Helsesystemer og finansiering

John-Arne Røttingen

16.6.16
Health Systems Foundations – WHO
Objectives of the system

- Responsiveness (to people's non-medical expectations)
- Fair (financial) contribution

Health

WHO World Health Report 2000
OVERALL GOALS / OUTCOMES

- IMPROVED HEALTH (LEVEL AND EQUITY)
- RESPONSIVENESS
- SOCIAL AND FINANCIAL RISK PROTECTION
- IMPROVED EFFICIENCY

OVERALL GOALS / OUTCOMES

ACCESS
IMPROVED HEALTH (LEVEL AND EQUITY)

COVERAGE
RESPONSIVENESS

QUALITY
SOCIAL AND FINANCIAL RISK PROTECTION

SAFETY
IMPROVED EFFICIENCY

WHO World Health Report 2000

Functions the system performs

- Stewardship (oversight)
- Creating resources (investment and training)
- Financing (collecting, pooling and purchasing)
- Delivering services (provision)

Objectives of the system

- Responsiveness (to people's non-medical expectations)
- Fair (financial) contribution

Health
THE WHO HEALTH SYSTEM FRAMEWORK

SYSTEM BUILDING BLOCKS

SERVICE DELIVERY
HEALTH WORKFORCE
INFORMATION
MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES
FINANCING
LEADERSHIP / GOVERNANCE

OVERALL GOALS / OUTCOMES

ACCESS

COVERAGE

QUALITY

SAFETY

IMPROVED HEALTH (LEVEL AND EQUITY)
RESPONSIVENESS
SOCIAL AND FINANCIAL RISK PROTECTION
IMPROVED EFFICIENCY

Two different approaches and processes

**Approaches**
- Bottom up – disease specific
- Top down – holistic

**Processes**
- Lancet Commission on Investing in Health
- Chatham House Working Group on Health Financing
Two Global Processes on Health Financing

- The World Bank’s World Development Report 1993
- The Lancet Commission on Investing in Health (2013)
- Commission on Macroeconomics and Health (CMH) (2001)
- Chatham House Working Group on Global Health Financing (2014)
Global Health 2035: The World Development Report 1993 at 20 Years

The World Bank’s World Development Report 1993

- Demonstrated that evidence-based health expenditures are an investment not only in health, but in economic prosperity
- Argued for additional resources for cost-effective interventions to address high-burden diseases

The Lancet Commission on Investing in Health (2013)

- 25 economists and global health experts re-examined the case for investing in health, chaired by Lawrence H. Summers, former Chief Economist at the World Bank and Undersecretary for International Affairs of the U.S. Department of Treasury
- Proposes a health investment framework for low- and middle-income countries
- Provides a roadmap to achieving gains in global health through a ‘grand convergence’
Shared Responsibilities for Health
A Coherent Global Framework for Health Financing

**Commission on Macroeconomics and Health (CMH) (2001)**
- every developing country should begin to map out a path to universal access for essential health services and should increase spending on health to 2 per cent of GDP by 2015 and use these resources more efficiently
- donors should increase their support to countries to $38 billion by 2015, and to global public goods including research and development
- new funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria

**Chatham House Working Group on Global Health Financing (2014)**
- 20 policy-makers and researchers, health economists and legal scholars, representatives of civil society and governmental organizations and of national and international institutions. Consisted of members from 15 different countries and chaired by Professor John-Arne Røttingen
- Proposes a coherent global framework for health financing in and for low- and middle-income countries
- Provides a framework for health financing to be integrated in the post 2015 development framework
Global Health 2035: 4 Key Messages

A grand convergence in health is achievable within our lifetime.

The returns from investing in health are extremely impressive.

Fiscal policies are a powerful, underused lever for curbing non-communicable diseases and injuries.

Progressive pathways to universal health coverage are an efficient way to achieve health and financial protection.
A Grand Convergence in Global Health by 2035

Countries with the highest child mortality

Countries with the lowest child mortality

CONVERGENCE TARGET
Historical Precedent: China

Under-five mortality, China and Sweden, 1751-2011

[Graph showing the under-five mortality rates for China and Sweden from 1750 to 2000, with a significant decline in both countries over time.]
Rwanda: Steepest Drop in Child Mortality Ever Recorded

Probability of a child dying by age 5 per 1,000 live births

How We Modeled Convergence

Diverse group of middle-income countries showed the way
Previously had high death rates
Low- or lower middle-income in 1991
Achieved high level of health status by 2011 largely because of scale-up of health sector interventions

“4C Countries”
Costa Rica, Cuba, Chile, China

We show that nearly all countries could reach the same health status by 2035
Modeling Convergence Investment Case

LICs and Lower MICs

- HIV
- Malaria
- RMNCH
- TB

UN One Health Tool

Country-level cost and impact model to 2035

+ NTDs
+ HSS
+ New tools

THE LANCET
2035 Grand Convergence Targets = “16-8-4”

- Under-5 death rate per 1,000 live births: 16
- Annual AIDS deaths per 100,000 population: 8
- Annual TB deaths per 100,000 population: 4
Convergence Targets are Based on Death Rates Today in 4C Countries

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Low-Income Countries</th>
<th>Lower Middle-Income Countries</th>
<th>4C Countries (Range)</th>
<th>2035 Convergence Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-5 death rate per 1,000 live births</td>
<td>104</td>
<td>63</td>
<td>6 - 14</td>
<td>16</td>
</tr>
<tr>
<td>Annual AIDS deaths per 100,000 population</td>
<td>77</td>
<td>23</td>
<td>1.4 - 8.7</td>
<td>8</td>
</tr>
<tr>
<td>Annual TB deaths per 100,000 population</td>
<td>55</td>
<td>28</td>
<td>0.3 - 3.5</td>
<td>4</td>
</tr>
</tbody>
</table>
## Impact and Cost of Convergence

<table>
<thead>
<tr>
<th></th>
<th>Low-income countries</th>
<th>Lower middle-income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deaths averted from 2035 onwards</strong></td>
<td>4.5 million</td>
<td>5.8 million</td>
</tr>
<tr>
<td><strong>Approximate incremental cost per year, 2016-2035</strong></td>
<td>$25 billion</td>
<td>$45 billion</td>
</tr>
<tr>
<td><strong>Proportion of costs devoted to structural investments</strong></td>
<td>60-70%</td>
<td>30-40%</td>
</tr>
<tr>
<td><strong>Proportion of health gap closed by existing tools</strong></td>
<td>2/3</td>
<td>4/5</td>
</tr>
</tbody>
</table>
Global Health 2035: 4 Key Messages

A **grand convergence** in health is achievable within our lifetime

The **returns from investing in health** are extremely impressive

**Fiscal policies** are a powerful, underused lever for curbing non-communicable diseases and injuries

Progressive pathways to **universal health coverage** are an efficient way to achieve health and financial protection
Full Income: A Better Way to Measure the Returns from Investing in Health

Between 2000 and 2011, about a quarter of the growth in full income in low-income and middle-income countries resulted from VLYs gained.
Impressive Benefit: Cost Ratio

- Economic benefits: $9-$20
- Cost: $1

THE LANCET
Global Health 2035: 4 Key Messages

- **A grand convergence** in health is achievable within our lifetime
- **Fiscal policies** are a powerful, underused lever for curbing non-communicable diseases and injuries
- **The returns from investing in health** are extremely impressive
- **Progressive pathways to universal health coverage** are an efficient way to achieve health and financial protection
Introduction of UHC provides FRP

1. **UHC is end state of coverage to everyone** with **comprehensive set of interventions** and **no out of pocket expenses** for this package.

2. Involves **pre-payment** and **pooling of funds** to extend publicly financed insurance.

3. It has a **positive effect on FRP**. Households in Mexico and Thailand enrolled in UHC schemes saw reduced incidence of catastrophic health expenses.
Progressive Universalist Pathways to UHC
Protect the Poor from the Outset

Pathways toward universal health coverage
How to Move Through the Cube?

What works best depends on country’s starting point, nature/capacity of its institutions, national values, etc.

Global Health 2035 argues for initial focus on financing interventions towards grand convergence + essential interventions for NCD/injury to maximize health status and FRP.

Progressive universalism: “a determination to include people who are poor from the beginning” (Gwatkin & Ergo).

Builds on Gro Brundtland’s new universalism: “if services are to be provided for all, then not all services can be provided. The most cost-effective services should be provided first.”
Advantages of Progressive Universalism

- Government does not have to incur costly administrative expenses identifying who is poor (*everyone is covered*)
- Universal package promotes broader support among population and health providers than schemes targeting poor alone—such support helps to sustain financing over time
Shared Responsibilities for Health
A Coherent Global Framework for Health Financing

Final Report of the Centre on Global Health Security Working Group on Health Financing
Five questions on Health Financing

• Why?
• How?
• For what?
• Who?
• How much?
Five questions on Health Financing

• **Why?**
  • “Moral case”: intrinsic value
  • “Business case”: instrumental value

• **How?**

• **For what?**

• **Who?**

• **How much?**
Five questions on Health Financing

- Why?
- How?
  - Universal Health Coverage
  - Health Systems
- For what?
- Who?
- How much?
Five questions on Health Financing

• Why?
• How?
• For what?
  • domestic financing of national health systems
  • joint financing of global public goods for health
  • external financing for national health systems
• Who?
• How much?
Five questions on Health Financing

• Why?
• How?
• For what?
• Who?
  • Governments/countries and voters/citizens
  • Shared responsibilities – within and between countries
  • Shared but differentiated responsibilities
• How much?
Five questions on Health Financing

• Why?
• How?
• For what?
• Who?
• How much?
  • Clear goals and targets – international norms
Five questions on Health Financing

- Why?
- How?
- For what?
- Who?
- How much?

A case for a *global framework* that is capable of securing sufficient and sustainable funding and of both mobilizing and using it efficiently and equitably.
A Coherent Global Framework for Health Financing

**GHE**
- Mandatory
- pre-paid
- pooled
- health
- funding
- per capita
  ($)

**Investment norm – % of GDP**

**External financing**

**Financing floor**

<table>
<thead>
<tr>
<th>GHE</th>
<th>GDP/capita ($)</th>
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<tr>
<th>Mandatory pre-paid pooled health funding per capita ($)</th>
<th>GDP/capita ($)</th>
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</table>
Domestic financing

Mobilizing more resources
GHE per capita

GHE/cap, 2012

GHE/cap if GHE/GDP 5%
GHE per capita

$196 billion gap

$86

GHE/cap, 2012

GHE/cap if GHE/GDP 5%
GHE/GGE and GDP per capita

Source: The World Bank, World Development Indicators Database, 2010
General government expenditure (GGE) as a share of GDP

Source: The World Bank, World Development Indicators Database
Governmental Health Expenditures (GHE) (% of GDP)
GHE per capita

$86
GHE per capita

Gap reduced to $65 billion

$86

5% of GDP

GHE/cap, 2012

GHE/cap if GHE/GDP 5%
Domestic financing

Mobilizing more resources

GHEpc>$86, GHE/GDP>5%, $196 → $65 billion

Chatham House | The Royal Institute of International Affairs
## Global public goods for health

*Non-excludable, non-rival, global*: No country can be prevented from enjoying a global public good provided; nor can any country’s enjoyment of the good impinge on the consumption opportunities of other countries.

<table>
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<tr>
<th>Cofinancing</th>
<th>Health information, surveillance, preparedness and response, R&amp;D</th>
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<tbody>
<tr>
<td>Support institutions</td>
<td>WHO capacity</td>
</tr>
<tr>
<td>Support enabling environment</td>
<td>Illicit financial flows, tax havens, harmful tax competition, overexploitation of natural resources</td>
</tr>
</tbody>
</table>
External financing

Primary role

65 billion

Contributions

HICs + most UMICs, 0.15% of GDP

Allocation

Criteria, processes, MICs challenge

Increased pooling

Broader mandates + mergers (Global Health Fund?)
A Coherent Global Framework for Health Financing

GHE
Mandatory
pre-paid
pooled
health
funding
per capita
($)

$86

Investment norm – 5% of GDP

External Financing
0.15% of GDP
(HICs and UMICs)

Financing floor

GDP/capita ($)