T17aP07 / Going Universal? Universal Health Coverage on Paper and in Practice

Topic : T17a / Sectorial Policy - Health

Chair : Federico Toth (Università di Bologna)

GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

The literature on Universal Health Coverage (UHC) comes from several disciplinary perspectives. It addresses various themes: access to essential health care, population coverage, the package of entitlements or benefits to which the covered population is entitled, and protection from the economic and social consequences of illness [Stuckler et al. 2010].

UHC is obviously a multi-dimensional concept [Abiiro and De Allegri 2015]. It can be pursued by a variety of pathways and health financing arrangements [Savedoff et al. 2012]. There is no single way to to achieve universal coverage, and fully achieving UHC is all but impossible for any country [Kutzin 2013]. All national governments face trade-offs and must make choices regarding the coverage [WHO 2010]: the proportion of the population; the range of services to be made available; the share of total costs the individual patients have to pay (user charges).

The proposed panel will provide an opportunity to discuss the various facets and dimensions of UHC, both as empirical studies about its experience in different countries as well as theoretical studies. The panel especially welcomes papers with a comparative perspective.

References

Abiiro, G.A. and M. De Allegri (2015), Universal health coverage from multiple perspectives: a synthesis of conceptual literature and global debate, in «BMC International Health and Human Rights», 15, 1, pp. 17-23.

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CALL FOR PAPERS

Universal health coverage (UHC) is a rather ill-defined concept, which has been given multiple meanings. The absence of a clear definition of UHC has resulted in various interpretations and representations. For instance, the World Health Report 2010 unpacked the concept of UHC into three dimensions:

1. the proportion of the population to be covered (who is insured?);
2. the range of services to be made available (which benefits are covered?);
3. the proportion of the total costs to be met (what proportion of the costs the individual patients have to pay?)

The theoretical goal of the panel is to identify the key dimensions of UHC, in order to arrive at a clearer definition of the concept.

On the empirical level, many national governments have recently adopted reforms aimed at extending and improving health coverage on their territory. In some countries, insurance coverage has been extended to individuals who previously lacked it. In other countries, it was decided to redefine the basic package of health care services, making it more generous. In still other cases, reforms were intended to ensure equity in access and good quality care.

One could argue that, as a general trend, health coverage is becoming increasingly universal. But it is really so? Evidence suggests that in many countries patients' rights - although established in principle - still remain on paper. And there are also countries where, due to the recent economic crisis, health insurance coverage has declined in recent years.

What is the impact of these recent health reforms? To what extent have they made health coverage more universal?

The panel provides an opportunity to discuss the various facets and dimensions of UHC, both as empirical studies about its experience in different countries as well as theoretical studies. The panel especially welcomes papers with a comparative perspective.

T17aP07 / Going Universal? Universal Health Coverage on Paper and in Practice

Chair : Federico Toth (Università di Bologna)

Session 1

Wednesday, June 28th 14:00 to 16:00 (CJK 1 - 2)

Discussants

Kieke Okma (Catholic University Leuven)

Ryozo Matsuda (Ritsumeikan University)

Insider-Outsider Politics and Support for Universal Health Coverage in Low and Middle Income Countries: Evidence from Afrobarometer Surveys

Ashley Fox (Rockefeller College, University at Albany, State University of New York, State University of New York)

Background. The global health community is increasingly promoting universal health coverage (UHC) as a solution that can strengthen health systems, raise revenue for health care, and improve social risk protection in low- and middle-income countries (LMICs). Described as “universal prepayment,” the national health insurance model has particularly caught on and is being diffused internationally by such actors as the World Bank and Rockefeller Foundation. However, one central political dilemma in establishing systems of universal prepayment in low and middle income countries is the low tax base available to contribute to the financing of health care. Many middle class workers in the formal sector (labor market insiders) may already get insurance through the state or private insurers leaving them little incentive to contribute in tax dollars to a universal coverage system that will primarily benefit indigent workers in the informal sector (labor market outsiders).

Methods. We explore attitudes towards UHC using recent data from Afrobarometer surveys in 32 countries comprising Sub-Saharan and North Africa. The 2016 round of Afrobarometer asks respondent about their willingness to pay more taxes to increase government health spending. We explore predictors of low support for paying more in taxes to increase health spending including profession and labor market status. We hypothesize that labor market insiders (professionals working in the formal sector) will be more strongly opposed to UHC financing than labor market outsiders (wage laborers and informal sector) who would presumably benefit more from the system and pay in less. We adjust for other factors likely to affect support for UHC including attitudes towards the government, health care and demographics.

Results. We find that in spite of growing attention to universal coverage among policymakers, support among the average citizen is low, though variable across countries. Over 40% of the public opposes the idea of paying more taxes to increase health spending in 25 countries. Moreover, being a labor market insider is significantly associated with opposition to paying more in taxes to increase government spending on health.

Conclusions. Insider-outsider politics is a framework that has been used to explain divisions within the political left that contribute to social policy retrenchment. Here the framework is used to test why support for UHC might not be as high as we might think among the public at large in LMICs. As UHC hinges on tax financing structures that demand the small tax paying middle class in a country to finance health care for a large informal sector of low-income, non-tax payers, the widespread support required for universalistic policies may not be forthcoming in LMICs.

Measuring Financial Protection through public funding of insurance programmes in Indian Context: Evidence from 71st Round of India's National Sample Surveys

Alok Ranjan (Indian Institute of Technology-Jodhpur)

Priyanka Dixit (Tata Institute of Social Sciences, Mumbai)

Sundararaman Thiagarajan (Tata Institute of Social Sciences, Mumbai)

Background : Recently world has moved from Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs), where Universal Health Coverage (UHC) is one of the important goals (Goal 3).Insurance is projected as playing a key role. In recent years India and its different states have witnessed the roll-out of various government sponsored health insurances schemes to improve financial protection for the poor. Present study is based on India's 71st Round National Sample Survey (NSS), 2014 presents a comparative study of progress towards UHC in dimension of access and financial protection in India (population: 1221 million) and its two most populous states, Uttar Pradesh (population:199 million) and Maharashtra (population:112 million)- which are at very different levels of social economic development.

Methodology: Data collection under 71st Round of National Sample Survey was done for 65932 households (rural: 36480, urban: 29452) in India which included 3, 33,104 individuals (male: 1, 68,697 female: 1, 64,407). Also, 7921 and 5403 households were selected from Uttar Pradesh (UP) and Maharashtra, respectively. Hospitalization rates- reflective of access to secondary care, average out of pocket expenditure (OOPE), catastrophic health expenditure (CHE) at 10% (CHE-10) and 25% (CHE-25) and impoverishment due to hospitalization cost were taken as outcome variables for the study. Expenditure was considered as catastrophic for 10% and 25% threshold, if OOPE proportion compare to total usual consumption expenditure of the household was higher than given threshold. For impoverishment calculation, poverty line was taken from Planning Commission Report, 2014. Simple and two way cross tabulation, multivariate logistic regression and propensity score matching were main analytical methods.

Results: Proportion of ailing persons who sought any treatment were 76 per 1000 population for Maharashtra and it was 73 for Uttar Pradesh. Hospitalization rates were 4.9% in Maharashtra and 3.4% in Uttar Pradesh. Both Maharashtra and Uttar Pradesh had modest insurance coverage- 7.2% and 4.1% respectively. Although only 3.4%, of total government sponsored insured population, reported cashless care during hospitalization in India- and the figures were even lower in Maharashtra -only 2%, but in Uttar Pradesh it was 7.2%. At 10% of threshold 39.7% of hospitalized population had CHE in India. For Uttar Pradesh and Maharashtra it was 43.7% and 49.2% respectively. Propensity score matching showed government funded insurance schemes reduced CHE incidence at the 25% threshold by a meagre 6% (95% CI: 4-9) in India. Furthermore in all the three contexts (the two states and at the all India level) insurance did not help the household from getting impoverished. OOPE, CHE and impoverishment was significantly lesser if households took services from public provider compare to private provider.

Conclusion: Universal health coverage is much more than insurance coverage and in the given context insurance coverage did not facilitate access or financial protection for hospitalization. Also, it was inefficient in protecting households from CHE and impoverishment. Indian policy makers should be cautious while choosing insurance as the path towards UHC. Considering this present study fit aptly with the given theme.

Implementing Policy Under A Decentralized and Democratic Polity: Lesson Learned from Indonesian Policy Towards UHC (Universal Health Coverage)

Wahyudi Kumorotomo (Gadjah Mada University)

Implementing Policy Under A Decentralized and Democratic Polity: Lesson Learned from Indonesian Policy Towards UHC (Universal Health Coverage)

(Abstract)

Wahyudi Kumorotomo

This study is aimed at explaining the implementation process of a public policy using an Indonesian case, especially the health policy towards a UHC (Universal Health Coverage), an area of policy that is being planned and implemented in many developing countries. Since 2014, the Indonesian government launched a comprehensive policy for more effective social welfare system. Under a grand design of the National Social Security System, two agencies called BPJS (Badan Pelaksana Jaminan Sosial, Social Security Administering Bodies) are set up. The BPJS program on health is targeted to cover at least 121.6 million Indonesian in the first year and would cover all the population in 2019. The government is trying to deal with a far-reaching health-care reform to create a Universal Health Coverage (UHC) that has been in practice in many developed countries.

In order to finance the program, the government has worked out two systems. First, individuals living below the

poverty line will get financial assistance under the Premium Payment Assistance (PPA). Second, individuals who are employed and able to finance the premium are included in the non-PPA group consisting civil servants, private sector employees, entrepreneurs, military and police officers.

However, it is still unclear whether the government is ready to deal with financial provision according to the initiated coverage. The financial shortage might also be expected in providing premium for wage-earners and non-salaried workers. The BPJS finance has run a deficit in the last three years at about 4 percent. Under a decentralized system, there have been issues about coordination of policy and expenditures between the central and regional governments, in the interests of both equity and also efficiency. Deteriorated quality of services in health care have forced well-paid workers to seek higher-quality care elsewhere under a financial scheme of insurance providers.

Aside from describing the national picture of the health insurance policy, the study will be explaining its implementation at a provincial level. In order to get the international perspectives, comparative analysis will be exercised using the experience of European countries adopting the UHC. Policy notes, journals, and references in the WHO will help to conduct such analysis.

In Indonesia, statistics on local hospitals, clinics, diagnostic centers, and available human resources such as doctors, nurses and paramedic officers are collected from the local Dinas Kesehatan (local agency for health) and public hospitals. Data from two health facilities already accommodating BPJS programs, i.e. Sardjito general hospital and Panti Rapih hospital are collected from the contact persons. In order to obtain financial details and opinion of the stake-holders, interviews are conducted with the hospital managements, doctors and patients.

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Session 2

Wednesday, June 28th 16:15 to 18:15 (CJK 1 - 2)

Discussants

Ryozo Matsuda (Ritsumeikan University)

Kieke Okma (Catholic University Leuven)

Inequalities in Health Care in China 1991-2011: Evidence from the China Health and Nutrition Survey

Xun Wu (Hong Kong University of Science and Technology)

Yifei Yan (University of Southampton)

Qian Jiwei (East Asian Institute, National University of Singapore)

While China's health system has undergone significant transformation since the 1990s, including several major policy shifts, the impacts of this transformation on inequalities in health care have not been well understood. Our study examines the trend of inequalities in health care from 1991 to 2011, using data from the China Health and Nutrition Survey. Results reveal that inequalities in health care in China over those two decades were shaped by several structural factors, including geographical location, profession, employment status, type of work unit, and income level. And though recent reform efforts focused on strengthening social health insurance appear to have been effective in achieving a high level of equalities in health insurance coverage, inequalities in actual health care have persisted, or worsened, in important respects, such as utilization of health services and expenditures on health care.

Universal Access to Health Care in Russia: Right or Reality?

Tatiana Chubarova (Institute of Economy, Russian Academy of Sciences)

Natalia Grigorieva (Lomonosov Moscow State University)

Accessibility is one of the basic principles which ultimately determine structure, aims and objectives, evaluaton of outcomes in health system. The citizens' right to health and health care is enshrined in the Constitution of the Russian Federation together with guarantees of their fullfulment - the possibility for citizens to receive decent quality and timely health care. Improving accessibility of health care is one of the mechanisms of smoothing social inequality in Russian society. In turn, population health status is considered as one of the criteria of effectiveness of social and economic policy. However, even if a country sets a political task to ensure universal access, its practical implementation is likely to face serious difficulties.

The paper is divided into two parts. The first part discusses theoretical issues as defininng access to health care has a number of methodological difficulties, reflected in the works of both researchers and such bodies as WHO. As main indicators of access experts distinguish the share of population covered by health system, the content of health package, the presence of cost-sharing, geographic, organizational barriers and the level of utilization of available services. Access is often defined “negatively” via “absence of barriers” approach – territorial, financial, cultural that weakeans the operational use of the concept. The authors put up a proplem of developing aggregate indicator (indice) to provide a measure of access at the level of the health system.

The second part analyses the actual state of affairs with access to health care in Russia using the data available in two ways – summing up entitlements to health care fixed in legislation and defining barriers to access –

financial and delivery. The analysis shows that low public spending together with increase in out of pocket payments as well as restructuring of health delivery netwerk might hamper access for ceirtan population groups. One of the problems might be the so called optimisation of Russian health system that reflects the contradiction between two roles of the state – a quardian of people's access to health care and a manager whose main task is cost-effectivve use of limited resources.

The Effectiveness of Health Expenditure on Health related Developmental Goals and Targets in South-East Asia

Deepak Kumar Behera (Indian Institute of Technology Madras)

Umakant Dash (Indian Institute of Technology Madras)

Research Question

Universal Health Coverage is central to the UN Sustainable Development Goals (SDG), adopted on 25th September, 2015 with a specified target to ensure healthy lives and promote wellbeing for all at all ages. Before SDGs, the UN general assembly had adopted Millennium Development Goals (MDSs) in September 2000, in which health related development goals such as reduced child mortality, improved maternal health and combatting HIV/AIDS, malaria and other diseases have also been important targets. During the MDG era from 2000 to 2015, South-East Asia countries have shown notable progress towards reaching the MDGs, but achievement remains below the potential level. Despite the surge of health expenditure since 2000, there is persistence of inequality in health related millennium developmental goals and targets which vary across the South-East Asia.

Significance

In the light of the post-2015 SDGs, against the backdrop of the surge of public health expenditure since 2000, the paper seeks to find out whether the increased spending on health in region of the South-East Asia has yielded better health outcomes. The paper progresses in three stages: first, we examine the effect of health spending on the ultimate goals. Second, with the understanding that health spending has specific targets, we examine its effectiveness on some of the proximate targets. Third, we examine the effects of the proximate targets on the ultimate goals while controlling for economic growth, UHC index, government effectiveness, political stability, gender parity index and urbanization. The ultimate goals are of interest to us because they capture the cost-benefit relationship of public health expenditure.

Methodology

The dataset is made up of 11 countries (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Democratic People's Republic of Korea and Timor-Leste) of South-East Asia of World Health Organization over the time period 2000-2015. The time period 2000-2015 enables us to capture the surge in public health expenditure since the enactment of the MDGs (2000) and allows to us examine the effectiveness of the financial upsurge into the health sector. The health expenditure variables are: total health expenditure, public health expenditure, private not-out-of-pocket and private out-of-pocket collected from global heath expenditure data of WHO. The healthcare outcome variables are ultimate goals (life expectancy index, infant and child mortality rates) and proximate targets (the percentage of immunized children, the cases of malaria reported at a health facility; HIV/AIDS prevalence and the percentage of the population undernourished) collected from the WDI. We use the two-step system Generalized Method of Moment (GMM) (Arellano & Bover, 1995; Blundell & Bond, 1998), which provides a robust estimator. The two-step system GMM would capture all the endogeneity problem in the series such as lagged effects of the dependent variables, individual unobserved effects, problem of multicollinearity, heteroscedasticity, and autocorrelation in the explanatory variables and error term.

India is Moving Towards Universal Health Coverage

ROY DEVI (Jawaharlal Nehru University, CCUS&LAS,SCHOOL OF INTERNATIONAL STUDIES)

KEYWORDS: universal health coverage, out -of -pocket payments, health services

Each health system in the world is unique in terms of the Universal Health Coverage (UHC); it will show in terms of population, costs, and services. The 2010 World Health Report describes UHC as "access to good quality health services without people facing financial hardship because they pay for care." Since the 2010 World Health Report, the concept of UHC has gained importance and thrust, and most of the countries making commitments to achieve it. It's a high time to develop universal health coverage in India and dedicated to the promotion of public health and well-being of all the citizens.

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Report, the concept of UHC has gained importance and thrust, and most of the countries making commitments to achieve it. It's a high time to develop universal health coverage in India and dedicated to the promotion of public health and well-being of all the citizens.

The health dissimilarities between rich and poor states, between rural and urban populations, and different social classes still exist in India. A large section of the population is underprivileged and could not afford or access good quality health services, because of high out-of-pocket healthcare expenditures in India. The present goal of the Indian health system is access to universal health coverage. There are currently many subsidized health insurance schemes for poor people. An insurance-based method of facilitating access to health services has been chosen as the method for attaining this (universal health coverage) goal. The government of India in 2008 launched the Rashtriya Swasthya Bima Yojana (RSBY), or the national health insurance scheme, covering all households which falling below the poverty line. The present government of India takes a step towards universal healthcare system known as the National Health Assurance Mission, which would provide all citizens with free drugs, diagnostic treatments, and insurance for serious diseases. But this national healthcare system is still pending due to budgetary concerns. One needs to understand the universal health coverage would provide access to free medicines for all individuals seeking care, which would reduce OOP (out-of-pocket) payments. And it would be to extend existing services to the most vulnerable sections of the population.

The present paper will critically examine that many health schemes which are launched by the government, questions to which is really moving towards UHC or not? The questions to be considered for moving towards universal health coverage are: which population will be covered, what services would be provided, what proportion of health expenditure would spend by the government. It is in this context the proposed paper attempts to analyses above three issues and there is an urgent need for UHC and quality health services to everyone especially poor people and to eliminate out-of-pocket payments.