Σrsa Economic Research Southern Africa

ERSA Research Brief

April 2014

Economic aspects of universal health coverage[1]

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This brief sums up the findings of his presentation, focusing on themes and insights that are most relevant to South African health policy. The objective is to encourage public discussion amongst practitioners, policy makers, academics and NGOs on the broad process of health system reform in South Africa.

The World Health Organization has called for countries to take steps to achieve universal health coverage (UHC), which in its simplest form means providing all people with access to needed health services of sufficient quality without imposing financial hardship. Studies show that broader health coverage leads to improved population health, particularly for the poorest members of society. Developing countries in Africa and Asia such as Ghana, Rwanda, Kenya, Mali, Nigeria, Vietnam, India Indonesia, and the Philippines, have attempted to reach UHC by different paths and from different existing health systems (Lagomarsino et al, 2012). Countries still striving to reach UHC can learn from these countries' experiences to optimise their transition.

The benefits of universal health coverage

The two broad social groups that benefit most from UHC are:

- the very poor, who would otherwise have foregone treatment because they could not afford it, and
- those who would normally have paid for and received treatment but can now access treatment without charge (thus benefiting in financial rather than health terms).

UHC is thus principally a redistributive mechanism, transferring wealth from the rich and healthy to the poor and sick. In essence, it purchases health insurance for those who would otherwise have limited cover or no cover at all. However, for UHC to work it must be genuinely universal. All of society, rich as well as poor, must use the services provided, so that those who are subsidising the system will feel that they have a stake in its success. Services therefore need to be of a high enough quality that everyone will want to use them. This quality must not be compromised. If the public health system has to cut back on the range of services it can offer, to keep the quality level acceptable, then this is a necessary sacrifice.

Health benefits of UHC in poor and unequal countries

Beyond the financial benefits of UHC, studies show that increasing pooled expenditure (i.e. publically funded health coverage) improves health outcomes markedly. In low income countries it costs just $145 to save a life year, while in high income countries this figure can be as high as $50,000. In addition, private spending on healthcare, whether in the form of out-of-pocket or private insurance, has been found to be less effective at saving life years. This is understandable, since it tends to be the richer households who pay for private care, and they already have a higher life expectancy than the poor, who cannot afford any private expenditure. In low income countries the relationship is such

[1] On 6 February 2014 ERSA hosted a symposium in Stellenbosch on Critical Choices Regarding Universal Health Coverage. The full presentation may be found at: www.econrsa.org/system/files/workshops/papers/2014/peter_smith_cape_town_uhc_jan2014.pdf

that more spending quickly increases life expectancy, while in middle and high income countries this relationship is somewhat weaker.

Inequality has an effect on a society's health outcomes. Research shows that health coverage is less effective in countries with high social inequality. UHC is a redistributive mechanism, but it cannot be considered a prime approach to address all of society's inequities – that would be too heavy a burden for the health system alone to bear. A health system has to work within the broader context of existing social inequalities. UHC can certainly go a long way towards alleviating the problem – by ensuring, for example, good access to healthcare for disadvantaged people – but it should not be peddled as a cure-all for inequality.

The transition to universal health coverage

The fundamental question for countries seeking to roll out UHC is how to move from where they are now to where they want to be. Timing is important. To take an example, the UK's attempt to implement UHC in 1948 was not well-timed, given that the country was still recovering from World War II. (But because the political rhetoric of the time strongly emphasised equality and solidarity, the UK's health system did benefit.) The Lancet published a series of papers in 2012 on countries that have introduced UHC. It is interesting to note that nearly all these countries took the opportunity to seize an auspicious political moment to introduce UHC.

Each country institutes UHC in its own way, but three common features may be noted:

- political will and social support for generalising healthcare,
- a rise in per capita income together with a rise in government spending on health, and
- an increase in the share of health spending that is pooled rather than paid for directly by individuals and families.

Financing universal coverage

In health systems, pooled financing is money raised through taxes or premiums that individuals must pay whether or not they need healthcare. The criteria for contributing funds (such as income, occupation or residence) should be unrelated to the criteria for receiving benefits: needing healthcare but being unable to pay for it. Pooled financing can substantially improve the use, equity, productivity and effectiveness of health systems compared with systems in which patients are individually responsible for their own health costs at the time of service. No country has achieved UHC while its health system relies predominantly on personal payment for medical treatment or basic preventive care.

The question of who provides funds for UHC is fundamental. It will determine revenue, which will in turn determine the range and magnitude of services that can be provided. One of the major policy decisions is the extent to which the middle class and the affluent will be required to contribute towards the system. There is a limit to people's willingness to pay. To ensure stability and buy-in, UHC must be designed to serve not only the poor but also those shouldering most of the tax burden. In some cases this can be achieved only by starting with a very narrow set of basic benefits, provided at a quality level that is also acceptable to wealthier citizens, and then gradually broadening the benefits as fiscal means and human resource capacity increase.

What type of coverage?

With limited resources it becomes essential to find a way of defining a limited basket of treatments to be covered by public insurance. Many countries have used cost-effectiveness analysis because it sets explicit rules about how to ration access to care. Moreover, it avoids involving politicians, public sector and hospital managers and clinicians in case-by-case decisions and instead allows insurers and other health authorities to set the basket of health services in a systematic and transparent way. If rationing is not done with an explicitly defined benefits package, it will be done in other less acceptable ways, in the form of excess waiting times, inferior service delivery, bribes, price hikes, and so on.

But cost-effectiveness analysis also has its drawbacks. It works on the assumption that:

- the objectives are known (e.g. to maximise health, enhance financial protection, promote equity),
- treatments are independent, with no economies of scope or scale,
- there are no transition costs,
- there is a fixed budget, and
- there are no significant constraints, apart from the budget.

Learning from Chile

Chile's approach to defining a benefits package makes an interesting case study. The country had a segregated health system. Private social insurers covered a mere 17.5% of the population – the high-income and upper-middle-income workers and their families. The rest – the lower-middle-income and lower-income workers and their families, and the elderly and the indigent – relied on private service providers, or low-quality public health service providers, or a National Health Fund which covered 76.5% of the population.

The Chilean UHC plan AUGE (Acceso Universal con Garantías Explícitas or Universal Access with Explicit Guarantees) stipulated that people were free to choose their healthcare insurer, but whichever insurer they choose, public or private, it had to have a core benefits package that maintained certain quality standards. This began as a modest but well-defined minimum benefit package as an alternative to risk adjustment, to compensate insurers for differences in population risk. Insurers were then free to offer additional complementary services (at a premium). AUGE seems to have been a successful reform in so far as:

- access to health services has increased through use of the public insurer,
- the gap between use of public and private insurers has narrowed,
- the quality of care has improved owing to the use of treatment protocols, and
- the use of provider networks by public and private insurers has helped to contain costs.

Conclusion

In moving towards a universal package of insured health services, governments have to make some difficult decisions. The size of the offered package of health services will be determined largely by what the rich and healthy are prepared to distribute to the poor and sick. The contents of the package will be determined by cost effectiveness but the quality will have to be of a high enough standard to satisfy the entire population.

Whether the services are provided by the public or the private sector, the difficulty will be to ensure both quality and affordability. Success depends crucially on implementation, including issues such as quality assurance, access for vulnerable populations, setting of user charges, provider payment systems, and monitoring and feedback systems.

Selected references

Moreno-Serra, R. and Smith, P. (2012), "Does progress towards universal health coverage improve population health?". The Lancet, 380, 917–23.

Savedoff W., de Ferranti D., Smith A., Fan V. (2012). "Political and economic aspects of the transition to universal health coverage". The Lancet, 380, 924–32.

Lagomarsino, G., Garabrant, A., Adyas, A., Muga, R. and Otoo, N. (2012), "Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia". The Lancet, 380, 933–43.