

**HEALTH SYSTEMS
GOVERNANCE &
FINANCING**



Efficiency in SDG world: the UHC shift

Improving Efficiency in Health
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and Governance



**World Health
Organization**

Efficiency and health: The UHC shift

- It is not about health outcomes only
- The full pie
- Systems as unit of analysis
- Technology

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Health and the Sustainable Development Goals

Health is in a central place

- **SDG agenda adopted on 25 September 2015**
 - Agenda for all countries 2015-2030
 - Includes economic, social and environmental dimensions of development

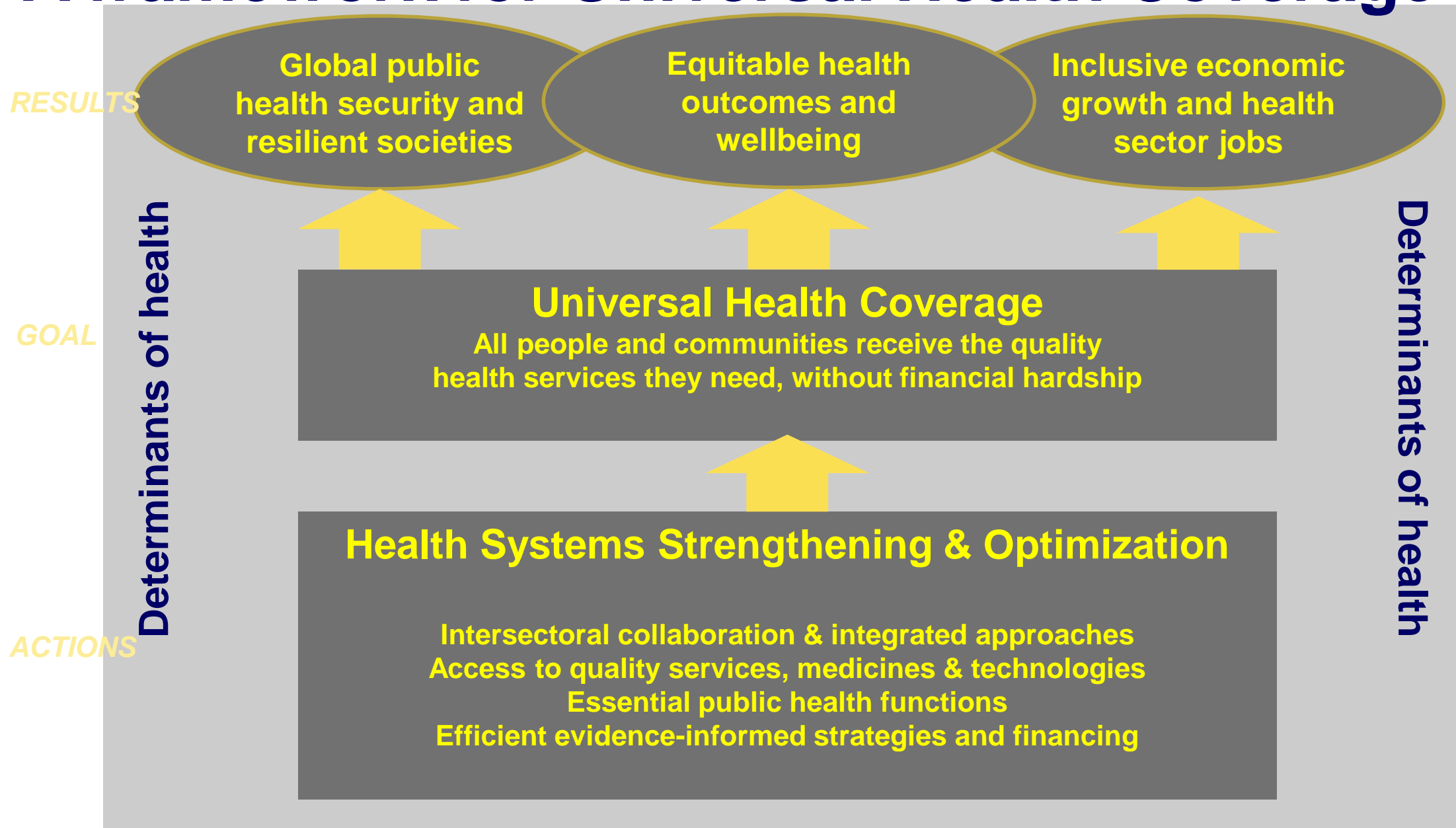
- **SDG text on the new agenda (point 26 of declaration):**

“To promote physical and mental health and well-being and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to...” .(thereafter follows a brief summary of health targets).

This places **UHC** as the target that underpins and is key to achievement to all the other health targets.

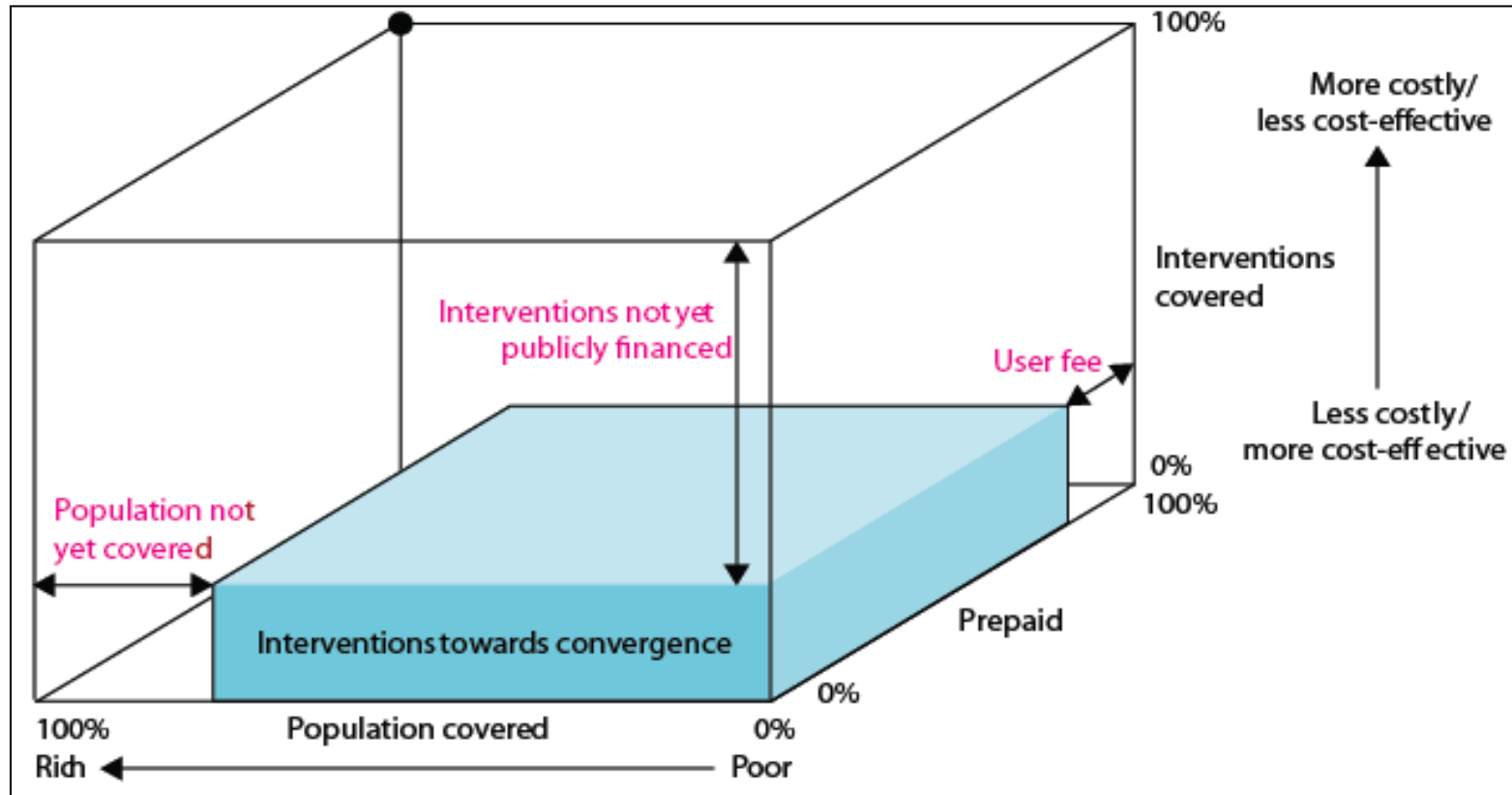
From MDGs to SDGs

A framework for Universal Health Coverage



Progressive Universalist Pathways to UHC

Protect the Poor from the Outset



Pathways toward universal universal health coverage

Efficiency and health: The UHC shift

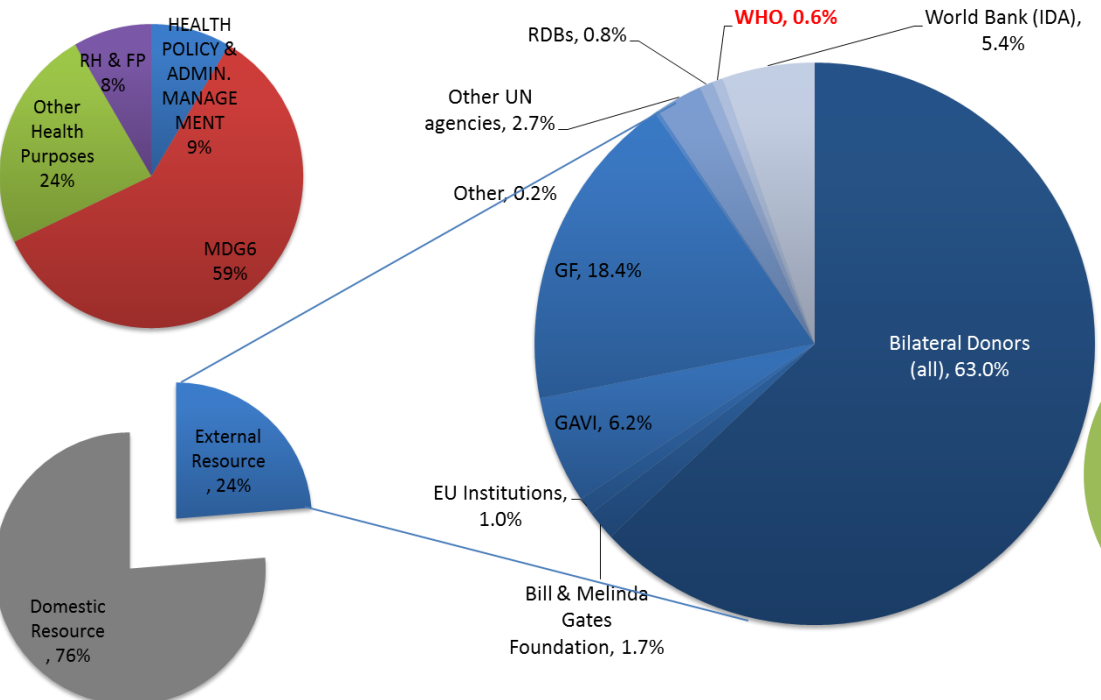
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What is the UHC gap?

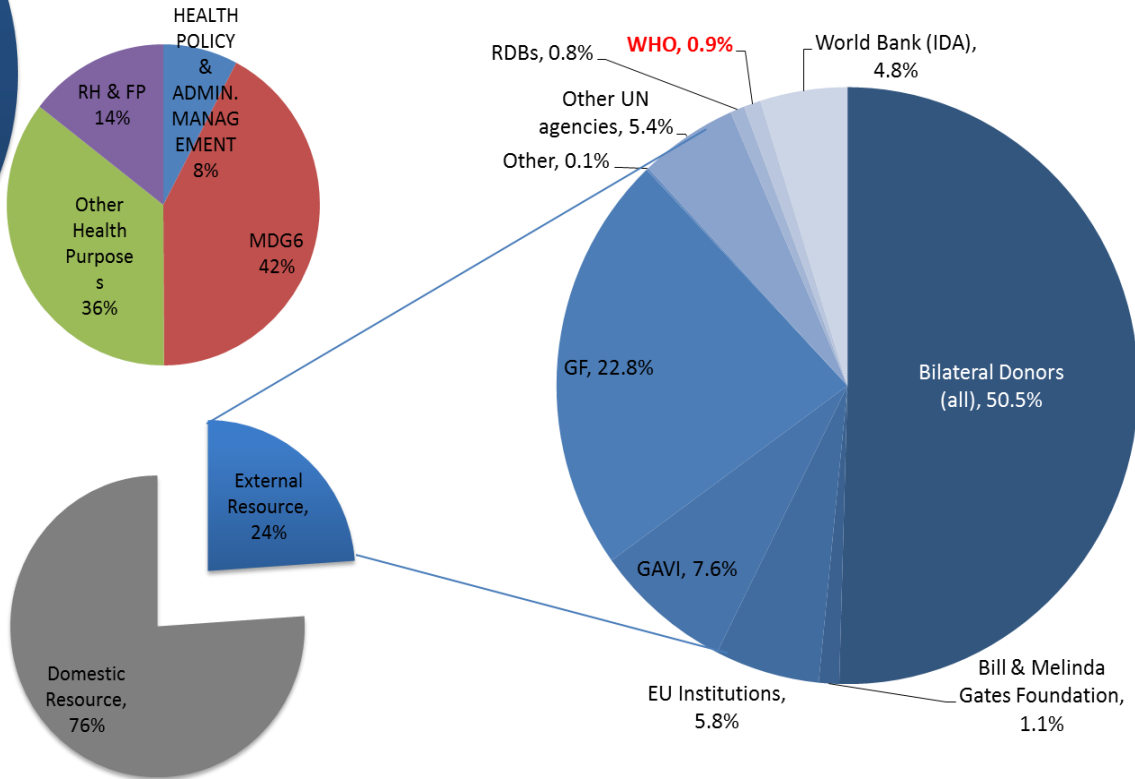
- **\$55 billion**: minimum estimate of additional annual resources needed globally for low- and lower-middle income countries to attain the SDG health targets by 2030
- **\$35-\$40 billion**: is the amount needed for health systems strengthening investments, as part of the \$55 bln
- **\$2.3 billion**: current annual external funding for HSS in these countries
- Funding for health systems, even in most low income countries and fragile states, comes predominantly from **domestic sources**

*Based on our work as part of the Lancet Commission Global Health 2035, and analyses prepared for the 3rd Financing for Development Conference

Most of the gap will be funded domestically (even in low income and fragile states)



Domestic and External Resources for Health in non-fragile LICs (2011-13)



Sources:

- OECD DAC2011-2013 (28 Fragile States, 10 billion constant 2013 USD/7.57 per capita, 26 non-fragile LICs (20 billion constant 2013 USD/10.45 per capita) : other includes donors who gave less than 100 M\$; disbursement-base data to a country from a donor and not include multi-country donations; World Bank "HARMONIZED LIST OF FRAGILE SITUATIONS FY15" was used for the fragile status.
- WHO Global Health Expenditure Database (24 Fragile States, 24 non-fragile LICs): external resource represents health expenditure from external source as percentage of total health expenditure; domestic resource includes both private and public health expenditures

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Universal health coverage (UHC)

all people and communities obtain the health services they need without suffering financial hardship when paying for them.

This relies on:

- A strong, efficient, well-run health system that meets priority health needs
 - Affordability – a financing system to avoid financial hardship
 - Access to essential medicines and other health technologies
 - Sufficient capacity for well-trained, motivated health workers to provide the services needed
- Resources are scarce in all settings and the setting of priorities is indispensable

World Health Report 2010 : identifying inefficiencies

1. Medicines: underuse of generics and higher than necessary prices for medicines
2. Medicines: use of substandard and counterfeit medicines
3. Medicines: inappropriate and ineffective use
4. Health-care products and services: overuse or supply of equipment, investigations and procedures
5. Health workers: inappropriate or costly staff mix, unmotivated workers
6. Health-care services: inappropriate hospital admissions and length of stay
7. Health-care services: inappropriate hospital size (low use of infrastructure)
8. Health-care services: medical errors and suboptimal quality of care
9. Health system leakages: waste, corruption and fraud
10. Health interventions: inefficient mix/ inappropriate level of strategies

Technical Efficiency

- Technical efficiency is concerned with producing the maximal outputs from a given set of inputs
- Data Envelope Analysis (DEA) can help to quantify the efficiency frontier
- DEA and related techniques are useful for establishing, for example, best practice guidelines for how to produce a given output.
- They rely on a sample of DMUs, so the frontier estimated is always sample dependent.

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Allocative efficiency in health benefit package design for UHC

- Priority setting needs to be done across the whole benefit package
- The benefit package needs to optimize the goals of the health system to be “allocatively efficient”
- Allocative efficiency is just one Value for Money consideration

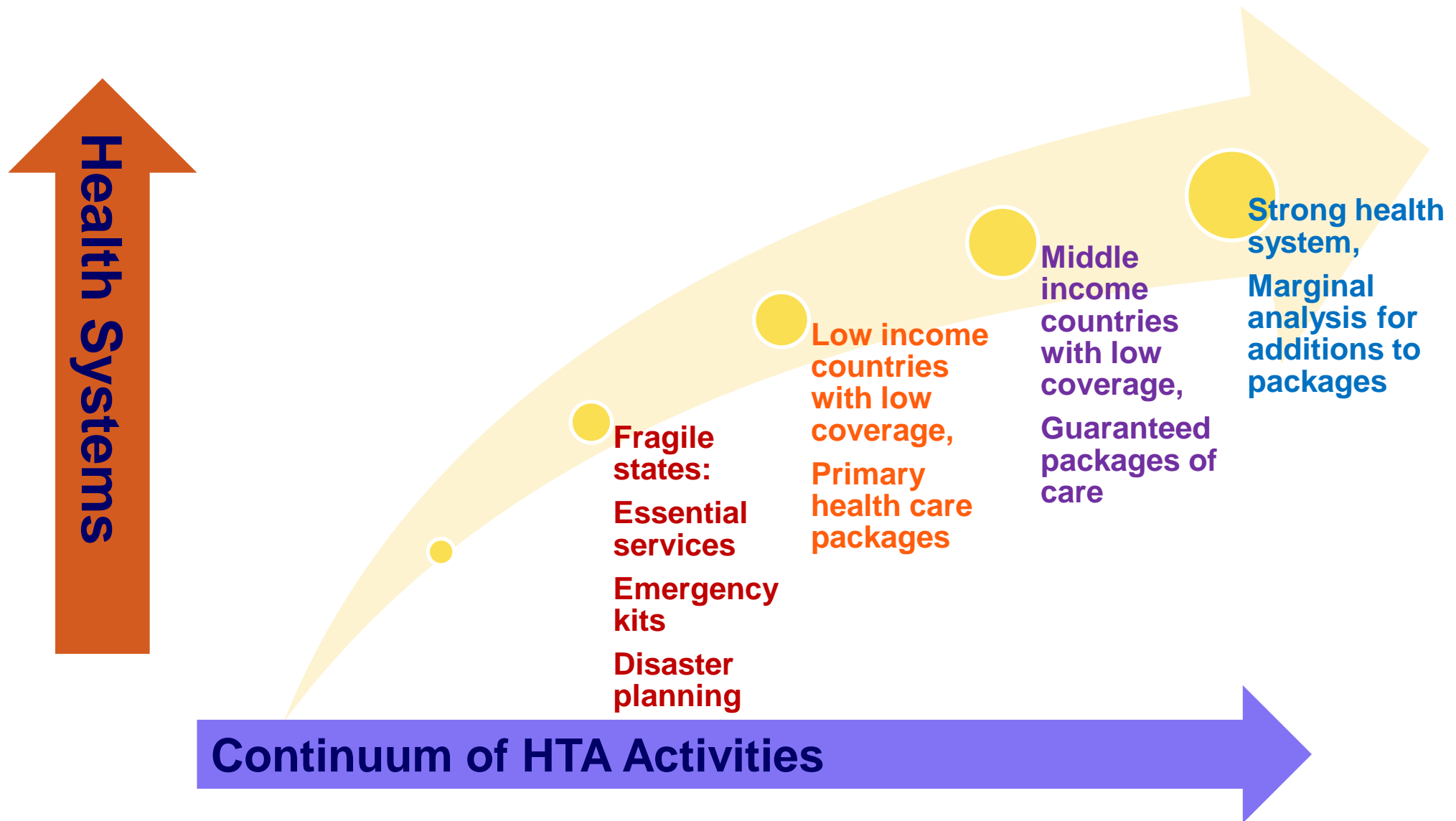
Health Intervention and Technology Assessment at WHO

- **Health technology** is the application of organized knowledge and skills in the form of interventions, devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives
- **Technology assessment** in health care is a multidisciplinary field of policy analysis. It studies the medical, social, ethical, and economic implications of development, diffusion, and use of health technology
- **H(I)TA** does not automatically translate into a set decision, however the systematic assessment of the evidence makes the trade-offs between alternative actions clear

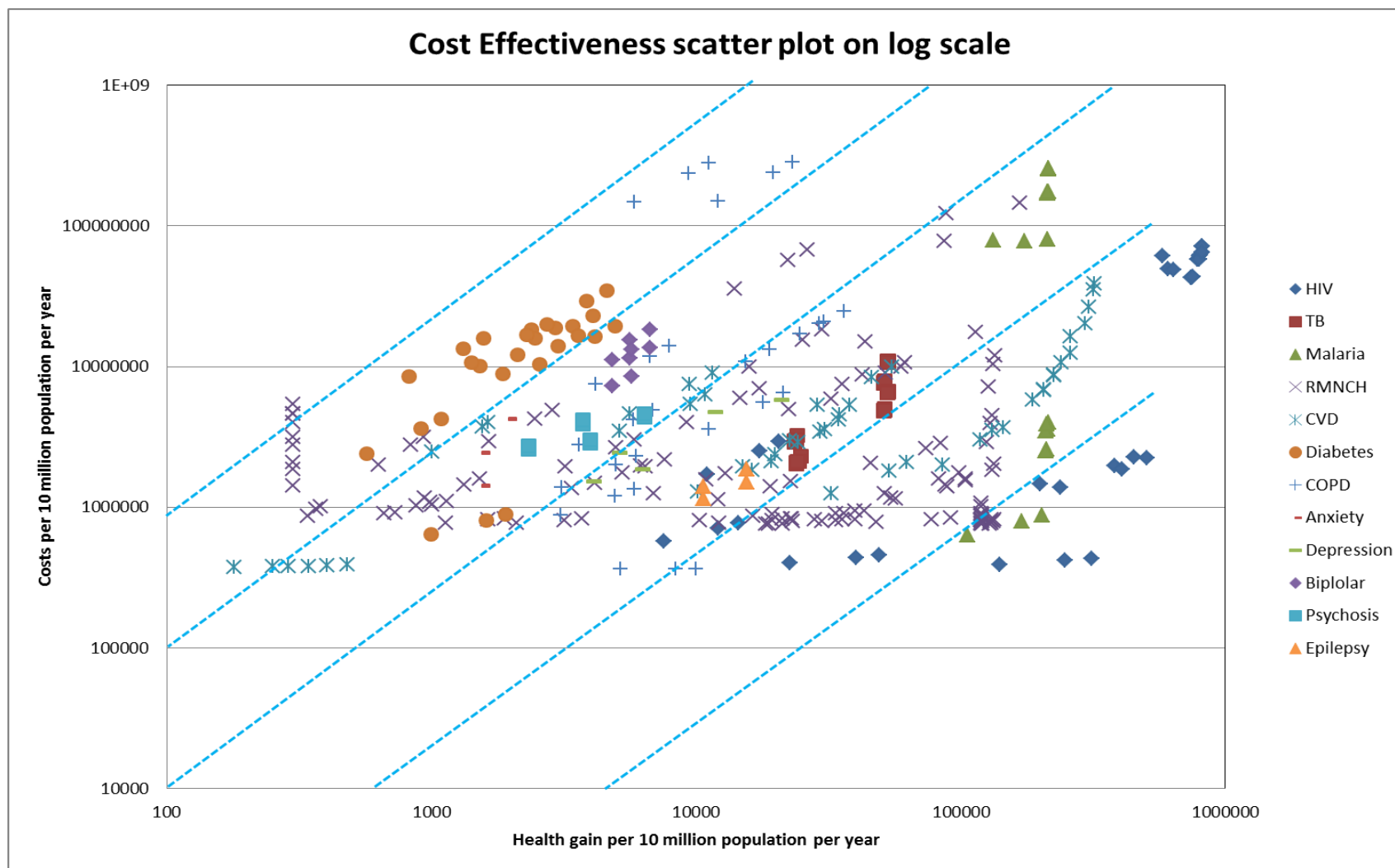
HTA and UHC

- HTA can accelerate countries toward UHC by introducing discussions around efficiency into decision making
 - Strong economic analytical capabilities are part of this
 - Understanding of the political economy within which priorities are being set
 - Multi sectoral responses are needed
 - Alignment of development partner responses

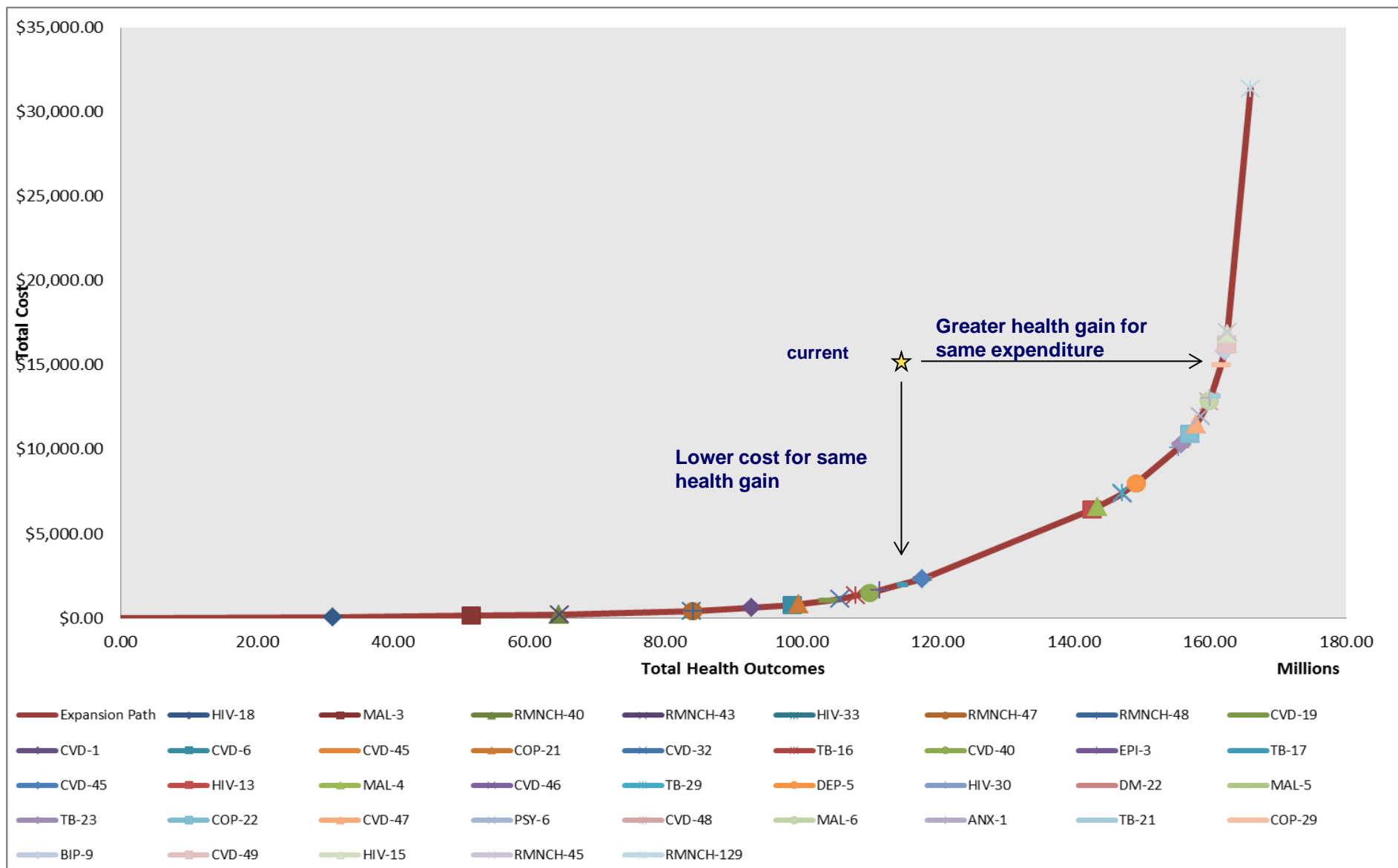
The continuum of HTA activities



Using allocative efficiency to analyze a health benefits package



Using allocative efficiency to analyze a health benefits package



Bringing fairness into efficiency discussions

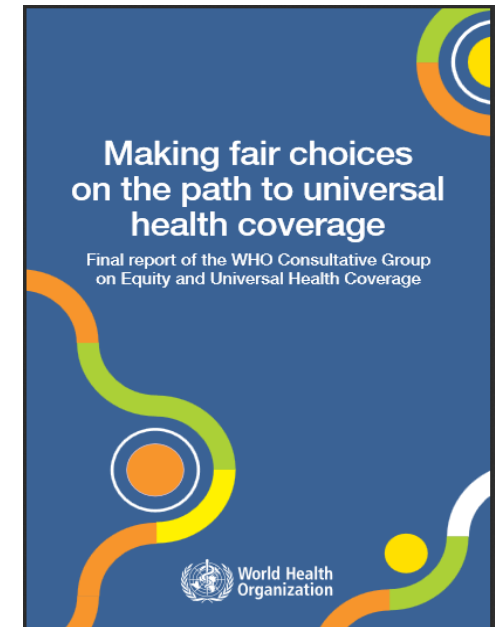
- WHO Guidance is delivered in the Making Fair Choices report
- Categorize services into priority classes, using multi-criteria analysis. Relevant criteria include cost-effectiveness, priority to the worse off, and financial risk protection

E.g.:

First expand coverage for high-priority services to everyone. This includes eliminating OOP payments while increasing mandatory, progressive prepayment with pooling of funds.

Expansion needs to consider existing constraints (financial, health systems)

While doing so, ensure that disadvantaged groups are not left behind. These will often include low-income groups and rural populations



Conclusion: The UHC shift

- **not health outcomes only**

- Financial protection and poverty reduction
- Social cohesion
- Employment and growth

- **the full pie**

- Funding for health systems, even in most low income countries and fragile states, comes predominantly from domestic sources
- Aid is a decreasing share of resources

- **Systems as unit of analysis**

- Unit of analysis for efficiency of UH is entire system, not program or scheme
- Can have multiple “efficient programs” that are collectively inefficient
- Goal is to sustain effective coverage of priority interventions, not to sustain a “program” or even the health system per se

- **Technology is an increasingly powerful driver**