THE UNIVERSITY of York

Universal Coverage and Equity in Health Care

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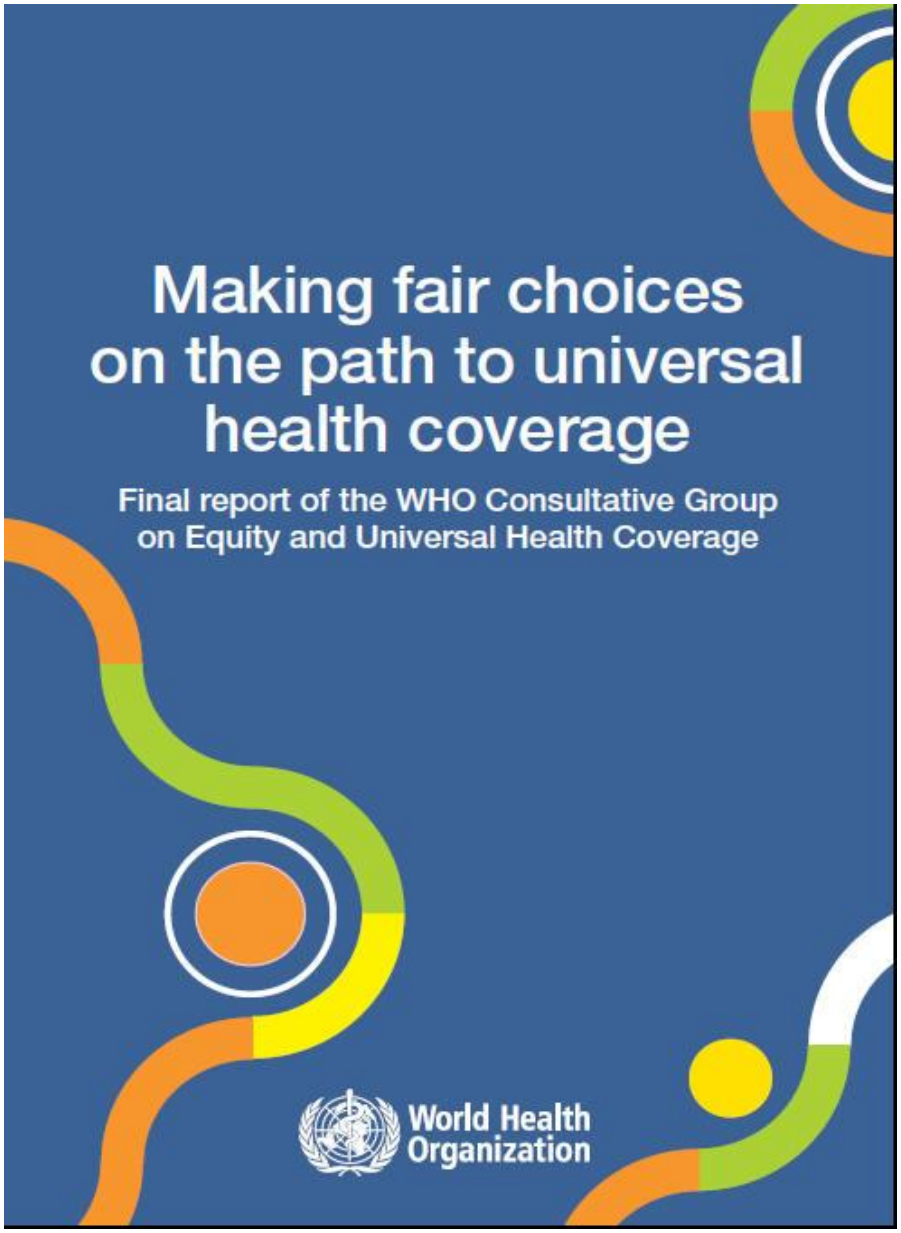
Outline of Talk

1. WHO Report

2. UK and Chile



Making Fair Choices on the Path to Universal Health Coverage

The WHO Consultative Group Report (2014)

http://www.who.int/choice/documents/making_fair_choices/en/

Members of the WHO Consultative Group:

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Background on the Report

More than 70 countries have requested support and advice on UHC reform from the WHO.

The WHO plan of action included offering guidance on **choosing a fair path to UHC**.

The WHO Consultative Group on Equity and Universal Health Coverage was set up to develop this guidance.

18 ethicists, economists, and policy experts of 13 nationalities; drafts circulated for external review.

Focus on low income countries, but principles also relevant to high income countries like UK and Chile.

Chapters 1 & 2: UHC & core values

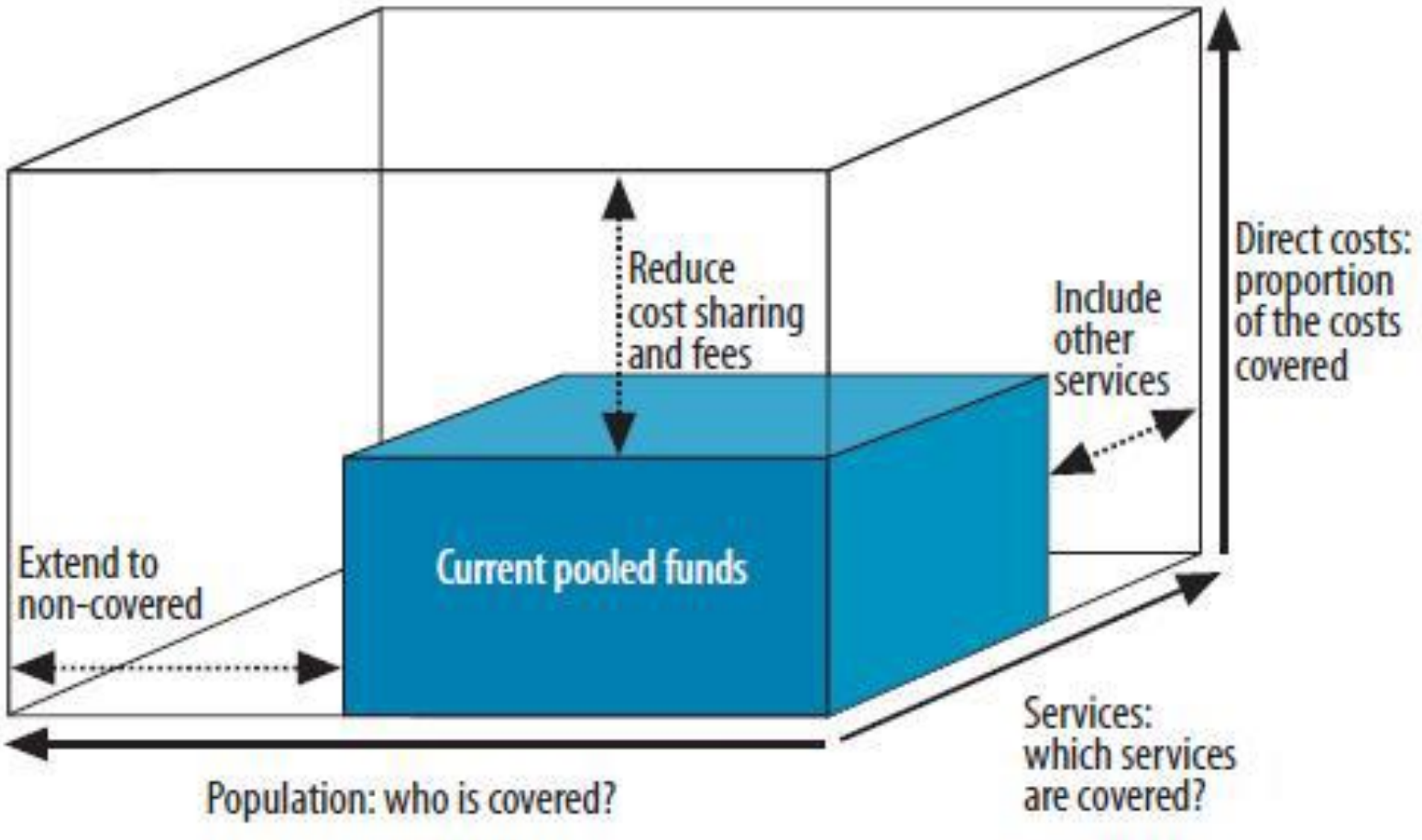
Universal Health Coverage (UHC):

> "all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services" (WHO 2013).

Given resource constraints, this does **not** entail all possibly effective services.

Instead: a **comprehensive range** of **key** services that is **well aligned with other social goals**.

Moving towards UHC along 3 dimensions



The "WHO Cube"

Dimension of progress	Critical choice
Expanding priority services	Which services include first?
Including more people	Whom to include first?
Reducing out-of-pocket payments	How shift to prepayment?

Core values:

I. **Fairness:** Coverage and use based on need only; priority to the worst off.

II. **Benefit maximization (cost-effectiveness):** Priority should be given to policies that generate the greatest sum of health-related well-being in a given population; operationalized as prioritizing policies with a lower cost-per-healthy life year.

III. **Fair contribution:** Contributions based on ability to pay and not need.

IV. **Accountability:** Public justification of decisions & results; public involvement; robust monitoring.

Chapter 3: Prioritizing services

Services include both treatment and prevention.

Divide into 3 priority tiers: **high**, **medium**, **low**.

Taking into account our values of:

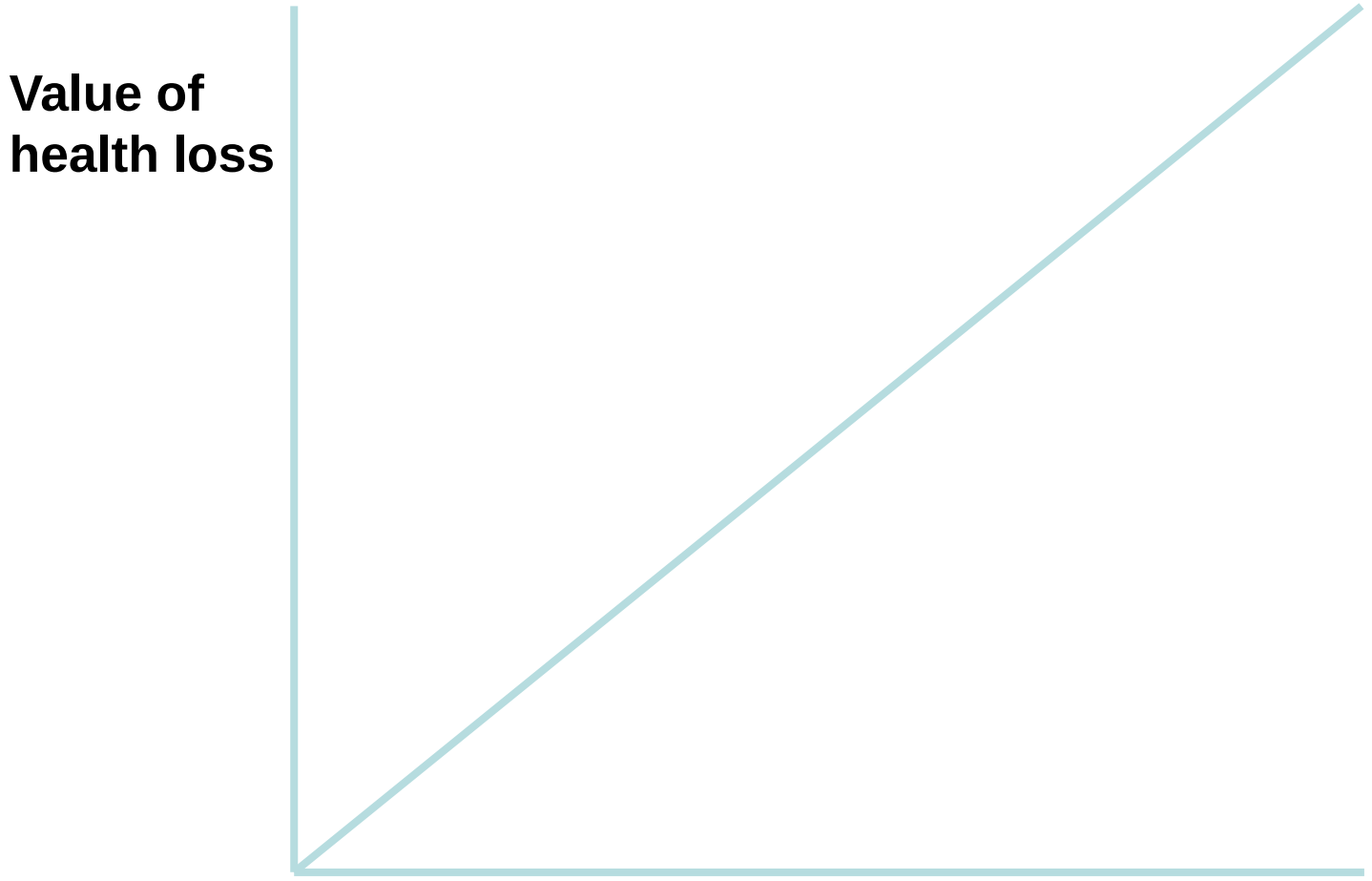
I. **Fairness —** priority to the worst off;
II. **Benefit maximization —** cost-effectiveness;
III. **Fair contribution —** financial risk protection.

Start with benefit maximization and adjust based on the other factors.

Why is benefit maximization central?

- It provides the greatest health improvement for a given budget;
- There is extreme variability between health services:
  - CE is spread over 4 orders of magnitude;
  - For two random services, on average one is 100 times as cost-effective as the other;
- Failure to prioritise on this often means giving up **99%** of the potential health gain.

NICE's valuation of health opportunity costs

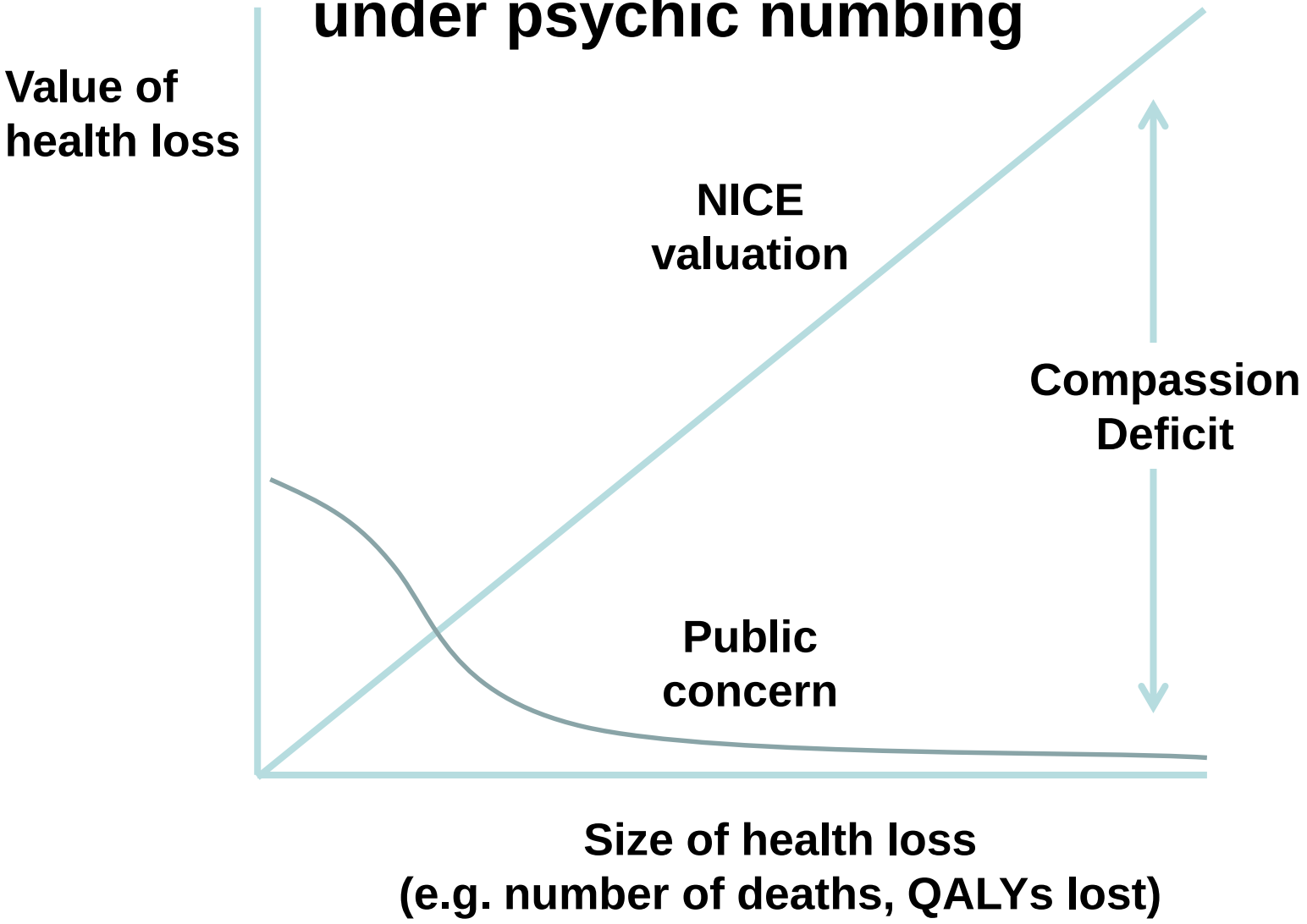


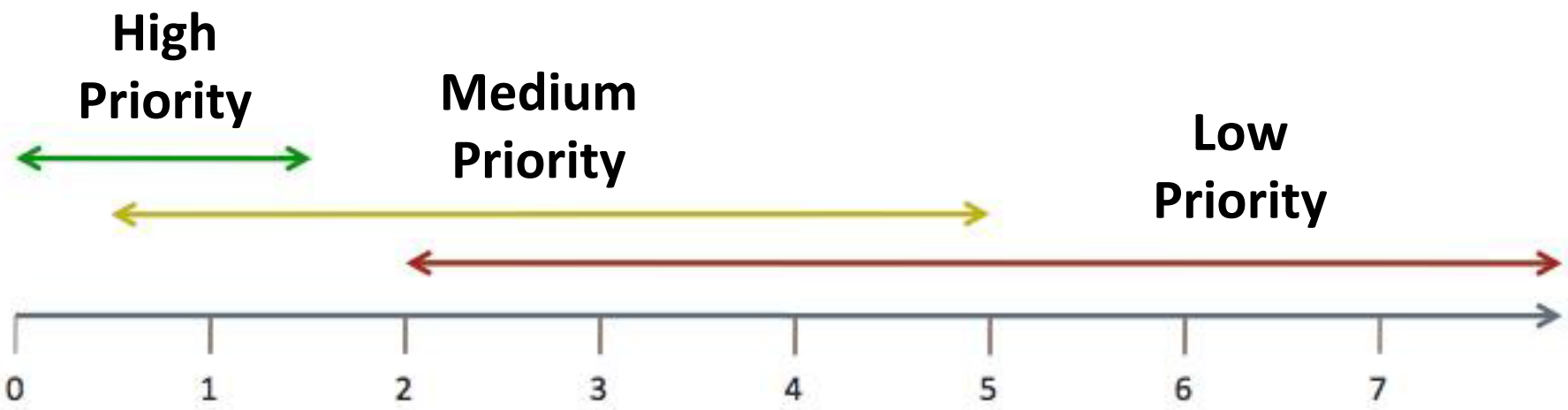
“Psychic Numbing” - Public (lack of) concern about health opportunity costs

Slovic P. “If I look at the mass I will never act”: Psychic numbing and genocide. *Judgment and decision making* 2007;**2**(2):79-95

Zafrada boy

Compassion deficit – NICE valuation vs. public concern under psychic numbing

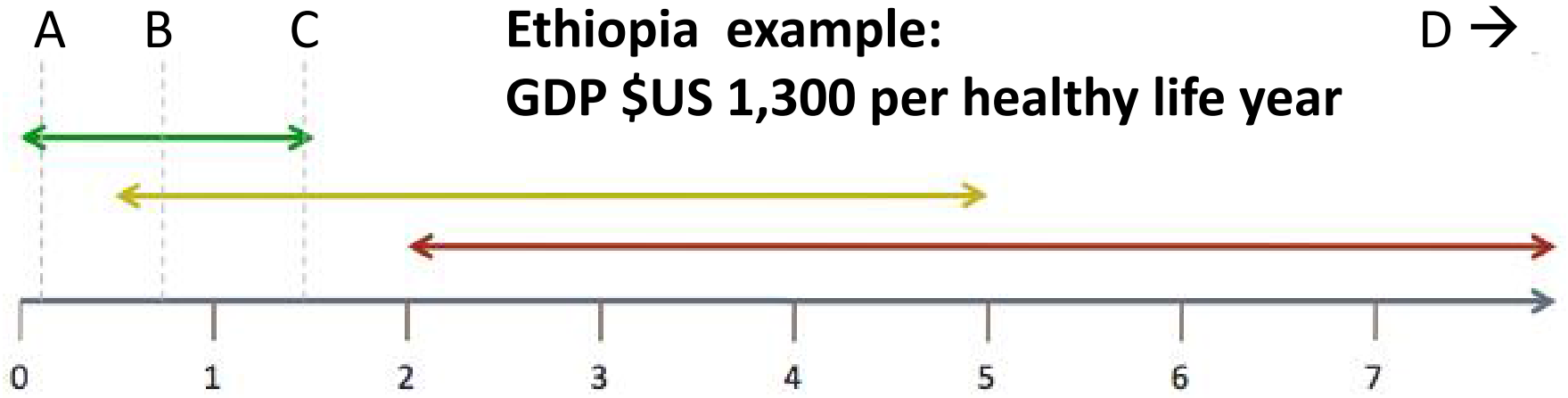




Multiples of GDP per capita for one healthy life year.

e.g. in US$ PPP in 2013:

USA	53,100
UK	36,100
Chile	21,900
China	11,904
India	5,410
Ethiopia	1,300



A: *Tuberculosis diagnosis and treatment:* **high**.

B: *Traffic safety regulation*: 80 percent of GDP per capita per healthy life year, this falls in overlap region; priority to the worse off relevant as traffic accidents often cut down young people. Expected verdict: **high**.

C: *Treatment for mild asthma*: 149 percent of GDP per capita per healthy life year, only just in overlap. Expected: **medium**.

D: *Dialysis for renal failure:* > 30 times the GDP per capita per healthy life year: **low**.

Chapter 4: Including more people

- Countries must seek coverage for *everyone.*
- If this cannot be done immediately, strive first to reduce barriers for:
  - low-income groups, rural populations;
  - others that are disadvantaged in terms of service coverage or health.

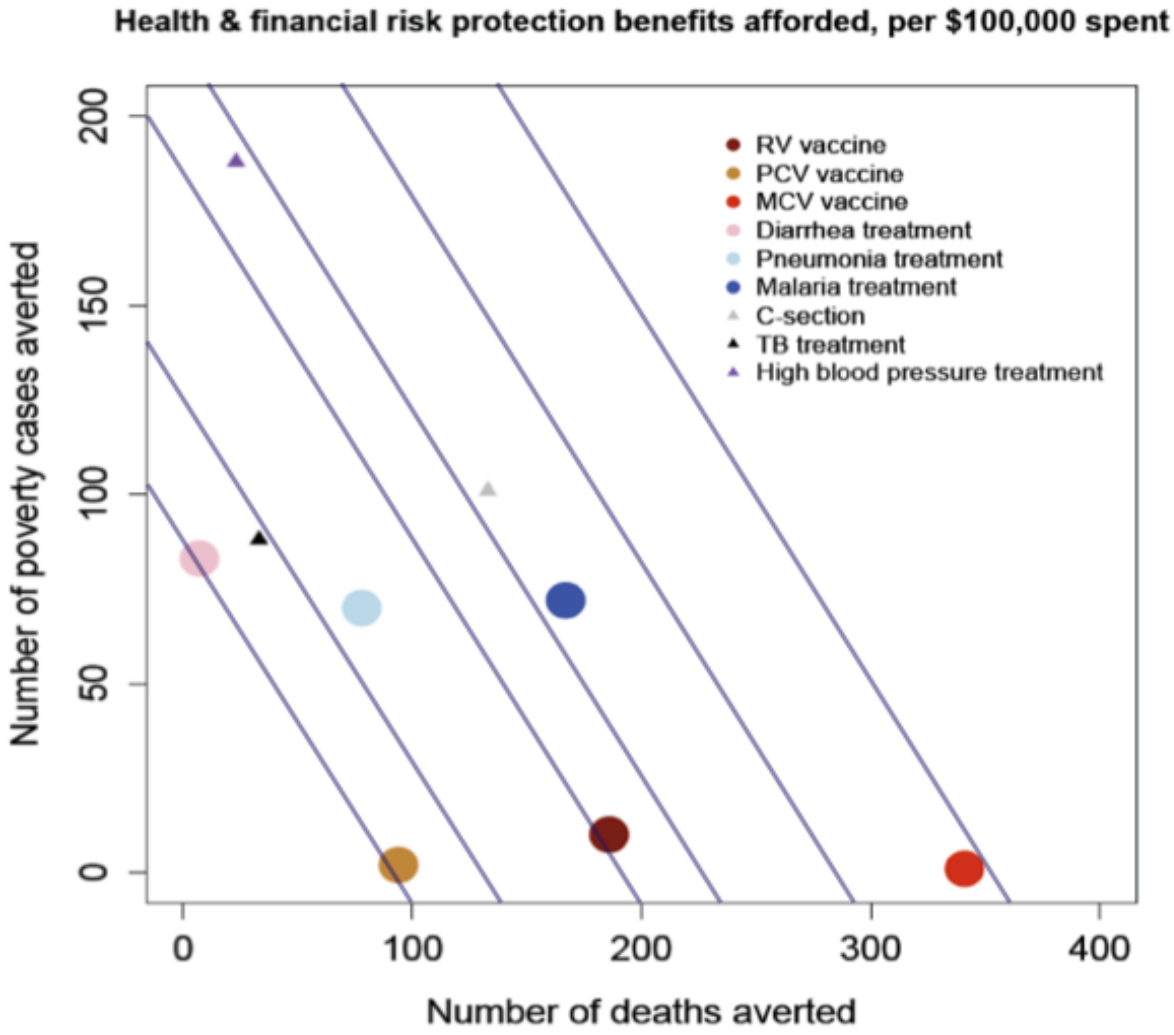
Chapter 5. Reducing out-of-pocket payments

An essential part of UHC, to ensure people are not exposed to financial hardship in paying for health care.

Helps reduce risk of “catastrophic” and “impoverishing” health care payments.

Aligns with our third core value of “Fair contribution based on ability to pay and not need”

Trade offs between improving health and protecting against financial risk



Recommendations:

- Shift away from out of pocket payment and toward mandatory prepayment with pooling of funds.

- When making such a shift, countries should seek to
  - first eliminate out-of-pocket payments for high-priority services
  - first eliminate out-of-pocket payments for low-income groups and other disadvantaged groups, if it can be done effectively
  - make financial contributions generally depend on ability to pay and receipt of services primarily depend on need

Chapter 6: Unacceptable tradeoffs

Making fair choices means…

some trade-offs are **unacceptable**.

Unacceptable trade-off 1: 'Low before high priority'

- To expand coverage for **low**- or **medium**-priority services before there is near universal coverage for **high**-priority services.
  - This includes reducing out-of pocket payments for **low**- or **medium**-priority services before eliminating them for **high**-priority services.

Unacceptable trade-off 2:
‘Financial protection before substantial health gains’

- To give high priority to very costly services whose coverage will provide substantial financial protection when the health benefits are very small compared to alternative, less costly services.

Unacceptable trade-offs 3 and 4:
'Well-off before worse off'

- To expand coverage for well-off groups before doing so for worse off groups, when the costs and benefits are not vastly different.
- To first include in the universal coverage scheme only formal workers or those with the ability to pay, and not informal workers and the poor.

Unacceptable trade-off 5:

‘Reduce OOPP by regressive mandatory prepayment’

- To shift from out-of-pocket payment toward mandatory prepayment in a way that makes the financing system less progressive.

Summary of WHO recommendations

a. **Categorize services into priority classes, using:**
   I. Cost-effectiveness;
   II. Priority to the worse off;
   III. Financial risk protection.

b. **First expand coverage for high-priority services to everyone.**
   Includes eliminating out-of pocket payments while increasing mandatory, progressive prepayment with pooling of funds.

c. **Ensure disadvantaged groups are not left behind.**
   Will often include low-income groups and rural populations.

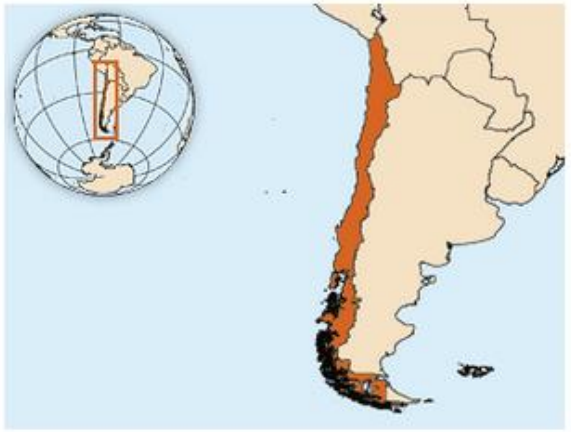
Universal Health Coverage in the UK and Chile

United Kingdom

Map

Chile

Map



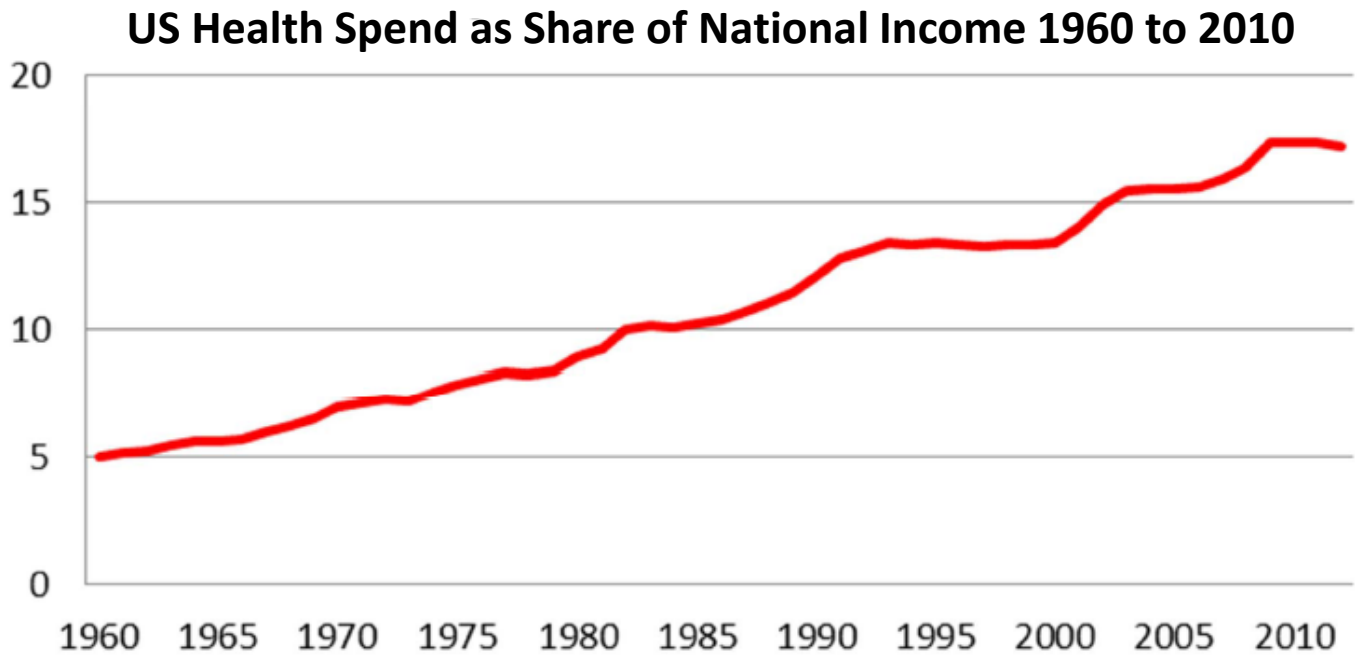
Statistics

	UK	Chile
Total population (2012)	62,783,000	17,465,000
Gross national income per capita (PPP international $, 2012)	37,340	21,310
Life expectancy at birth m/f (years, 2012)	79/83	77/83
Probability of dying under five (per 1 000 live births, 0)	not available	not available
Probability of dying between 15 and 60 years m/f (per 1 000 population, 2012)	90/56	110/56
Total expenditure on health per capita (Intl $, 2012)	3,495	1,606
Total expenditure on health as % of GDP (2012)	9.4	7.2

Latest data available from the Global Health Observatory

High income countries also face ethical dilemmas on the path to UHC

- Clash between health economics and tax politics
- As people get richer, they want to spend a higher % of their income on health, but not pay higher taxes



Source: Perspectives on Health Care Spending Growth, Louise Sheiner, Senior Economist, Federal Reserve Board of Governors, USA, 2014

UK NHS

Tax-funded “single payer” system

Universal, nearly comprehensive, nearly free at the point of delivery

Expanding priority services

- Almost all health services are free, except:
  - Copayments for community medicines and dentistry
  - Opticians and most complementary medicine
  - Long-term care for older people
  - Non-cost-effective services listed by the National Institute for Health and Care Excellence (NICE)
- Effective coverage can vary by social group
  - e.g. large inequality in uptake of invitations to NHS screening and vaccination programmes
  - e.g. small pro-rich inequality in specialist visits

Including more people

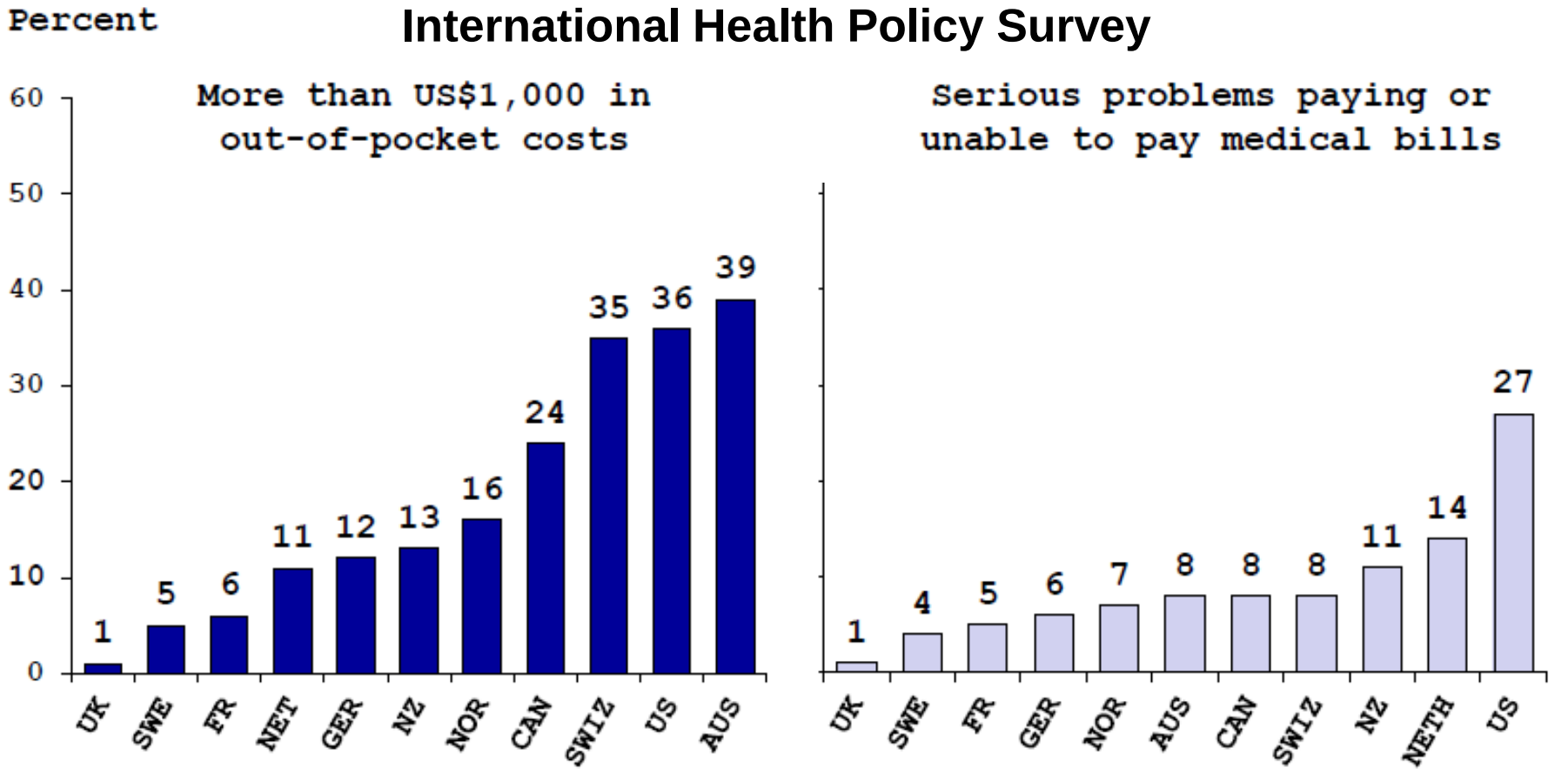
- All UK citizens are covered by the NHS
- NHS makes up 82% of health expenditure
- Private expenditure for “top up” care
  - Typically for low-risk, low-cost services where “going private” allows care shorter waits and better amenities (e.g. “hotel” services)
  - NHS care same clinical quality (same doctors)

Reducing out of pocket payments

(The OOP share of total health spend in the UK is about 10%)

Commonwealth Fund 2011

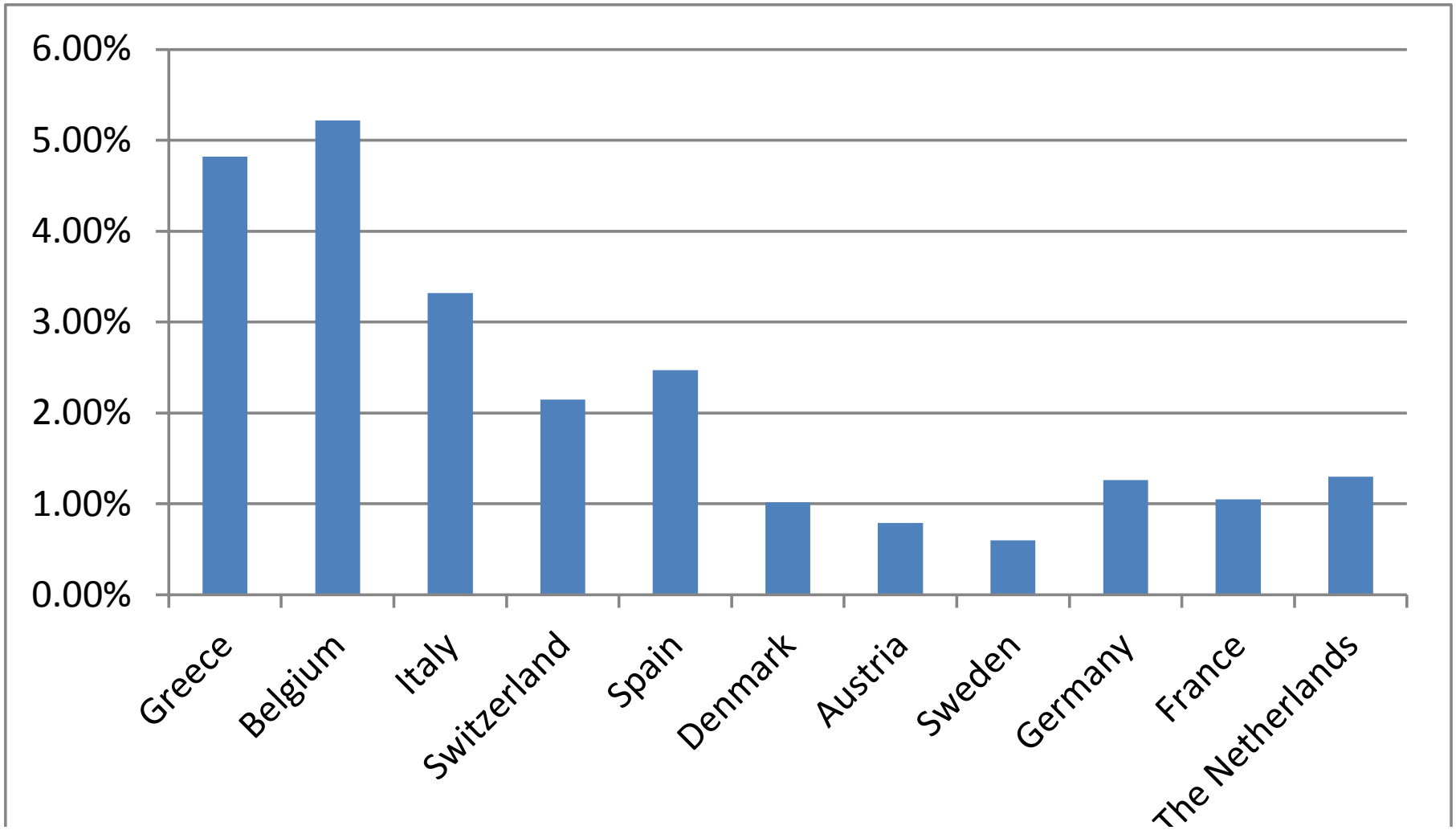
International Health Policy Survey



Final samples: Australia 1,500, Canada 3,958, France 1,001, Germany 1,200, Netherlands 1,000, New Zealand 750, Norway 753, Sweden 4,804, Switzerland 1,500, United Kingdom 1,001, and United States 1,200

THE COMMONWEALTH FUND

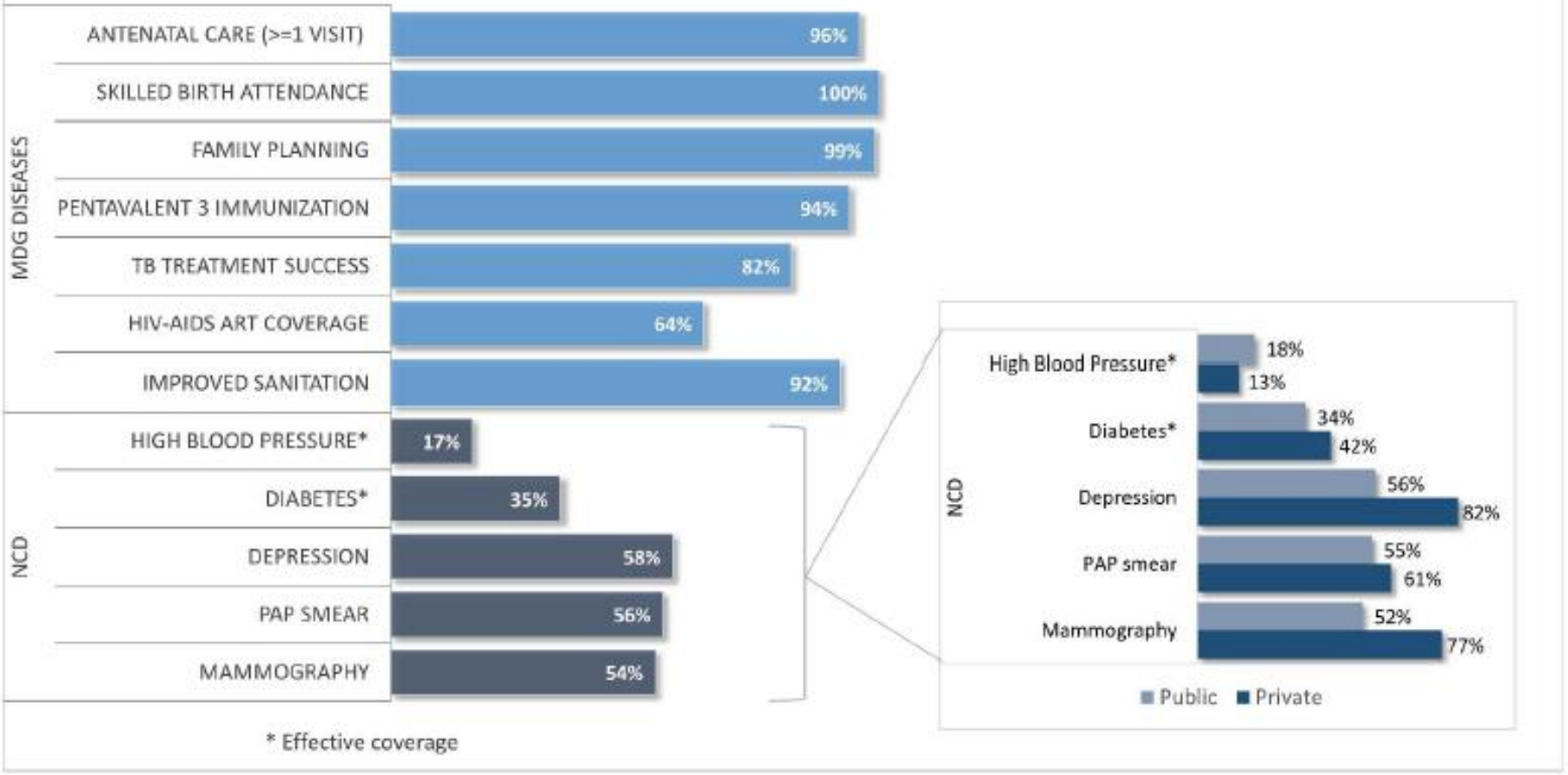
Catastrophic medical expenditure
(2004; >25% disposable income)



D. Lambrelli, O. O'Donnell, The large burden of direct payments for health in Greece in comparison with other European countries, in A Lyberaki, P. Tinios and T. Filalithis (eds.) Life 50+: Health, Ageing and Pensions in Greece and Europe. Kritiki, Athens, 2009.

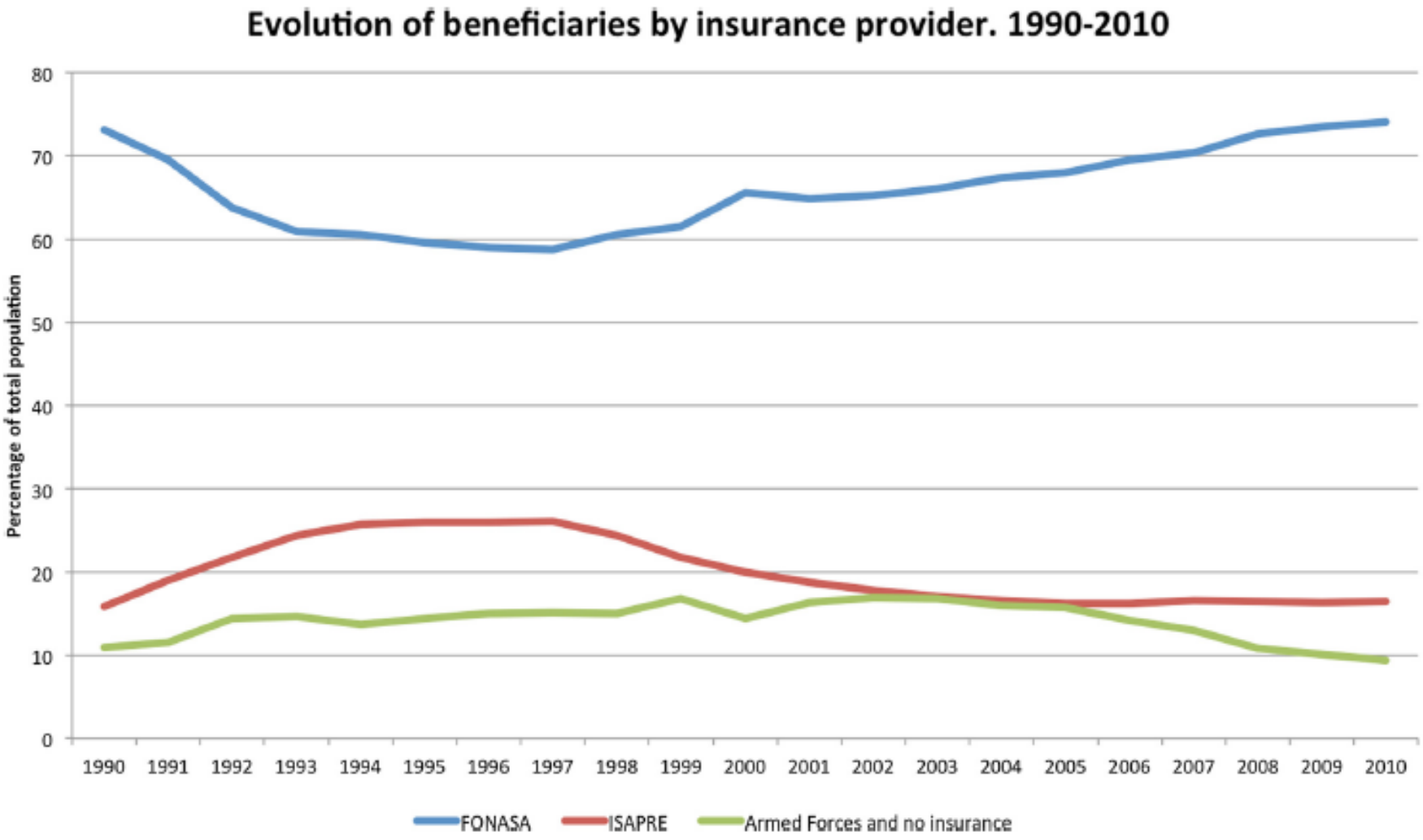
Chilean FONASA and ISAPREs

Expanding priority services



Source: Aguilera X, Castillo-Laborde C, Ferrari MN-D, Delgado I, Ibañez C (2014) Monitoring and Evaluating Progress towards Universal Health Coverage in Chile. PLoS Med 11(9): e1001676. doi:10.1371/journal.pmed.1001676

Including more people



Source: Paraje and Vásquez: Health equity in an unequal country: the use of medical services in Chile. International Journal for Equity in Health 2012 11:81.

FONASA vs. ISAPREs Inequality

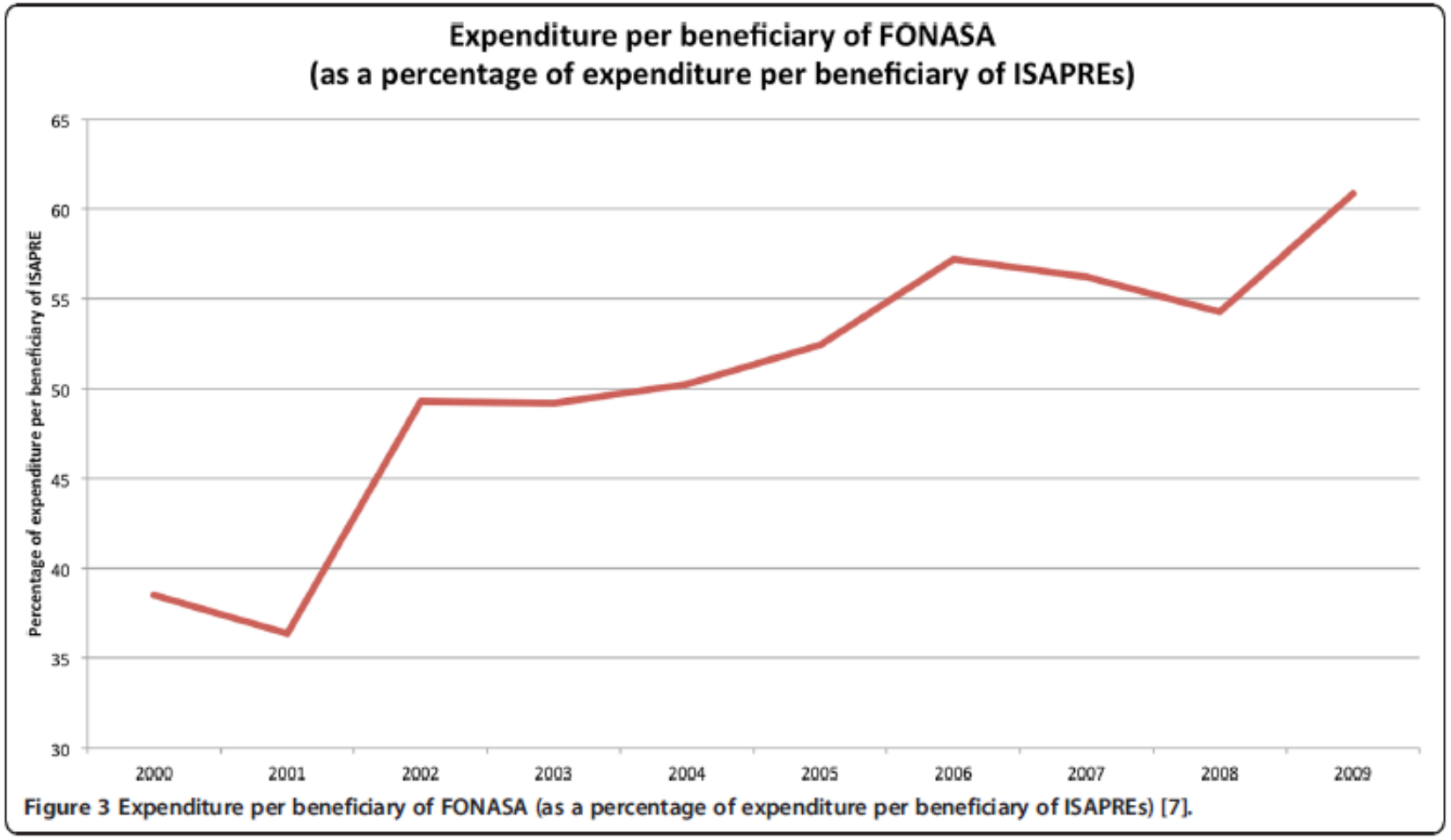


Figure 3 Expenditure per beneficiary of FONASA (as a percentage of expenditure per beneficiary of ISAPREs) [7].

Source: Paraje and Vásquez: Health equity in an unequal country: the use of medical services in Chile. International Journal for Equity in Health 2012 11:81.

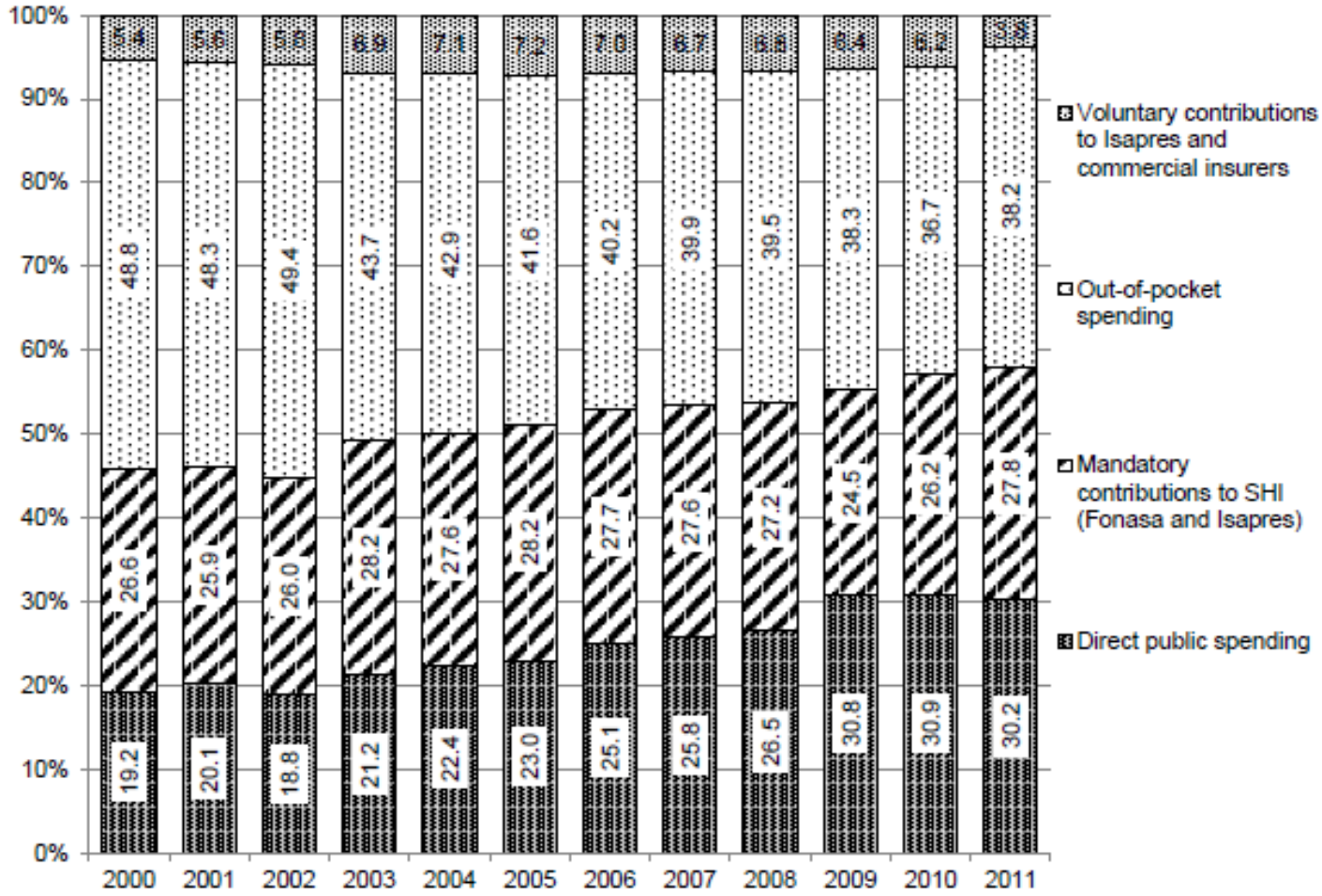
Income-related inequality in utilisation

	Household per capita income				
Year 2009	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
FONASA	93.2	90.3	85.1	72.3	44.6
ISAPRE	1.5	3.5	6.7	16.6	44.3
Others/don't know	5.3	6.2	8.2	11.1	11.0
TOTAL	100.0	100.0	100.0	100.0	100.0

Substantial pro-rich inequality in use of specialist visits, laboratory exams and x-ray and ultrasound.

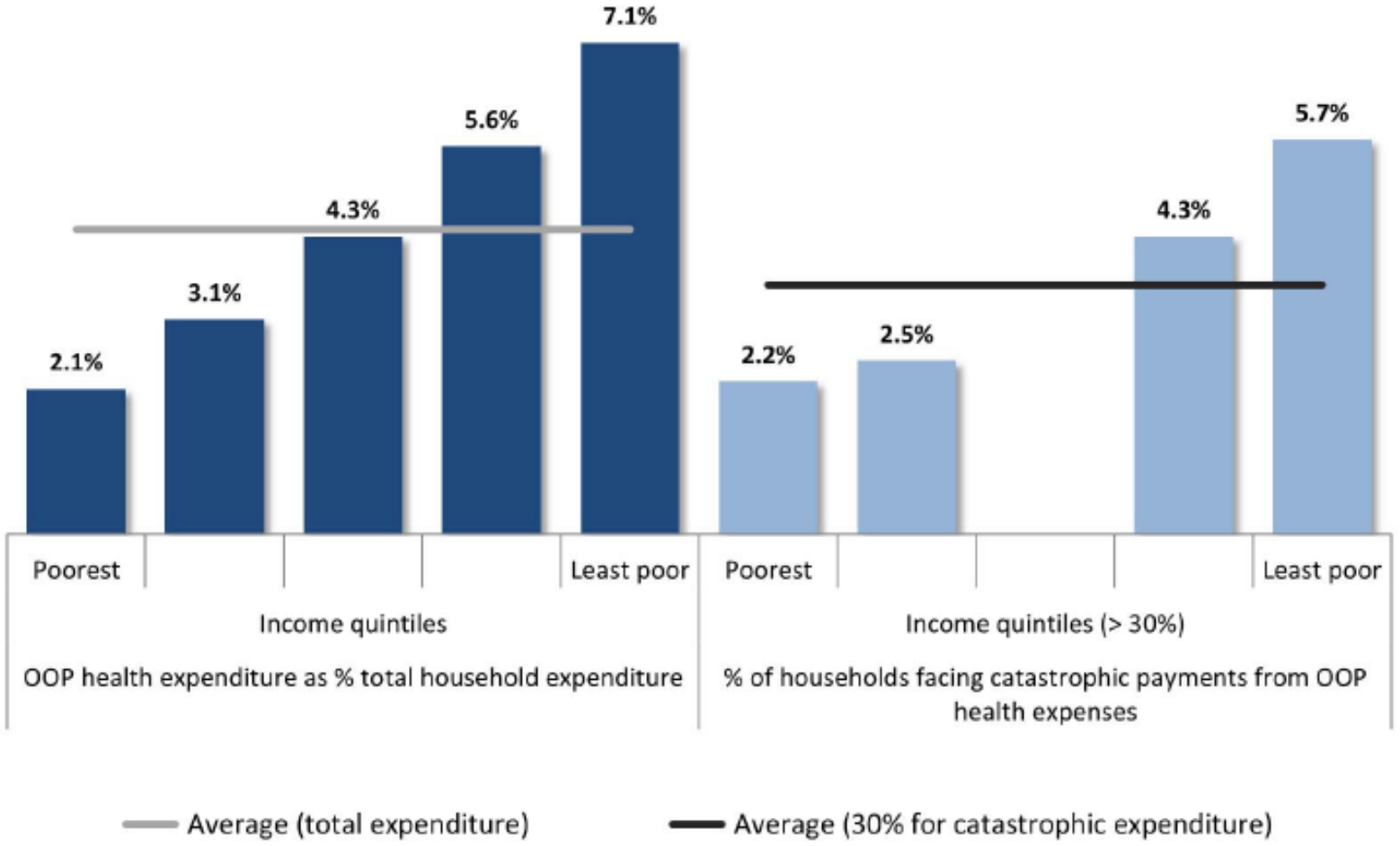
Source: Paraje and Vásquez: Health equity in an unequal country: the use of medical services in Chile. International Journal for Equity in Health 2012 11:81.

Reducing out-of-pocket payments



Source: Bitran, R. (2013). Explicit Health Guarantees for Chileans: The AUGE Benefits Package , UNICO Studies Series 21 , The World Bank, Washington DC.

OOP payments by income group



Source: Cid C, Prieto L (2012) El gasto de bolsillo en salud: el caso de Chile, 1997 y 2007. Rev Panam Salud Publica 31(4): 310–316.

What UHC goal should Chile aim for in ten years time?

- Goal 1: "Single payer" system
  - Merge FONASA and ISAPREs
  - Everyone pays a mandatory x%, and gets the same nearly universal high quality coverage
  - Private insurance as "top up" only

- Goal 2: "Multi payer" system with risk adjustment
  - Retain FONASA vs. ISAPREs split
  - Everyone pays a mandatory x%, but coverage varies by health plan
  - Risk adjustment ensures coverage does not vary too much
  - Top ups allowed for anyone

What path should Chile take?

- Option 1: Risk adjustment within ISAPREs only
  - Attractive to the richest 50% of voters: lifelong insurance against getting old and sick
  - FONASA C,D likely to migrate to ISAPREs
  - Risk of getting "stuck" at this intermediate point, with FONASA remaining a "poor service for the poor"
- Option 2: Risk adjustment within ISAPREs, plus small but growing contribution to FONASA
- Option 3: Full risk adjustment within the whole system, including FONASA and ISAPREs

Thank You.

Chile Health Outcomes in 2010

(Compared with Upper Middle Income Countries Using World Bank Development Indicators)

Country Data	Chile	UMIC	% Diff.
GNI pc (2000 USD)	4690.9	1899.0	147.0%
IMR	7.7	16.5	-53.3%
U5MR	8.8	19.6	-55.2%
Stunting	2.0	14.8	-86.4%
MMR	25.0	53.2	-53.0%
Adult Mortality	122.9	160.6	-23.5%
100-Life Expectancy	21.1	27.2	-22.3%
Neonatal Mortality	5.0	11.4	-56.1%
CD mortality	17.0	22.0	-22.7%

Source: Bitran, R. (2013). Explicit Health Guarantees for Chileans: The AUGE Benefits Package , UNICO Studies Series 21 , The World Bank, Washington DC.