Universal Health Coverage from the bottom-up: How it is implemented in 25 countries and how operational research can help -- Emerging Findings

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## Contents – The delivery of UHC

- Introduction – The UNICO program and the Nuts and Bolts case studies
- Key Findings and implications
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Introduction

UNICO Activities

Case studies of programs that expand health coverage from the bottom-up (in 25 countries)

Develop UNICAT (Universal Coverage Capacity Assessment Tool) to help countries identify their strengths & weaknesses in the implementation of UHC
Objectives

Objectives of Nuts and Bolts Case Studies

- Make WB country dialogue on UHC more systematic
- Identify global trends in UHC implementation
- Identify implementation (delivery) challenges facing policymakers
Themes covered by case studies

Focusing on equity, fiscal sustainability and efficiency the emphasis of the case studies is on:

• Managing Benefit packages
• Managing bottom-up inclusion of the poor and vulnerable
• Nudging reforms to the provision of services
• Strengths and new challenges in primary care
• Financing – Revenue collection, pooling, allocation, purchasing
25 UNICO Country Case Studies
Methodology

Science of Delivery: Implementation, health systems/public sector management

- “Sample” – as many countries as possible within the universe of countries which in the last decade made significant efforts to expand coverage from the “bottom-up”
- One health coverage program per country – the one that produced the greatest expansion of coverage in last decade – policy flow rather than policy stock
- A common questionnaire: 9 modules, 329 questions
- Respondents are client-facing Bank staff (case-study authors)
- Quantitative results are simply orders of magnitude

What UNICO is not: Not an attempt to establish/identify best practice, and not an attempt to emphasize a “model”
Findings and implications for research

Findings

- Huge diversity in the specific needs, objectives and health system models
- Despite the diversity, countries implementing UHC are converging to a common set of operational (delivery) policies or instruments
- Several areas of convergence operationalize rights and accountability

Implications for future operational research

Be responsive to the operational (“delivery”) challenges facing policy makers
- Focus on the areas of convergence
- Future research should continue to emphasis rigorous methods but should increase the effort to respond to the delivery/operational needs of policy-makers

Focus on strengthening accountability
- Identify instruments and institutions
- Identify partners and stakeholders
A New Convergence

- Political commitment to UHC (85%)
- Benefits package is made explicit (95%)
- Expansion financed by general taxes (89%)
- Expansion purchases outputs, not inputs (89%)
- Primary Care pillar moving beyond “strong MDG interventions” (85%)
- Programs require enrolment (81%)
- Programs nudge reform of public providers (74%)
- Little monitoring of health outcomes – only 44%!
Orders of magnitude defined

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<td>Most</td>
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1. Managing Benefit Packages

Description and Design:

- BPs are increasingly explicit, positive lists, of health conditions (but not standardized e.g. by ICD10 codes)
- Design of “basic package” based on cost-effectiveness
- Beyond basic package based on “affordability” and guesswork

What is covered?

- All include immunization, child and maternity care
- Few LICs but most MICs cover primary outpatient care (OPC) – including pharmacy, lab, basic radiology and specialist consultation. Also high-end diagnostic imaging
- Inpatient care coverage (IPC) slightly less common than OPC; also grows with income
Managing benefits (continued)

Cost sharing

- Rare in maternity and public health interventions
- Required in a third of IPC and in half of OPC (especially for drugs)

Enforcement of the right to a benefit package

- Big effort to publicize rules for BP, especially in MICs
- Complaints: **Areas of strength**...process of complaint, use of local languages, existence of redress, use of NGOs, no fees. **Areas of weakness**...process of response, independence of adjudicator, use of internet, publication of complaint statistics, systematic learning by agency from complaints
BP -- Policy makers struggle with...

- The tension of using an explicit BP with a fixed tax-financed budget... the reputational risk of chronic underfinancing
- Prioritization. The question is not what to cover first. The real question is what to cover second.
- Covering outpatient care (especially drugs) or inpatient care?
- Co-payment policies – especially for drugs and tertiary services
- Systems to manage the BP? – costing, pricing, claim management, medical audits, financial audits, prior authorization, clinical pathways. Do they all really need to be reinvented in each country?
Benefit Package: Researchers could...

- Prioritization: Institution building or quick rules?
- Evaluate the impact of various accountability systems. How best to empower users to obtain the benefits promised to them?
- Undertake multi-country comparisons of BP to identify variance from “best buys”
- Investigate the transportability of existing administrative systems to manage BPs. How to purchase/adapt existing systems? Adoption of ICD10 codes would help?
- Compare lessons from different paths of expansion of BP – impact on BOP, impoverishment, fraud, politics.
2. Managing inclusion – “from the bottom-up”

Mechanisms to manage inclusion:

• Eligibility criteria – as defined in the statement of objectives of the health coverage program
• Identification system of beneficiaries – as used in practice
• Enrolment of beneficiaries
• Self-selection
Eligibility – per programs’ objectives

- Multiple target populations
- Most programs aim for the poor, few are only for the poor
- Most programs aiming for the poor include the near-poor
- “Vulnerable”: often mothers and children, rural, specific diseases; the elderly
- Risk of medical impoverishment increasingly recognized
- Special historical categories. Hot political targets
Criteria utilized: Demographic 40%, Geography 52%, Proxy-means test 59%, Local Government procedures 52%. (Categories overlap)

Systems to identify the poor (SIPs)
- Most countries have a SIP (18/25 countries).
- 20 programs are in countries w/SIP, however only 9 programs use the SIP. Why?
  - Politics: Focus not really the poor; Inter-ministerial or central/local government politics
  - Universality: Target geographically and make them locally universal
  - Logistics: out of date, has data on households but not on individuals), poor quality,
  - SIPs don’t recognize Medical “risk”: Vagueness is required
  - Medical risk: monetary poverty is inadequate indicator
Most programs require enrolment. Why?
• Not a sign of health insurance
• Not an instrument for revenue collection – prepayment fees are rare

Hypotheses:
1. Enrolment serves to prioritize
2. Enrolment establishes a contract, it strengthens the entitlement of users to benefits -- accountability
3. Enrolment provides incentives for outreach
   • Enrolment by HCP, providers, insurers, local governments
   • Enrollers face financial incentives to enroll. Difficult to get the incentives right.
Self-selection as a tool for targeting

- Rich and poor rarely use the same primary or secondary facilities. Integrated use is only common for tertiary care.
- Even as they access the same tertiary hospital, the poor often have significantly less access to high tech services or hotel facilities.
- In almost half the countries, social security systems run their own segregated hospitals.
Managing inclusion
Policy-makers struggle with

- Politics – interagency; central/local; SIPs
- Who to prioritize? Often clear who goes first, but who goes second?
- How to identify your desired beneficiaries?
- Improving responsiveness and quality of public provision weakens self-targeting
- Politics. Universal vs. Targeted – clear in theory, much less clear in practice
Managing inclusion: Researchers could...

- Seek lessons from history about the path to “universal coverage” and integrated schemes
- Look for evidence about successful contributory efforts to expand coverage of the non-poor in the informal sector
- Help redefine eligibility and identification systems in ways that take medical risk into account?
- Develop incentives for the enrolment agent in ways that generate outreach
- Look for lessons on how to manage the double cost of improving public hospitals: (i) the investment; (ii) the loss of self-selection as a targeting tool as the better off begin to use the public services
3. Nudging reforms to the public provision of services

Reforming provision is a key benefit of 20 of the 27 programs

- Most link new financing to greater accountability
- Most introduce accreditation, a few choice and competition
- Almost all focus on improving public delivery:
  - Generalized use of signaling with output-related payments
  - Output payments are a small complement to input payments – no transition from supply to demand subsidies
  - Flexible cash for hospital and clinic managers
  - Incentives for civil servants or new cadres of health workers
- Few programs/countries report on health indicators
Reforming provision
Policy makers struggle with..

- Flexibility within rigid fiduciary rules
- The politics of quality by accreditation
- The politics of autonomy of third party purchasers and autonomy of public providers
- Reinventing purchasing systems for public providers
- Why are health programs not reporting on health indicators?
Reforming Provision - Researchers could...

- Look for evidence:
  - Does accreditation “work” to improve quality?
  - Does “choice and competition” work?
  - What set-ups work best for third-party purchasers?

- Transfer and adaptation of technology on “payment systems for public providers” (with supply subsidies and limited autonomy). Operators need to learn about elasticity, threshold values for impact, minimum operational autonomy.

- Lessons from countries that have transitioned to more flexible fiduciary systems – inform risk taking and risk management of “fraud”

- Successful human resource practices in reformed environments
4. Financing

Revenue collection and pooling
- All programs are general tax financed, usually by central govs
- Subnational governments participate half the time
- External financing also common, even in UMICs
- Beneficiaries participate half the time, very rarely pre-pay; contributions are under 1% of cost in Mexico, Peru, India RSBY; only 20% in China’s rural scheme

Purchasing
- Programs pay for outputs – usually to providers; also increased use of conditioned Inter Government Transfers
- Budgeting remains traditional, only begins to recognize the challenge of “public insurance” – Regional differences...
- Excess demand usually managed through stock-outs, arrears
- Underfinancing usually results from unmet requests (not from ex-post adjustments)
Financing
Policy makers struggle with...

Getting the money

- Those who succeed get it from MoFs, subnationals, external
- Less success from payroll taxes, sin taxes
- No success from voluntary contributions – except China, Rwanda

Loss of credibility due to chronic arrears

Misalignment of central/subnational governments

Inflexible fiduciary arrangements
The Primary Care pillar

• Strong programs for Communicable disease and child health – population based, technical protocols in use, regular reporting, safer funding, rarely involve point of service payments

• Maternal services are weaker but improving – often exempt from fees for delivery, sometimes finance transport, big pipeline for investments. But poor quality.

• NCD programs are weak. Rare reporting, rare use of protocols, uncertain funding, legal and illegal payments common
Primary care pillar
Policy makers struggle with...

**Incremental challenges:**
- Completing integration of vertical programs while retaining their advantages
- Expanding PC to deal with NCDs
- Advancing supply chain reforms – procurement, distribution, communications
- Introducing new payment systems (eg RBF) – sometimes linked to increased autonomy
- Stronger information systems and use of management agreements

**Model**
- Decentralization and national steering
- Family health programs
- Sequencing strengthening of PC and expanding beyond PC
Conclusions

- Despite diversity of models, there is a new convergence in operational policies.
- Results may depend more on quality of implementation than on choice of model.
- Accountability is key to ensure that implementation of UHC is equitable, efficient and sustainable:
  - Empowering users to demand the promised benefits.
  - Using technical criteria to expand BP.
  - Using systems that incentivize productivity and control costs of BP.
  - Using appropriate systems to follow bottom-up path to UHC.
  - Reporting improvement of health indicators.
- The new convergence relies on healthy tensions to improve bottom-up inclusion, efficiency, fiscal sustainability: users providers purchasers local & central Government; MoH/MoF.
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