalize strategic purchasing

Key function	Problematic (common) situation	Direction to enable strategic purchasing
Forming budgets	Historical line-item	Stable and predictable, not related to infrastructure
Paying providers	Rigid line-item	Linked to information on outputs & population need
Provider management	Administer rather than manage, reallocation requires permission; just spend budget	Autonomy to manage resources; accountable for results, not inputs
Financial reporting	By line-item	By line-item

3. CONCLUDING COMMENTS

Implications for African health and finance dialog on UHC – the path to sustainability

- Moving towards greater reliance on public funding will mean general government budget revenues in particular
- Key challenge is to use these revenues effectively; hard to do in many rigid public finance systems
- This requires intensive and effective dialog between health and public finance authorities on level of budgets…
- …and the ability to transform these revenues into services and drive efficiency gains…
- …while at the same time ensuring accountability for the use of these scarce public funds

Set priorities and don't get distracted

- Without a strong, effective purchasing function, more revenues won't help very much – building and institutionalizing this foundation is the top priority

- It's not about filling a funding gap based on international norms, or magical "innovative" new sources

- You can't "align donor funding" until the architecture and engineering of your domestic system is in order

The path to UHC runs through PFM