The Universal Health CoverUP

David Legge

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UHC – le slogan de jour

- Sponsors: Margaret Chan (ex DG WHO), Jim Kim (ex Pres WB) and many more
- UHC2030: a ‘multi stakeholder global partnership’ (countries, banks, PPPs, philanthropies, CSOs and PSEs)
  - Reborn from IHP+ established in 2007
- Included in SDGs

Definitions

- *3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (SDGs)*
- *Universal health coverage means that all people receive the health services they need, including public health services designed to promote better health (such as anti-tobacco information campaigns and taxes), prevent illness (such as vaccinations), and to provide treatment, rehabilitation and palliative care (such as end-of-life care) of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship. (WHO & WB 2015)*

Indicators

- Health services coverage (a composite indicator of essential health care services coverage)
- Financial protection (incidence of catastrophic health expenditure and of health care impoverishment)

WHO & WB 2017

Hidden debates (obscured by the slogan of UHC)

- National financing model
  - Single payer
  - Health insurance marketplace
- Roles of public and private sectors in service delivery
  - Mixed public private but private dominated
  - Dominant public sector
- Relevance and interpretation of primary health care (versus primary clinical care)
- Policy differences around:
  - the challenges of domestic resource mobilisation and fiscal capacity
  - the critical shortages with respect to human resources for health
  - the prices of medicines and vaccines

Efficiency, equity and quality and health care financing

- Single payer provides policy leverage over efficiency equity and quality
  - Major risk is under funding
- Stratified health insurance and competitive health insurance markets provide for weak control of distribution or assets, efficiency of use of resources and quality of care
- Incentives
  - Push up premiums
  - Select for low risk customers
  - Contain expenditure

Efficiency, equity and quality and models of service delivery

- Public sector provision gives policy makers significant power over efficiency, effectiveness, quality and equity; at the provider level and at the wider network and program level
- The main risks associated with public sector provision arise from under-funding.
- Private sector provision insulates providers from policy control over efficiency and quality
  - Private hospitals encourage over servicing and resist clinical governance
  - Private ambulatory practice congregates around communities who can pay; has no capacity to implement comprehensive primary health care

Fiscal capacity and domestic resource mobilisation

- Constraints include
  - illicit financial flows
  - tax evasion
  - tax competition / extortion
  - challenges of tax collection in the informal sector
- Inequality weakens community solidarity; resistance from the wealthy to progressive tax rates (effectively transfers from rich to poor)
  - stratified health insurance enables the wealthier to buy more generous plans without contributing to the health care costs of the poor

Human resources for health and continuing brain drain

- Limited training capacity
- Fragile and under-resourced health systems
- Brain drain complex
  - Some people come home
  - Domino sequences of migration within the global South
  - Internal migration: public to private; public to partner-funded vertical programs; domestic to foreign; and out of the health system entirely
- Compensation for the net transfer of value represented by the net migration to the North
  - Pay for human resources at the cost of Northern education!

Access to medicines

- Proportion of total health expenditure (THE)
  - 20-60% of THE in global South
  - 18% of THE in global North
- Cameron (2008) review 45 drug price surveys in 36 L&MICs
  - Governments paid 11% above international reference prices
  - Private patients paid 9-25 times int ref prices and over 20 times int ref prices for originator products
  - Mark ups in private sector:
    - Wholesale: 2-380%
    - Retail: 10-552%

Causes of high prices for medicines

- Monopoly pricing capacity behind intellectual property protection
- Cost of R&D (and expenditure on marketing)
- Profit directed investment in pharma R&D aligns poorly with public health needs
- Profit directed investment in production aligns poorly with security of supply
- Delinking

The domestic politics of health care financing

- Private medical autonomy confronts popular demands for collectivising health care funding
- Military and productivity arguments for investing in public health and medical care
- Increasing cost and efficacy of modern medical care contributes to pressure for collectivising the cost burden
- In UK and Germany health insurance starts with small scale mutual funds which then get ‘scaled up’
- In US health insurance starts with hospitals at risk of bankruptcy during Depression; consolidated by tax concessions for employers and employees
  - Medicare and Medicaid (1967) serve to relieve the private insurers for the cost of aged or indigent health care
  - Managed care (from 1980s) provides new ways of stratifying health expenditure
- In post colonial countries starts with generous programs for military and public officials and private insurance for the rich (often with tax concessions); contributes to huge inequities in public expenditure and access to care and powerful forces opposing universal single payer financing

Global health systems policy (WHO)

- 1950s: ‘basic health services’ (WHO chastised for discussing health insurance)
- 1970s: Non Aligned Movement and G77: NIEO and PHC
- Late 1970s: stagflation and the end of the Long Boom
- Interest rate hikes, debt crisis and Structural Adjustment (dismantling public health care)
- 1993: *Investing in health*: “structural adjustment is good for you”
- 1990s: AIDS crisis, ARVs, TAC and Doha 2001
- 2000s: relegitimation and the MDGs
- 2007: IHP+
- 2015: UHC

The financial crisis of WHO drives it into the arms of the World Bank

- Increasing dependence of WHO (and UN more broadly) on donor funding: from 80:20 to 20:80
  - Rich countries
  - Philanthropies
  - Development banks
- The WB progressively losing legitimacy in health from its support for the 1993 model
- WHO offers UHC
- The Bank offers funding
- UHC 2030 locks in support for the UHC slogan

Neoliberalism

- Liberalisation of trade and investment
- Global economic slow down
- Austerity: privatisation and marketization

How health systems develop

- Health systems develop through incremental change. Such change takes place when established institutions ‘unfreeze’ (often because of increasingly evident dysfunction or wider institutional turmoil), *and* there are clever policies on hand, *and* public interest constituencies are driving towards a coherent vision for change (Kingdon, 1984).
- Opportunities for change arise unpredictably; both in terms of timing and location of the institutional unfreezing.

Creating reform readiness

- building consensus around preferred directions and why change is necessary;
- building policy capacity and policy dialogue among stakeholders, including various affected communities, to ensure that there will be constituencies ready to drive clever policies to address the various contingencies that will emerge;
- strengthening the political leadership needed to drive change