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
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
## UNICO programs:
### Coverage and date of creation

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

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

- Bottom up approach or not?
- How to cover the nonpoor informal sector: Contributory or non-contributory?
- Link with social health insurance: Autonomous or embedded?
- What benefits to expand? Inpatient, specialist outpatient, drugs, high cost tertiary services?
- Supply- or Demand-side programs? Few countries do both simultaneously
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
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”)
Thank You