Achieving Universal Coverage of Health Care

Issues & Lessons from Regional and Global Experience

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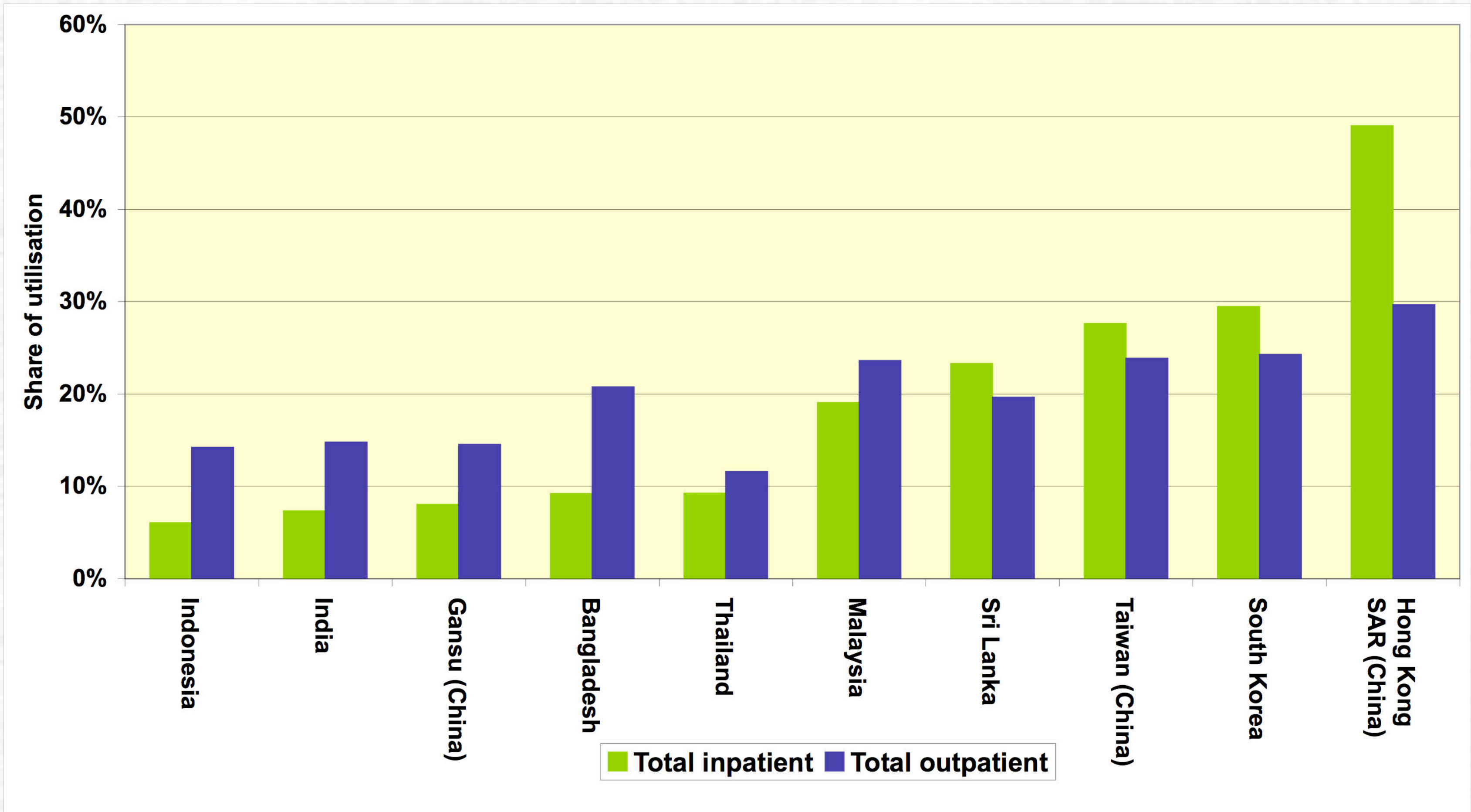
Key Lessons from Thai Experience

- Limits of targeted approaches - Necessity to switch to universal approaches to reach very poorest
- Importance of protection against catastrophic risks as dimension of universal coverage
- Importance of expanding supply to complement financing
- Importance of behavioral change/other barriers to allow very poorest to make use of opportunities

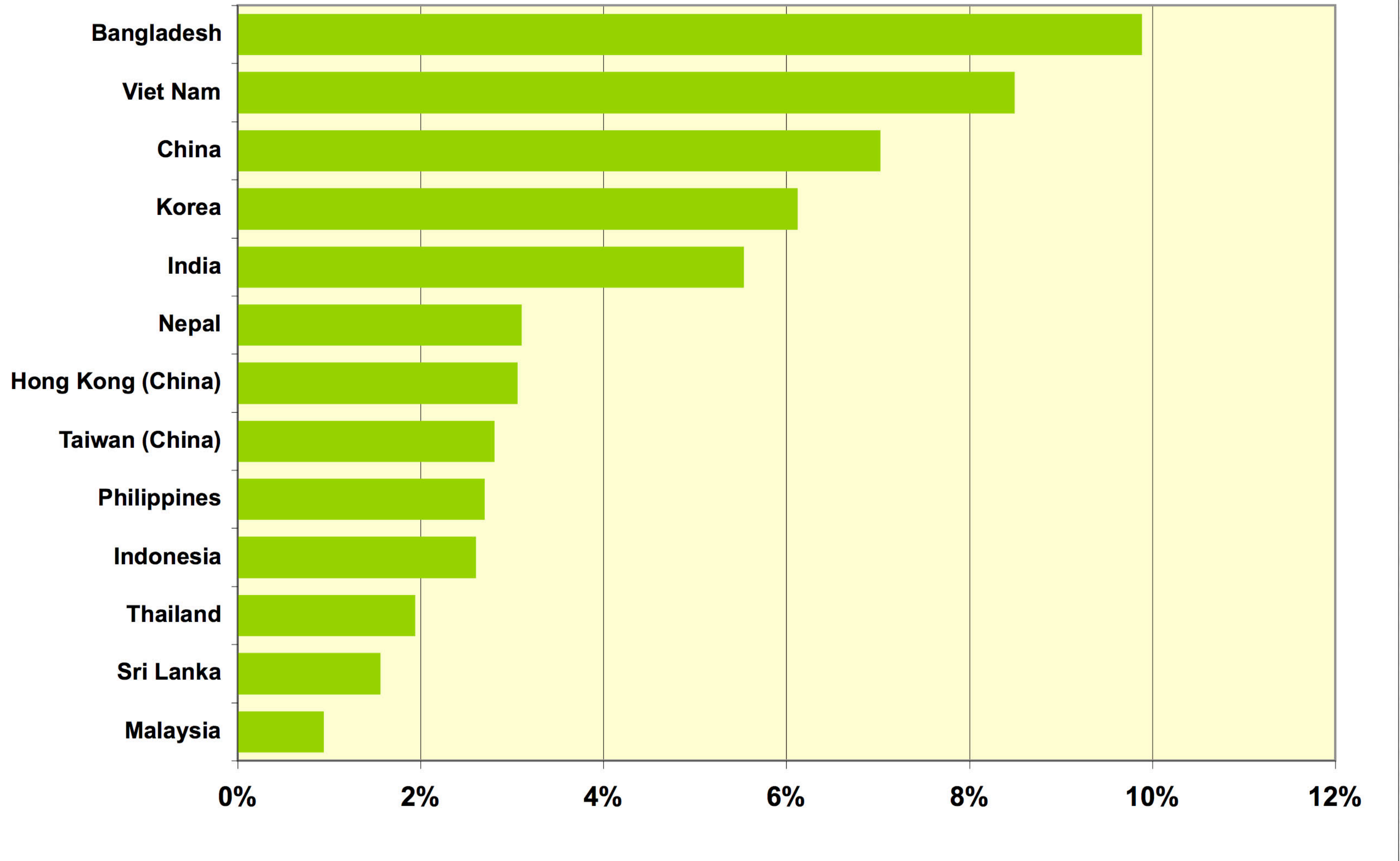
What is “Universal Coverage?” & “Reaching the Very Poorest”

- Not sufficient to define in terms of having access
  - Many countries offer free “access”, but outcome is different
- Not sufficient to define in terms of health care treatment/outcome
  - Curing sickness not only or even most important policy goal
  - Risk protection/solidarity key motivating principle
    - Germany 1860s - Solidarity principle/Risk protection
    - Japan/Sri Lanka 1930s - Risk protection
    - Thailand 2000s - Solidarity/Equity principle

Poorest quintile share of total health care use



Catastrophic impact



Global Experience: Two paths to UHC

- Historical experience in Europe and Asia the same - Only two paths
- **Tax-based Government Supply Model**
  - Tax-financed, integrated financing/delivery
  - E.g., Sri Lanka, Kerala, Malaysia, Hong Kong
- **Social Health Insurance Model**
  - Social insurance financed with tax contribution, split financing/delivery
  - E.g., Mongolia, Thailand, Japan, Korea

Global Experience: Critical Issues to reach UHC

- Coverage expansion - critical challenge always for very poorest/rural population
- Tax-financing critical in both SHI and tax-based systems to reach the very poorest
  - Japan, Thailand, Sri Lanka, Malaysia
- Feasibility
  - SHI universalism only proven successful in middle-income and higher settings - Relevance dependent on legacy
  - Tax-based universalism only approach proven successful in low-income settings
- Governance
  - State capacity for implementation
  - Political commitment - importance of democratic accountability

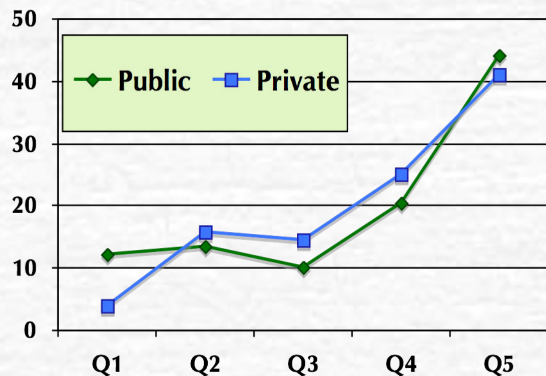
Relevance of Tax-based Approach to Bangladesh

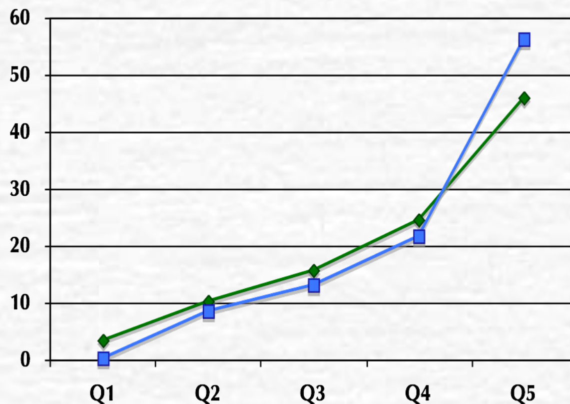
- No legacy of experience with substantial social health insurance mechanisms
- Existing government supply system
- Lack of government capacity to collect social insurance premiums or to manage complex public payment mechanisms

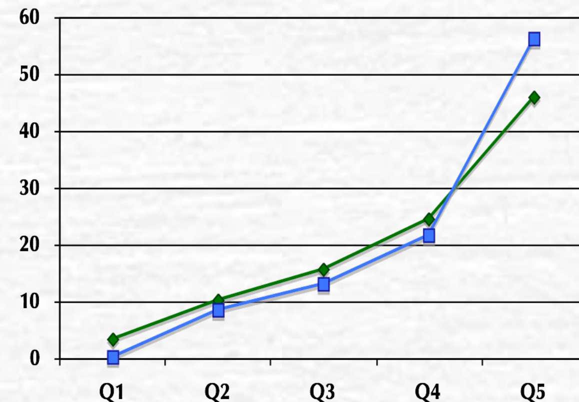
Global knowledge gaps relevant to Bangladesh

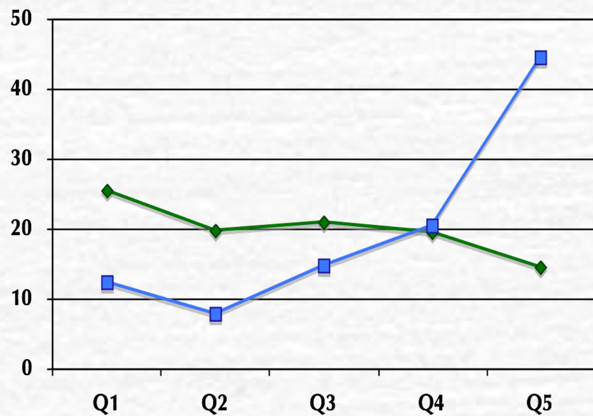
- How to implement tax-based model when the budget is only half-sufficient
- How to ensure public sector reaches the very poor
- How to achieve technical efficiency in public sector delivery

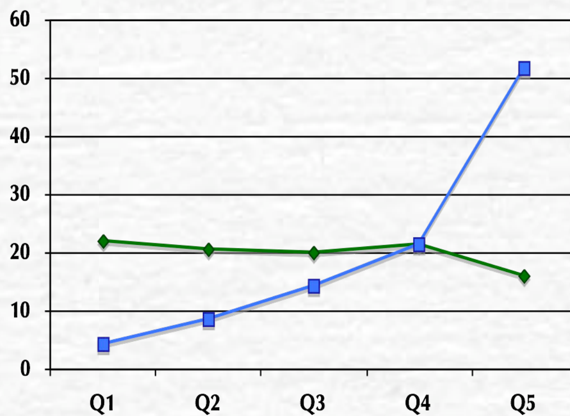
Use of public-private inpatient services by income quintile

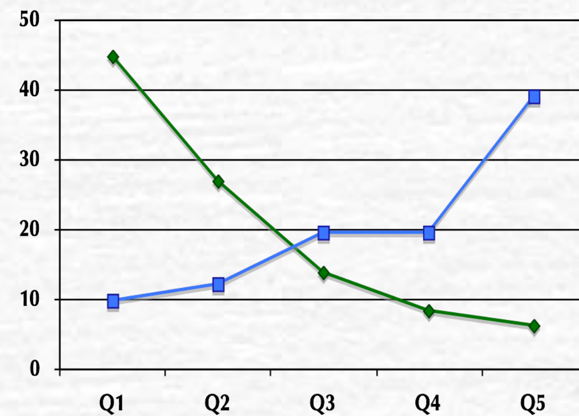




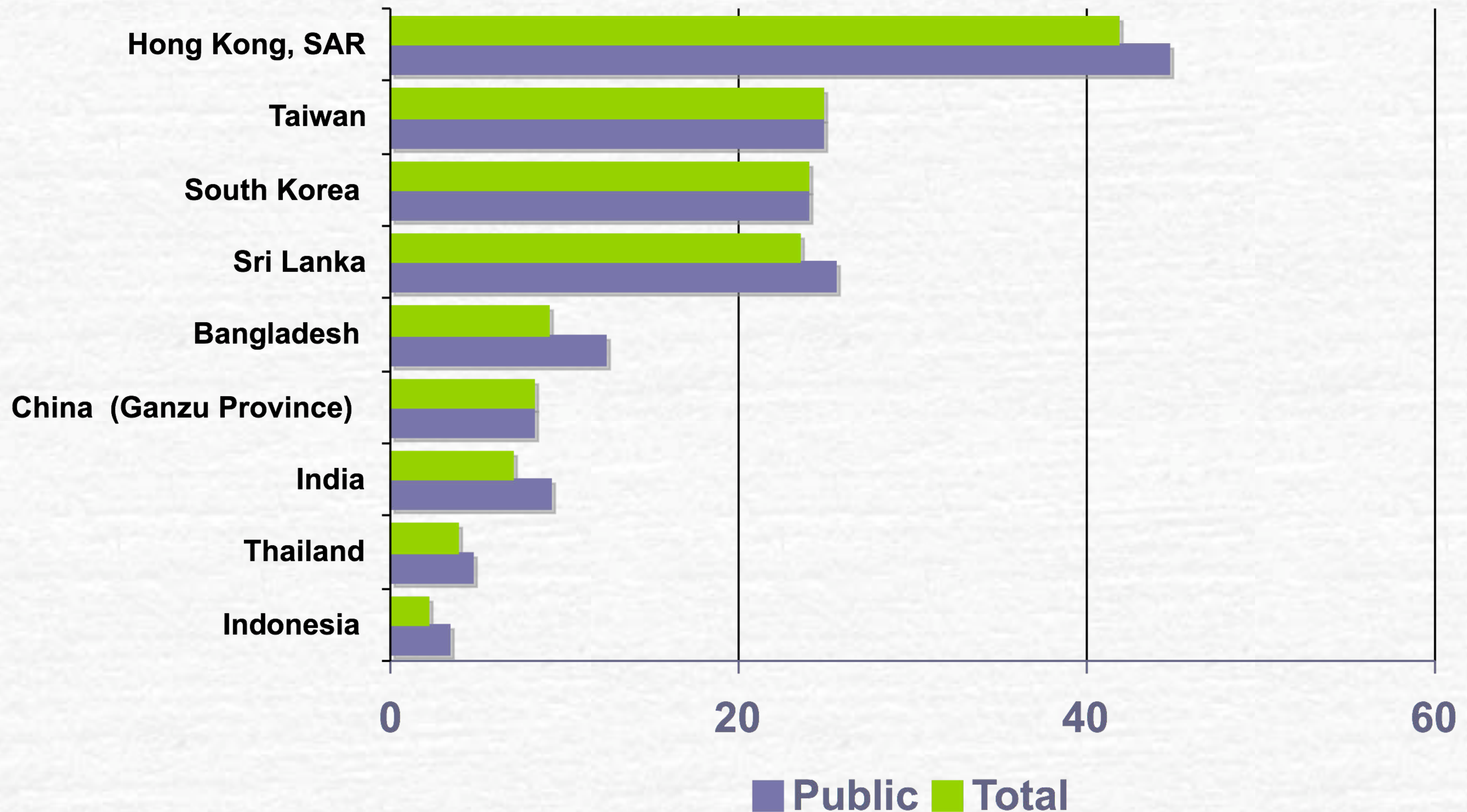








Importance of public supply in reaching very poorest



Tentative explanations relevant to Bangladesh

- Sustained commitment to improve governance and management of public sector - "Not cut and run"
  - No global evidence to indicate that success at national scale can be achieved without building effective public sector
- Focus on technical efficiency in public sector delivery over resource mobilisation
- Focus on expanding public sector supply

Observations

- Only two approaches have worked:
  - Tax-based, integrated financing/provision
  - Social health insurance
- Success requires commitment of tax financing by governments to fund poor
- Legacy, context and global experience does not support feasibility of social insurance based approaches in Bangladesh
- Challenge is how to work with existing system to make it reach the poor

Challenges

- To explain and learn from global and regional experience on how countries have achieved universal coverage through public financing/supply
  - E.g.,: Sri Lanka, Malaysia
- To develop national capacity to assess national situation, learn from global experience, and develop appropriate and feasible solutions