Universal Health Coverage [UHC] in Global Health

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My presentation today:

The Changing World of Global Health

The Economic Transition of Health

The Global Movement for UHC
The Changing World of Global Health

1960's

- Colonial arrangements
- Pioneer age/missions
- Western tech experts
- Parasitic diseases and anti-viral vaccines
- Eradication campaigns

1990's

- New UN member states
- East-West geopolitical divide
- International solidarity
- Health as social construct
- Primary Health Care for all (Alma Ata to Selective PHC)

Globalization: trade, markets, information and communication technology (ICT)
- AIDS and Millennium Development Goals (MDGs)
- World Health Organization joined by World Bank, Non-governmental organizations (NGOs)
- New Philanthropy & Funds
- Public-private partnerships
- Health Systems neglect

2010's

- End of Euro-colonialism
- End of the Cold War

Tropical Medicine
- International Health
- Global Health

3
Development Assistance for Health: The Golden Era of Global Health

IHME
2016
International private flows overtake ODA

![Graph showing Official Development Assistance vs. Private flows, United States (1960-2010)]

Source: OECD database: http://stats.oecd.org

*Private includes private flows at market terms and net private grants
Active NGOs Registered with the UN

Dramatic results since 1990

✓ HIV incidence & mortality cut by half
✓ TB and Malaria deaths reduced by 40%
✓ 50% fewer women have died giving birth
✓ 125 million children’s lives have been spared
✓ Family planning has empowered women, saved lives and brought a demographic dividend to families and national economies.
A Grand Convergence in sight
The Changing World of Global Health

- 1960's: End of Euro-colonialism
- 1990's: End of the Cold War
- 2010's: The Grand Recession

Tropical Medicine → International Health → Global Health

1960's → 1990's → 2010's

?
Development Assistance for Health:
FLAT BUDGETS SINCE 2010

IHME
2016
## Impact and Cost of Convergence, 2035

<table>
<thead>
<tr>
<th></th>
<th>Low-income countries</th>
<th>Lower middle-income countries</th>
</tr>
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<tbody>
<tr>
<td><strong>Annual deaths averted from 2035 onwards</strong></td>
<td>7.4 million</td>
<td>7.5 million</td>
</tr>
<tr>
<td><strong>Approximate incremental cost per year, 2016-2035</strong></td>
<td>$25 billion</td>
<td>$45 billion</td>
</tr>
<tr>
<td><strong>Proportion of costs devoted to structural investments (HSS)</strong></td>
<td>60-70%</td>
<td>30-40%</td>
</tr>
<tr>
<td><strong>Proportion of health gap closed by existing tools</strong></td>
<td>2/3</td>
<td>4/5</td>
</tr>
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</table>

$$$ Full-income return of $9 to $20 per dollar invested

At global level, *development assistance* is diluted with new focus on fragile and the poorest states and *global public goods* like normativity and innovation.

At national level, growing political demands for social protection promote *domestic resource mobilization* and *universal health coverage*.

Opportunities arise for *member-state organizations like WHO* to reposition itself and confront emerging challenges like pandemic threats, HSS, and NCDIs.
My presentation today:

The Changing World of Global Health

The Economic Transition of Health

The Global Movement for UHC
Unprecedented Economic Growth

World per capita GDP
1990 dollars

"The First Law of Health Economics"

Source: Jacques van der Gaag; WHO/IMF 2004
The Economic Transition of Health

India - Projected THE/K and Affordability

[Diagram showing projected Total Health Expenditure per capita (in US dollars, current prices) from 2000 to 2016. The graph includes lines for CMH $38 assuming 2.5% inflation and TFIF $54 assuming 3.5% inflation.]
Domestic resources will cover most basic health needs

Grand convergence costs in 63 low- and lower-middle-income countries
Example from GFFEWE2C

Peak gap of US$25-27 billion per year, of which ~US$11 billion is covered by international financing
Global distribution of countries by income group, 2000–2020
Financing trends in developing countries
(USD Bn, 2013 prices), 2000–2014

USAID Global Health Programs, 2015

Current Bilateral Programs
Former Bilateral Programs
Out-of-Pocket Expenditures: Inefficient and Regressive

Source: WHO 2011 data based on World Bank Country Income Groupings
Out of Pocket payments lead to impoverishment

The incidence of financial catastrophe falls to negligible levels when the reliance on direct payments falls to less than 15–20% of total health expenditures

![Fig. 3.2. The effect of out-of-pocket spending on financial catastrophe and impoverishment](image)

The WHO report 2010: Health systems financing: The path to universal coverage

Out-of-pocket expenditure on healthcare as percent of total healthcare expenditure. 'Out-of-pocket' refers to direct outlays made by households, including gratuities and in-kind payments, to healthcare providers.

My presentation today:

The Changing World of Global Health

The Economic Transition of Health

The Global Movement for UHC
Health Systems Strengthening

Finance

Human Resources

Governance

Information

Medical Products

Service Delivery
Transforming Health Systems for UHC

“ACCESS FOR ALL TO APPROPRIATE HEALTH SERVICES WITHOUT FINANCIAL HARDSHIP”
"The First Law of Health Economics"

Source: Jacques van der Gaag; WHO/IMF 2004
THE by Government Health Spending Quintiles

2013 Total Health Expenditure as % of GDP

By quintiles of government health spending

n=150
Source: WHO's Global Health Expenditure and IHME
WGI: Voice and Accountability matters more!
UHC does not seem to increase THE !!!
UHC in Mexico through “Seguro Popular”

Source: Jacques van der Gaag; WHO/IMF 2004

N   = 178
R2  = 90%
1965: Medicare and Medicaid Law Signed
1973: HMO Act signed
1983: SSA mandates prospective payment system for hospitals
1993: Clinton Health Plan fails
1997: Height of HMO backlash: HMO rant on "As Good As it Gets"
2010: Obamacare passed

USA Health Spending (GDP%), 1950-2013
## Segmented model of organization of the health system

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<th>Social groups</th>
<th>Non-poor</th>
<th>Poor</th>
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<td></td>
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<td>Socially insured</td>
<td>Privately insured</td>
</tr>
<tr>
<td>Stewardship</td>
<td></td>
<td>Social security institutions</td>
<td>Private sector</td>
</tr>
<tr>
<td>Financing</td>
<td></td>
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<tr>
<td>Delivery</td>
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*Source: Frenk J. The Lancet 2015 385, 1352-1358 DOI: (10.1016/S0140-6736(14)61467-7)*
Structured pluralism of the health system by functions

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Source: Frenk J. The Lancet 2015 385, 1352-1358 DOI: (10.1016/S0140-6736(14)61467-7)
Old role models & new examples existed already
All for universal health coverage

Laurie Garrett, A.Mushtaque RChowdhury, Ariel Pablo Méndez
Universal health coverage (UHC): A New Frontier for Global Health

Source: The Lancet 2009 (based on ILO data).
Towards universal coverage

Coverage mechanisms

Reduce cost sharing and fees

Include other services

Services: which services are covered?

Financial protection: what do people have to pay out-of-pocket?

Population: who is covered?

Extend to non-covered
Figure 4: Health Financing Revenue Collection Mechanisms

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<th>Type of Collection</th>
<th>Description</th>
<th>Example</th>
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<td>General Taxation/Other Government Revenues</td>
<td>Funding comes from the national budget, which consists of revenues mainly from general taxation</td>
<td>National Health Services (NHS)</td>
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<tr>
<td>Payroll-Tax</td>
<td>Contributions are made usually in the form of payroll taxes, which make the formal workforce eligible for health services</td>
<td>Social security organizations</td>
</tr>
<tr>
<td>Risk-rated and Flat Premiums</td>
<td>Contributions are paid according to individual health risks and usually rise with age</td>
<td>Voluntary or mandatory health insurance systems</td>
</tr>
<tr>
<td>Personal Savings (e.g., Out-of-Pocket)</td>
<td>Payments from own savings made at the point of service, alternatively personal savings are mandated to be eligible for coverage</td>
<td>Individual health provision, personal medical savings program</td>
</tr>
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Source: WHO, World Bank, IMF, McKinsey

Figure 5: Framework for System Reform and Management Capacity Costs

- **System Stewardship**
  - System design: Policy and technical investment required to define vision for system and overall implementation plan
  - Program management: Prime Minister’s Office function to coordinate implementation of system reform vision
  - Stakeholder management: Cost of engagement and communications with stakeholders to ensure alignment behind transition
  - Performance management: Creation of a performance management function to manage relationships with elements of system
  - Market regulation: Set up costs of market regulator where private insurance is an element of the overall solution

- **Revenue Collection**
  - Enrollment/Collection networks: Creation of distributed network of enrollment/collection agents to collect contributions
  - Government administration: Costs associated with implementation of new payroll or other taxes for financing health system

- **Risk Pooling**
  - Fund set up and administration: Creation of a new institution to administer health system funds
  - Fund Management: Ongoing management of funds (e.g., auditing, accounting)
  - Risk equalization: Costs of a risk equalization design, analytics and processes

- **Purchasing**
  - Network management: Specifying minimum standards and determining which providers are included within network
  - Contracting: Cost of drawing up and negotiating contracts with health system providers
  - Monitoring: Creation of systems and processes to monitor provider performance
  - Claims management: Costs of defining claims management processes and regulations
  - Set up and administration: Administration costs of building new payer institution (where applicable)

- **Enablers**
  - Information technology: Infrastructure costs to support insurance systems
  - Health cards: Issuing cards to contributors to determine who is eligible for benefits
  - Buildings and infrastructure: Investment costs of office facilities

Source: McKinsey
Global health 2035: a world converging within a generation

UHC reaches the top of the global agenda
New DG for WHO: *a historical election 2017*
My Key Recommendations to Dr. Tedros:

1. Harnessing the global momentum behind UHC: UHC2030, G20, UN, Tokyo
2. Supporting countries reform efforts towards UHC: Revamped cluster, +WB, JLN
3. Monitoring coverage and accountability to SDG: Countdown

+ 1 Bn covered by 2025
Conclusions:

- Unprecedented gains in health and development during the golden era of global health and a historical shift in the political economy following the 2008 market crash are ushering in a new world health with serious implications for health systems:
  - At global level, development assistance is diluted with progressive focus on fragile states and global public goods like normativity, innovation & GH security become more important.
  - At national level, the economic transition of health and growing political demands for social protection promote domestic resource mobilization and universal health coverage which has reached the top of the international agenda and is emerging as a new frontier for social justice and health equity.
Thank you
Health worker skill mix and density changes through economic transition

[Graph showing health worker density per 1000 people against GDP. The graph includes symbols for nurses/midwives, doctors, and CHWs with varying sizes representing different countries.]

*WHO Global Health Observatory Data
SDG indicator or other outcome measure

• The UN statistical commission has finalized the SDG indicators

• WHO and WB agreed on the two indicators for UHC:
  3.8.1 Coverage of essential health services
  3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income.

• Additional indicators should be considered, including total health spending, OOP/THE, public/private financing and provision, quality of services (effective coverage), **disaggregation** of coverage by income quintile, urban/rural/county, age, gender and economic sector.
US Hospital Spending, 1970-1990

1983: SSA mandates prospective