

Universal health coverage (UHC): magic cube or pandora's box?

Background Paper

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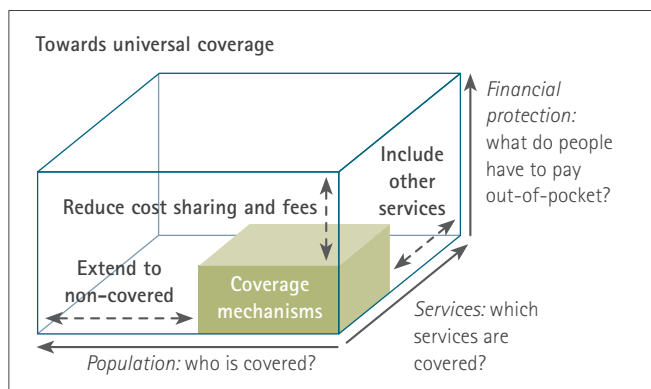
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This paper starts by outlining what 'universal health coverage' is understood to mean and highlights that its application is context specific, as are the means to achieve it. It will suggest that UHC requires a holistic approach, integrating timely and adequate fiscal space, public finance management and health sector reform. The paper will situate several health financing mechanisms within UHC, and how they can contribute to achieving it: tax financed systems, social health insurance, and community based health insurance and user fees for example.

What is universal health coverage?

UHC has been defined by the WHO as ensuring that "all people obtain the health services they need without suffering financial hardship when paying for them."¹ The three dimensions of UHC (population coverage, package of services provided and level of financial protection) are often represented through the UHC cube (see Figure 1 below).

Figure 1: The UHC Cube²



BOX 1: REVOLUTIONARY OR EXCESSIVELY CONSENSUAL?

The joint enthusiasm of the World Bank and the WHO towards the UHC agenda may suggest, for those health policy makers old enough to remember the somewhat overt tensions between these two institutions in the past few decades, as suspiciously consensual.

"We must be the generation that delivers Universal Health Coverage" Dr Jim Kim, President of the World Bank, 21/05/2013

"Universal coverage is the single most powerful concept that public health has to offer" Dr. Margaret Chan, DG of WHO, 23/05/2012

BOX 2: IMPLEMENTING UHC: BEST PRACTICE FROM THAILAND

Despite considerable investment in health since the 1970s, in 2000, Thailand continued to face massive challenges in health care delivery. Approximately 30% of the population (18m people) did not have health insurance and no guaranteed access to free medical care. OOP payments accounted for a third of THE and these impacted poor households disproportionately. Thailand adopted a UHC scheme in April 2001, with public primary health facilities as the main providers of healthcare.

The main objectives of the UHC scheme were to focus on promoting health, prevention and care, while emphasising the role of primary health care. In addition, equity was a key consideration for the government – in an attempt to ensure that health subsidies were progressive, largely benefitting the poor and ensuring all citizens were protected against financial risks to obtaining healthcare.

The UHC had three main features:

1. a tax-financed scheme free at the point of service
 - chosen based on the progressivity of the tax system in Thailand, where the rich pay a much larger proportion of taxes than the poor
2. a comprehensive benefits package with a primary care focus
 - this package covered outpatient, inpatient and accident emergency services, dental care, diagnostics and medical supplies
3. a fixed annual budget with a cap on provider payments

Despite increased general government expenditure on health between 2001 and 2008, from US\$1.9bn to US\$7.4bn (76% real increase), health expenditure as a percentage of GDP remained between 3 and 4%.

The scheme encountered significant challenges initially, in part caused by the move from supply side financing (where the MoH allocated budgets to its administrative units and service tiers) to demand side financing and organisational reforms required within the MoH, but is nevertheless seen as being very successful not least in reducing OOP payments by households from 33% of total expenditure to 15% in 2008.

1 World Health Assembly Resolution 58.33, 2005

2 WHO (2010) – World Health Report 2010 – health financing: the path to universal coverage

Indeed, the UHC agenda, through its recognition of the context specificity of each of the three dimensions (population coverage, service coverage and level of financial protection) and the specificity of the path through which each of these dimensions could be extended, can be seen as an overly consensual tool, in which anything and everything could be thrown. Indeed, a country with OOP representing 70% of its Total Health Expenditure (THE) could as easily claim its progress towards UHC as a country with OOP representing only 10% of THE, to take one dimension as an example. As such the UHC cube has been criticised for being more of a Pandora's box than a real answer to improving people's access to good quality care.

A useful framework

What the UHC agenda clearly recognises is the common ultimate objective of offering good quality services to all. It also recognises that every country will be at a different stage on this path, offering more or less services to more or less people with more or less financial protection. The UHC cube offers a clear structured approach to making this happen:

- Firstly, the benefit package must be defined as no country can afford to pay for all services. Choices need to be made through a combination of technical judgements - such as the most cost effective interventions - and political settlements, as removing any intervention from an existing package is an extremely contentious exercise.
- Secondly, who should benefit? Universal means that 100% of the population should be able to access services. Yet this is a near impossible feat. Many countries start with 'low hanging fruits' i.e. the formal sector employees, and slowly extend coverage to other population groups. The most vulnerable are often the hardest to reach and the last to be included unless a specific equity goal drives the country's health financing reforms.
- Finally, level of financial protection. A central aim of UHC is to ensure that people do not face financial hardship in the process of seeking care, defined by the level of OOP. Yet in many SSA and Asian countries today, OOP continue to represent a large proportion of THE. An explicit goal of UHC is therefore the reduction of OOPs, and specifically user fees. This is one of the central challenges of achieving UHC: how to replace user fees.

How to finance UHC to reach the greatest possible level of financial protection

Replacing user fees leads to a broader question: how to finance the great ambition of UHC. Funds, or rather fiscal space, can come from four distinct sources: increased aid allocated to health, increased government allocation to health and/ or increased domestic resource mobilisation (DRM) (the focus of this section), borrowing for health or improved technical efficiency (more health for the money, covered in paper 2).

Domestic Resource Mobilisation (DRM)

Domestically, UHC can be financed through various sources: public (taxation and social/ national health insurance) and/ or private (user fees, community-based health insurance, private health insurance or medical savings account³).

- **Taxation:** generally speaking, tax financed systems offer the largest potential for revenue raising, as the tax base is very large (anything from corporate taxation to property taxes, to VAT etc.). This large revenue base also offers the greatest potential for pooling, hence of cross subsidisation between the rich (who should pay the largest proportion of the taxes if the system is progressive) and the poor (who should pay a lesser proportion). In low-income countries particularly, direct taxation is often seen as hard to enforce and collect and IMF advice for example has focused on the need to prioritise VAT. Literature suggests that there may be further avenues to explore around taxation even in low income countries, and that choosing the VAT route may be too regressive and restrictive an approach.⁴
- **Social or national health insurance:**⁵ is mainly financed through a tax on payroll, but often complemented by public subsidies. Resources are pooled ideally at the national level, offering some level of cross subsidisation between people who have contributed. In Low and Middle Income Countries (LMICs) with large informal sectors unable to take part in SHI, this leads to a large proportion of the population remaining uncovered.
- Direct taxation and/ or national health insurance systems are considered the most progressive generally, as they overall ensure that the richer the individual, the more he/ she pays as a proportion of their revenue.⁶ Taxation and S/NHI also dissociate the episode of ill health from the payment itself, which offers the greatest potential for financial protection. These two mechanisms, either together or separately, have been recognised as the most suitable to reach UHC.⁷
- **Private health insurance:** insurance for those able to pay the premium. Whilst it can be useful in providing secondary or tertiary level care for those who can afford the premium, it is of little relevance to countries aiming to reach UHC of a basic package of services.⁸
- **Community based health insurance (CBHI):** any scheme managed and operated by an organization, other than a government or private for-profit company that provides risk pooling to cover all or part of the costs of health care

3 Medical Savings Accounts have only been used in Singapore. As they are so rare, we will not discuss them here.

4 Di John (2013) The political economy of taxation and resource mobilisation in sub-Saharan Africa, World Bank working paper. and McIntyre and Meheus (2014) Fiscal space for domestic funding on health and other social services, Chatham House paper

5 These two terms (social health insurance and national health insurance) are used interchangeably in the literature. We here will use SHI to mean either.

6 There are of course nuances to this statement as both systems can be made relatively less progressive through tax ceilings for example or exemptions. This is beyond the scope of this paper however.

7 WHO(2010) op.cit.

8 WHO (2010) op. cit.

services – usually voluntary. CBHI were very popular in the 1990s and 2000s mostly in sub-Saharan Africa. However experience has been disappointing: they create small pool funds, raise very limited revenue, offer little financial protection from catastrophic payments and continue to exclude the poorest who can't afford the premium.⁹ However, Rwanda is one of the countries where CBHI type organisations provide a basis for future health financing.

- **User fees** are any payment at the point of use by patients. User fees were introduced in the 1980s in most developing countries as a conditionality of SAPs. They were meant to raise much-needed funds to finance healthcare and reduce frivolous demand. The overwhelming consensus for the past 10 years has been that not only are user fees neither able to raise sufficient funds to pay for healthcare nor reduce frivolous demand particularly of the poor, they also and mainly have an extremely negative impact on the poor's ability to access care.¹⁰ David De Ferranti, long time World Bank economist and strong advocate of user fees for health within the WB, has recognised their catastrophic impact and the need to consistently remove them.

The debate about user fees has today moved on from whether to remove user fees to how to remove them.¹¹ This has become

a particularly pressing question in the context of UHC, and, as highlighted above, in the realisation that many LMICs still greatly rely on user fees to finance their health sector.

In conclusion, evidence shows that a journey towards UHC implies the gradual removal of user fees and a replacement by national level collection and pooling mechanisms such as taxation and/ or social health insurance¹². Yet health financing, as outlined in Paper 2 – Financing health care and health system reform, is but one of the pillars of the health system, and to ensure good quality care requires a health system response, which includes, but cannot be limited to, financing.

UHC is a societal goal that needs the backing of the MoH and the MoF to make it happen. Only through collaboration can these institutions solve the fiscal space conundrum, which in practice means recognising the need for additional resources for health (without which UHC will remain an empty political promise), identifying progressive ways of raising domestic resources (remit of both MoH and MoF), and getting more health for the money through better spending of these resources (remit of the MoH).

9 Chuma, Mulupi and McIntyre (2013), Providing financial protection and funding health service benefits for the informal sector : evidence from sub-Saharan Africa, Resyst working paper 2

10 WHO (2010) op. cit.

11 McPake et al (2011) : How to remove user fees : an international experience

12 WHO (2010) – World Health Report 2010 – health financing: the path towards UHC.



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