Philip A. Musgrove Memorial Lecture

Priority Setting for Universal Health Coverage: Challenges and Potential Solutions

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Center for Global Development

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- I am honored to be here, remembering my best friend and colleague, Phil Musgrove. I want to thank Elinor Schwartz, Phil's companion, for her drive and hard work to make this event possible. I also thank the Center for Global Development for hosting this Memorial Lecture, and its Chief Operating Officer, my long time friend Amanda Glassman. Amanda and I arrived in Buenos Aires the day after Phil's tragic death, knowing already that Phil would not be at the meeting where we were supposed to work together. Gina Lagomarsino, President and CEO of Results for Development, was also instrumental in making this event possible. I thank my former boss, colleague and friend Marty Makinen, Executive Vice President of Results for Development, for his willingness to be a discussant of my presentation. Thank you all for coming to this event today.
- Phil was a lucid and passionate health economist who made an indelible contribution to our field. He was a highly respected reference point on technical matters. He was never shy to express any of his dissenting views on matters of international health policy and helped us all remain technically consistent in our work. Our field and our work are stronger because of his existence, but weaker since his absence.

Motivation

In many developing countries, health benefits packages (HBPs) stand at the center of UHC policy. Their design and implementation give rise to several policy and implementation challenges. Offering sound advice is essential.

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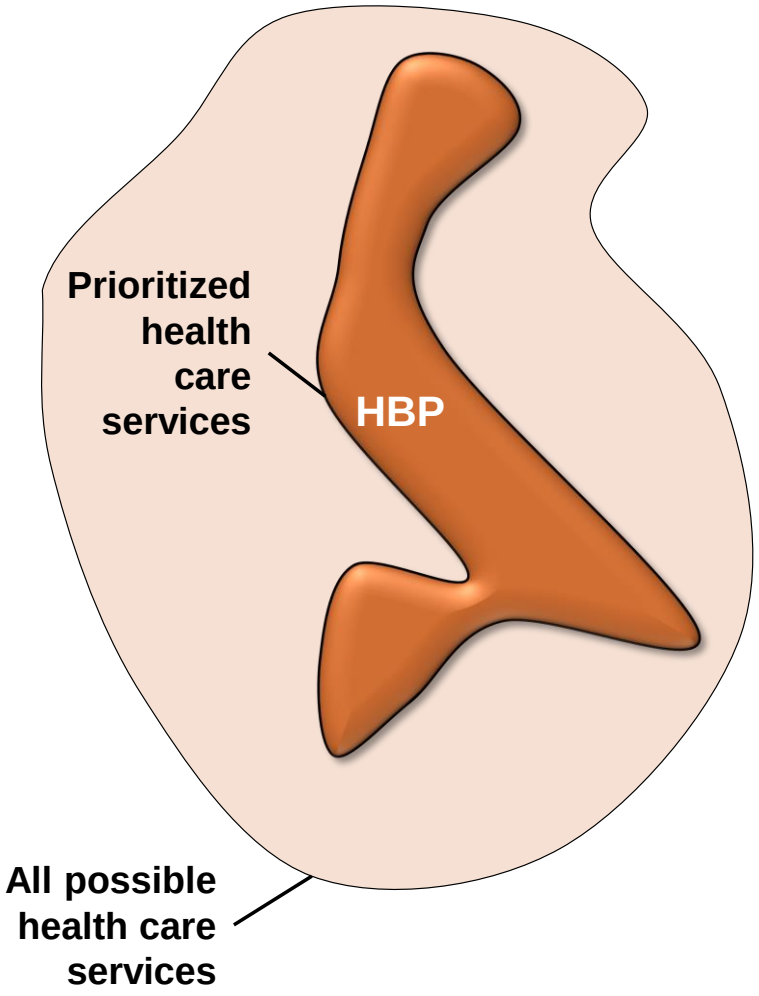
- The World Health Organization defines universal health coverage as "ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO."

The need to set priorities in health



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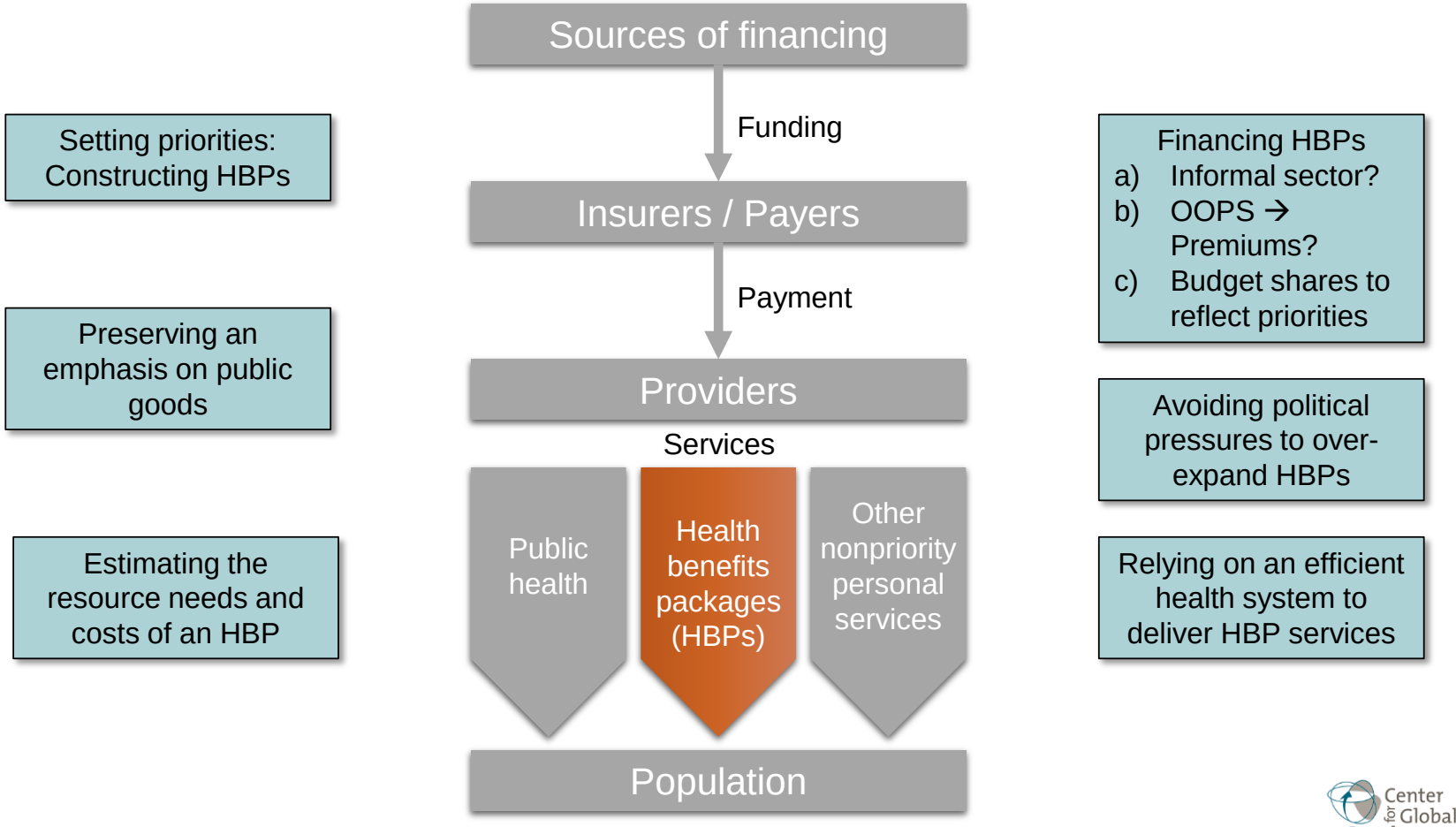
- Human, physical, and financial resources are limited in the health sector and in other sectors. This is a fact that all countries face, not only poor countries. This scarcity of resources has led some countries to establish health priorities through the definition of a “health benefits package”, which I will refer to through the acronym HBP. A HBP is a subset of all possible health care services that exist. Defining the contents of a HBP is challenging on technical and political grounds. But that is only the beginning of the many challenges that follow in relation to the planning, implementation, and evaluation of the impact of HBPs.

The central role of HBPs in UHC policy: selected design and implementation challenges covered in this presentation.



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- As the figure shows, HBPs are at the center of UHC policies. However, not all countries have an HBP. In countries without HBPs, patient queues, or poor quality of services, or demand deflection by providers are implicit mechanisms that ration health care services for citizens. These supply and demand forces configure an “implicit HBP”.
- Many challenges arise in the context of HBPs. In this presentation I will cover only 6 of them. I will therefore leave many important challenges out. For example, I will not talk about the equity implications of HBPs, contracting and payment methods for HBPs, not because they are unimportant, but because I have limited time, and I need to ration what I present. The challenges are…

Setting priorities in health

Policymakers often lack tools and technical assistance to decide how to construct an HBP, and this may lead to poor decisions.

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- Many tools have been produced by development organizations to help countries construct HBPs. For example, the Center for Global Development, through the books produced by Amanda Glassman and her colleagues, are helping to advance knowledge and the use of practical techniques in the area of HBPs. I encourage you to read their recently published book “What's In, What's Out: Designing Benefits for Universal Health Coverage.” The Joint Learning Network has also put out tools related to HBPs.

How to set priorities to construct an HBP? Many countries face this challenge. Some where I have worked…

Africa

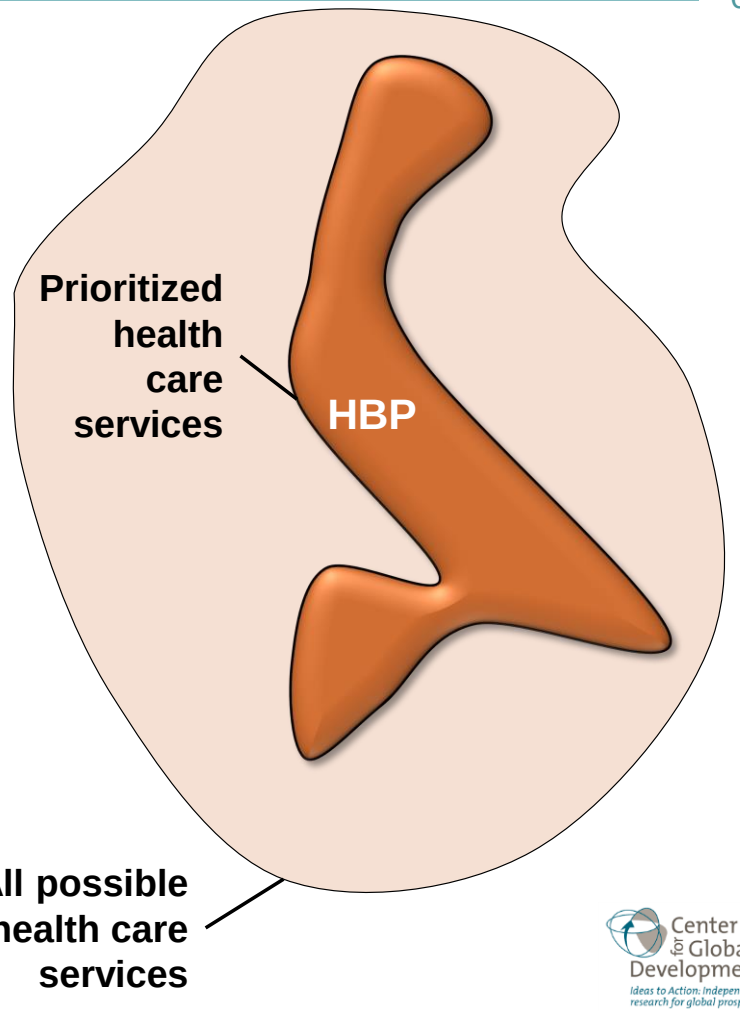
Congo
DR Congo
Kenya
South Africa

Asia

Bangladesh
Cambodia
China
Philippines
Vietnam

Latin America

Argentina
Bolivia
Chile
Colombia
D. Republic
El Salvador
Guatemala
Honduras
Mexico
Peru



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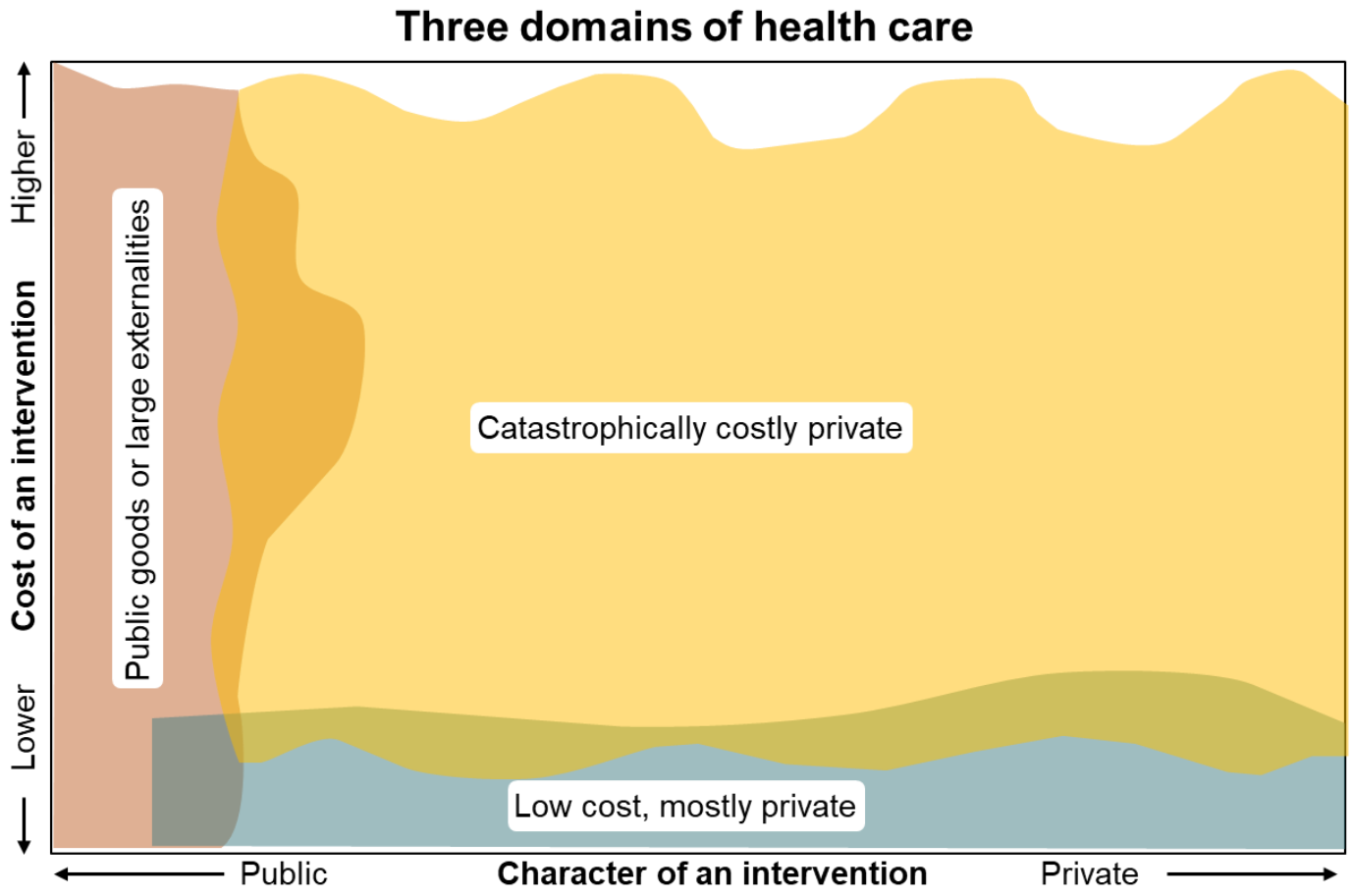
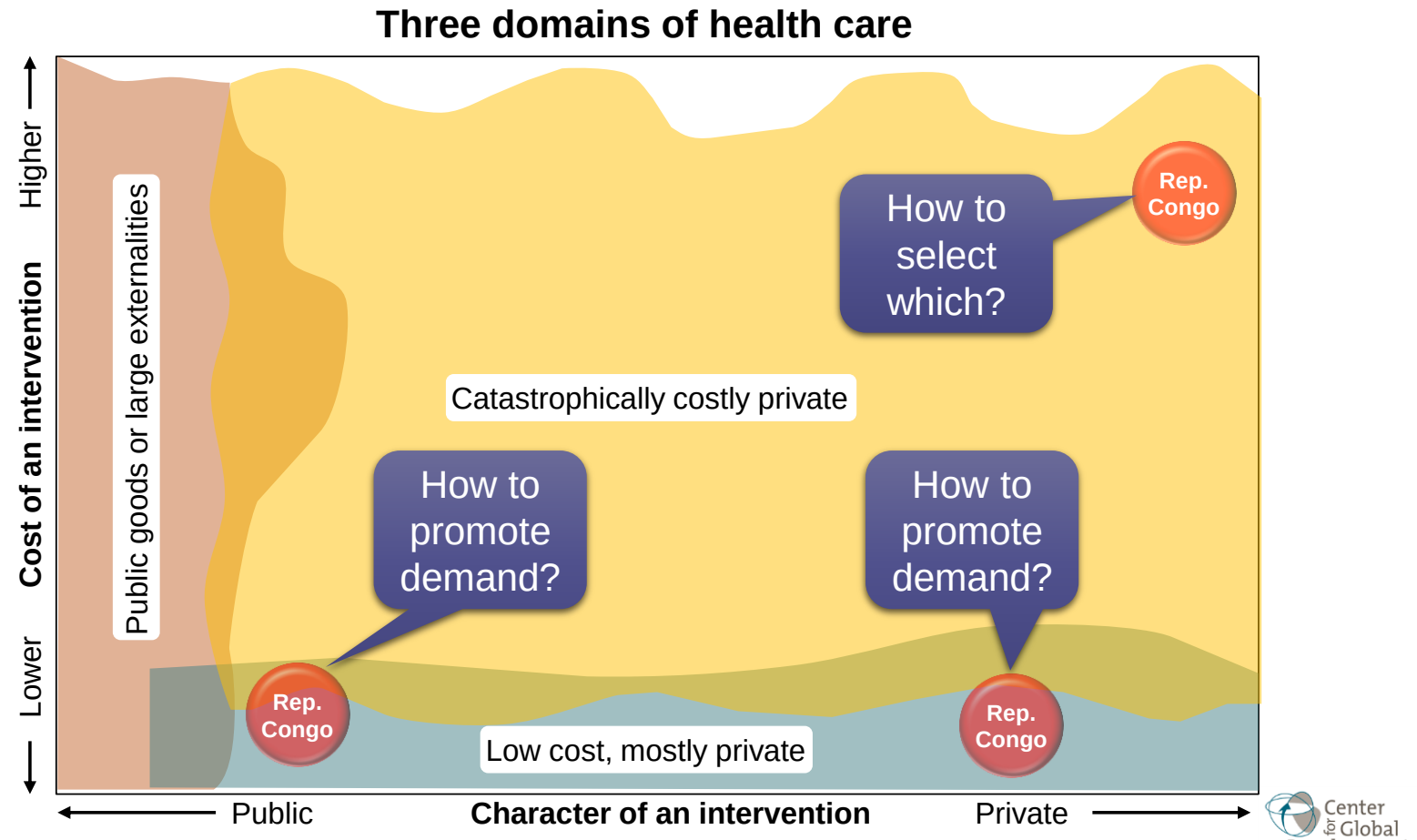
Different countries set different priorities. Typically they consider (a) 2 policy objectives (health status improvement & financial protection); and (b) their financial constraints.



Musgrove, P. (1996). Public and Private Roles in Health. Theory and Financing Patterns. Washington, D.C., The World Bank.

- Phil Musgrove proposed this conceptual scheme to think about the role of government, and the role of the private sector in health. Along the horizontal axis is the nature of a health service. Health services can be purely private, when their consumption only benefits the individual patient, or they can be purely public, when their consumption benefits the patient and all others in their society; or health services can be mixed, when they partly benefit the patient, and partly society. Along the vertical axis is the production cost of a service. Health services can be costly to produce, such as cardiovascular surgery and emergency care for trauma, or they can have a low production cost, such as oral rehydration salts.

Different countries set different priorities. Typically they consider (a) 2 policy objectives (health status improvement & financial protection); and (b) their financial constraints.



Musgrove, P. (1996). Public and Private Roles in Health. Theory and Financing Patterns. Washington, D.C., The World Bank.

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- Some countries, such as the Republic of Congo, find it difficult to decide which private services –both low- and high-cost – should be included in their benefits package. They lack the conceptual tools to do so.
- In addition, developing countries often include in their HBPs services which policymakers would like to see consumed, but for which there is low demand by target users. Should such services be included? If so, what specific interventions should governments use to promote demand for them.

What about public health interventions?

An excessive focus on personal health interventions, which compose a HBP, often distracts policymakers' attention from public health goods, some of which are under-provided.

Musgrove, P. (1999). "Public spending on health care: how are different criteria related?" Health Policy **47**(3): 207-223.

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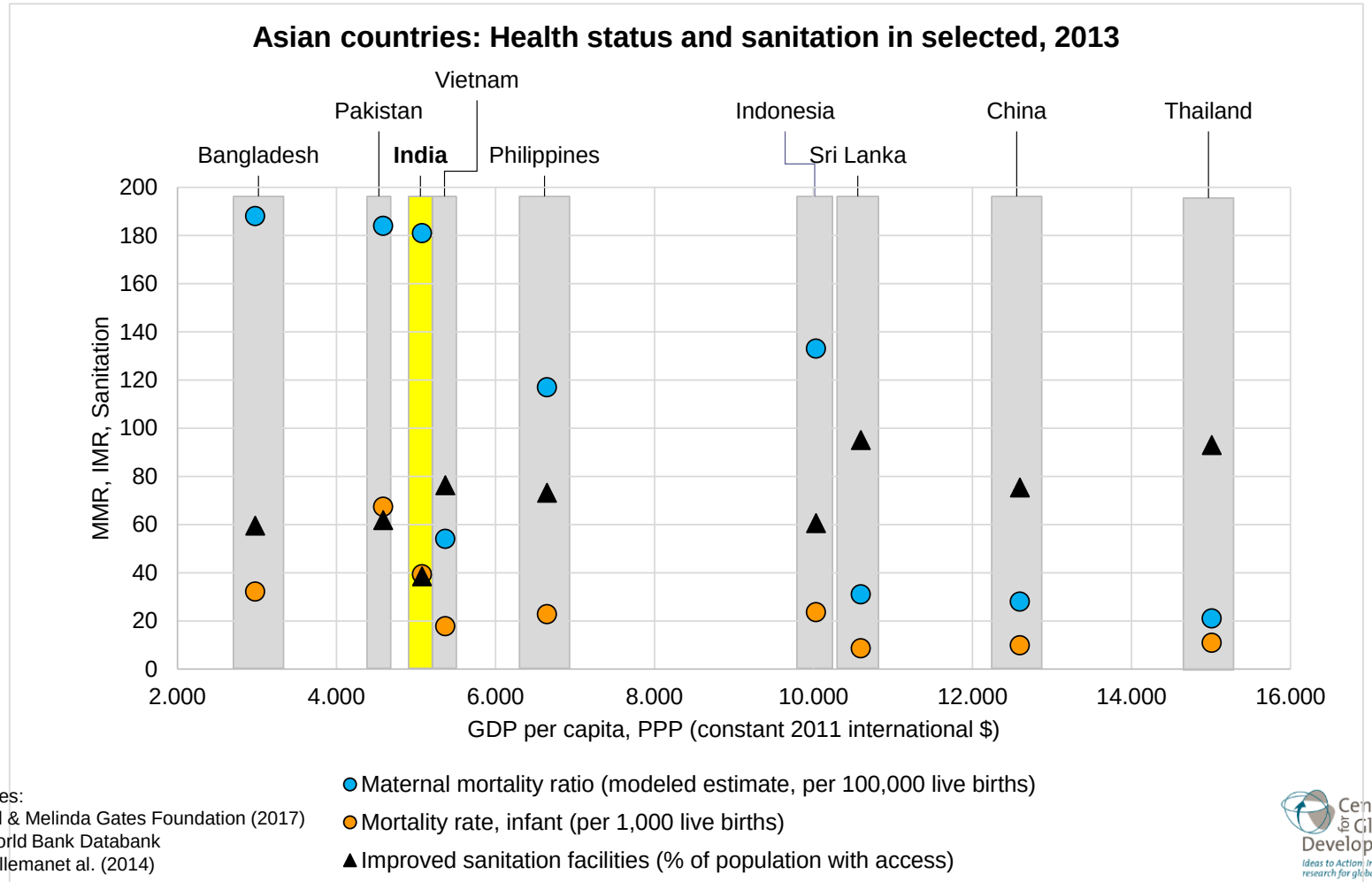
- Around 1993 Phil had a heated debate the World Bank with another health economist, about public health goods within, when the World Health Report "Investing in Health" was being produced. The debate was, among other things, around the criteria that should be used to select public health interventions worthy of public financing. He argued that cost-effectiveness was the appropriate criterion. By the way, the debate became a public good, which is why I know about it.

In some countries, UHC efforts tend to focus on HBPs containing **personal** curative and preventive care, and a neglect of **public** health interventions.



Sources:
(a) Bill & Melinda Gates Foundation (2017)
(b) World Bank Databank
(c) Vellemanet al. (2014)

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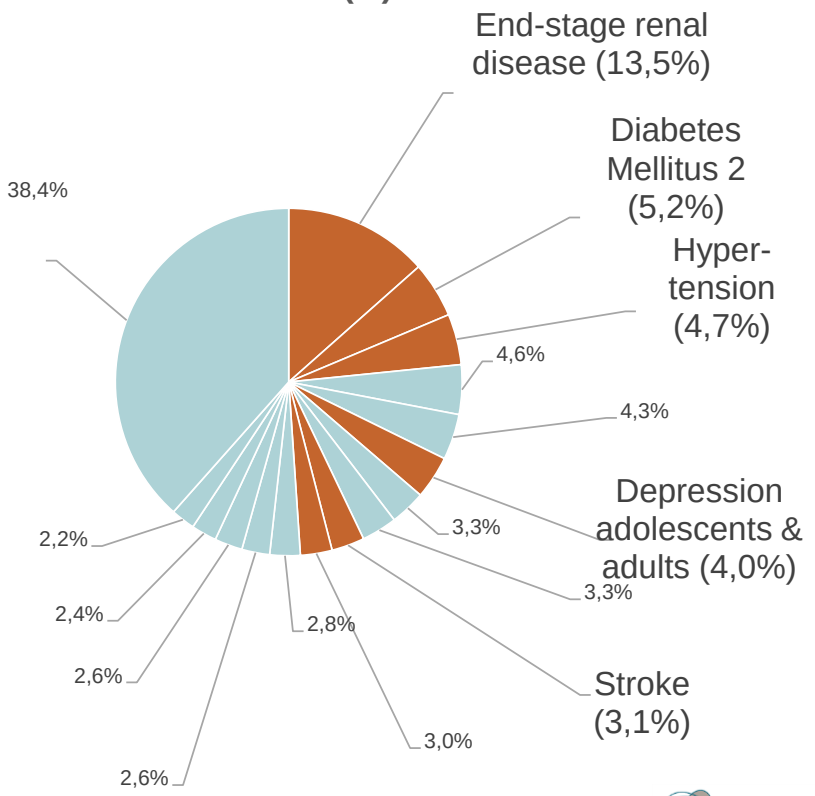
- India is a country which shows under provision of public goods. This is shown in the above figure, with data on infant and maternal mortality, and coverage of sanitation facilities, for selected Asian countries sorted in ascending order by the per capita gross domestic product. In India, there is a low provision of improved sanitation facilities – only about 40% of the population has access to them. This limited access results in diseases that affect especially pregnant women, mothers, and children. Vietnam, which has about the same per capita income as India, has a much higher provision of improved sanitation facilities. It also has much lower infant and maternal mortality. Efforts in India to define a HBP should be accompanied by concrete initiatives to improve the coverage of sanitation.

Chile: Health benefits package deals prominently with consequences of obesity but prevention & public health interventions to prevent it are lacking

Chile: Obesity indicators, 2003 and 2010 (%)

Ministry of Health of Chile (circa 2010). Principales Resultados Encuesta Nacional de Salud 2010. Santiago.

Chile: Per capita cost of GES benefits package, 2015 (%)



Ministry of Health of Chile (2013).Estudio Verificación de Costos GES. Informe Final. Santiago.

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- In Chile, overweight and obesity have experienced a steep increase over the past 10 years, a phenomenon common in multiple countries around the world. I believe there is under-provision of public goods to prevent or combat obesity. As a consequence, a lot of money is being spent in the country to pay for curative health interventions that are required to deal with the consequences of obesity. The pie on the right highlights in brown the health services that are partly a consequence of overweight and obesity –such as diabetes and hypertension-- and which account for a large proportion of the delivery cost of Chile's GES benefits package. GES stands for its Spanish acronym for Explicit Health Guarantees.

Costing of HBPs and financial feasibility analysis

Multiple computerized tools exist to estimate the cost of an HBP. Yet, no tools or methods seem to be available to interpret resulting costs.

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- Costing an HBP is a key part of the prioritization exercise to define the contents of an HBP. The question is: Will public and private resources suffice to pay for the costs of delivering the services contained in the HBP? How much money will be left to pay for health services outside of the HBP?

Costing tools are abundant…

- An impressive set of tools is available to assess resource needs & costs of various health services for different target groups.

Selected health services costing tools

General	Service specific
• Marginal Budgeting for Bottlenecks • OneHealth Tool • CORE Plus • Planning, Costing and Budgeting Framework (PCBF) • Integrated Health Model • Integrated Healthcare Technology Package (iHTP) Simulation Tool	• Costing and Financing Tool for Childhood Immunization • Child Health Cost Estimation Tool • Malaria Costing Tool • Planning and Budgeting for TB • Reproductive Health Costing Tool • Resource Needs Model, HIV/AIDS • Spectrum, PMTCT module

Source: http://www.who.int/pmnch/knowledge/publications/costing_tools/en/index17.html

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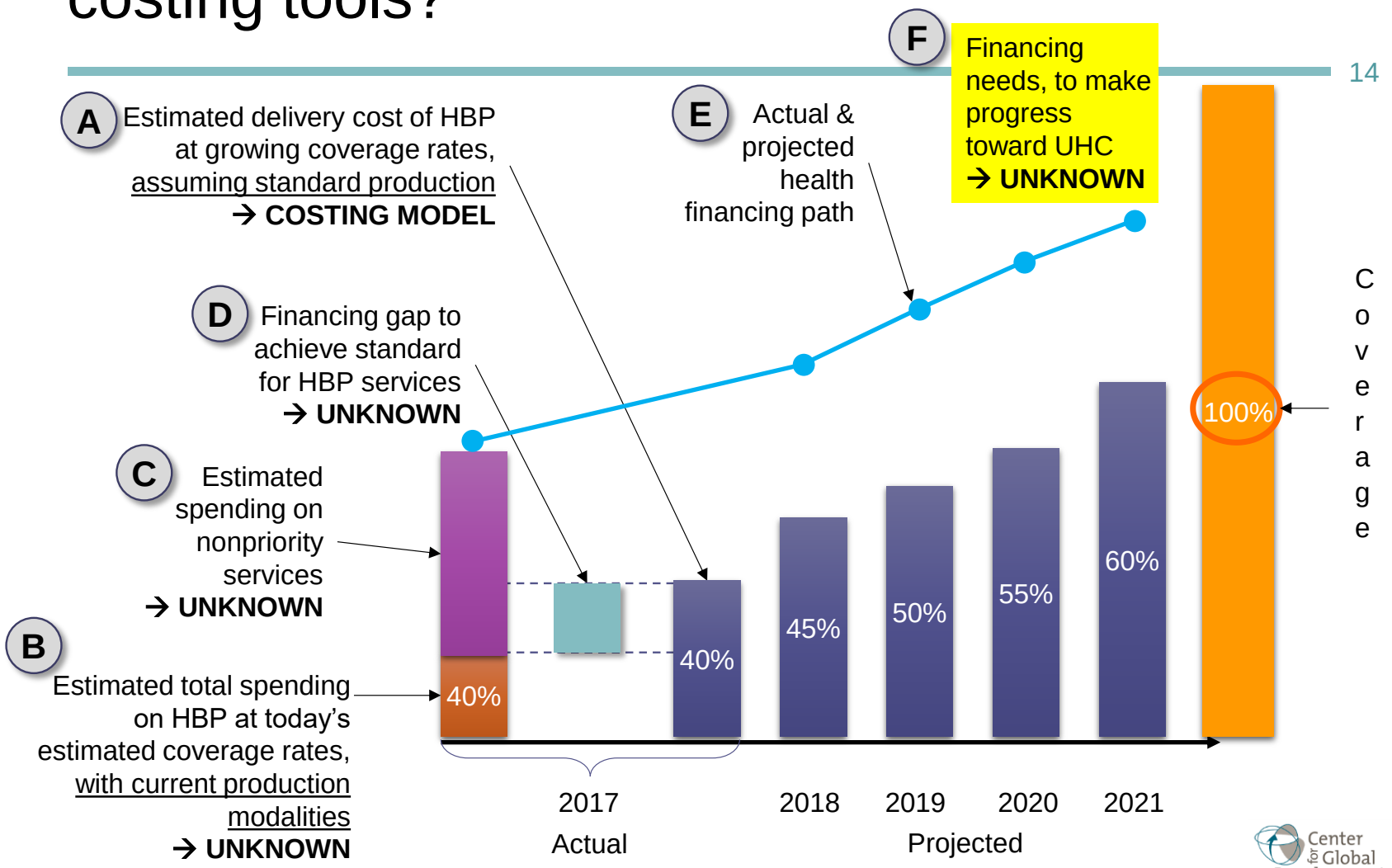
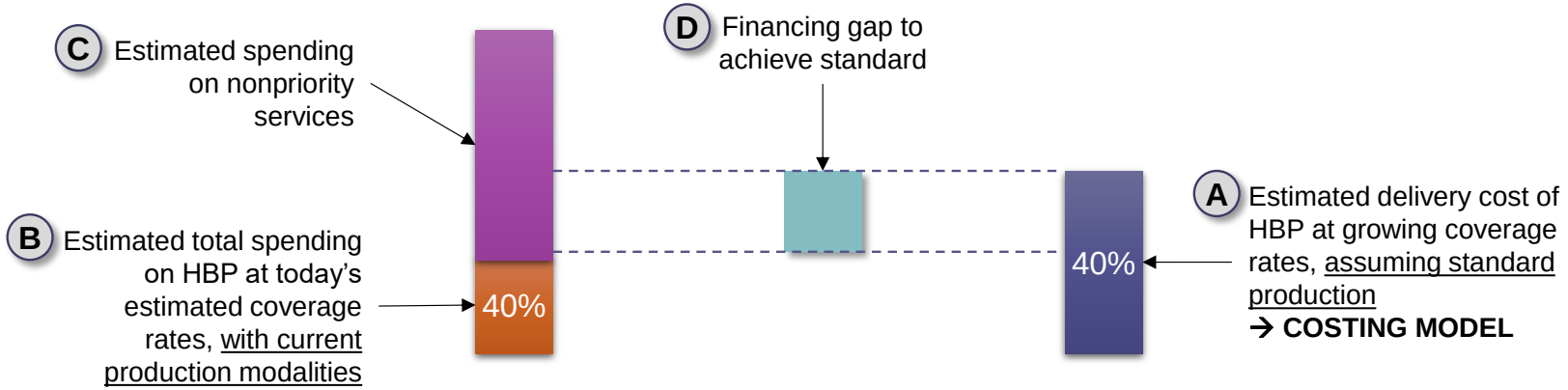
- An impressive set of tools is available to assess resource needs & costs of various health services for different target groups. Some of the tools help the user determine the needs for, and expected cost of human resources, physical infrastructure, drugs and medical supplies needed to deliver the HBP. Tools designed to deal with a broad range of health services are shown on the left column of the table; those designed for specific types of services are shown on the right column.

…but how do we interpret the results of these costing tools?



- But most of these tools have limitations that restrict their usefulness. They use standard production functions when in reality production does not conform to standards. Further, often data requirements to populate these tools are enormous. But most importantly, it is hard for the users of these tools to interpret the results they get.
- The models compute the standard cost of production assuming certain rates of delivery, or coverage –for example 40%, 45%, etc. However, users of these models often project 100% coverage for all services, and therefore obtain an estimate of total cost of full coverage, once UHC will be achieved, X years from now. What can they do with such a result? Further, because costing is based on standard production functions, the cost computed at, say, 40% coverage, will most likely be much higher than the actual cost. What is the cost gap? It is unknown. What is the cost of non-priority services delivered outside of the HBP? It is unknown. Thus, the financing needed to be able to afford the delivery of the HBP and eventually to achieve UHC remains unknown.

→ Judicious use of National Health Accounts information is necessary to link estimated HBP costs with actual health spending patterns and to estimate financing gaps.



Ethiopia: Spending on Health Priority Areas by Sources of Financing, 2010-11 (million Birr)

Source of finance	General health	Child health	Four sub-accounts					All others
			HIV/ AIDS	Repro-ductive health	Malaria	Tubercu-losis	Subtotal	
Government	4,127	737	698	894	273	97	1,963	2,164
Households	8,927	1,425	97	997	550	297	1,940	6,986
Other private sources	218	6	29	22	9	7	66	151
Rest of the world	13,194	806	4,120	1,699	3,060	424	9,302	3,892
Grand total	26,465	2,974	4,943	3,612	3,892	825	13,271	13,193
Share of total spending	**100.0%**	**11.2%**	**18.7%**	**13.6%**	**14.7%**	**3.1%**	**50.1%**	**49.9%**

Source: Ministry of Health (2014). Ethiopia's Fifth National Health Accounts, 2010/2011. Addis Ababa, Ministry of Health.

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- National health accounts can help to solve this problem, even if the degree of detail that NHAs offer is limited. But it is possible –and indispensable– to develop methods to help countries determine the real cost and the financial feasibility of their proposed HBP.

Financing: (a) Converting out-of-pocket payment into prepayment

A common –and wrong– assumption is that households will readily convert their out-of-pocket spending on health into health insurance premiums.

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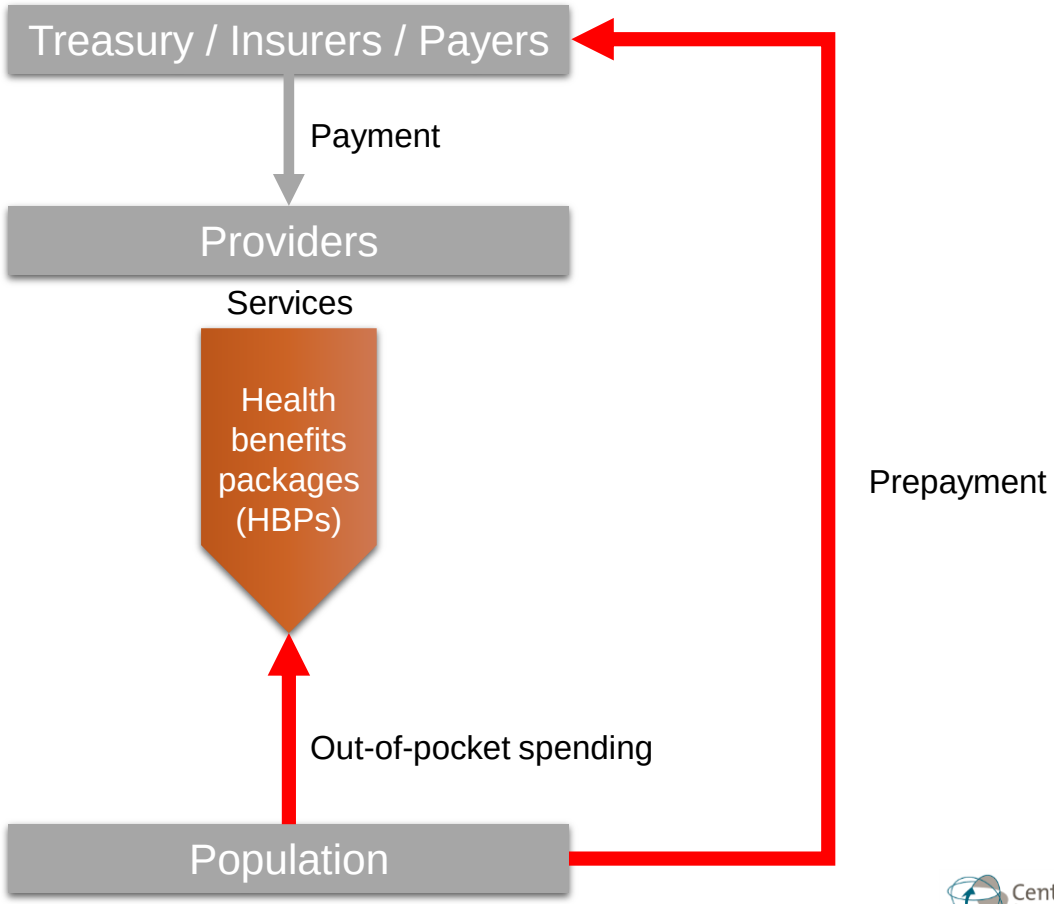
- Let's now move on to other issues that arise in the context of the policy effort to adopt an HBP.

A frequent report financing and recommendation…

- *"Capitalize on the payments that households are already making out of pocket to get them to channel that same money to a health insurance agency."*



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- Over the years I have read many prominent technical reports that lead the reader to believe what is blatantly wrong: that patients can easily be induced to stop paying for health services out-of-pocket and to direct those exact same payments to a health insurer. That is plain wrong. It will lead policymakers to believe that UHC can easily be made financially feasible, when in reality that is not the case.

Financing: (b) Evolution of budget shares on priority and nonpriority services

Effective implementation of UHC policy implies in most cases that the proportion of the public budget spent on HBP services should grow over time. This is not always the case.

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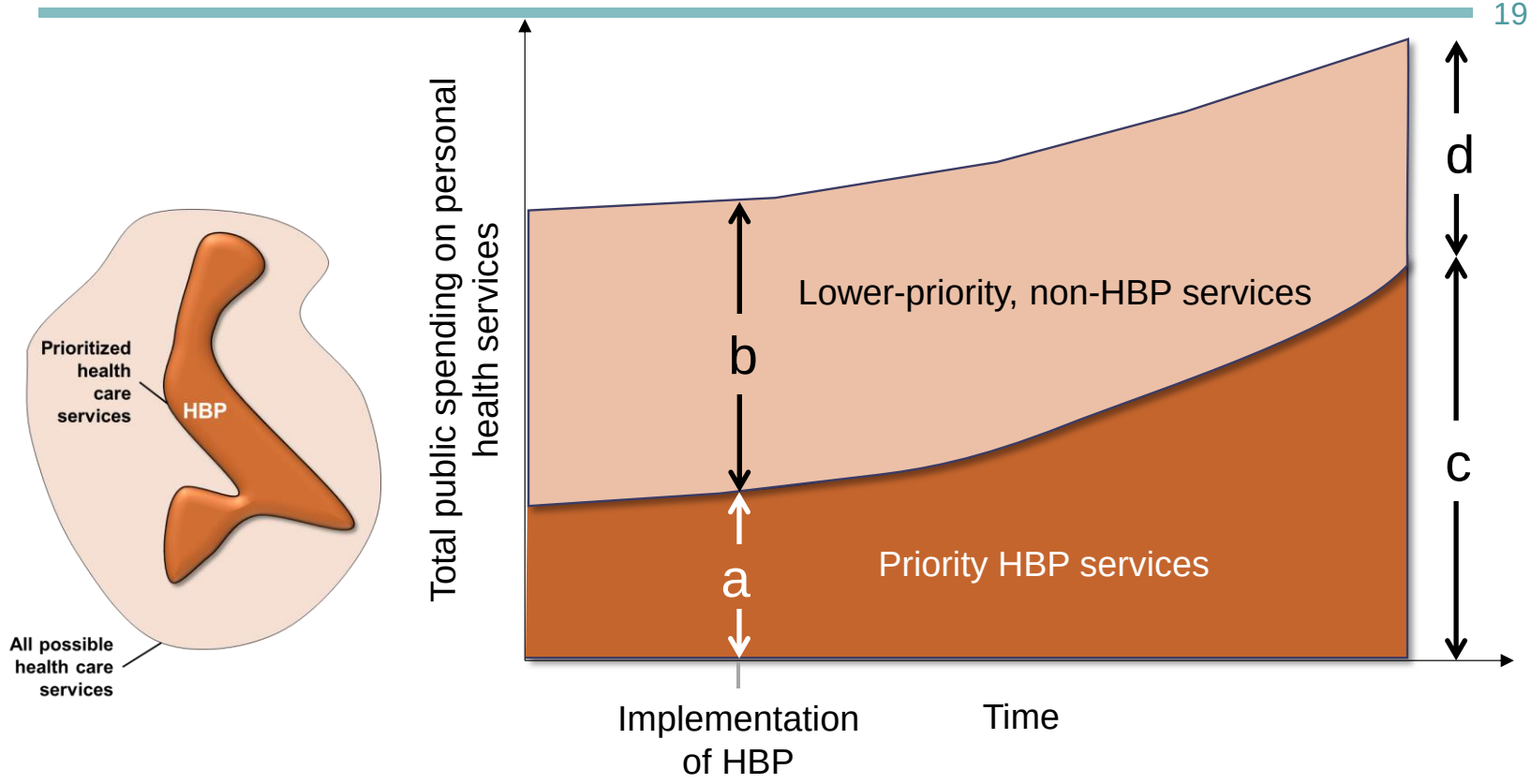
- Another problem is that of budget shares…

Is the evolution of public budget shares on priority and nonpriority services coherent with priorities?



In this case: $\frac{a}{b} < \frac{c}{d} \rightarrow$ Priority services gained importance over time, as expected.

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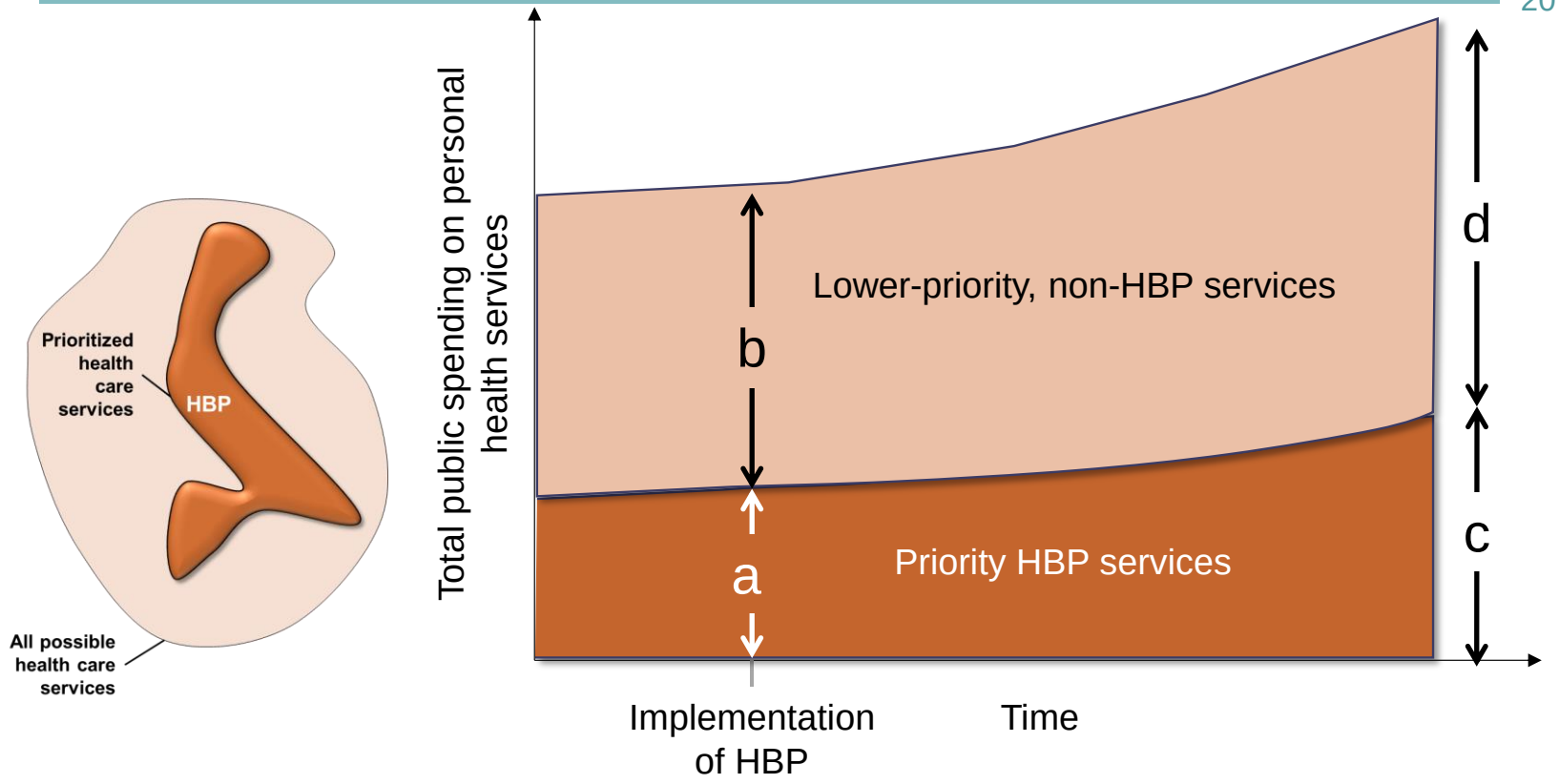
- If HBP services are national priorities, shouldn't we would expect that their share of the public health should grow over time, especially if there is significant under-provision of the services today? That is the situation that this figures illustrates.

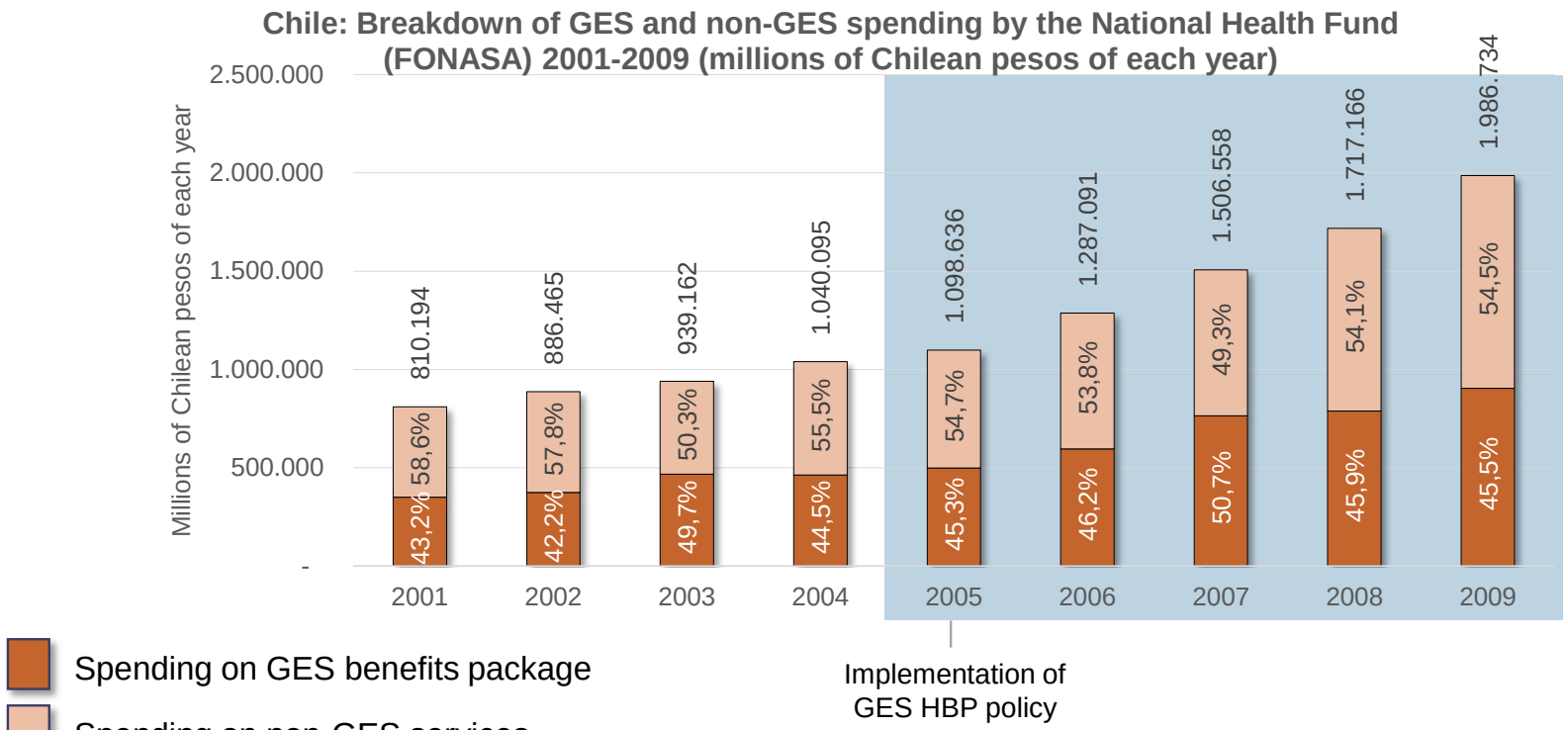
Is the evolution of public budget shares on priority and nonpriority services coherent with priorities?



In this case: $\frac{a}{b} = \frac{c}{d}$ → Priority services did not gain importance over time, an inconsistent result.

- But health policy and budget negotiations are complicated, and that is sometimes not the outcome. Budget shares for HBP and non-HBP services may remain constant over time (as shown in the figure) or, worse, the budget share of the HBP may drop with time.

In Chile, public budget shares on HBP and non-HBP services remained constant 5 years into the reform



→ The population became acquainted and enjoyed a policy of legally guaranteed Access to HBP services. It then started to exert political pressure and to demand nonpriority services.

Ministry of Health of Chile (2012) Impacto de las Garantías Explícitas en Salud en producción y en gasto en la Red Asistencial de Salud. Informe Final. Santiago.

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- An empirical study of the public budget shares spent on Chile's HBP known as GES showed that 5 years into the reform the budget share going to HBP and non-HBP actually services remained constant. How could that be? I believe it was partly the result of political pressure by the population and doctors to ascribe equal priority to services within and outside of the HBP. Doctors are not trained to deal with the concept of rationing. In fact, the population got used to the notion that they have a legal right to obtain HBP services, and they exported that notion to all other services outside of the HBP. Politicians have difficulties dealing with that phenomenon.

Financing: (c) Covering the informal sector and collecting revenue from it

Despite abundant evidence to the contrary, in many countries policymakers and some of their advisors believe that substantial financing will be collected from informal workers to pay for UHC.

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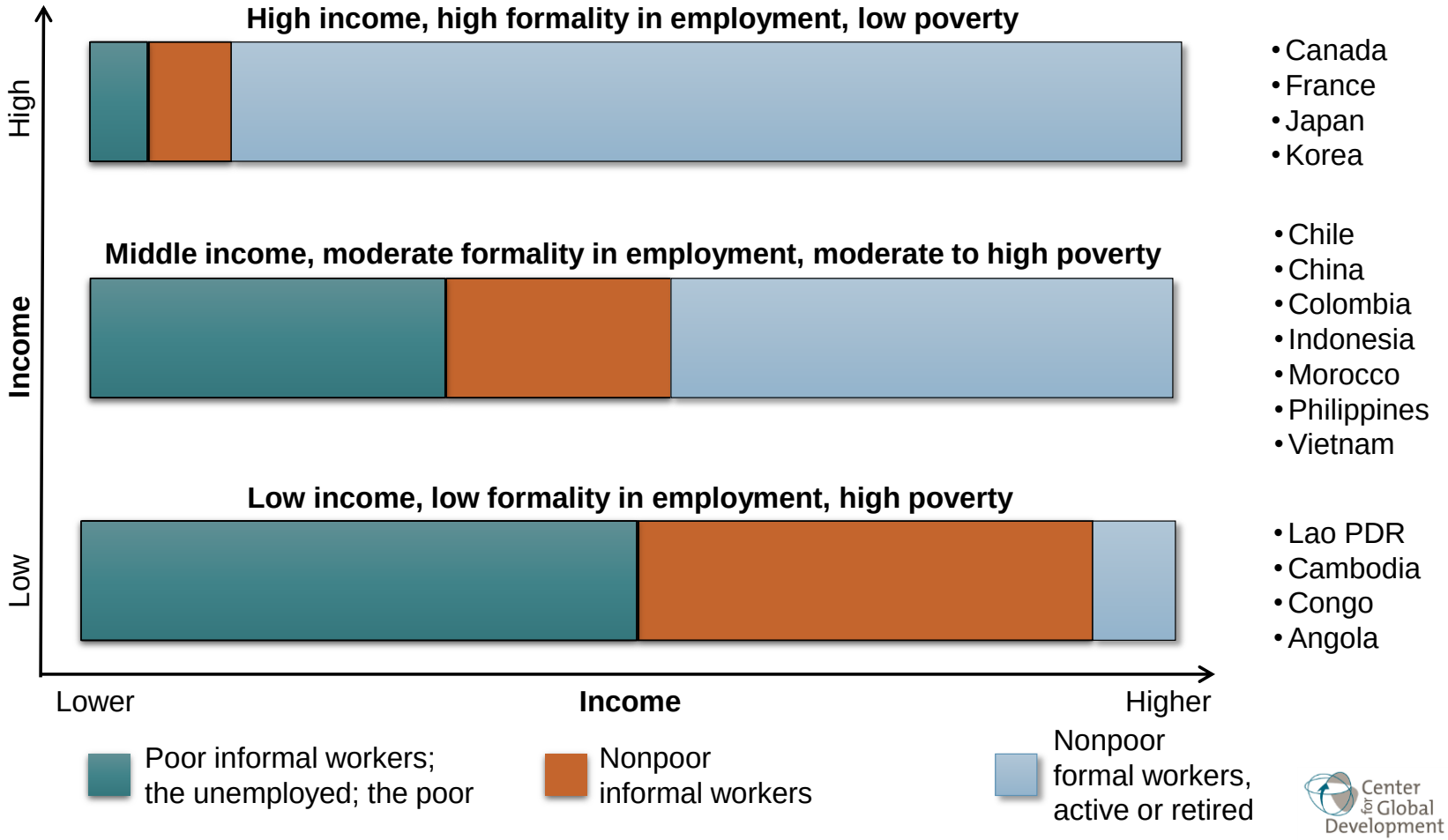
- Another challenge: covering and financing the HBP for the informal sector.

In low- and middle-income countries, the informal sector accounts for the majority of the population



Bitran, R. (2014). UHC and the Challenge of Informal Employment: Lessons from Developing Countries. HNP Discussion Paper. The World Bank.

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- In middle- and low-income countries, the informal sector represents a large proportion of the workforce and population. A significant share of the informal sector families are nonpoor. This leads policymakers –and some consultants, I'm afraid- - to the wrong prescription: "since they are not poor, we must get them to pay for their HBP coverage."

Relying on unrealistic assumptions to achieve UHC

- There's only a handful of instances around the world of selected informal sector groups joining a contributive health insurance.
- Yet policymakers in nearly all developing countries start out with the assumption that in their country it will be possible to get massive insurance enrolment and financing from informal workers

Selected countries that have tried –but failed– to get the informal workers to enroll in contributory health insurance

- Dominican Republic
- Nicaragua
- Peru
- Ghana
- Republic of Congo
- Democratic Republic of Congo
- Cambodia
- Indonesia
- Vietnam
- U.S.

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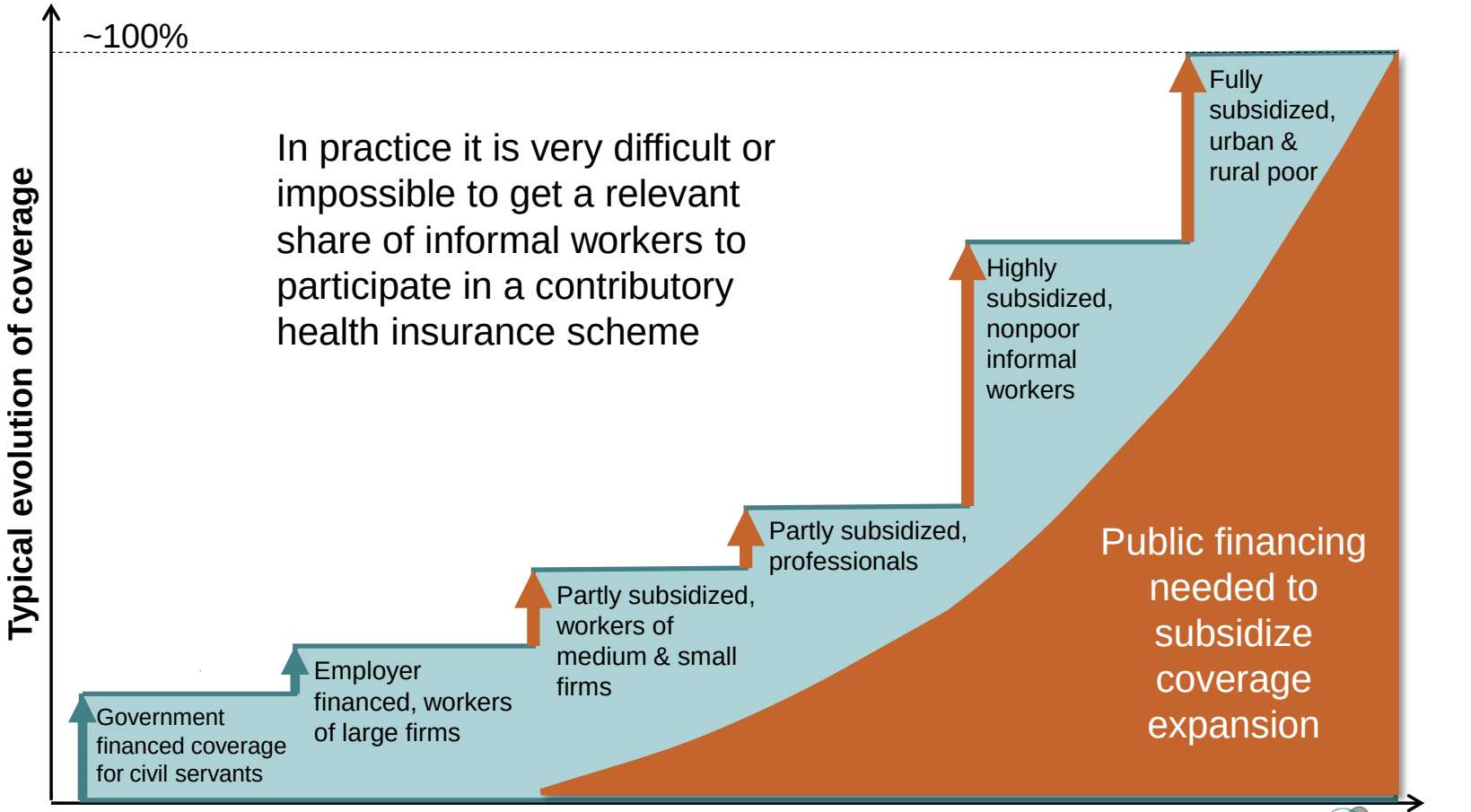
- I could produce a dossier of technical reports that recommend collecting substantial revenue for UHC from the informal sector.

The international evidence shows that population coverage expansion calls for vast sums of public financing



Source: Bitran (2004). Health Insurance Issues in East Asia. Unpublished manuscript. World Bank.

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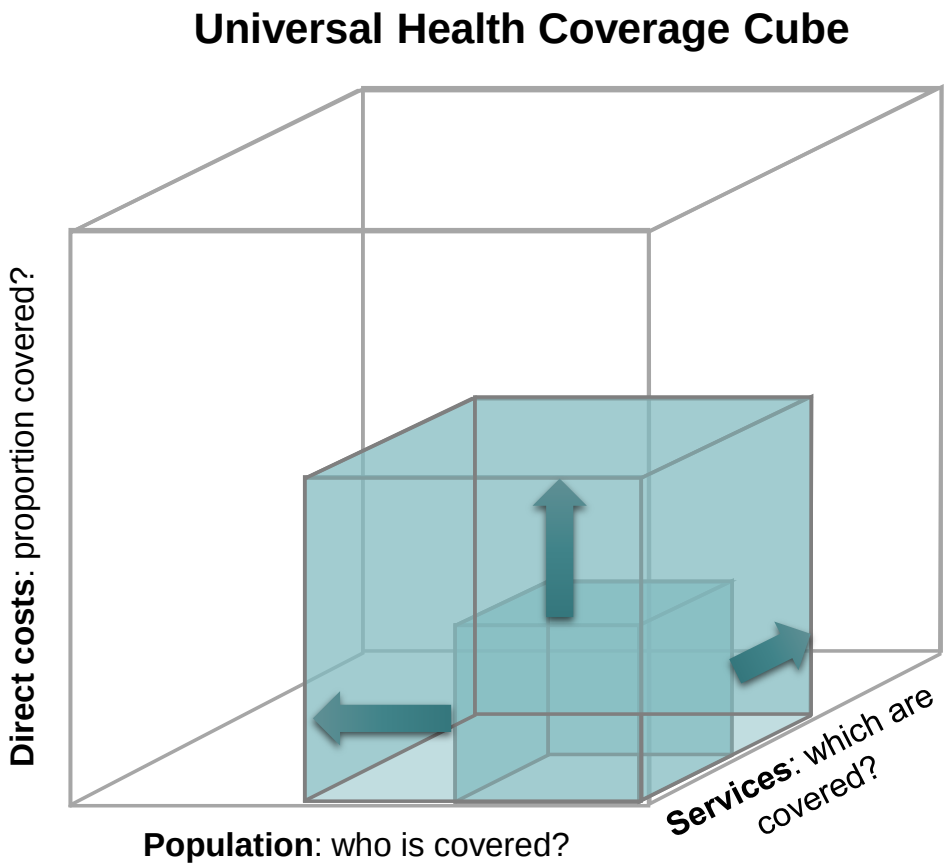
Coverage expansion speed and the preservation of fiscal balance

Too often policymakers choose to expand – nominally– the contents of the HBP to gain popularity, even in the absence of additional financing. In practice, UHC becomes discredited because HBP rationing arises, through queues, demand deflection, and low quality.

Given resource constraints, one would expect countries to expand coverage gradually, only as more financing becomes available



Source: World Health Organization (2010). World Health Report -Health Systems Financing. The Path to Universal Coverage.

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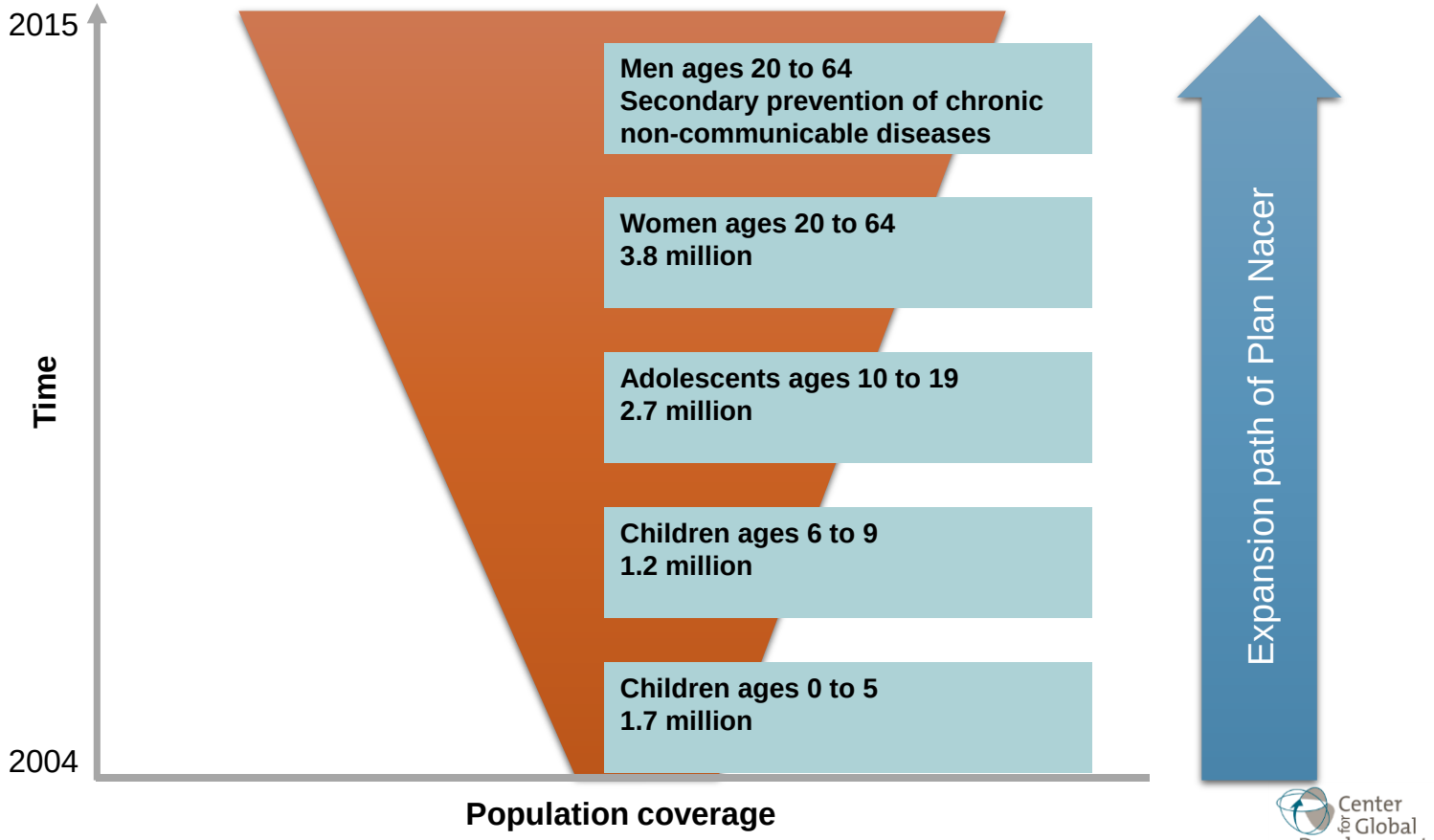
The political temptation to expand an HBP at a pace that is inconsistent with public finances: the case of Argentina's *Plan Nacer/Sumar*



Source: Sabignoso, M., H. Silva and J. Curcio (2014).

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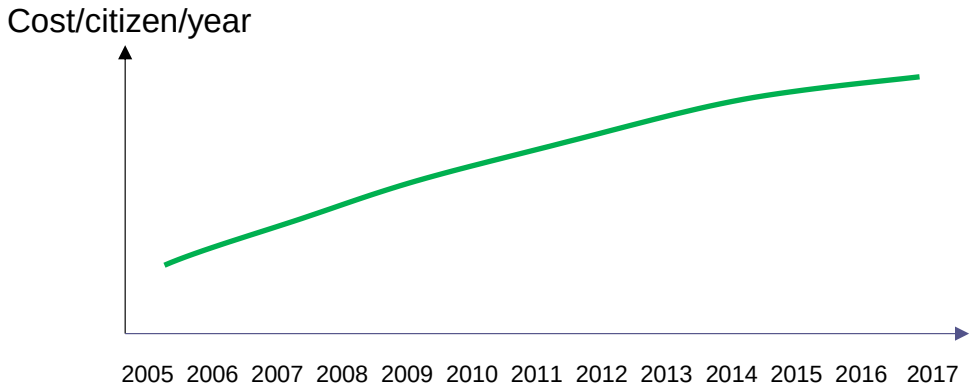
- Argentina's Plan Nacer, later named Sumar, if an example of this practice. In its beginning Plan Nacer set out to deliver a very narrow, well prioritized HBP for low-income mothers and children. Initially it was thoroughly evaluated and showed positive results early on. Regretfully, political pressures led to an expansion in the contents of the HBP to the point that it currently contained several hundreds of interventions. Public financing for them is obviously insufficient. This is no longer a feasible and prioritized HBP. It is more of the same fallacy: "all services for all citizens."

- Phil Musgrove did a lot of work on Plan Nacer. He didn't get to see this expansion in benefits. I can only imagine his face and his reaction.

Chile: The progressive expansion of the GES benefits package under a tight fiscal rule

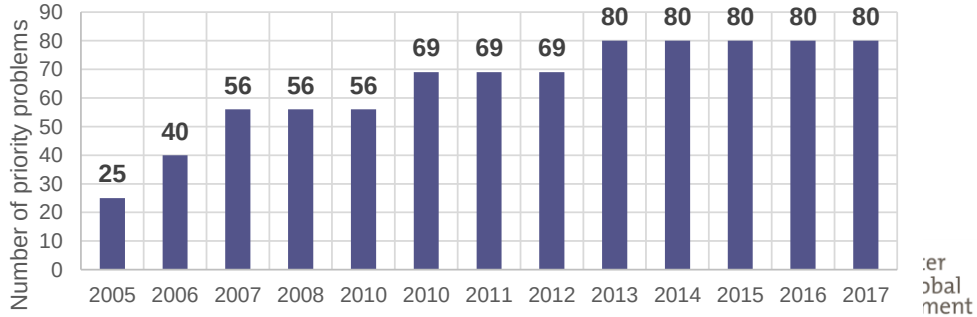
- The Ministry of Finance participated in the GES law to ensure that the cost of GES for the government would not exceed a ceiling, set annually.

Chile: Universal premium ceiling in GES Law



- Accordingly, the number of priority medical problems with GES guarantees has grown progressively and cautiously.

Chile: Number of priority problems with guarantees in the the GES benefits package, 2005-2017



Source: Ministry of Health, Chile.

- The top figure shows as a green line the annual financing ceiling, linked to an index of real salaries in the economy. The bottom figure shows in the bars the number of priority health services included in the GES package over the same period.

Despite this conservative approach, waiting lines for priority health services in GES HBP have been accumulating for the past 5 years.

Waiting lines for GES benefits package services as of June 30, 2015

Prority health problems in GES benefits package	30 days or less	Between 30 and 60 days	Between 60 and 90 days	More than 90 days
11-Cataratas	401	804	482	416
31-Ret inopatia Diabética	249	323	234	525
66-Salud Oral Intearal de la embarazada	154	106	89,134	439
64-Prevención Secundaria IRCT	108	133	351	n6
03-Cáncer Cervicouterino	236	136	S968	165
08-Cáncer de Mama	173	140	110	491
26-Colecistectomla Preventiva	135	104	6,957	121
36-Órtesis	163	110	57	79
29-Vicios de Refracción	222	139	28	10
ss-Hipocacusta Bilateral Adulto Uso de Audífono	98	11	3	107
…	…	…	…	…
17-Linfoma en Adultos	28	29	11	116
30-Estrabismo	68	24	11	9
43-Tumores Primarios SNC	23	22	21	41
01-InsuficlenciaRenalCrónicaTerminal	49	17	9	25
28-Cáncer de Próstata	22	20	16	36
27-Cáncer Gástrico	29	30	811	1,711
07-Diabetes Mellitus Tipo 2	37	20	79	
37-Acci dente Cereb rovascular	33	20	15	8
21-Hipertensión arterial esencial	33	25	718	S13
24-Prev ención Parto Prematuro	12	13	6	19
18-VIH/SIDA	29	9	2	5
38-Enfermedad Pulmonar Obstructiva Crónica	17	13	4	8
…	…	…	…	…

Source: Ministry of Health, Chile.

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- This has been partly the result of limited human resources in the public sector, as many medical specialists have decided to migrate to the private sector, lured by higher income. Which probably implies that, to meet demand, the public insurer should factor in higher costs, that is, the real cost of having to purchase those services from private providers.

Improving health system performance to achieve UHC

To be successful, a UHC policy must rely on a effective and efficient health care delivery system, but that is a rare species…

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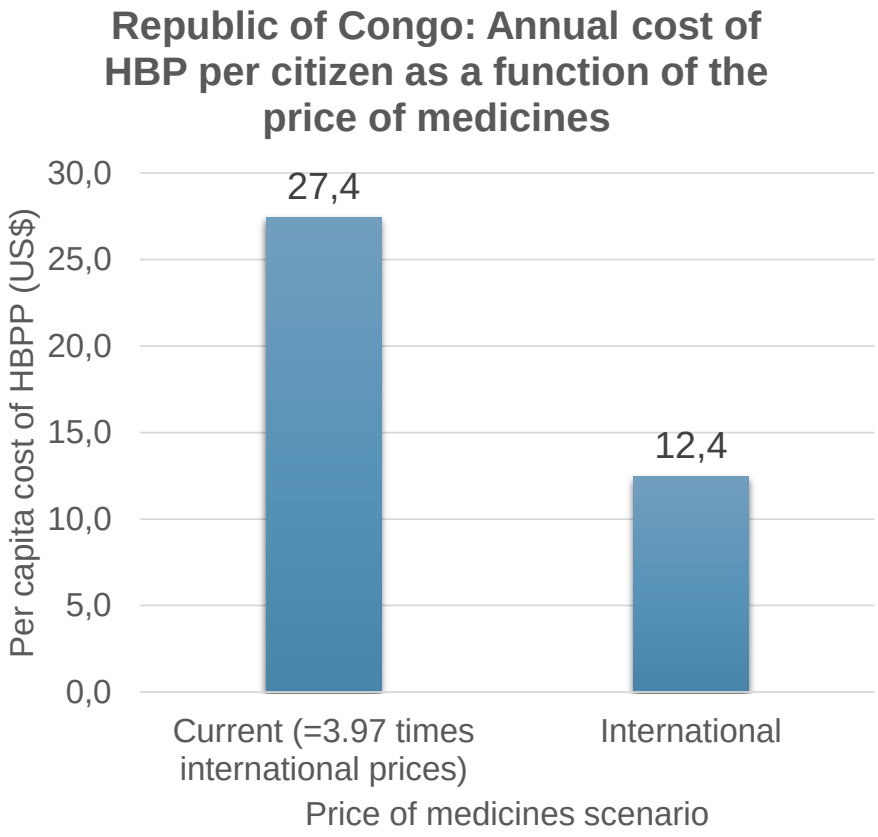
- To be successful, a UHC policy must rely on a effective and efficient healthcare delivery system, but that is a rare species. The development community is well aware of this –World Bank, WHO, and other agencies have recognized this as a prominent challenge--, but in reality many inefficient practices remain in the health sector of developing countries. Some of them lingered for decades without much change…

Republic of Congo, Nigeria, and many countries in Sub-Saharan Africa: The high prices of essential medicines

- Highly inefficient pharmaceutical policies greatly increase the cost of UHC, especially in the poorest countries.
- In the Republic of Congo, drugs prices are on average 4 times as high as international reference prices.
- This more than doubles the per capita cost of the country's proposed HBP.



Source: World Bank (2017).

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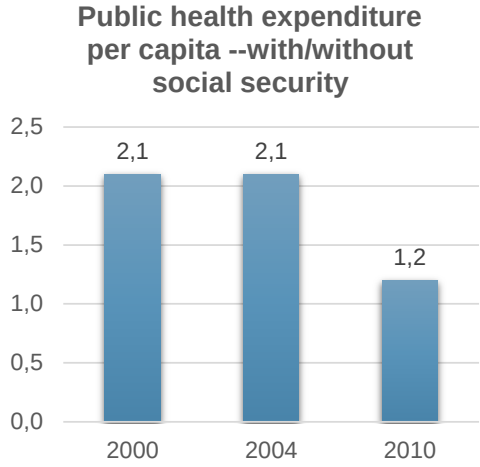
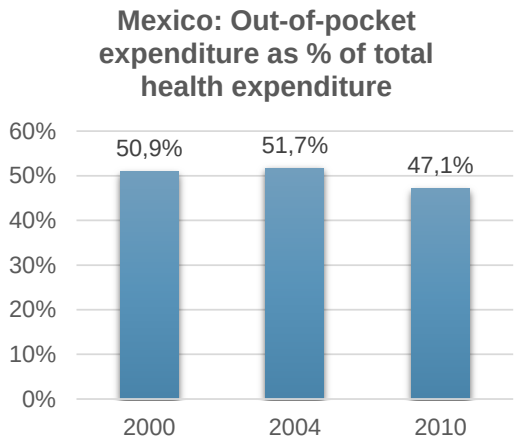
- For as long as I have been practicing my profession – about 35 years now– I have observed countries in Sub-Saharan Africa that have a highly inefficient drug procurement and distribution system. There, governments typically run a National Drugs Agency which does a terrible job and which is captured by the pharmaceutical industry. I have seen little to no change in such a critical area.

The experience of Mexico's Seguro Popular –Many significant achievements, but quality, productivity & availability problems in public provision persist.

- Mexico's Seguro Popular has shown great achievements in terms of health status, accessibility to services and equity. Yet it continues to face quality and efficiency problems in government health care delivery.
  - "until universal access includes a guaranteed, acceptable level of quality, the egalitarian exercise of the right to protection of health will remain an elusive goal and inefficient out-of-pocket spending will grow."
  - "without efficient use of current resources, generating the additional fiscal space required to face the burden of chronic diseases is politically unfeasible."
  - "Out-of-pocket spending persists (alongside reductions in the prevalence of catastrophic spending) because families face issues with access and quality.
  - "Gaps in access persist because of continuous limitations in crucial health-care inputs, especially human and organizational resources."





Source: Knaul, F. M., et al. (2012). "The quest for universal health coverage: achieving social protection for all in Mexico." The Lancet 380(9849): 1259-1279.

- In Mexico, the reform known as Seguro Popular was implemented in the early 2000s to improve coverage, equity, financial protection and health status of the poor population without social health insurance coverage. Between 2000 and 2010 the difference in per capita financing between those with social security and without dropped dramatically, from 2.1 to 1.2, as the upper figure shows,--a reflection of the fresh financing made available for Seguro Popular.

Conclusions

Conclusions

- In many developing countries, UHC policies rely on the definition and implementation on an HBP.
- In addition to generally higher levels of public spending, defining and implementing an HBP calls for broad technical knowledge and experience which many countries lack.
- Development agencies have access to such a knowledge and offer some of it to recipient countries.
- However, much remains to be done among development agencies in terms of generating evidence and good practices.
- Further, strengthening health systems remains an indispensable action if UHC ought to succeed.
- This presentation has pointed to some of the technical areas where further knowledge and development assistance are badly needed.

- Thank you all. I encourage us all to remain keenly analytical and logical in our work, and to base our advice on empirical evidence. Thank you Phil.

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