International Alliance of Patients' Organizations
A global voice for patients

Country examples of progress towards universal health coverage

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Introduction

Universal health coverage (UHC) is an ambition for all nations although the schedule and priorities for action will vary between countries *(1,2)*. Countries generally differ on how they finance UHC. Governments across the world tailor financing systems to specific economic and social conditions. While some bear a strong resemblance to the traditional models of healthcare[1] others adopt some features from traditional systems, with innovative departures designed to cater to specific contexts. This paper will highlight examples from six countries that have developed innovative strategies to expand healthcare coverage across the population including information about how they are financed.

When considering the examples presented in this paper from a patient perspective, some issues or questions may arise. These may include: how much should patients have to contribute financially to their own care and who determines this? How can patients be involved in the development of financing models for universal health coverage? Who ensures that quality of care and safety are balanced with expanding access to healthcare? Are the financing models described appropriate from a patient perspective? How do people outside of health insurance schemes receive care? IAPO's 6th Global Patients Congress will provide a great opportunity to discuss these questions in further detail, and define what universal health coverage means from a patient perspective. This paper should be read together with IAPO's Information Paper: Universal health coverage. Both papers consist of referenced research material and have been developed to provide background information in the lead up to IAPO's 6th Global Patients Congress. They, therefore, do not constitute an IAPO position on UHC.

Mexico

Mexico's experience is an example of the expansion of UHC through legislated access to a comprehensive package of services *(3)*. Progress towards UHC received a boost in 2003 with the passing of the System of Social Protection in Health (SPSS) legislation, and introduction of the Seguro Popular (Popular Health Insurance), accessible to all Mexicans not covered by a social security scheme. By 2012, the program had provided access to a package of comprehensive health services to more than 50 million Mexicans who were previously uninsured *(4)*. Service coverage has improved, with the number of cumulative interventions covered by the Seguro Popular and related health protection mechanisms increasing from below 100 in 2004 to 472 in 2012. Infant and under-five mortality have fallen significantly and are on track to achieve the Millennium Development Goal in this area *(4)*. Further, health financing gaps between the population with and without social security fell by over 70% between 2004 and 2010 *(4)*.

[1] Traditional models of healthcare financing include the Beveridge and Bismarck models. The Beveridge model relies on general taxes and utilises a single risk pool, with publicly provided services available to all. The Bismarck model on the other hand is funded from household premiums and payroll taxes. It encompasses many risk pools, with services purchased from private providers *(5)*.

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Financing

The Mexican healthcare financing system separates funding between personal health services and health-related public goods. This protects public health services, which could otherwise be at risk from reforms that expand insurance *(4)*. Funds are aggregated across the population and divided into four components: stewardship, information, research and development; community health services; non-catastrophic personal or clinical health services; and high-cost, catastrophic health interventions. The regular budgets of the Ministry of Health and the Fund for Community Health finance the first two components, the third is covered by funds administered at the state level, and the fourth is funded by the national Fund for Protection against Catastrophic Expenditures (FPGC). The healthcare systems in Mexico are funded by tripartite arrangements. The federal government makes a social contribution to all beneficiaries, benchmarked against the minimum wage *(6)*. The beneficiaries themselves make a prepaid contribution, capped at 5% of disposable income for contributions to the Seguro Popular *(6)*. For salaried employees and their families[2] the employers make a third contribution. In the absence of employer contributions, the Seguro Popular is funded from a solidarity contribution by both federal and state governments *(4)*. The federal solidarity contribution is allocated to states by use of a formula based on enrolled individuals, health needs and performance. This provides budgetary incentives for states to increase enrolment *(4)*.

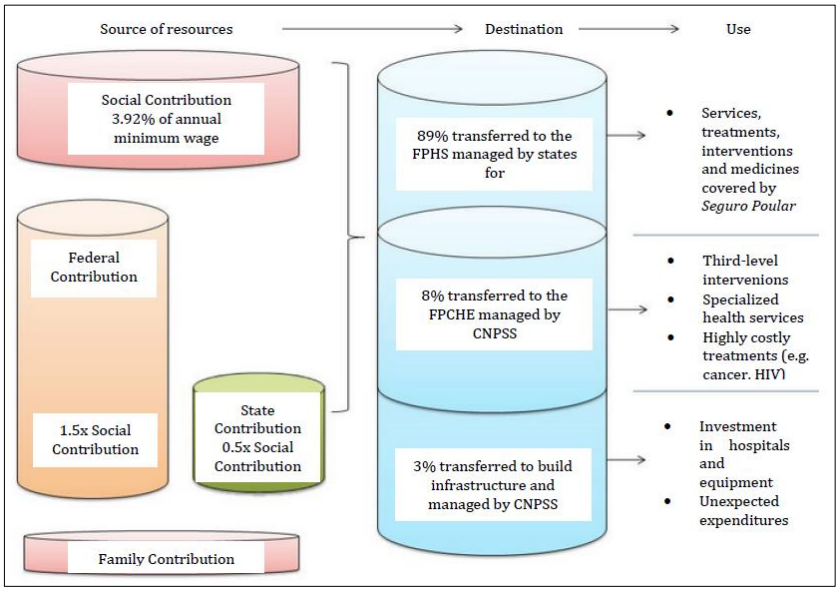

Figure 1. Financing Sources and Uses of Mexico's System of Social Protection in Health (SPSS) *(7)*
(FPHS – Fund for Personal Health Services, FPCHE – Fund for Protection against Catastrophic Health Expenditures, CNPSS – National Commission for Social Protection in Health)

Supply-side improvements in health infrastructure are encouraged by adjusting resource use at the state level *(8)*. For instance, a minimum of 20% of federal contributions should pay for promotion, prevention and disease detection activities, while a maximum of 40% should finance the payroll.

[2] The health coverage systems for salaried employees are the Mexican Social Security Institute (IMSS) and the Institute of Social Services and Security for Civil Servants (ISSSTE).

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Rwanda

Rwanda has invested in its health infrastructure, by building hospitals and clinics, and by training 45,000 community health workers *(9),* which has extended the reach of health services in more rural areas. The country has also established a national insurance system known as Mutuelle de Santé (Mutual Health), building on previously fragmented community insurance systems. This insurance system offers comprehensive preventive, primary, hospital and medicine benefits. In the last decade, coverage has increased to over 90% of the population *(10)*. As out-of-pocket payments have decreased, the utilisation of health facilities has increased dramatically which has led to significant achievements in health indicators. For example, Rwanda's life expectancy has increased by 10 years, and deaths from malaria have been cut by two-thirds *(11)*.

Rwanda's advancements in health coverage were enabled with effective centralised planning. Healthcare was a key pillar of the government's Vision 2020[3] plan *(9)*, and the government's development plans continue to hold influence over its healthcare policies, for example, how it organises foreign aid.

(Photo source: 12)

Financing

Rwanda spends $55 per person on healthcare and public health each year, it is 22nd highest among the 49 countries in Sub-Saharan Africa *(9)*. It funds its Mutuelle de Santé system through donor funding, government revenue, household premiums and formal-sector payroll contributions. As taxes may be hard to levy on the informal sector, the government has relied on compulsory premium collection from all but the poorest people. To facilitate this, 55% of Rwanda's health budget has been decentralised, and is managed at the community level.

This significantly reduces monitoring and collection costs. The level of premiums paid depends on the level of income *(14)*, and government covers the insurance premiums for the poorest 25% of the population. Rwanda has been recognised for its results-based financing approach *(14)* that pays healthcare providers based on their performance in relation to healthcare objectives, for example the number of children immunised. This is a shift from traditional funding models, which are directed towards inputs; salaries, construction, training and equipment *(15)*. The system encourages providers to improve their quality of care and thus achieve healthcare objectives.

[3] Vision 2020 is a government-led development program aimed at "transform[ing] Rwanda into a middle-income country by the year 2020" *(13)*. It sets short, medium and long-term priorities for the government.

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Japan

Japan was one of the first countries to move towards a UHC system in 1961. Japan's system is characterised by mandatory participation in an insurance program *(16)*, tight supply-side cost control measures, and a deregulated approach to service delivery *(17)*. In Japan many people receive insurance through their employers. Those who do not have insurance through their employers, or are unemployed, are able to participate in a national health insurance programme, which is administered through local governments. Although many of the insurance programmes are run by private organizations, they are bound to provide uniform benefits and to cover all eligible beneficiaries; patients cannot be denied coverage *(18)*. Furthermore, patients are free to select physicians and healthcare facilities of their choice.

Japan's demographic changes have led the government to fine-tune its healthcare system. In particular, the government has taken decisive efforts to cope with the country's ageing population. In 2000, the government legislated compulsory long-term care insurance for those over 40 *(19)*. This policy is funded by monthly contributions from individuals above the age of 40. When an individual reaches 65, they are able to access wide-ranging social care support *(19)*.

(Photo source: *20)*

Financing

Japan's health insurance system is funded primarily through payroll taxes by employers and employees, and income-based premiums by the self-employed. 32% of national healthcare expenditures come from national and local public funds, and 12% comes from out-of-pocket payments *(18)*. The health insurance systems available differ with regard to the levels of co-payments for inpatient and outpatient care *(18)*. To increase equity in the system, the government subsidises payments on plans that incur higher costs[4]. There is also subsidisation where lower cover plans are supported through a national pool funded from the national and local governments and other insurance schemes. The Ministry of Health and Welfare has established a point-fee system *(18)* which sets fee payment schedules for medical procedures and hospital visits. These are standardised regardless of complexity or the institutional setting (e.g. type of hospital) preventing competition among insurers *(16)*. Every other year the system is renegotiated within its Central Social Medical Care Council, but constrained by a cap set by the Ministry to limit the overall increase in costs.

[4] For example, 50% of the benefit payments to self-employed individuals were subsidised by the government.

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Ghana

Ghana's National Health Insurance Scheme (NHIS) is one of the more comprehensive schemes in sub-Saharan Africa *(21)*, covering the basic health needs for a large proportion of its 24 million population. It is a single-pool health-financing program[5] *(14),* which includes and targets the rural and agricultural populations. The system has decreased out-of-pocket payments, increased health service utilisation and increased government expenditure on health *(21)*. Residents in Ghana are required to join the NHIS, a private commercial health insurance scheme or a private mutual health insurance scheme *(22)*. The level of coverage across health insurance schemes is mandated, covering 95% of the disease burden in the country[6]. Ghana has placed strong emphasis on district-level health planning and management *(23)*. Services at the district level are managed as part of the Ghana Health Service, a public agency separate from the Ministry of Health. The Ministry of Health on the other hand is responsible for healthcare policy at the national level *(23)*, setting the strategic direction for the system and ensuring policy implementation.

Financing

Ghana's NHIS relies on a diverse set of funding sources *(24)*. It has increasingly relied on tax revenues to fund coverage expansion – earmarking the revenues from a 2.5% increment in consumption taxes[7] towards the scheme, known as the National Health Insurance Levy (NHIL). This has improved funding sustainability, as NHIL receipts account for 75% of NHIS funding.

The second source of NHIS financing comes from a 2.5% payroll tax for formally employed workers, which is redirected from Social Security and National Insurance Trust (SSNIT) pension contributions to the insurance scheme. This has been an effective means of cross-subsidisation *(21)*, as all NHIS beneficiaries obtain the same benefits from the scheme regardless of their contribution. Additionally, the NHIS collects voluntary premiums from households through district-level insurance offices, although this represents less than 5% of its insurance scheme revenues *(21)*. The government is considering moving to a single lifetime premium, and relying on its consumption tax to generate the bulk of its revenues *(14)*. This would reduce the administrative costs of collecting premiums annually.

[5] The single-pool approach is a risk-pooling approach where one risk pool is designed to cover all populations.
[6] Services covered include outpatient consultation, essential drugs, inpatient care and shared accommodation.
[7] Consumption tax is a tax on spending on goods and services. Consumption taxes are usually direct e.g. sales tax or value added tax.

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Thailand

(Photo source: *26)*

Thailand has made big steps in expanding healthcare coverage. Since 2001 Thailand's Universal Coverage Scheme (UCS) has targeted 45 million people who were not previously covered by existing insurance schemes (these tended to cover only the formally employed population). The National Health Security Office (NHSO) administrates the UCS *(25)*. The NHSO is chaired by the Minister of Public Health, and develops contracts with healthcare providers to provide health services for UCS beneficiaries. The Ministry of Public Health and its network of hospitals are the main contractors of the NHSO *(25),* though health services may be subcontracted to private health centres. Enrolment to UCS is automatic, however members must register with a contracted unit for primary care (CUP)[8] to receive outpatient services and referral services for inpatient care.

Financing

Thailand has designed innovative payment mechanisms to help contain its healthcare costs. The UCS is funded through the central government, and funds are channelled to providers through a system of strategic purchasing. For outpatient services, the most common payment mechanism is capitation[9], depending on the number of beneficiaries registered with a given CUP. Payments to provider networks are adjusted by age composition. For inpatient case, the most common payment mechanism is case-based payment[10] *(27)*. The NHSO has monopoly power in negotiations with providers and pharmaceutical companies *(25)*, and therefore significant bargaining power to influence healthcare costs. Both outpatient and inpatient payments fall under a global budget ceiling encouraging healthcare providers to be cost-conscious *(25)*, however to avoid compromising quality of care, additional payments are included for specific high-cost treatments. The NHSO provides financial incentives for desired provider behaviours leading to quality improvement *(25)*. Evaluation of health technologies, or health technology assessments (HTAs) have also helped to contain costs *(28)*. In 2007 the Health Intervention and Technology Assessment Programme (HITAP) was set up to assess the costs and benefits of medications and medical procedures, as well as public health interventions. HITAP leverages on the strong research environment *(28)* in Thailand, conducting both primary and secondary research, which has allowed the government to make use of its health budget more efficiently.

[8] These comprise a district hospital and health centres.
[9] A capitation payment arrangement pays health providers a set fee per person, instead of paying per service provided.
[10] Case-based payment links payment to hospitals to the number and severity of individual cases treated.

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Chile

Chile is a good example of how a rights-based approach *(29)* can increase access to healthcare. In Chile, individuals who cannot afford insurance premiums receive free treatment in primary health care clinics or in hospitals. Individuals who contribute to Chile's Fondo Nacional de Salud (FONASA), or National Health Fund, can also receive free primary treatment, or make a co-payment if they choose a private health provider, for up to 20% of treatment costs *(30)*. In 2004, the Plan for Universal Access with Explicit Guarantees (AUGE) was implemented which made guarantees regarding the access, timeliness and quality of treatment for a set of prioritised health conditions. This stretched across to existing public and private health insurance mechanisms, namely the FONASA and the private Instituciones de Salud Previsional (ISAPREs), evening out previous inequalities in coverage, access and the quality of healthcare services.

The AUGE reform was seen as a people-centred policy that was legally enforceable. Although the reform applied to those already covered by FONASA or one of the ISAPREs, it sharply increased effective access to services, especially for those from lower socio-economic groups. Service coverage has also improved over time; the number of conditions covered by guarantees under the AUGE increased from 25 in 2004 to 69 in 2010 *(29)*.

Financing

Mandatory payroll tax contributions of 7% are used to finance about half of private and public insurance schemes in Chile, while the other half is covered by government revenues *(31)*. Those unable to contribute are covered by government revenues under the FONASA scheme. With the implementation of the AUGE in 2004, existing budget revenues were reallocated to fund the increased government spending. In addition to this, VAT and tobacco taxes were increased, the revenues from which were earmarked for spending on health *(29)*.

To cope with the increased demand for health services as a result of the AUGE, the government has also increased public investment in the supply side, such as by building healthcare infrastructure and training health workers *(29)*.

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