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Going Universal

How 24 developing countries are covering people from the bottom up

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on behalf of the UNICO team

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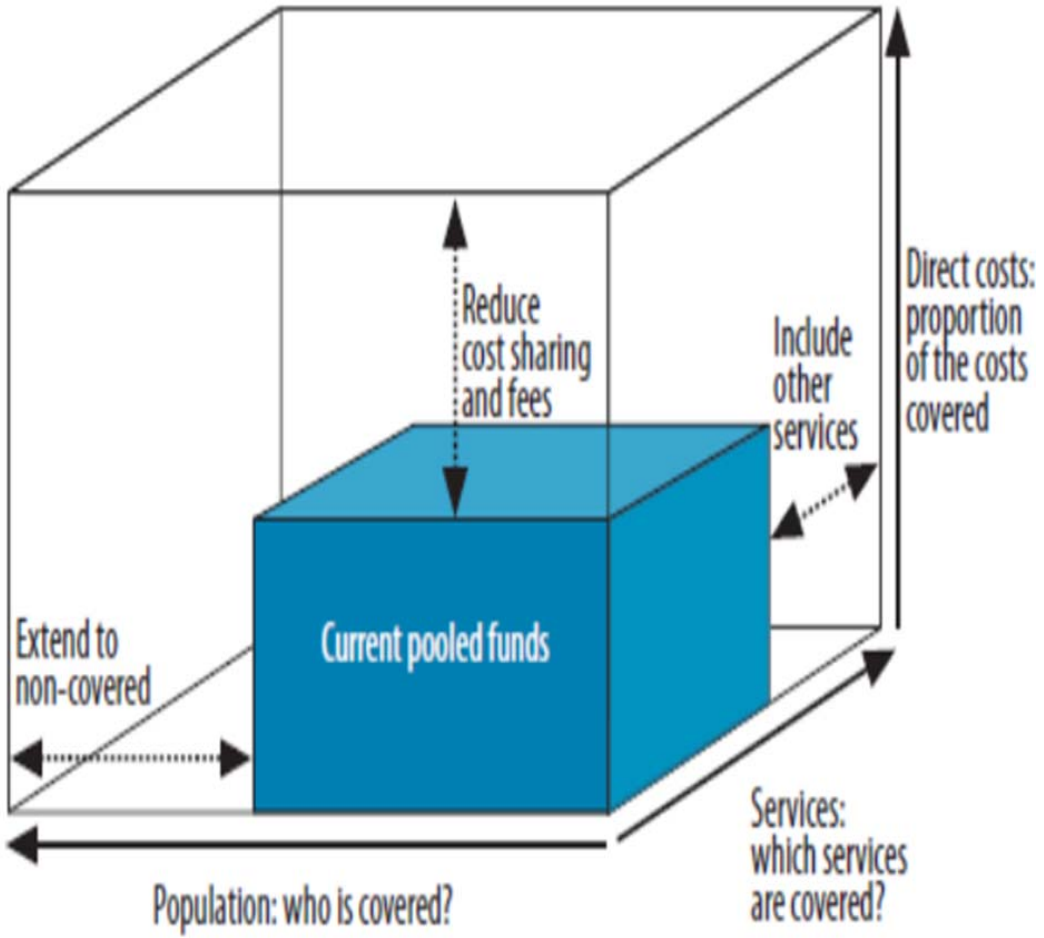
UNICO study – Objective and approach

- Objective: To learn *how* countries are implementing UHC
- Descriptive; researchers learning from policy-makers; not prescriptive
- Focus on countries that have adopted a “bottom-up” approach to implementing UHC post-2000
- 26 programs in 24 countries
- Systematic data collection: Common questionnaire – 9 modules, 300 questions
- Published reports: www.worldbank.org/universalhealthcoverage

Five aspects of “how” programs are implemented

The UNICO Study

- Covering People
- Expanding Benefits
- Managing Money
- Improving Supply
- Strengthening Accountability



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24 UNICO Country Case Studies

- Argentina
- Brazil
- Chile
- China
- Colombia
- Costa Rica
- Ethiopia
- Georgia
- Ghana
- Guatemala
- India
- Indonesia
- Jamaica
- Kenya
- Kyrgyz Republic
- Mexico
- Nigeria
- Peru
- Philippines
- South Africa
- Thailand
- Tunisia
- Turkey
- Vietnam

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UNICO programs: Coverage and date of creation

Country	Health Coverage Program	Creation	Coverage (millions)	Coverage (% of pop)
Argentina	Maternal-Child Health Insurance Program (Plan Nacer)	2003	1.7	4%
Brazil	Family Health Strategy (Programa Saúde da Família, FHS)	1994	102	51%
Chile	National Health Fund (Fondo Nacional de Salud, FONASA)	1981	13.2	78%
China	New Rural Cooperative Medical Scheme (NRCMS)	2003	832	64%
Colombia	Subsidized Regime (SR)	1993	22.3	47%
Costa Rica	Social Security of Costa Rica (Caja Costarricence de Seguridad Social, CCSS)	1984	4.3	91%
Ethiopia	Health Extension Program (HEP)	2003	60.9	68%
Georgia	Medical Insurance Program (MIP)	2006	0.9	20%
Ghana	National Health Insurance Scheme (NHIS)	2005	8.2	33%
Guatemala	Expansion of Coverage Program (Programa de Extensión de Cobertura, PEC)	1997	4.4	29%
India	National Rural Health Mission (NRHM)	2005	840	70%
	Andhra Pradesh Rajiv Aarogyasri (RA)*	2007	70	85%
	Rashtriya Swasthya Bima Yojna (RSBY)	2008	70	6%
Indonesia	Jamkesmas	2005	76.4	32%
Jamaica	National Health Fund (NHF)	2003	0.5	19%
Kenya	Health Sector Services Fund (HSSF)	2010	20	48%
Kyrgyz Republic	State-Guaranteed Benefit Package (SGBP)	2005	4.2	76%
Mexico	Popular Health Insurance (Seguro Popular, PHI)	2004	51.8	43%
Nigeria	Ondo State National Health Insurance Scheme (NHIS-MDG-MCH)*	2008	0.1	4%
Peru	Comprehensive Health Insurance (Seguro Integral de Salud, SIS)	2002	12.7	42%
Philippines	National Health Insurance Program (NHIP)	1995	78.4	83%
South Africa	Comprehensive HIV and AIDS Care, Management and Treatment	2003	1.5	3%
Thailand	Universal Coverage Scheme (UCS)	2002	47.7	71%
Tunisia	Free Medical Assistance for Poor (FMAP)	1991	3.0	27%
Turkey	Green Card (Yesil Kart)	1992	9.1	12%
Vietnam	Social Health Insurance (SHI)	2009	55.4	63%
	Total/Average		**2,392.0**	**44%**

Starting point: Inequality and two gaps

Three challenges hide “inside the UHC Cube”

1. Populations are segmented in their access to health care
   - Formal sector (FS), Informal Sector (IS), Poor and Vulnerable (PV)
2. Health financing is fragmented
   - Social Health Insurance (SHI) covers formal sector relatively well
   - MoH covers PV and IS -- through supply subsidies
   - MoH spends less per capita than SHI (or private insurance); offers lesser benefits and greater financial risk
3. Insufficient provision combined with underutilized capacity
   - Lower access to care among the poor and lower quality of care
   - MoH has some no-fee care and higher-end facilities for paying users
   - More productivity and better quality can be achieved with better incentives and organization

These challenges create a provision Gap and a financing Gap

Conclusions

UHC programs are New, Massive and Transformational

- Growth in last 15 years
- Globally cover a third of world's population and nationally operate at scale
- Designed to change the health system

Substantial policy convergence

But countries must choose their path to UHC

Stepping Stones are common in the path

New Risks

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Policy Convergence

Two broad approaches:	•Supply-side and Demand-side approaches
Covering People:	•Acknowledge each population has different needs •Overcoming anonymity – use citizen ID and targeting systems •Getting better at it
Expanding benefits	•Most move beyond MDG interventions •Explicit benefits •New contracts and payment systems
Managing Money	•Coverage of the poor is always non-contributory •Programs complement rather than replace MoH; most countries combine demand-side and supply-side subsidies
Improving Supply	•Greater flexibility in public hiring and management of public clinics and hospitals •Half engage with private providers •Accreditation systems
Strengthening accountability	•Change the way stakeholders interact •Arms-length delegation; Output –based financing; greater data collection; empowering citizens

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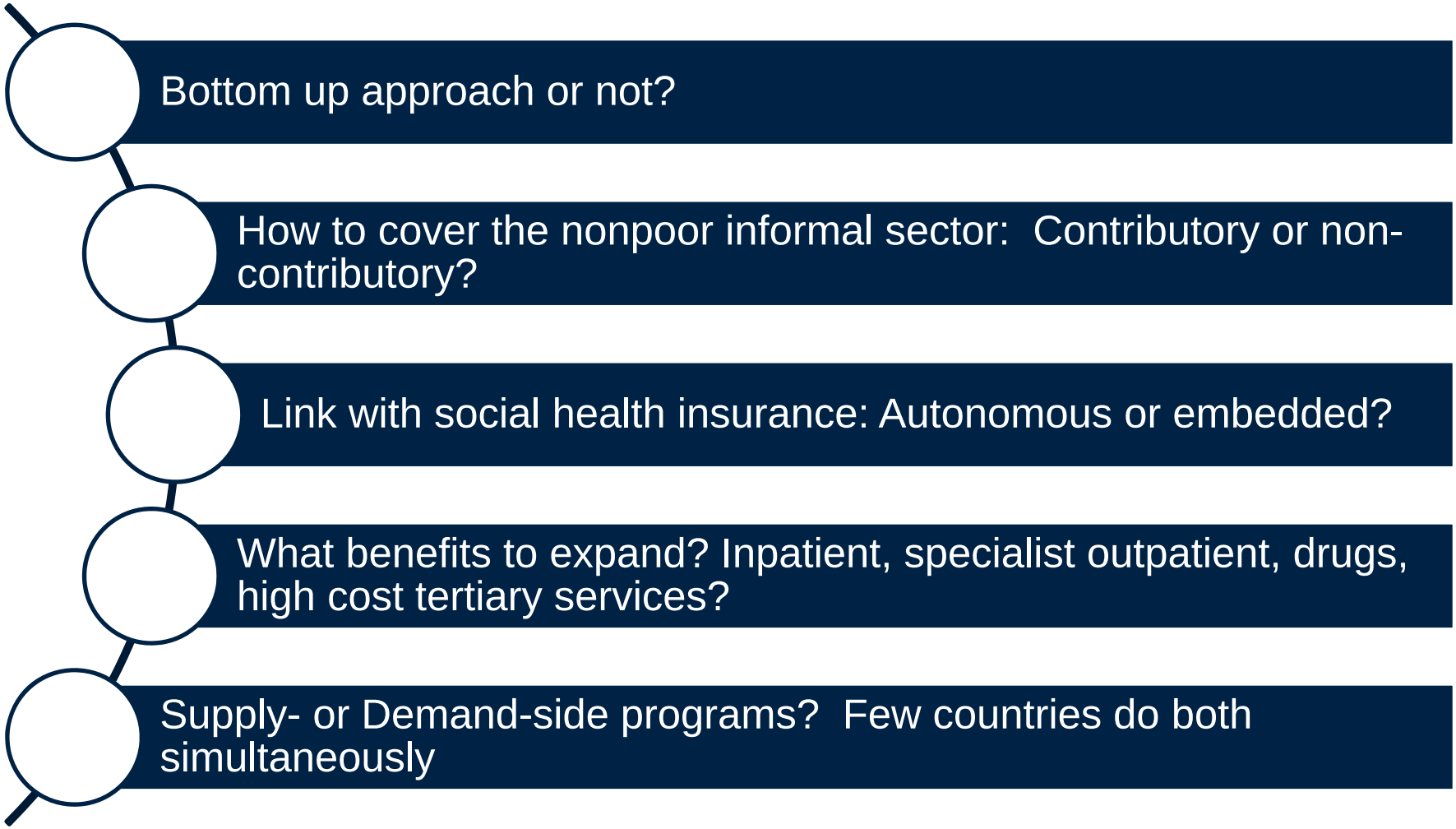
Policy Choices and Paths



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Stepping stones are often needed

Not ideal configurations for a final state, but a useful temporary solution.

- Programs targeted only to the poor and vulnerable.
  - Useful to develop new UHC skills,
  - To await for propitious socio-economic fundamentals to also cover the nonpoor
- Autonomous informal sector programs
  - Expand faster
  - Postpone needed reforms
- Voluntary health insurance
  - Not a path to UHC
  - Makes transitions smoother
- Key to determine if stepping stones are sticky

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New Risks

Increased complexity

- Technical – New activities, new ways of implementation
- Political – Prioritizing subpopulations, choice of expansion of benefits, avoiding populist promises

Broken Promises

- Implicit rationing: Gaps between promised benefits and de facto benefits
- Slow transition from implicit to explicit targeting
- Despite data abundance, very little monitoring and reporting

Fiscal Sustainability

- Program expenditures are fiscally manageable because they leverage existing spending
- Over-promising benefits may be costly once accountability procedures become stronger (e.g. “judicialization”)

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Thank You