Health System Financing and the Path to Universal Coverage: Voices of Experience

Implications for Research

1: The World Health Report: what we did not know
2: Dr Viroj Tangcharoensathien: Thailand
3: Professor Julio Frenk: Mexico
4. Dr Aquina Thulare/Mr Moremi Nkosi: South Africa
The World Health Report

HEALTH SYSTEMS FINANCING

The path to universal coverage

Implications for Research

World Health Organization
Universal Coverage: the Ambition

1. World Health Assembly Resolution of 2005 urged countries to develop their health financing systems to:

- Ensure all people have access to needed services without the risk of financial hardship linked to paying for care.

2. Universal Coverage defined as coverage with needed health services; financial risk protection; for everyone.
Millions miss out on needed health services: percentage of births attended by skilled health worker

Q1, Q5 and Average - 22

Source: Latest available DHS for each country (excl. CIS countries)
Millions suffer financial ruin when they use health services

When people use health services:

- Globally around 150 million suffer severe financial hardship each year

- 100 million are pushed into poverty because they must pay out-of-pocket at the time they receive them.
**Diagnosis:**

What are the causes?

1. **Exclusion linked to factors outside the health system** – inequalities in income and education and social exclusion associated with factors such as gender and migrant status.

2. **Weak health systems:** Insufficient health workers, medicines and health technologies. Ineffective service delivery. Poor information systems and weak government leadership.

3. **Health financing systems that do not function.** The other parts (frequently called health system building blocks) cannot function if the financing system is weak.
Proposing Solutions: 
The World Health Report 2010

1. Draws on country experiences and the best available evidence to suggest options that countries can consider to address their own specific health financing needs.

2. Solutions proposed in terms of three fundamental health financing problems:
   - The continual need to search for sufficient funds for health
   - Financial barriers to access such as direct out-of-pocket payments (e.g. fees and charges) discourage the most vulnerable from seeking care and result in financial hardship, even impoverishment, when they do
   - Inefficiency and inequity in use of resources.

3. Solutions relevant to countries at all income levels, while acknowledging that low-income countries face the greatest needs

4. Suggestions for how the international community can better help low-income countries develop their own health financing systems and institutions.
What we did not know

Coverage with health services

- Cross country data limited to very few health interventions: e.g. childhood immunization and births attended by skilled health workers
- Survey data rather than country reports largely limited to Demographic and Health Surveys (DHS)
- Effective coverage data lacking: what proportion of the people who need a particular service obtain it with a level of quality sufficient to elicit the desired impact?
- People fall back on self report: pretty useless
Self-reported need
(Source: World Health Survey)

Q1/Q5 vs. Average - need

- q5/q1
- q1
- q5
- total
What we did not know
Long term financial hardship

Fig. 3.2. The effect of out-of-pocket spending on financial catastrophe and impoverishment

- Financial catastrophe
- Impoverishment

Out-of-pocket payments as a percentage of total health expenditure
What we did not know: solutions
e.g. Results based financing (RBF)/pay for performance

RBF in low-income countries: some studies show a positive impact on some behaviours and outputs. But most studies did not even attempt to:

- Monitor possible negative impacts – e.g. what do providers stop doing when paid for particular activities or outputs; cheating; leakages?
- Measure the costs of implementation and additional monitoring;
- Compare RBF with alternative ways of achieving the same result (same for conditional cash transfers).
What we did not know
Global health community

- Changes in efficiency globally since Paris Declaration: increase in global health initiatives since 2005, but at what cost?

- What proportion of donor disbursements is actually being spent by recipient countries – "hidden data" globally. Requires national health accounts rather than more people tracking donor disbursements and commitments.

- Only scattered information on transaction costs at country level – e.g. Rwanda has to report on 890 different health indicators to the various donors, almost 600 for HIV and TB alone. Vietnam had 400 aid missions to review health projects in 2009.
WHY? Hypotheses for Discussion

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 Researchers are not interested in these questions?

 Funders will not fund this type of research?

 The potential users of this knowledge do not make their demands explicit or do not know what they need?

 The proponents of the interventions are the sources of funds for evaluation?

 ????
World Health Report 2010

Launch: 22 November 2010


Background papers:
http://www.who.int/healthsystems/topics/financing/healthreport/whr_background/en
Thank you
What we did not know

Nature of coverage

Towards universal coverage

- Reduce cost sharing and fees
- Include other services
- Extend to non-covered

Financial protection: what do people have to pay out-of-pocket?
Services: which services are covered?
Population: who is covered?