Universal Coverage – Does Sri Lanka Measure Up?

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The MDGs and the Post-2015 Debate about UHC

Millennium Declaration 2000

- Motivation
  - Reflected acceptance that development should encompass more than GDP growth and should address human capability and other dimensions of development
  - Reflected acceptance of the importance of **solidarity** – between rich and poor nations in banishing poverty
  - Built on international commitments to human equity and dignity

- Outcomes
  - 8 MDGs for 2015
    - 3 health MDGs
    - 3 health-related MDGs

Health MDGs

Reduce child mortality by two-thirds

Reduce maternal mortality by half

Reduce mortality from HIV/TB/Malaria

- Health MDGs 4, 5, 6 successful in part
  - Focused attention on maternal/child health, HIV/AIDS, malaria and TB
  - Shared burden at global level
  - Accelerated (somewhat) progress towards identified goals, but most countries still unable to reach Sri Lanka's rates of improvement

Weaknesses of Health MDGs 2013

- Narrow focus
  - International consensus that health outcomes are more than child and infectious disease, e.g., NCDs
- Lack of attention to equity
  - Risk of poorest being left behind with focus on aggregate indicators
- Lack of linkage to recent global consensus on desirability of UHC
- Focus on health outcomes means inadequate expression of core values that underpinned MDGs
  - Human dignity, well-being, solidarity, security

The growing push to position UHC as global goal

- Global consensus that financially catastrophic/impoverishing medical payments unacceptable
  - WHO WHA Resolutions on UHC and healthcare payments (2011, 2012)
  - UNGA Resolution on UHC (2012)
- Recognizes importance of health system as a means
  - Lack of access is barrier to achievement of better health
  - Lack of equity in outcomes hinders attainment of aggregate outcomes
  - Lack of financial protection causes poverty
- Recognizes importance of health protection as ends
  - Lack of risk protection is threat to human dignity and security
  - Importance of values of solidarity in providing protection

Conflicts about Post-2015 positioning of UHC

- Differing visions about what UHC is
  1. UHC is about equal or adequate levels of health outcomes
  2. UHC is about financial protection
  3. UHC is about healthcare access and financial protection

- Different views of why UHC is important
  1. UHC is important as a <u>means</u> to achieve better health or poverty outcomes
  2. Equity in outcomes or opportunities or risk protection are important as <u>ends</u> in themselves

Potential linkages of Health MDGs Post-2015 to UHC

- Current health MDGs fail to address core motivating values of the Millennium and other international declarations
- **Human dignity**
  - Recognizes that inequalities in access to treatment or gross disparities in health outcomes creates indignity
- **Human security**
  - Recognizes that forced payments for healthcare are a source of insecurity
- **Solidarity**
  - Implies that the burden of funding healthcare be distributed fairly, and that the better-off should assist the worst-off

Implications for Post-2015 MDGs

- UHC should be positioned as an overarching health goal in itself
  - To give full realization to the underlying international core values
  - To supplement the existing and other health MDGs
- Implies that UHC must be defined using measurable indicators
  - Indicators to define goals
  - Indicators to monitor progress

Proposed Health SDG

Hyderabad, August 2013

Goal – Achieve Health and Wellbeing at all ages

'All countries achieve universal health coverage, with emphasis on quality primary health services, while protecting all individuals from financial hardship AND develop policies and environments that promote healthy living among populations and individuals'.

Targets

1. Ensure universal coverage of quality healthcare, including the prevention and treatment of communicable and non-communicable diseases, sexual and reproductive health, family planning and routine immunization, emphasizing a primary health care approach.
2. Implement UHC and pro-health policies to accelerate decline in preventable deaths, for reducing under-five child mortality by at least two-thirds, maternal mortality by at least three-fourths, and mortality under 70 years of age from NCDs by at least a third
3. Adopt, implement and monitor policies which promote healthy diets, physical activity and overall wellbeing, and reduce unhealthy behaviors

Proposed Health SDG

Hyderabad, 20 August 2013

Concept

Three domains of UHC attainment:

1) Adequate access to quality healthcare
2) Equitable access to quality healthcare
3) Effective financial risk protection

Indicators

1. Outpatient healthcare utilization > 4 contacts/capita/year
2. Inpatient healthcare utilization > 7 admissions/100 capita/year
3. Essential immunization coverage ~100%
4. Zero impoverishment from out-of-pocket payments for health
5. Zero incidence of catastrophic healthcare payments (>25% of non-food expenditures)
6. Reduce out-of-pocket health expenditures to <30% of total healthcare financing

How well does Sri Lanka fare?

Brief History

- 1920-30s
  - Abysmal health outcomes worse than the average in India
  - Extensive impoverishment by sickness (1934-35)
- 1926–1931
  - Introduction of universal franchise
    - Expressly to improve child and maternal health outcomes
- 1930s–1950s
  - Increase in government health budget to 2.5% of GDP
    - Establishment of extensive government hospital-based delivery system partly to provide financial risk protection
    - Abolition of user fees in public sector
- 1960s-2010s
  - Continued progress and expansion
  - On track to achieve health MDGs 4, 5 and 6

Sri Lanka – Sustained reductions in maternal mortality faster than required to achieve MDG 5

Table 16. Time to Halve the Maternal Mortality Ratio, Sri Lanka, 1930–96

YEAR	MMR	INTERVAL (YEARS)
1930	2,136	n.a.
1947	1,056	17
1950	486	3
1963	245	13
1973	121	10
1981	58	8
1992	27	11
1996	24	4

n.a. Not applicable.
Source: Authors' compilation of data from various sources.

Sri Lanka MDGs

- MDG 1C
  - Not on track to reduce share of population suffering from hunger, but factors lie outside health system (growing income inequality, food insecurity)
- MDG 4
  - On track to achieve child mortality goal
- MDG 5
  - On track to achieve maternal mortality goal
- MDG 6
  - Malaria nearing eradication
  - HIV/AIDs remains low
  - TB – not on track, but levels lowest in region

Achieving UHC

Proposed Health SDG

Hyderabad, August 2013

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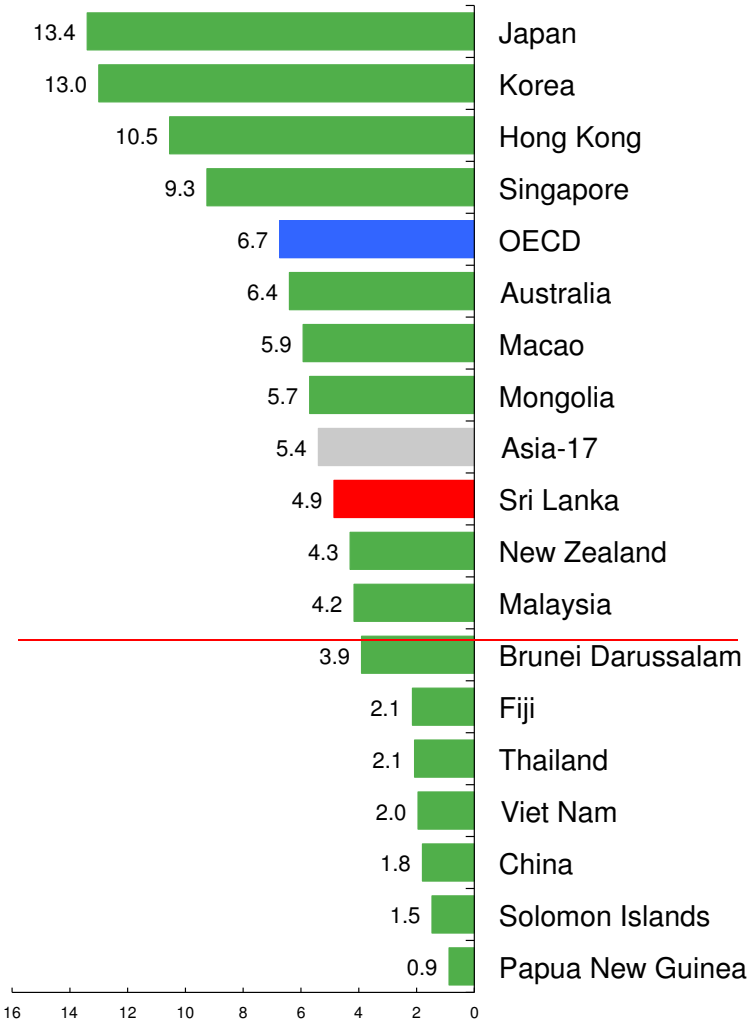
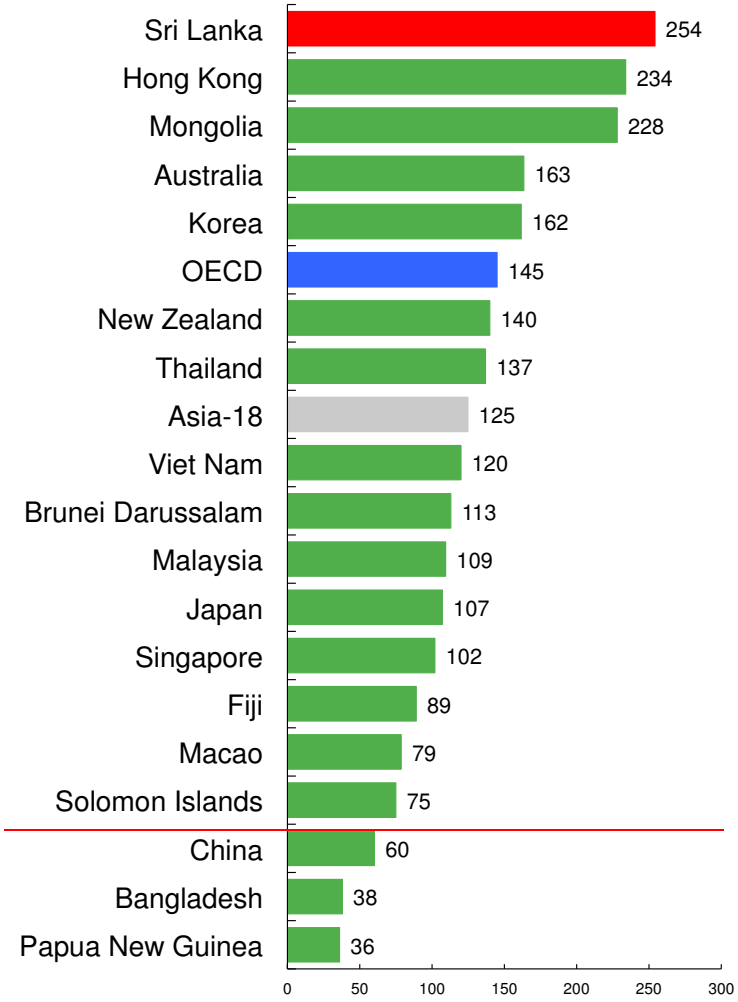
Adequate access to healthcare services



Consultations with physicians per capita

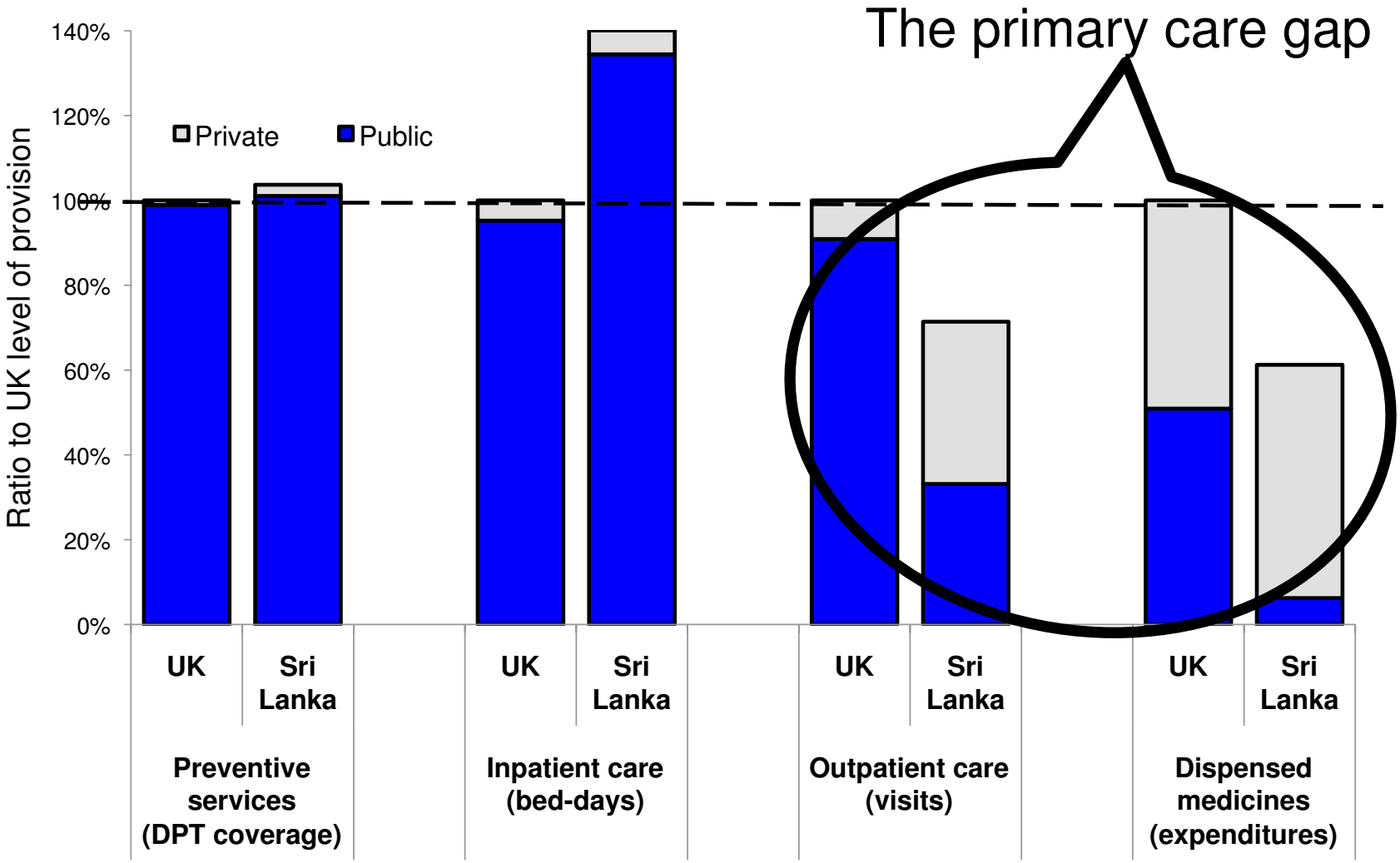


Hospital discharges per 1000 capita

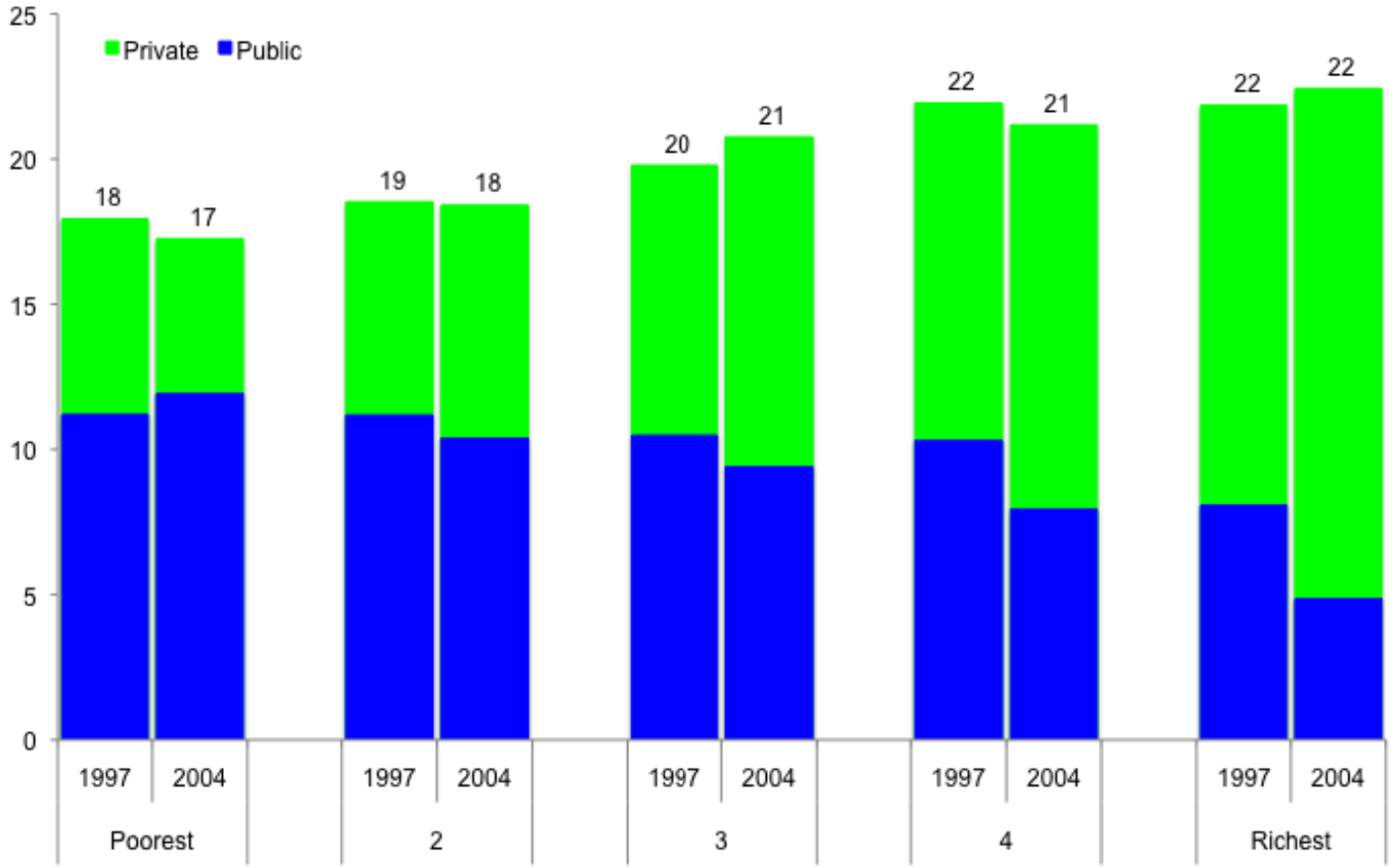
Source: IHP-OECD AP HaG 2010 Database

… but some gaps in primary care coverage

– outpatient care, medicines, oral health care



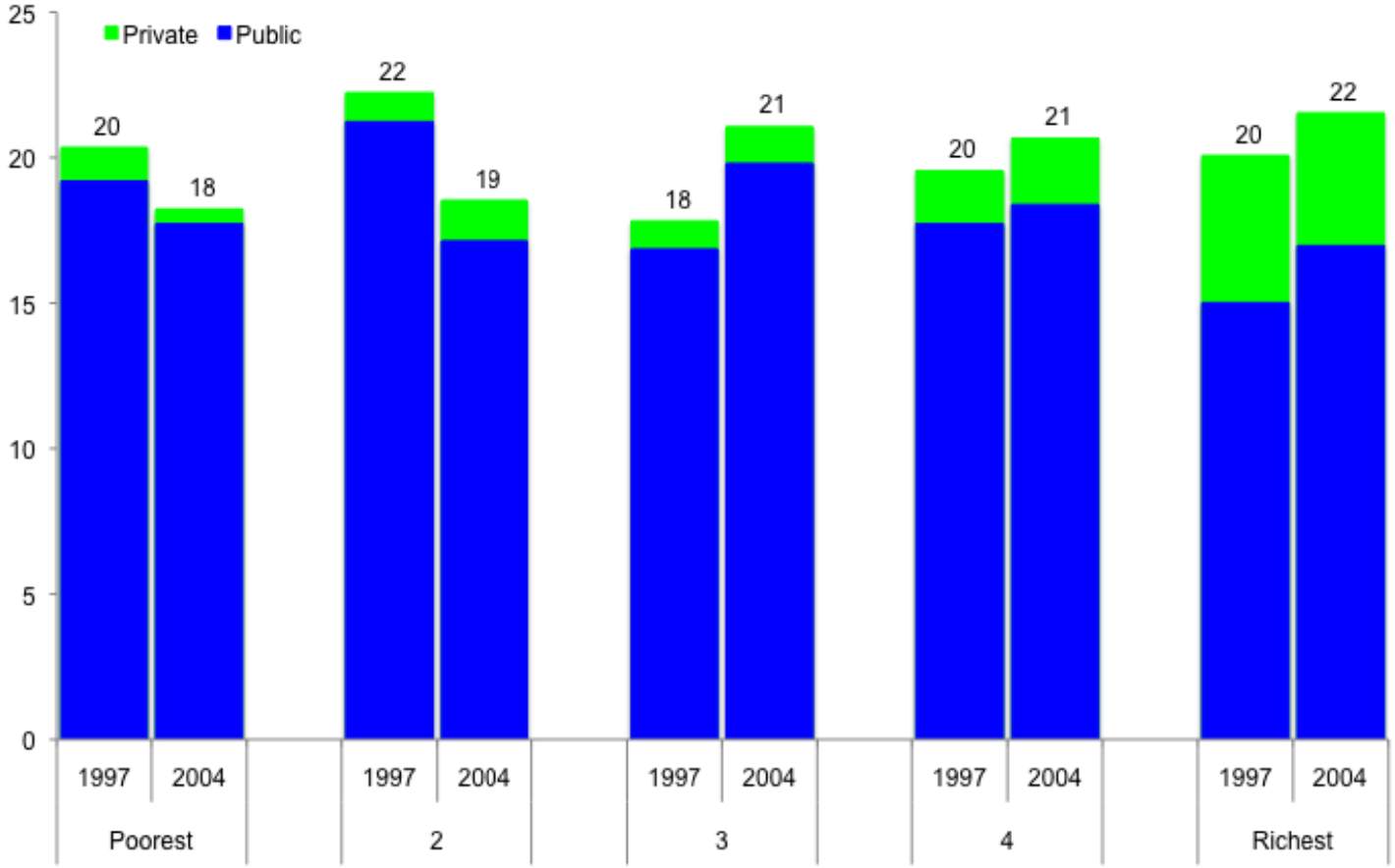
Lack of gross inequalities in outpatient access – Sri Lanka 1997–2004



Notes: Percentages refer to share of total utilization in that year.

Source: IHP analysis of the Central Bank Consumer Finance Surveys 1996/97 and 2003/04

… and in in inpatient use
Sri Lanka 1997–2004

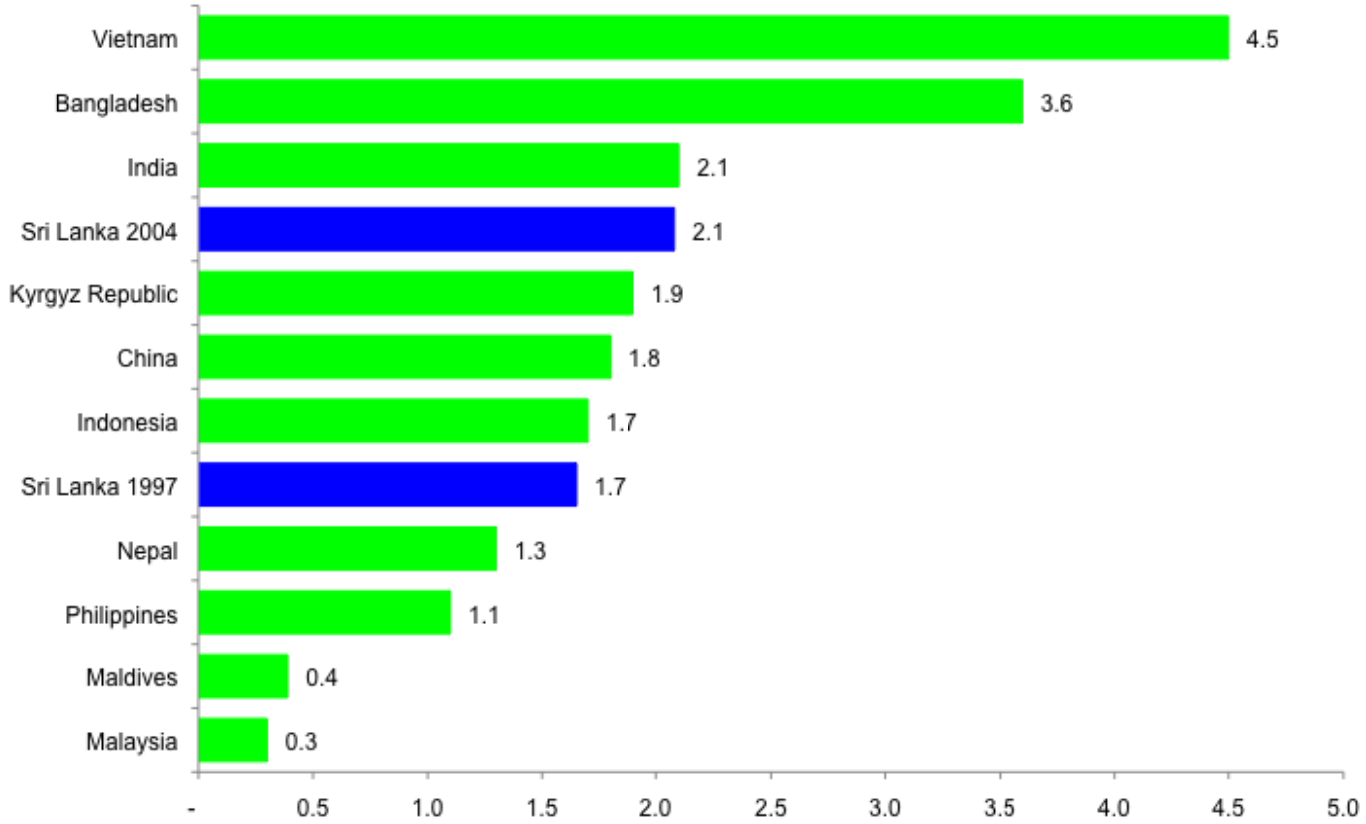


Notes: Percentages refer to share of total utilization in that year. Relative shares of inpatient utilization by sector have been adjusted to 10% private in both years to account for observed survey bias,

Source: IHP analysis of the Central Bank Consumer Finance Surveys 1996/97 and 2003/04.

Reasonable financial risk protection

Population (%) impoverished by out-of-pocket healthcare spending at the PPP$2.15 poverty line, Sri Lanka 1997–2004, compared with other Asian territories

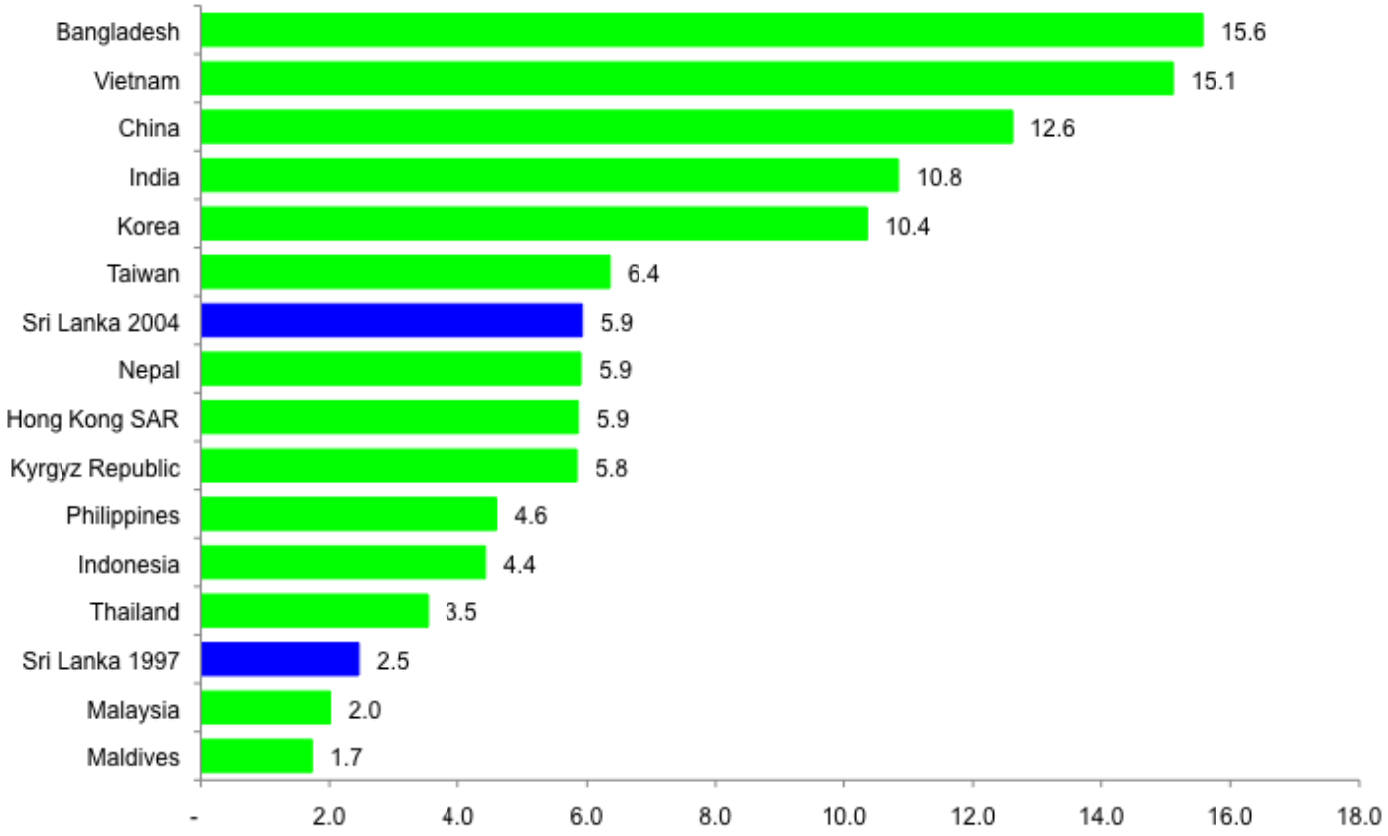


Notes: Estimates for Maldives are for 2006, and estimates for most other territories are for late 1990s and early 2000s.

Source: IHP analysis of the Central Bank Consumer Finance Surveys 1996/97 and 2003/04 for Sri Lanka, Anuranga *et al.* (2009) for Maldives, and Van Doorslaer *et al.* (2006).

… but indicators worsening

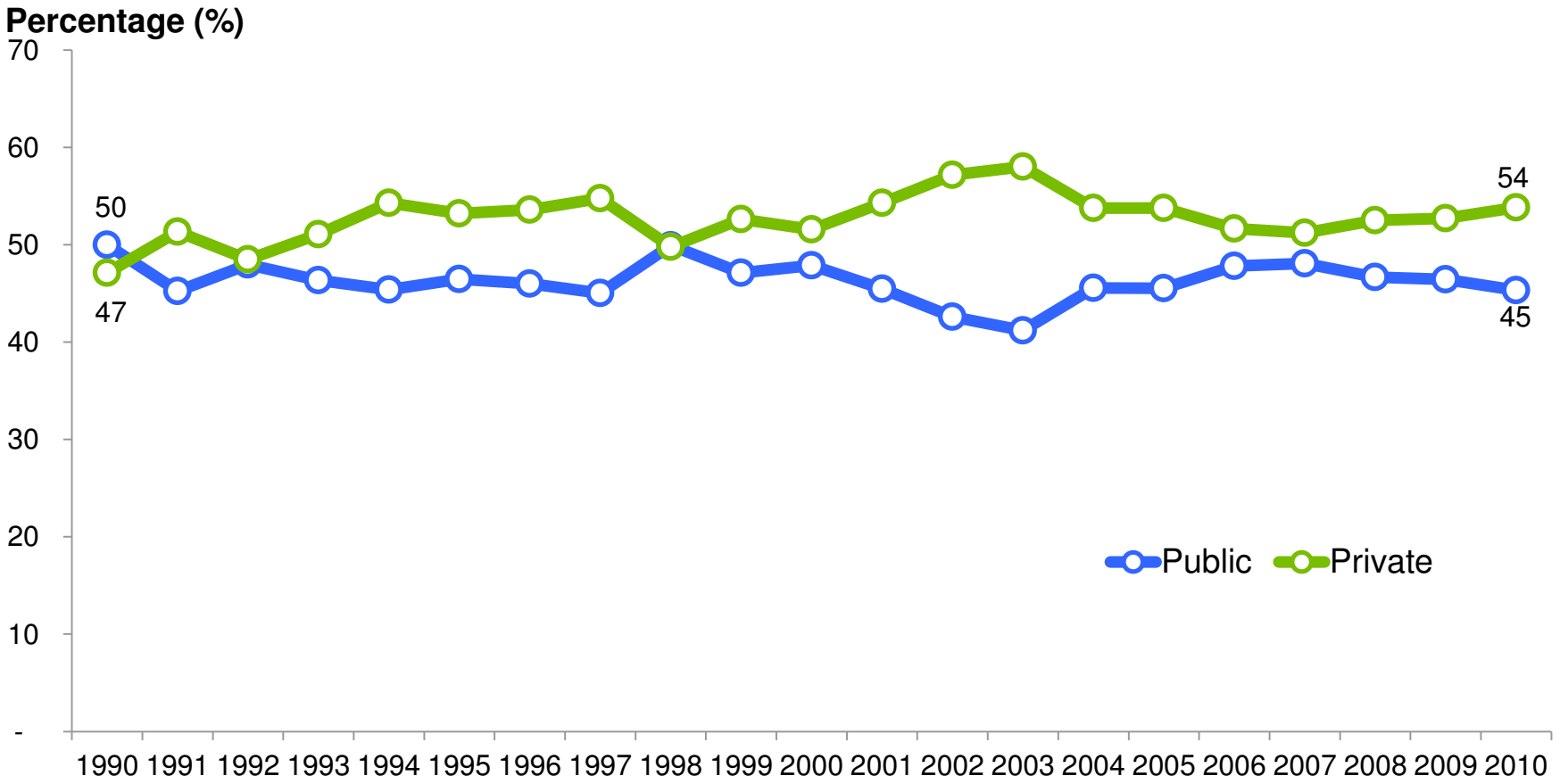
Percentage of households incurring catastrophic levels of out-of-pocket healthcare payments in Sri Lanka 1997–2004, compared to other Asian territories



Notes: Chart indicates the percentage of households spending more than 10% of their household consumption on medical expenses in a given month. Estimates for Maldives are for 2006, and for most other territories for late 1990s and early 2000s.

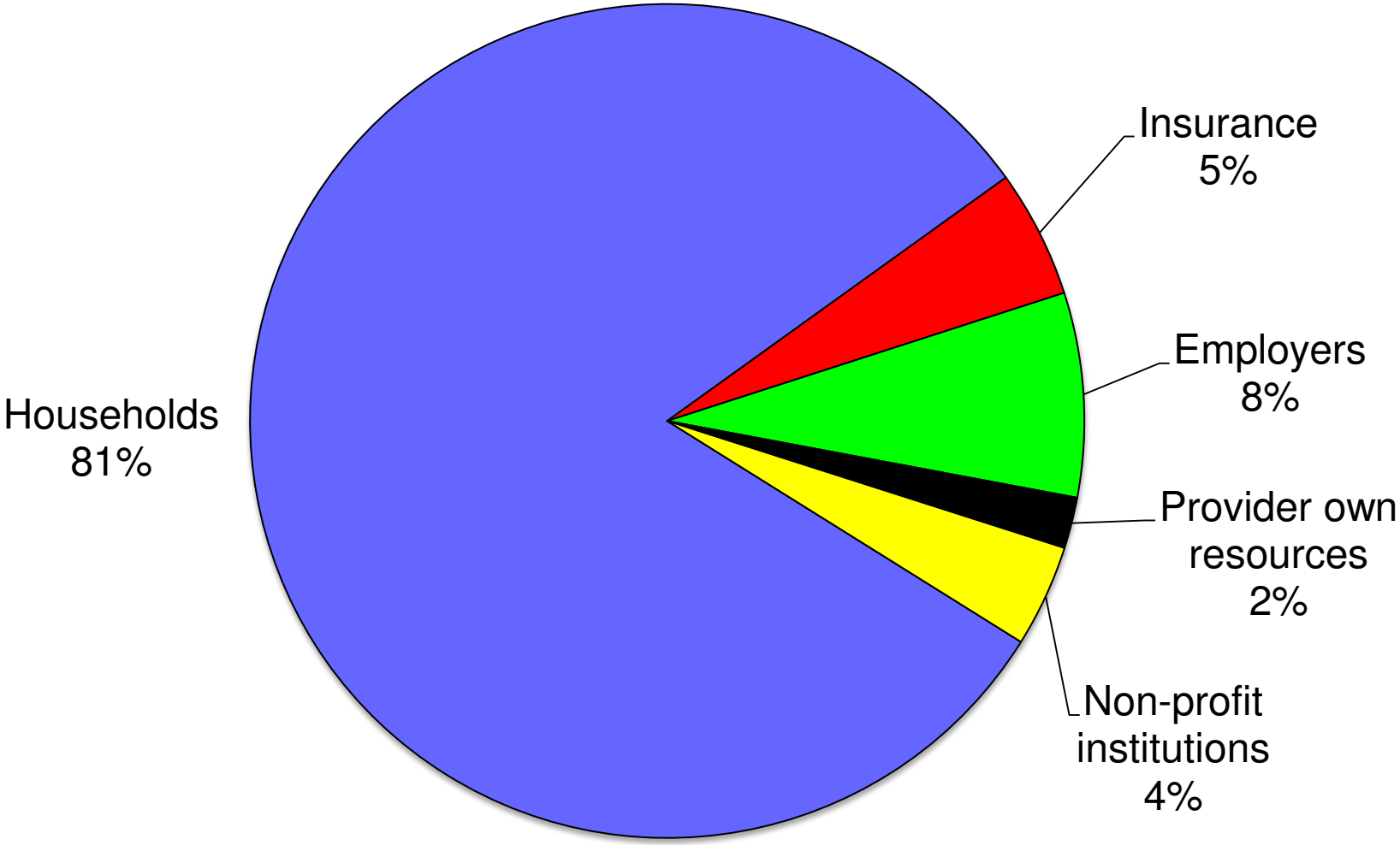
No reduction in reliance in out-of-pocket or private financing

Total expenditures on health by source (%), Sri Lanka 1990–2010



Source: IHP SLHA Estimates 2012

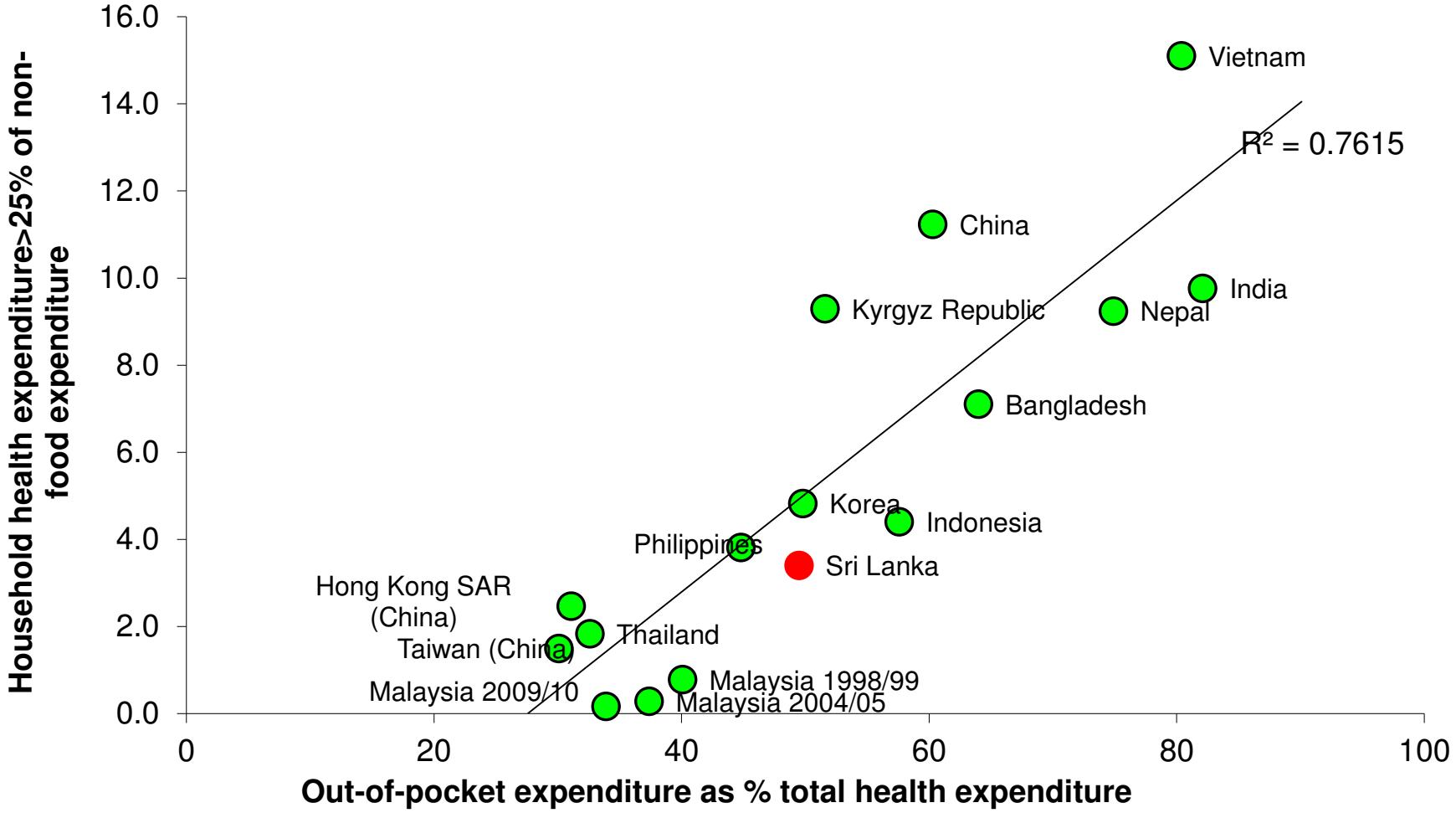
Private expenditures on health by source of financing (%), 2010



Source: IHP SLHA Estimates 2012

Catastrophic impact of health OOPE

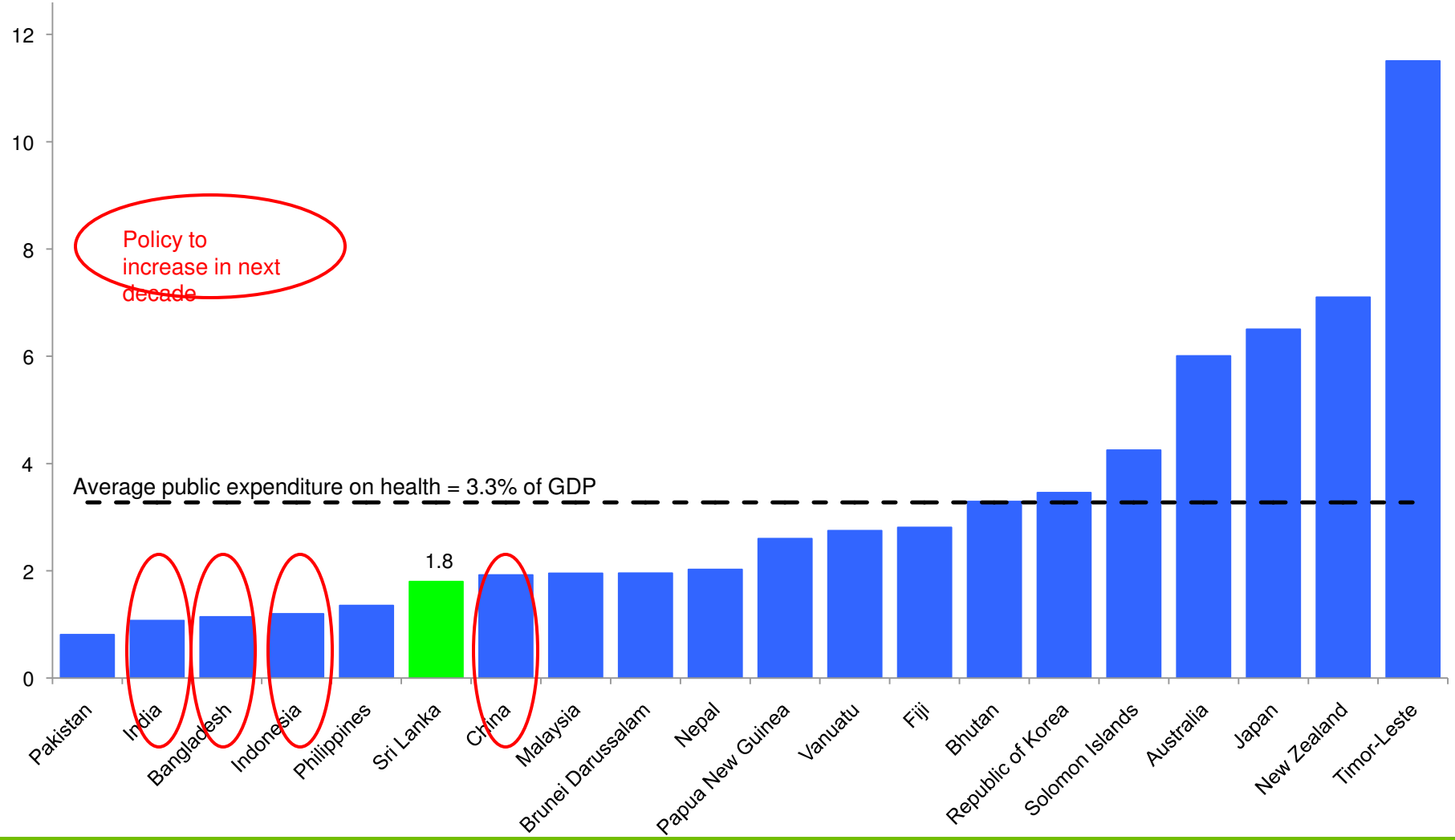
Vs. OOPE as % total health expenditure



Source: IHP analyses, van Doorslaer, E., et al. 2007 & Anuranga, C et al. 2012 for others in early 2000s.

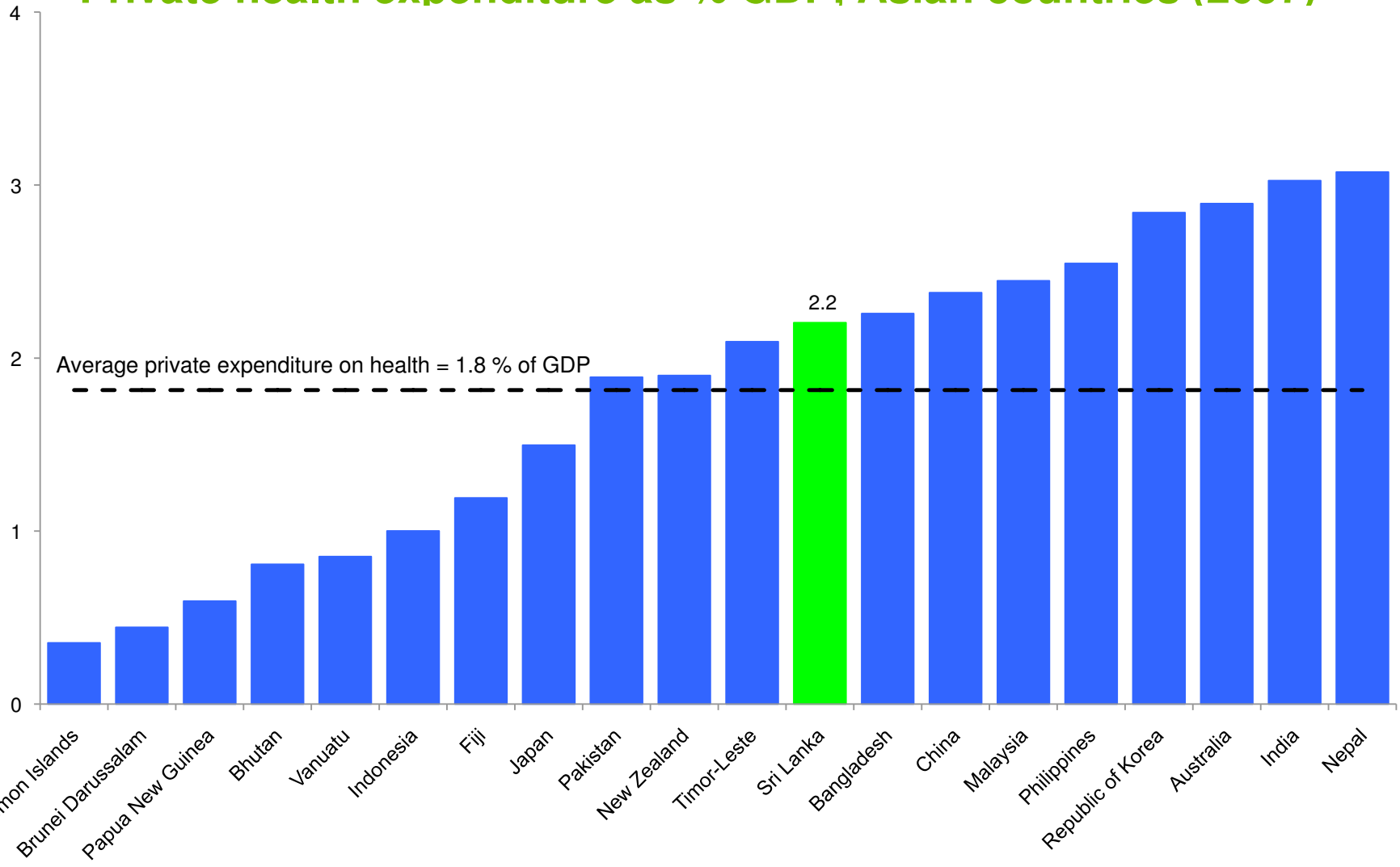
Low public financing for health

– Government health expenditure as % GDP, Asian countries (2007)



And above-average reliance on private financing

— Private health expenditure as % GDP, Asian countries (2007)



Sri Lanka – How well does it attain UHC?

1. Coverage and access
   - Good and relatively high
   - Reasonable degree of equity
   - Gaps in some primary care, medicines

1. Financial risk protection
   - Better than most other countries in region and poor relatively well protected, but indicators worsening
   - Deterioration linked to high and increasing reliance on out-of-pocket financing and failure to increase government spending as % GDP

Challenges in doing better

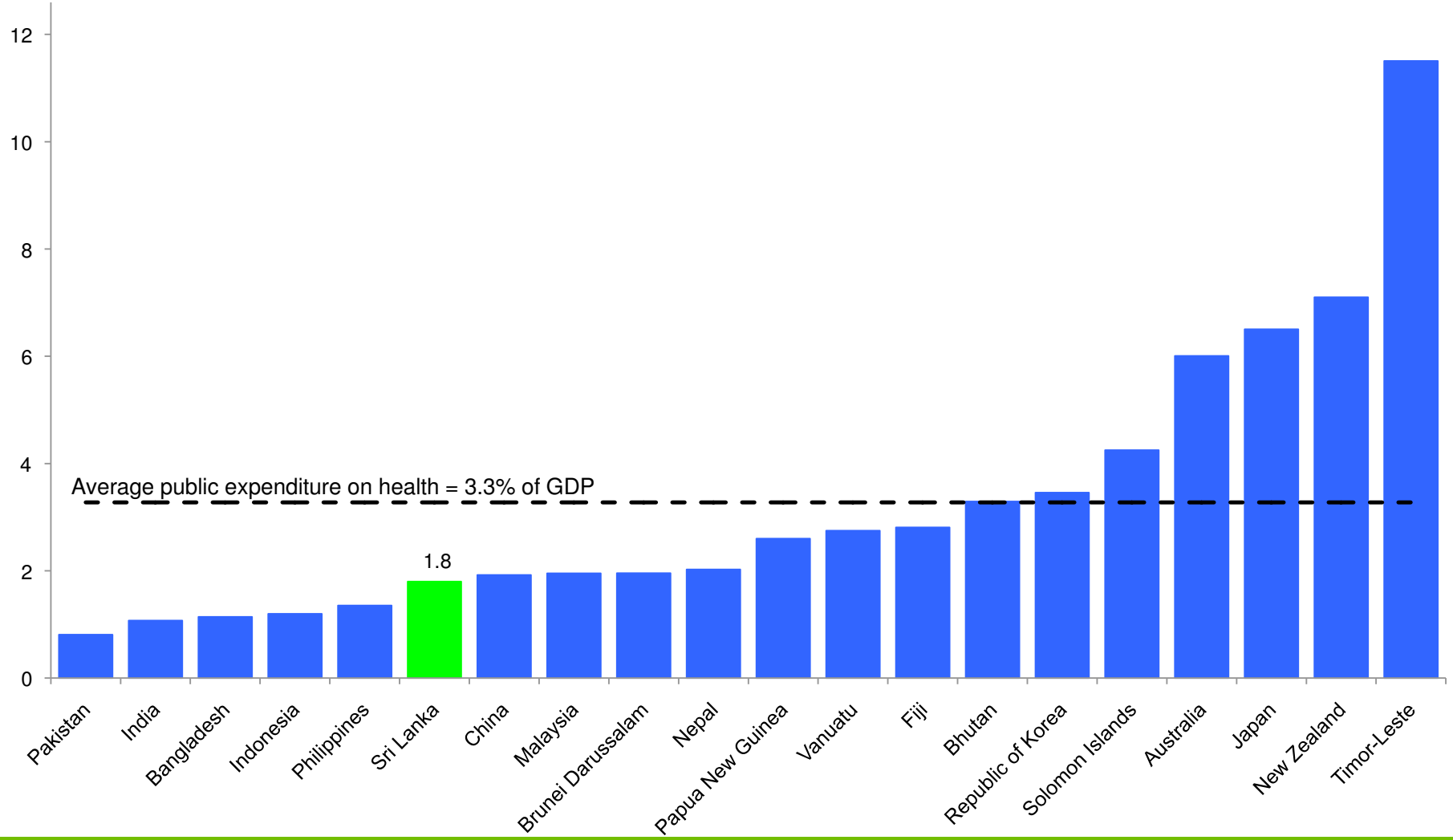
What is needed?

- Increase public spending on healthcare as % GDP
  - Necessary to improve financial risk protection
  - Necessary to fill major gaps in coverage
  - Necessary to improve quality of care
- Increased levels of taxation
  - Contributory insurance systems cannot cover poor
  - Clear evidence of problems resulting from inadequate taxation
- Will require political pressure and leadership
  - Increases in other countries driven by domestic political demands and needs
  - Consistency in pressure and messaging to both government and opposition from healthcare professions

Common Myths

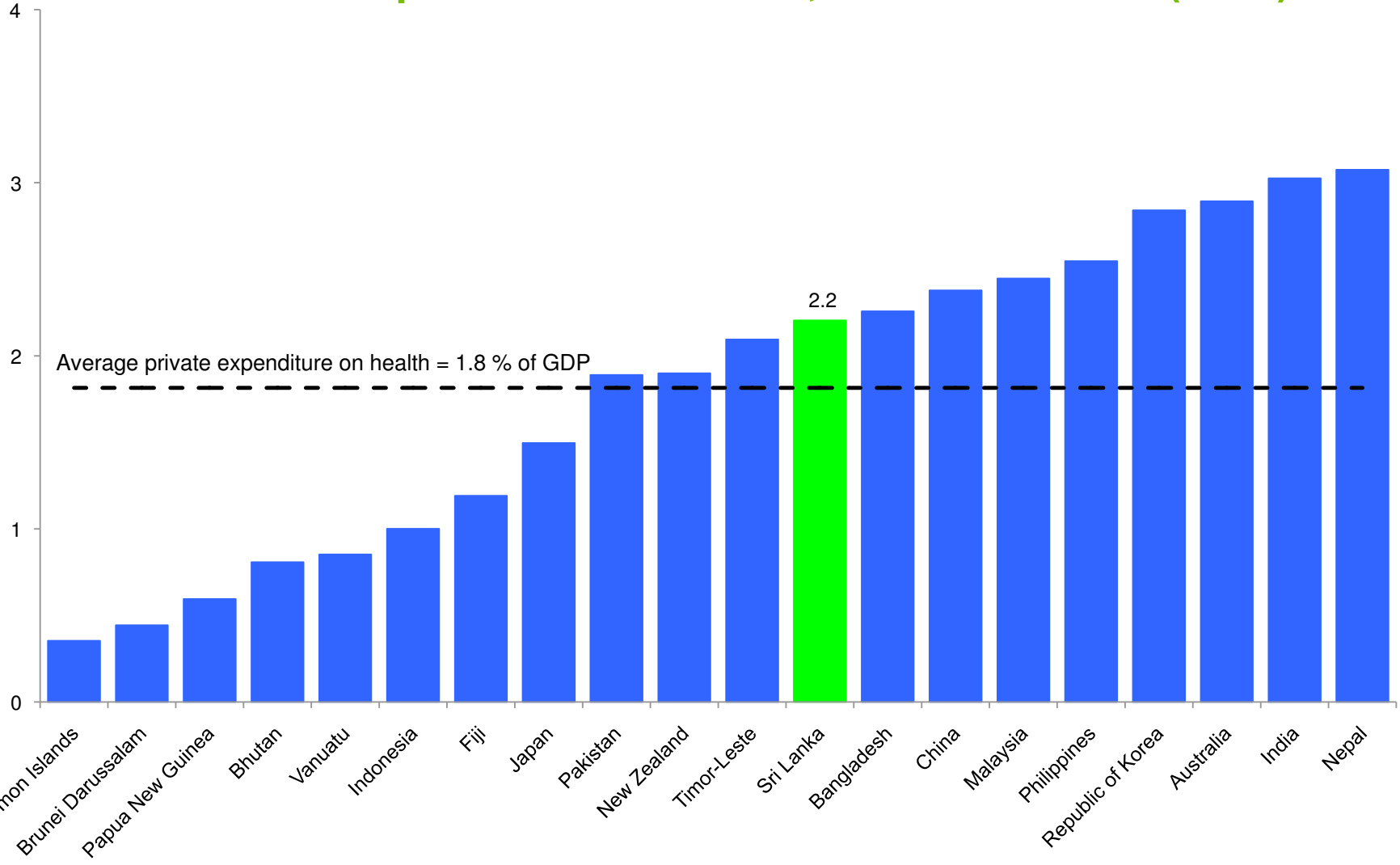
Myth 1 – Government spends too much on health

Government health expenditure as % GDP, Asian countries (2007)



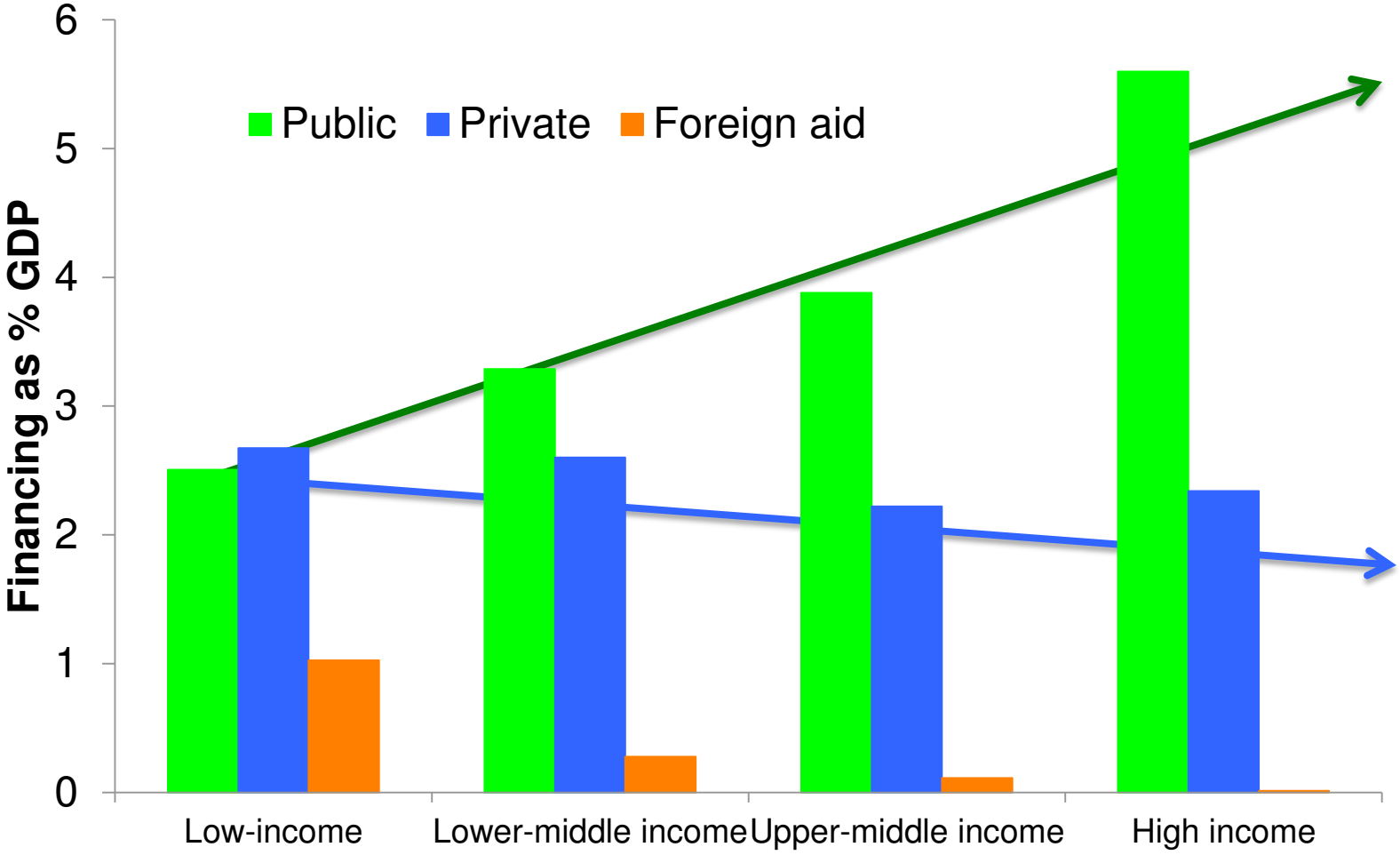
Myth 2 – Sri Lanka relies too little on private financing

Private health expenditure as % GDP, Asian countries (2007)



Myth 2 – Sri Lanka relies too little on private financing

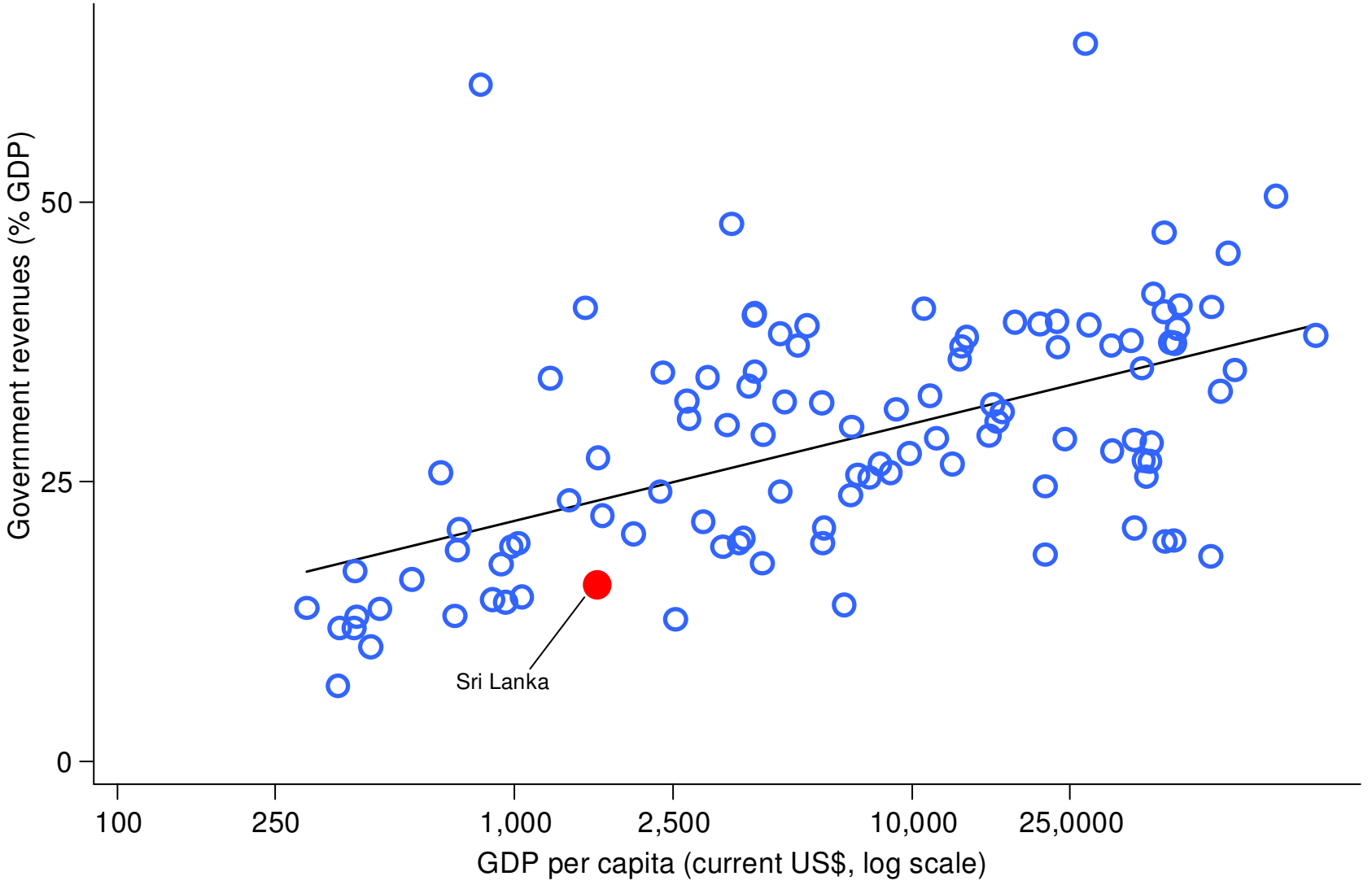
Globally, private financing falls with increasing incomes



Source: 2005 data from World Bank, WHO, IMF

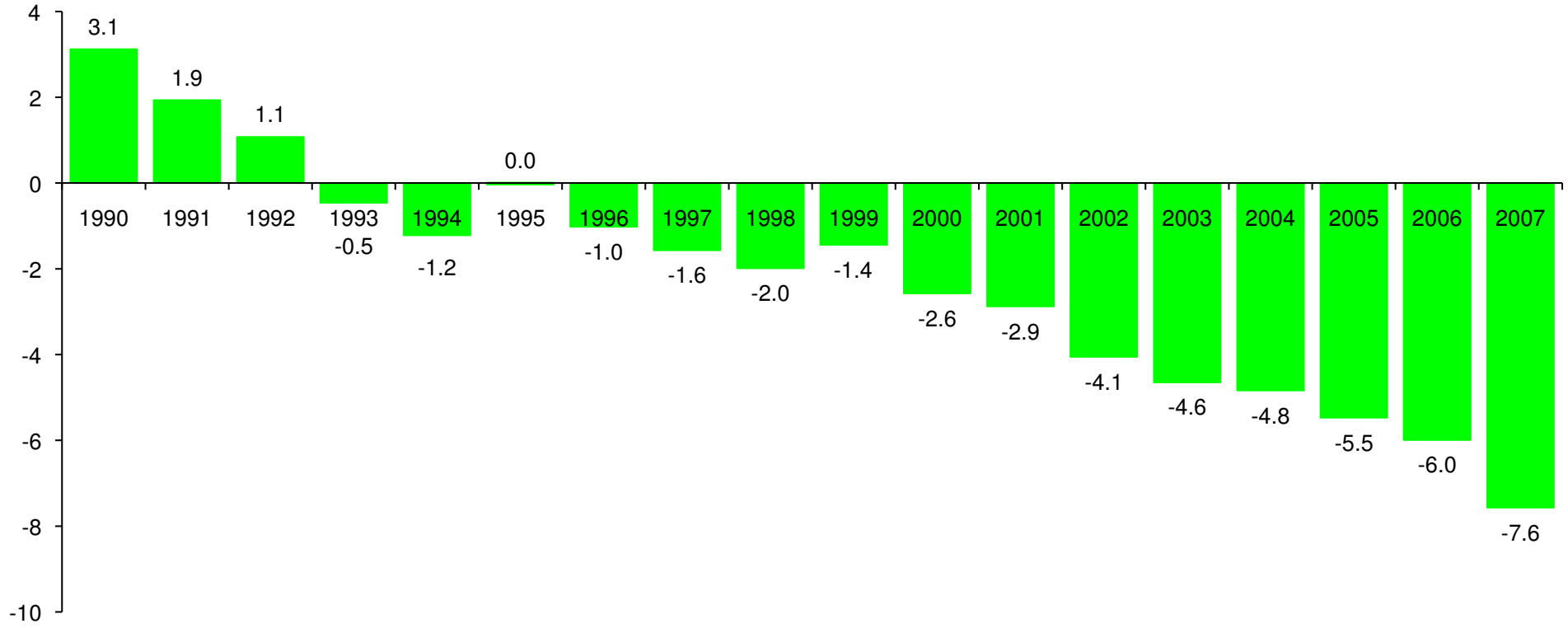
Myth 3 – Sri Lanka is overtaxed

Government tax revenue as % GDP against income (2007)



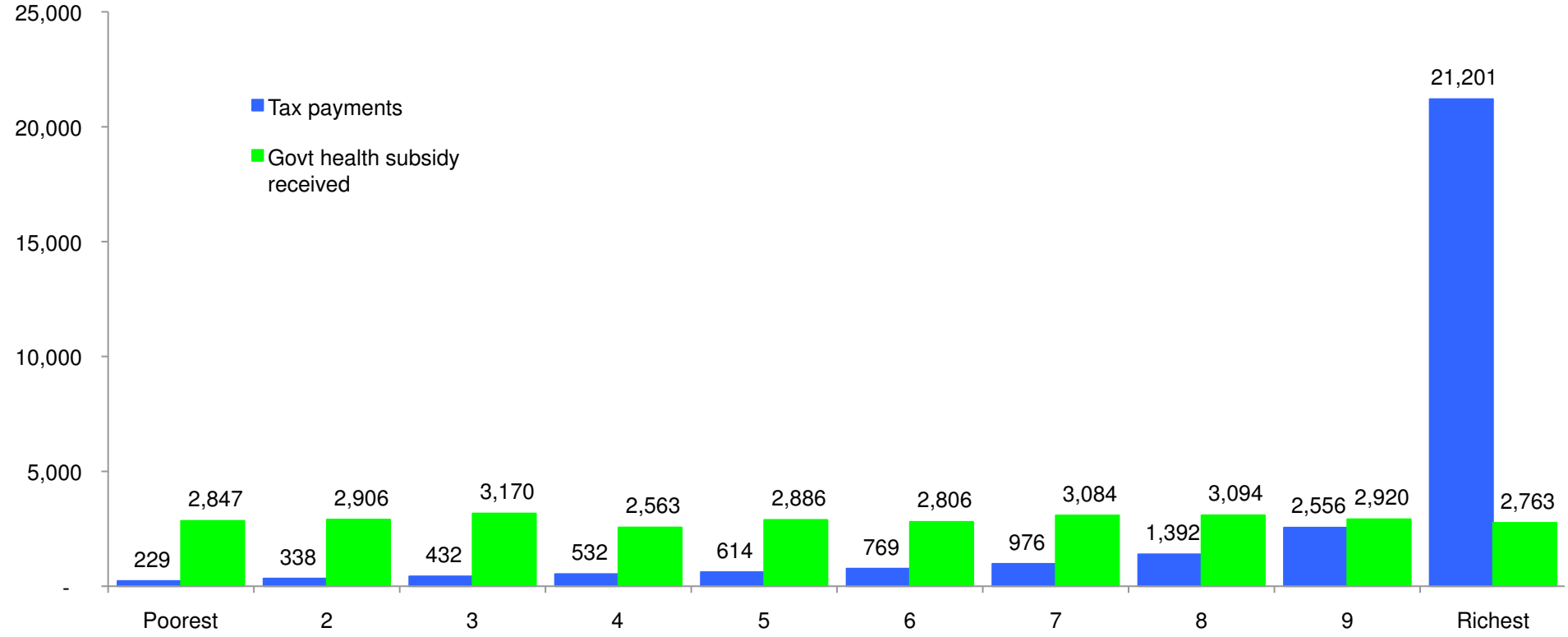
Myth 4 – Government financial deficit is result of failure to control spending

Short-fall in expected revenue given income level of country, Sri Lanka 1990-2007 (% GDP)



Myth 5 – Taxation is a regressive means of financing healthcare in Srl Lanka

The distribution of tax payments for healthcare and government healthcare subsidies by household income deciles, Sri Lanka 2006



Key Challenges

- To make a sustained and focused case to government and to society of the need for increased public investment to improve health services
- To make the case for increased taxation
  - To finance better health services (and other public goods)
  - To mitigate increased income inequalities
- To exploit and build on Sri Lanka's health achievements to promote the country's international legitimacy
  - Sri Lanka's health achievements an integral part of its democratic process

Thank you