Volume 2 | Issue 2 December 2016

Health Watch

UHC is an imperative. Beyond providing quality healthcare for all, it is a reflection of the kind of society we wish to live in: one based on justice, fairness and social solidarity. *-Dr. Aaron Motsoaledi, Minister of Health, South Africa*

Creating momentum for Universal Health Coverage (UHC) in Bangladesh: challenges and opportunities

In 2010, the Rockefeller Foundation (RF) began investing in key strategic areas of health and allied sectors (a 'multi-pronged' approach) which it believed would play a crucial role in facilitating Bangladesh's journey towards UHC. A case study was commissioned in 2015-'16 by the Centre of Excellence for Universal Health Coverage (CoE-UHC) to assess the contribution of RF in creating this 'momentum'. A variety of methods were used to elicit relevant data which included a) Review of GoB policy documents with implication for UHC (12 such documents); b) Review of RF funded projects with direct relevance for UHC (8 completed and 9 ongoing at the time of review); c) Key informant interviews (the respondents included grantees, relevant NGO partners, and development partners); d) Media review (selected Print and Online media on population, financial, and service coverage dimensions of UHC; e) Stakeholders' Workshop to share the learning and experiences of

Workshop on experience sharing for creating UHC momentum held in JPGSPH, BRAC University on November 25, 2016

grantees, and presenting Bangladesh UHC scenario at the Prince Mahidol Award Conference (PMAC 2016). A framework method of analysis was used for systematic synthesis of data.

Key findings from the case study revealed the followings: i) the GoB documents review revealed that it has come up with several national strategies and policies that were in alignment with its stated commitment towards UHC; ii) the review project reports revealed that initial investments were made by RF in key strategic areas of piloting different health insurance models, capacity development for implementation of UHC, ICT for UHC, and improving quality of services provided; iii) a lack of consensus existed on the meaning, scope and modalities of implementing UHC in public and private sectors; iv) the contribution of RF in accelerating UHC in Bangladesh by improving the opportunity to experiment and gain practical experiences were acknowledged unanimously by the grantees and other stakeholders. However, they thought that orchestration is needed in terms of scaling up was missing;

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How 24 countries are implementing UHC reforms from the bottom up

The launch of the Sustainable Development Goals (SDGs) at the U.N. General Assembly meeting in September 2015 brought especially welcome news: it now officially includes universal health coverage (UHC), as defined under SDG Goal 3, target 8. The World Bank publication "Going Universal..." finds that the UHC reform programs have mostly grown in size during the last decade. These are massive because these cover about one-third of the world's population (2.5 billion people), and because these are implemented at scale (no pilots here). It also finds that these programs are transformational. The programs do not simply add new schemes to expand coverage to a new population, but it also aims to fundamentally change the way health systems work, making them more pro-poor (equitable), comprehensive and efficient.

In terms of **population coverage**, countries have learned that without any dedicated approach to protect the poor, the poor will tend to be overlooked. Thus, many countries are implementing "bottom-up policies" that start with the poor and evolve towards populations up in the wealth quintiles. These policies begin to build on the consensus that the poor cannot pay for health care, individually or collectively. This implies the need for fiscal subsidies, a capacity to identify target populations and develop registries (inventory).

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How 24 countries are implementing UHC reforms from the bottom up

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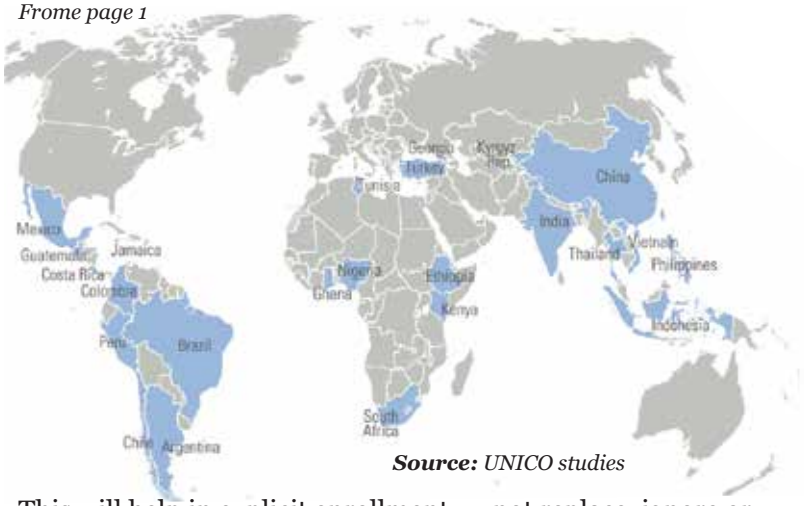


Source: *UNICO studies*

This will help in explicit enrollment of the beneficiaries. Besides, countries chose different paths regarding how to finance the coverage for the non-poor populations, especially in the informal sector.

On **expanding benefits**: Most of the countries studied (with only a few exceptions) make benefits explicit by issuing "positive lists" or "negative lists" that make clear what benefits can be expected and leave behind the rhetoric of providing all benefits to all citizens. There is a strong consensus about the first-tier benefits that need to be provided; all countries in the study have in place a system to deliver evidence-based and cost-effective programs to manage communicable diseases and maternal and child health problems, linked to the "Millennium Development Goals ("the MDG interventions").

In terms of **managing money**, the study found that (with the exceptions of two countries) UHC programs are designed to leverage public spending already used to finance public providers under the Ministry of Health. Countries are no longer willing to simply increase the traditional budgets of the Ministry of Health; however, UHC programs do not replace, ignore or compete with the Ministry. Instead, they refine, complement, incentivize, and generally work with the Ministry in various ways. Finally, the study yields an important warning: UHC programs are promising in terms of their potential to create health systems that are more pro-poor and more efficient, but they also create new risks. These technically and politically complex programs often lead to "broken promises," such as with generous benefit packages promised to the full population yet not really available at the point of services (usually at the primary care level). Broken promises can lead to fiscal risks, especially when accountability mechanisms become stronger and populations are empowered to claim the benefits promised to them.

Source | Cotlear, Daniel; Nagpal, Somil; Smith, Owen K.; Tandon, Ajay; Cortez, Rafael A.. 2015. Going universal: how 24 developing countries are implementing universal health coverage reforms from the bottom up. Washington, D.C.: World Bank Group.

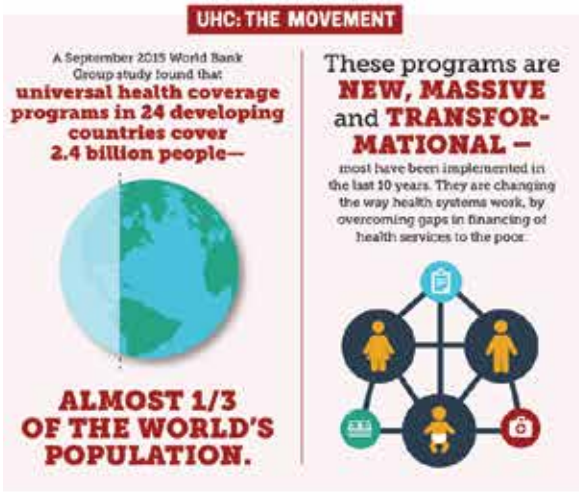
Recent Readings on Universal Health Coverage

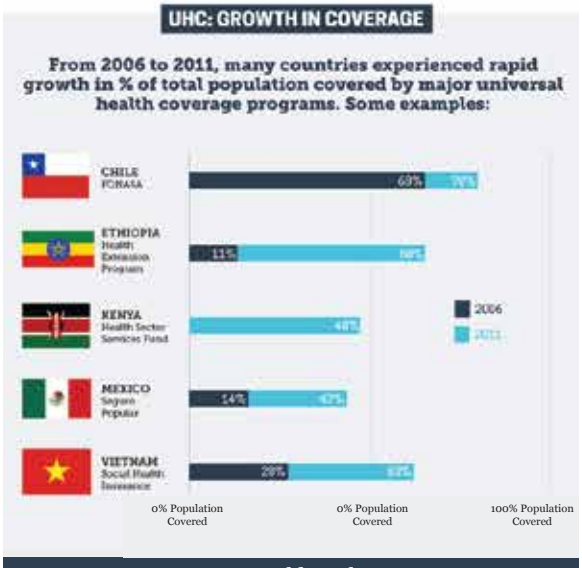
Pablos-Mendez A, Cavanaugh K and Ly C. The new era of health goals: universal health coverage as a pathway to the Sustainable Development Goals. Health Systems & Reform 2016; 2: 15–17

Reich MR, Harris J, Ikegami N, et al. Moving towards universal health coverage: lessons from 11 country studies. Lancet 2016; 387: 811–16

Morgan R, Ensor T and Hugh Waters. Performance of private sector health care: implications for universal health coverage. Lancet 2016; 388 (No. 10044): 606–612

UNIVERSAL HEALTH COVERAGE BY 2030





Source: World Bank Group

Why should the private sector engage with the public sector for driving UHC forward?

While there is a strong rationale for the public sector to work with the private sector, it is also in the interest of the private sector to collaborate with the public sector[1, 2]

Source: Google

By engaging with the public sector, the private sector can:

Increase and expand business. The private sector can increase and diversify both its service volume and revenues by making contract with publicly financed health agencies to provide preventive and curative services at the PHC level. This public-private collaboration allows patients to access care from private providers without paying out of pocket, and may allow private providers to improve quality and expand their operations. The private sector may also be given incentives to provide better quality services, which could attract more paying clientele, increasing and expanding the private sector's business.

Increase the source of funding for providing services. In the absence of collaboration, the main source of private sector financing is through OOP expenditure from the people or through private insurance. In both cases, no money flows from the government to the private sector. However, if the private sector is eligible and paid for providing services under a public sector insurance program, they can gain by solving the problem of resource constraints to reach more people at the margins. In addition, under the partnership, the private sector may be eligible for funding for preventive services (or in-kind supply of subsidized commodities, e.g., vaccines) and other government-sponsored health programs.

Provide comprehensive care. Most patients visit their private provider when they are sick, rather than to seek preventive care. In turn, most private providers provide mostly curative services to meet these demands.

However, if the private sector partners with the public sector, mechanisms can be put in place to give private providers incentives to provide preventive and promotive services that make the range of services they offer more comprehensive.

Achieve its social goals. In addition to profit generation, private health personnel (including owners of private provider units) have a social mission and aim to contribute to at least to some extent the well-being of their clients and communities by serving the needy population and contributing towards nation building.

By partnering with the public sector and expanding provision of both curative and preventive PHC services to the population, the private sector can contribute towards achieving these social goals.

Gain opportunities to upgrade knowledge and skills. When the private sector collaborates with the public sector, it may gain opportunities for upgrading and improving clinical knowledge and skills through participation in public sector-sponsored trainings and capacity-building activities. Private providers can use the upgraded skills to "market" themselves to their paying customers.

Source | [1] Harding, A. (2009) Partnerships with the Private Sector in Health What the International Community Can Do to Strengthen Health Systems in Developing Countries. Report of the Private Sector Advisory Facility Working Group. Center for Global Development.

[2] Smith E, Brugha R and Zwi A. (2001) Working with Private Sector Providers for Better Health Care An Introductory Guide. Options – applying expertise and effective management in health.

Creating momentum for Universal Health Coverage (UHC) in Bangladesh: challenges and opportunities

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v) grantees faced challenges in terms of knowledge gaps, lack of motivation, difficulties in involving different stakeholders and regulatory challenges while experimenting with different health insurance schemes, however, they acknowledged that their respective projects enabled them to become credible actors for advancing UHC in Bangladesh; vi) the media review (daily, online newspaper and blogs) highlighted the constant shortage of human and physical resources for providing services. Poor availability and cost of essential medicines including high out-of-pocket expenditure, emerging problems of NCDs, and corruption in health sector, all hampering Government's stated goal of providing 'health care for all'.

The study made recommendations for developing a country strategy plan, setting priorities and creating multi-sectoral multi-stakeholders' policy coalition to take forward the UHC momentum generated in the country.

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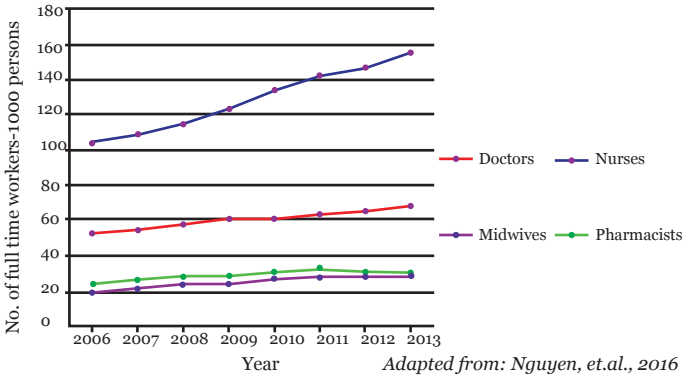
Health Watch

Health Outcomes in Vietnam: contributions of health workforce

Vietnam is a lower-middle income country divided into six economic regions which differ significantly in terms of socioeconomic development. This longitudinal study statistically explored and weighted the link between the availability of health workers and health outcomes in these six regions from a panel data derived from the nationally representative data in Vietnam. Principal component analysis (PCA) was done to estimate the impact of four categories of health workers (doctors, nurses, midwives, and pharmacists) on health outcomes such as life expectancy at birth, infant mortality, and under-five mortality.

The figure shows the availability of total number of doctors, nurses, midwives, and pharmacists in Vietnam between 2006 and 2013. These categories of health workforce have been rising over the last decade. However, there are notable differences between different categories. While the number of nurses rocketed from about 110,000 in 2006 to about 155,000 in 2013, increases in the availability of three other categories of health workers have been more gradual. While the overall number of pharmacists had risen between 2006 and 2013, it also found a slight reduction in their total numbers between 2011 and 2013.



Adapted from: Nguyen, et.al., 2016

Since 1990, Vietnam has undergone a variety of health sector reforms. Key reforms included recognition and legalization of the private health care, introduction of the user charges and health insurance, and liberalization of the pharmaceutical market, all leading to the state health budget becoming no longer the only source of finance for the Vietnamese health system. These reforms have affected governance and regulation of health workers. Following this, , the government has reduced its subsidy for health workers' education, and it is no longer compulsory for medical graduates to be assigned by the Ministry of Health to relevant work places and positions. Health workers are now free to choose their preferred working place in the job market. This policy has a two-sided effect on the distribution of health workers. On the one hand, this encouraged the health workers to respond to the demand of health care markets. On the other hand, the policy leads to imbalanced distribution of health workers across the different regions.

The empirical analysis showed a positive impact of the number of health workers on increases in life expectancy and decreases in infant and under-five mortality rates. This finding confirms the importance of availability of health workforce on improving health outcomes.

The availability of four main categories of health workers can contribute to achieving better health outcomes and ultimately expanding life expectancy of populations, underlining the importance of investing in health workforce in strengthening national health systems. Therefore, increasing investment into more equitable distribution of health workforce, with focus on four main categories of workforce (doctors, nurses, midwives, and pharmacists) represents an important strategy for improving health outcomes.

Source | Nguyen MP, Mirzoev T and Le T M. (2016) Contribution of health workforce to health outcomes: empirical evidence from Vietnam. *Human Resources for Health*. 14:68

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Initiated in 2006, Bangladesh Health Watch (BHW), a civil society advocacy and monitoring initiative dedicated to improve the health system in Bangladesh through critical review of policies and programmes, and recommendation of appropriate actions for change. It publishes a bi-annual report on the state of health in Bangladesh and does advocacy work to catalyze sustainable changes in the health sector. The health watch applies monitoring and advocacy measures such as round table discussions, meetings, press briefings and media reports to engage all key stakeholders in the health sector and the report findings are disseminated with wider audiences primarily on advocacy and recommendations.BHW has been currently funded by Rockefeller Foundation.

Centre of Excellence for Universal Health Coverage

Towards Universal Health coverage, together!

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