Summary report

1. Purpose

The purpose of the roundtable discuss was to bring together Nossal researchers, partner researchers and external experts to review recent Hub studies related to UHC and to:

- Identify / discuss key issues in relation to design and implementation of UHC schemes in countries of the Asia Pacific
- Inform AusAID’s proposed paper on significance of UHC in achieving health goals, and role of overseas development assistance in supporting UHC
- Identify potential areas for further research

2. Participants

Nossal researchers and staff: Peter Annear, Krishna Hort, Shakil Ahmed, Matthias Nachtnebel, Nami Kurimoto, Clare Barnett, Amanda Simmonds, Ashleigh O’Mahony, Michelle Kelsey, Brendan Allen, Judith Ascroft

Partner researchers: Prasanna Saligram (PHFI India), Andreasta Meliala (UGM Indonesia)

Expert reviewers: Paul Dugdale (Australian National University), Ajay Mahal (Monash University), Virginia Wiseman (London School of Hygiene and Tropical Medicine), Jim Buchan (Queen Margaret University)

3. Presentations and discussion: 23rd May

(1) Health finance strategies

Session 1: Principles and concepts in the pathways of UHC Reform

Presentations:

Virginia Wiseman: Equity in health care financing: international lessons and implications for paths to UHC. Virginia’s presentation dealt with the way different methods of raising revenue distribute the burden between rich and poor differently. She described Financial incidence analysis (FIA) as a method of measuring distribution. Results from Tanzania and Ghana indicate that out-of-pocket payment (OOP), community based health insurance (CBHI), and voluntary / private health insurance were regressive ie greater burden on poor than rich. Virginia also described Benefits Incidence Analysis (BIA) as a measure of the distribution of benefits. Studies have shown that PHC relatively benefits the poor while hospital services benefit the rich

Ajay Mahal : Health Financing for Universal Health Coverage: Some Key issues. Ajay’s presentation focused on allocation of revenues among different services / interventions and payment mechanisms as the key to achieving efficiency gains and distribution of benefits by rich / poor. Ajay discussed the implications of allocation of resources between different levels of care; different types
of services (preventive / curative) and suggested different types of payment mechanisms for different types of services (FFS or capitation). Payment mechanisms are the key to influencing efficiency, but Ajay noted that efficiency gains depend on capacity of provider to adapt / change service provision, which may be constrained for public providers.

Krishna Hort: Universal Health Coverage: reforming the health system. Krishna’s presentation examined the implications of UHC as a reform extending to the overall health system, beyond health financing. He stressed the need to consider how to leverage improvements in other health system components from UHC reforms; and the challenges for governments in leading and managing complex system reforms.

Discussion points:

- An element of compulsory contribution is required to achieve UHC – either through taxation or compulsory contribution. Contribution from the near-poor / informal sector is a key issue, and requires some contribution from government, depending on capacity to pay. There is a risk of creating additional burden for near poor and driving them back to poverty.

Session 2: Stewardship of institutional arrangements for health financing: country experiences

- Peter Annear: Institutional arrangements in Cambodia and Laos. Peter described the proposed approaches to integrating current fragmented schemes for financing of health services for the poor in the low income context of Cambodia and Laos. He emphasised the need for special arrangements to cover the poor.

- Amanda Simmonds: Institutional analysis of Indonesia’s Universal Health Coverage Policy. Amanda presented an analysis of the proposed ‘road map’ developed by the Indonesian government as a pathway to UHC. While the roadmap provides a good framework, it leaves many questions unanswered, such as: sustainability of government contributions; addressing persistent inequalities in distribution; the capacity of public services to respond to increase in demand; and the lack of engagement with the private sector and regional levels of govt.

- Ashleigh O’Mahoney: Purchasing health services from the private sector in LMIC. Ashleigh presented a summary of a literature review and two case studies of government purchasing of health services from the private sector in Cambodia and PNG. The review identified a range of issues related to the purchasing of services from the private sector. Lack of governance and accountability in the decisions to purchase and the process of contracting; information asymmetry between provider and purchaser; and lack of capacity to monitor outcomes undermine effectiveness.

(2) Service delivery

Session 3: Governance and regulation of access and quality of health services

Jim Buchan introduced the session with a brief outline of key policy issues in regard to the distribution of the health workforce.
Clare Barnett presented a summary of her findings from a literature review of regulatory approaches to the quality of care in hospitals in LMIC. The review identified the importance of addressing the broader enabling environment through strategies such as accreditation and licensing; while also addressing provider behaviour through hospital autonomy, provision of guidelines and quality improvement programs. Changes to payment mechanisms changed provider behaviour, but careful selection of indicators and close monitoring is needed to avoid perverse incentives leading to undesirable changes.

Prasanna Saligram’s presentation on Regulation of Quality of Health Services in India described the situation in India where the fragmentation of responsibility for regulation between federal and state levels, and ‘capture’ of regulatory institutions by the medical profession have undermined the effectiveness of regulation.

Andreasta Meliala’s presentation on Policy on Distribution of doctors to support UHC in Indonesia noted that a key constraint is addressing geographic inequalities in distribution of health workforce, and the preference of health workers for urban rather than rural locations. Andreas described how financial incentives (salary allowances) were not sufficient to overcome market / social preferences for urban location in Indonesia, and that different strategies including non-financial incentives and rotating teams were being considered by the Indonesian MoH.

Discussion points

- Availability and access to services will influence utilisation, and relative utilisation by rich and poor. The poor may not be able to benefit from services if there face other constraints to utilisation such as high costs of accessing services (distance, time).

- Conversely, finance strategies will also influence the distribution and availability of services, especially allocation and payment mechanisms, such as the amount of payments and the definition of benefit package – which services included / excluded; which providers included / excluded. This demonstrates the complex and dynamic interactions among components of the health system that will result from the introduction of UHC, and will determine the outcomes on utilisation.

- The dynamic interaction was further illustrated by recent experiences in Jakarta following the pilot introduction of UHC, which has resulted in increased demand for health workers in Jakarta, further exacerbating urban-rural differential. (Andreas, Kris).

(4) Discussion Points: Implementation issues

Implementation issues arose in the discussion of both the health financing strategies and the service delivery.

Peter Annear stressed three key issues to be considered in relation to implementation: Context – particularly institutional arrangements; timing, acknowledging the UHC is a long process that will require ongoing management; and the sequencing of the process to ensure a feasible and progressive expansion.

Context issues identified include: fiscal capacity of government and the general economy (the context of countries with limited domestic resources such as Laos and Cambodia, differ from the
larger almost middle income countries such as Indonesia or India; institutional capacity; public-private mix; geographic distribution / availability of health services; collective commitment to values such as ‘solidarity’; trust in government; and the relationship / trust between public and private sectors.

The Indian case study highlighted the lack of consensus between the Planning Commission preference for insurance based approaches and engagement of the private sector; and the MoH preference for more government funding for the public system. The next 5 year plan does not include earlier commitments to increase govt funding, nor how to address the high use of private sector services.

While the Indonesian analysis highlighted the protracted inter-ministerial negotiations on the government contribution amount which threatens the long term financial sustainability of the proposed. The low contribution determined by the Ministry of Finance risks payments not covering the costs of service provision, resulting in reduced availability, or quality, and or additional official or unofficial co-payments.

Information was identified as a key need and constraint to management of implementation, and to guiding purchasing decisions. Asymmetry of information between purchaser and provider reduces effectiveness of purchasing arrangements; while there is a need for ongoing information on utilisation and costs in order to manage contributions and benefits.

Paul commented that while there appears to be considerable attention and guidance for the financing strategies, knowledge on the regulatory aspects is much less. The combination of weaknesses at the base of the regulatory pyramid (lack of voluntary engagement / capacity) with reluctance to act at apex pyramid (lack of sanctions) is a recipe for ineffective regulation. (PD)

(4) Conclusions / key findings

UHC is likely to result in a range of outcomes and potential impact on public health goals. While there is the potential to increase access /use by poor; re-focus on PHC and efficiency; provide social protection and contribute to resilience, there is also a risk of deterioration in quality of services to the poor, increasing inequity and uncontrolled cost escalation. The result will depends on the interaction between context, key factors in design, and the management of implementation.

Key factors:

Purchasing / payment mechanisms and their impact on service delivery. This in turn is dependent on addressing asymmetry / lack of information on service costs / utilisation; IT capacity to collect and analyse information; relationships between purchasers and providers, public and private; and the capacity of provider to adjust / respond with service delivery changes, and the purchaser to adjust payment targets.

Extent of targeting of poor. Although ‘universal’, special consideration is needed in relation to the contribution from poor / near poor (govt subsidy); to address other barriers to access to services for poor (availability, suitability); and to respond to responses of service providers to UHC. But UHC provides the opportunity to expand resources available for the poor (both from government and from the wealthy), and to reduce inequities in financial contribution and service utilisation.
Regulatory capacity. Regulatory levers are needed to balance / align payment incentives with quality and appropriateness of services, and with equity of access. Voluntary engagement of providers and application of sanctions for non-compliers are weakest areas.

Implementation management. Management of UHC schemes is a different challenge for government, shifting from direct control and direction of service provision, towards management of a complex system. Attention is needed to appropriateness to context; timing; sequencing key features; extent of institutional capacity and building of that capacity; information collection, monitoring and adjustment to changes; and building and maintaining a shared / collective vision for UHC.

(5) Implications for development assistance

UHC is a potential opportunity for development partners to achieve long term objectives, including: build sustainability in reaching the poor; social protection for the poor against future shocks; strengthening health systems while achieving service delivery improvements for the poor more effectively than through vertical programs. However, poorly designed / implemented UHC schemes may result in worsening the situation for the poor, generating large unfunded future liabilities, and undermining public service provision.

Potential modalities / strategies for development assistance investment include:

- Technical assistance: design / implementation
- Finance: finance ‘gaps’ / ‘re-insurance’ for future unfunded liabilities
- Focus on targeting for poor: support for contribution of poor
- Institutional capacity building
- Information systems / research and monitoring capacity – centrality of HIS

(6) Research needs / opportunities

A number of ‘gaps’ in information and evidence were identified, where future research could focus, including:

- Payment mechanisms and impacts on service delivery: for different types of services, and different providers. Methods for engaging the private sector in UHC
- Measurement of relative health needs of rich and poor for BIA
- Methods of targeting the poor; Achieving better impact on poor from UHC – strategies for different contexts
- Ongoing monitoring and research during UHC implementation: data needs / analysis; comparability
- Aligning regulation / effective regulatory strategies to support UHC; addressing other provider motivations and incentives than payment.
- Measurement of costs of providing services and supporting fiscal sustainability of UHC
- Future challenges for UHC with growth in elderly, reduction in economically active
Day 2: 24th May

Discussion of themes for HPHF work during the No-Cost Extension Period of the HPHF Hub

1. Universal health coverage

UHC will be a focus of the 2013 World Health Report, which is now under preparation (including work done by David Evans) and which aims to advance WHO leadership in the health sector.

Paul Dugdale described comments he heard from David Evans and Tessa Tantoros in Geneva. The discussion pointed in the direction of more research and analysis on issues related to institutional strengthening, purchasing function and provider payment mechanisms. These points include:

- emphasis on access to health care and health outcomes
- need to strengthen domestic institutions for UHC
- health system may become two-tier, but must avoid a “three-tier” system
- there is an evidence/policy gap related to the purchasing function
- inefficiencies need to be addressed; and the proper role for hospitals
- we need to look for improved productivity and efficiency not just inefficiencies
- RBF and active purchasing are important issues

These questions relate to UHC implementation issues. In the description of UHC as a concept, we need to maintain the focus of UHC on poverty and equity.

- the principles of UHC (Virginia) including what hinders poverty reduction through UHC (using the example of Good Health at Low Cost +25)
- mechanisms of UHC including demand/supply side issues, fiscal space, purchasing function, efficiency
- mapping of what the global funders are doing on UHC

2. Beyond the horizon issues

The proposed list of issues and questions was thought to be somewhat too high level and needed to be narrowed to more specific issues. Need to make the questions concrete.

One suggestion was to use country surveys to identify the main population trends: India, China, Malaysia, Korea. The proposed scenarios could be in the form of case studies.

A more specific focus on BOD and post-MDG targets could help. This might include a focus on NCDs, the integration (from a policy point of view) of consideration of primary and hospital care services, and improved HIS and HRH. Look at the role of hospitals in the UHC discussion.

The best approach may be to focus on three topics:
- a stocktake of the current situation re MDGs
- identification of the big issues for the future, particularly UHC as well as HSS
- investigation of the opportunities for AusAID (in the region; focus on the Pacific)

We could learn from the Rockefeller agenda (population/climate/education) as well as the Commission on Macroeconomics and Health (together with DfID).