2020

5TH ANNUAL HEALTH FINANCING FORUM

Adam Wagstaff Memorial Lecture

November 24th, 2020

Health Financing Resilience during a Prolonged Pandemic

November 12 - December 10, 2020

Co-hosted by: WORLD BANK GROUP, USAID FROM THE AMERICAN PEOPLE, GLOBAL FINANCING FACILITY

Interpretation - Interprétation- Interpretación

1. **Click interpretation globe at the bottom of screen**

   Cliquez sur globe d'interprétation en bas de l'écran

   Haga clic en el globo de interpretación en la parte inferior de la pantalla

2. **Select your language channel**

   Choisissez votre langue

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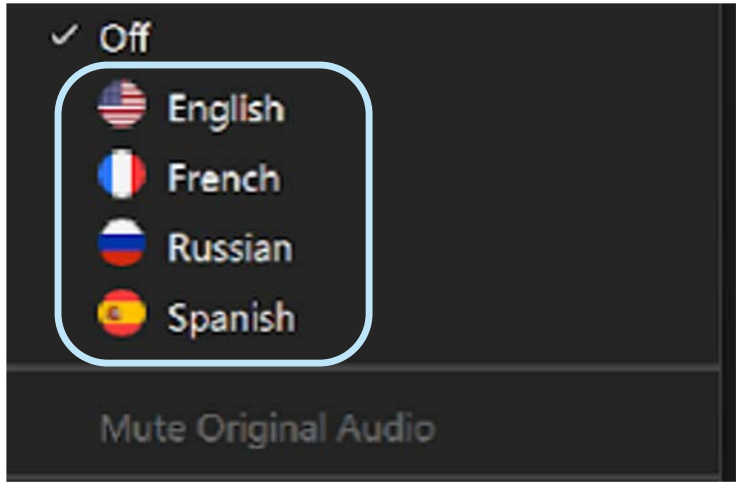

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Sven Neelsen

Economist,
Health, Nutrition, and Population,
World Bank

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Session Overview

Welcome	**Sven Neelsen**, Economist, Health, Nutrition, and Population (HNP) Global Practice, World Bank
Introductory remarks	**Muhammad Pate**, Global Director Health, Nutrition, and Population, World Bank and Director of the Global Financing Facility for Women, Children and Adolescents (GFF)
	Deon Filmer, Director of the Development Research Group, World Bank
Memorial Lecture	**Eddy van Doorslaer,** Professor of Health Economics, Erasmus School of Economics and Erasmus School of Health Policy and Management
Announcement of the Adam Wagstaff Memorial Prize	**Winnie Yip**, Professor at Harvard T.H. Chan School of Public Health, President of the International Health Economics Association

Muhammad Ali Pate

Global Director, Health, Nutrition, and Population, World Bank

Director, Global Financing Facility for Women, Children and Adolescents

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Deon Filmer

Director of the Development Research Group,

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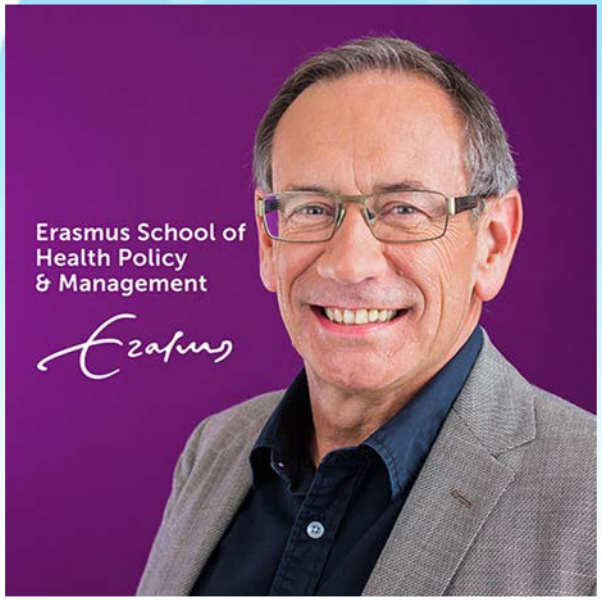

Universal Health Coverage: more than just old wine in a new bottle?

First Adam Wagstaff Memorial Lecture

24 Nov 2020

Eddy Van Doorslaer – Erasmus University Rotterdam

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Address three questions

1. Where did we come from?
2. Where did we go?
3. What lessons did we learn?

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Drawing on almost 40 years of friendship and collaboration

Students in York - 1981

South Africa - 2019

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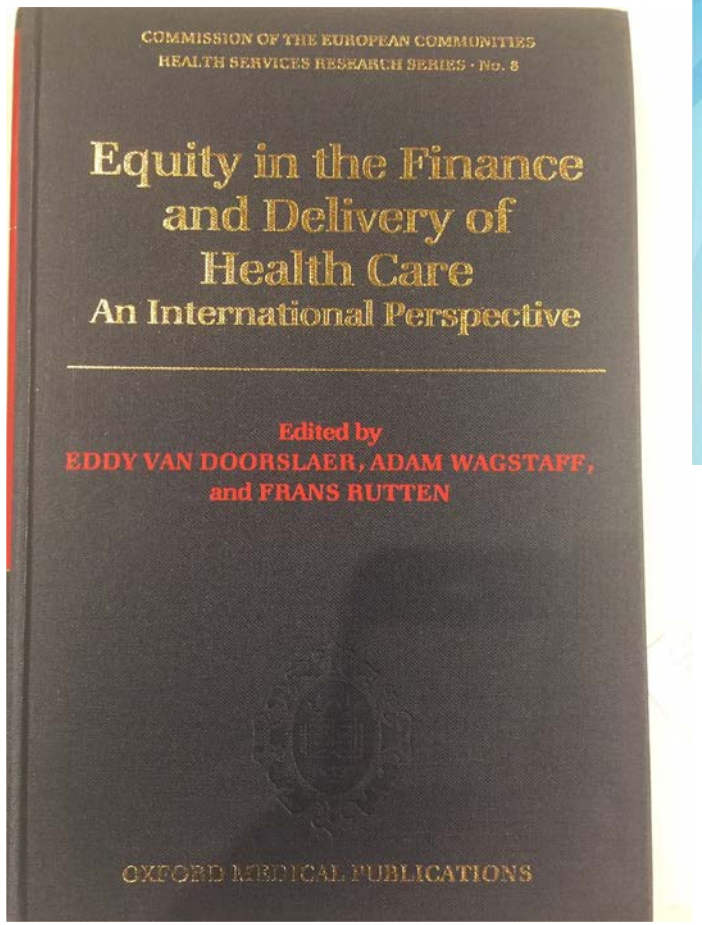
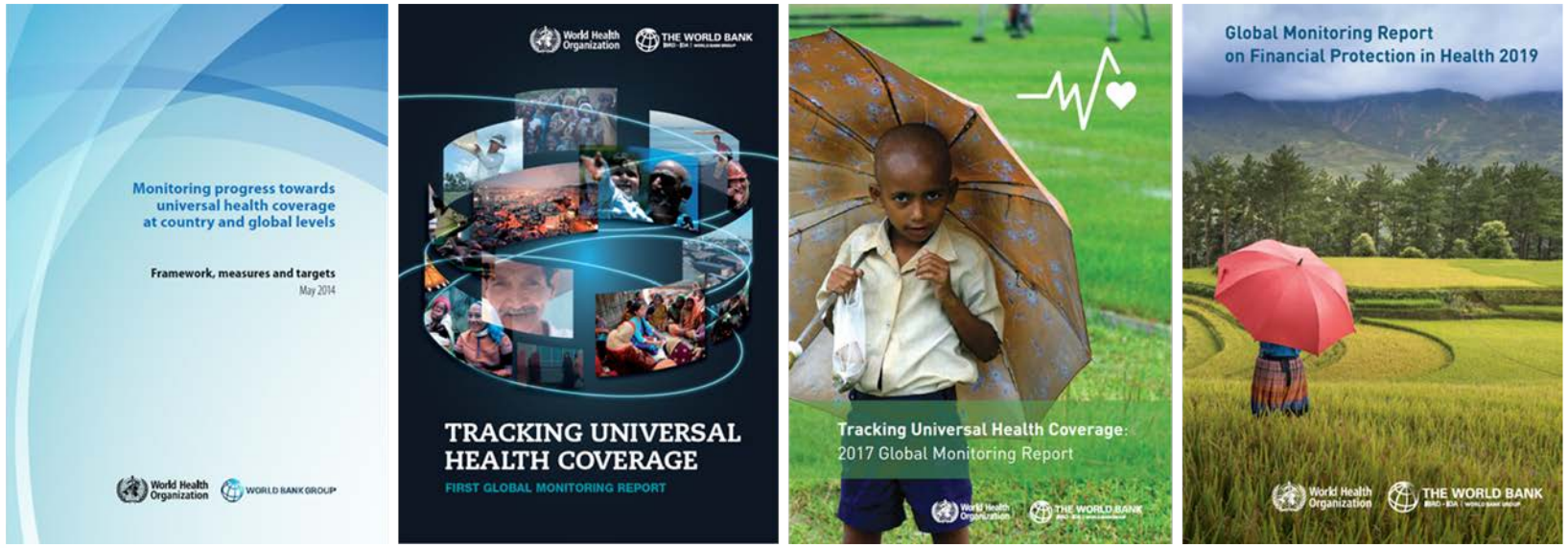
Universal health coverage: Old wine in a new bottle?
If so, is that so bad? (Wagstaff,2013)

Published on Let's Talk Development
(http://blogs.worldbank.org/developmenttalk)

Just rebottled wine?



1993



www.thelancet.com/lancetgh Vol 8 January 2020

A comprehensive assessment of universal health coverage in 111 countries: a retrospective observational study

Adam Wagstaff, Sven Neelsen**

2020

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What was/is meant by equity in health care in high-income countries health care systems?

Principles:

- Payments ought to be related to ability to pay (ATP)
- Receipt of health care according to need for care, irrespective of ATP
- But in an egalitarian way – no net redistribution goal

Visualized using graphs (e.g. concentration curves) and indices

What do governments want?
Examples of equity statements health policy documents

On equitable financing:

- "adjusted to each individual's ability to pay"(Denmark)
- ".. On the basis of their financial means" (Ireland)
- "linking payments to ability to pay" (UK)

On equitable access/delivery :

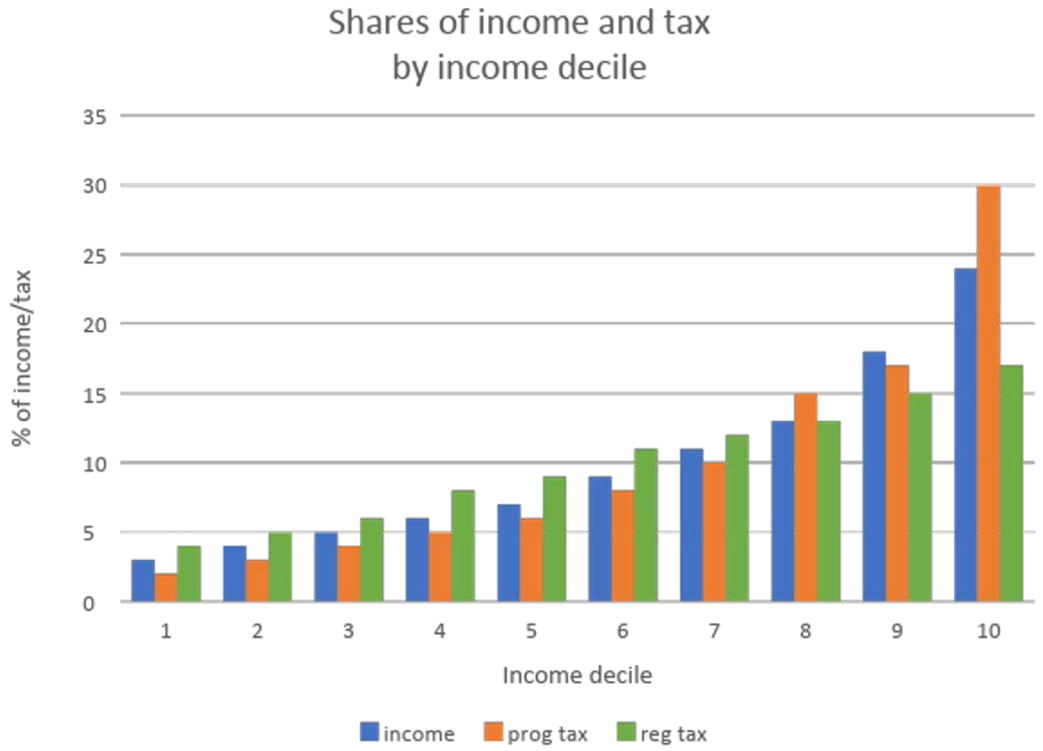
- "equal and free for all, irrespective of economic means and social status (Denmark)
- Distribution of available services on the basis of need"(Ireland)
- "access shall not depend on whether they can pay or any other factor irrelevant to real need"(UK)

Source: Van Doorslaer and Wagstaff (1993)

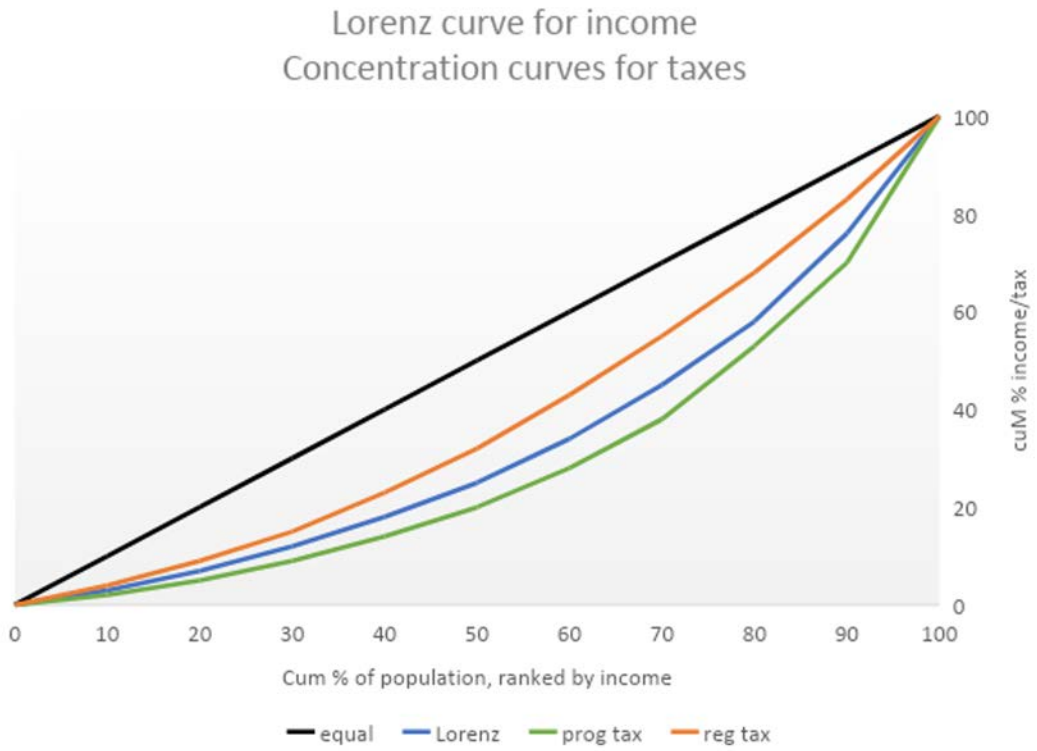
A graphical approach to unequal payment for unequal ability to pay:

Payments can be proportional to income (K=0), regressive (K<0) or progressive (K>0)
[K= C-G = Kakwani progressivity index]

From relative distributions



To cumulative distributions



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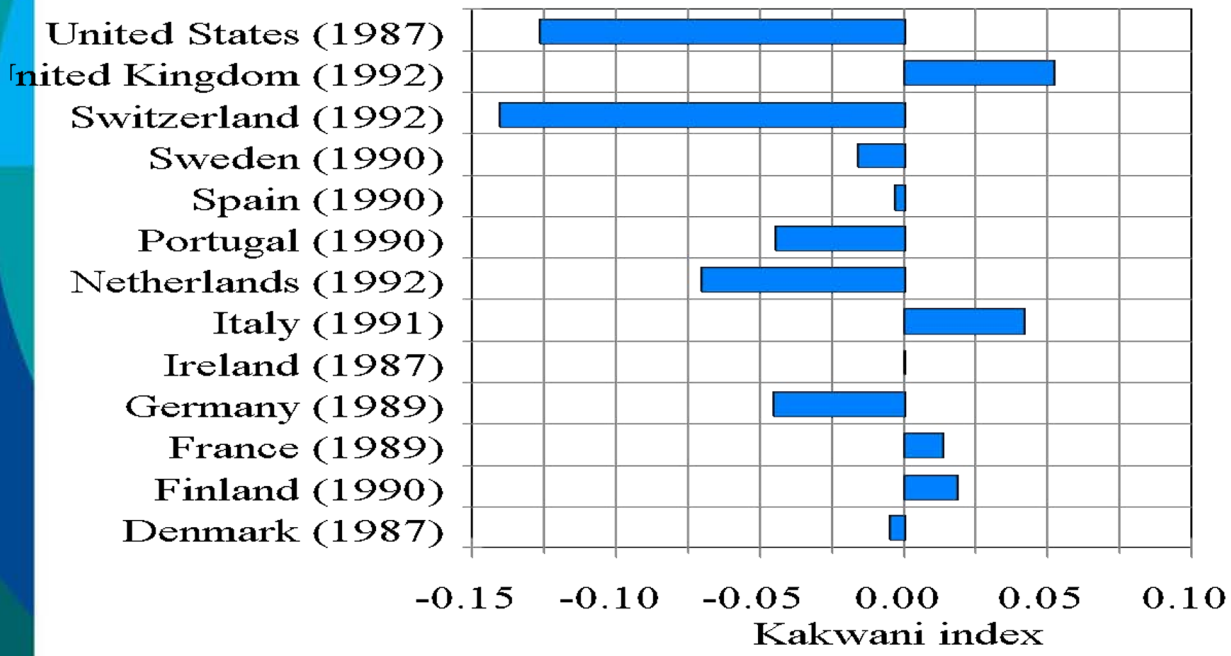
How pro- or regressive are total health care payments?

In OECD: mostly regressive



Source: Wagstaff, Van Doorslaer et al (1999)

In Asia?

Source: O'Donnell, Van Doorslaer et al (2008)

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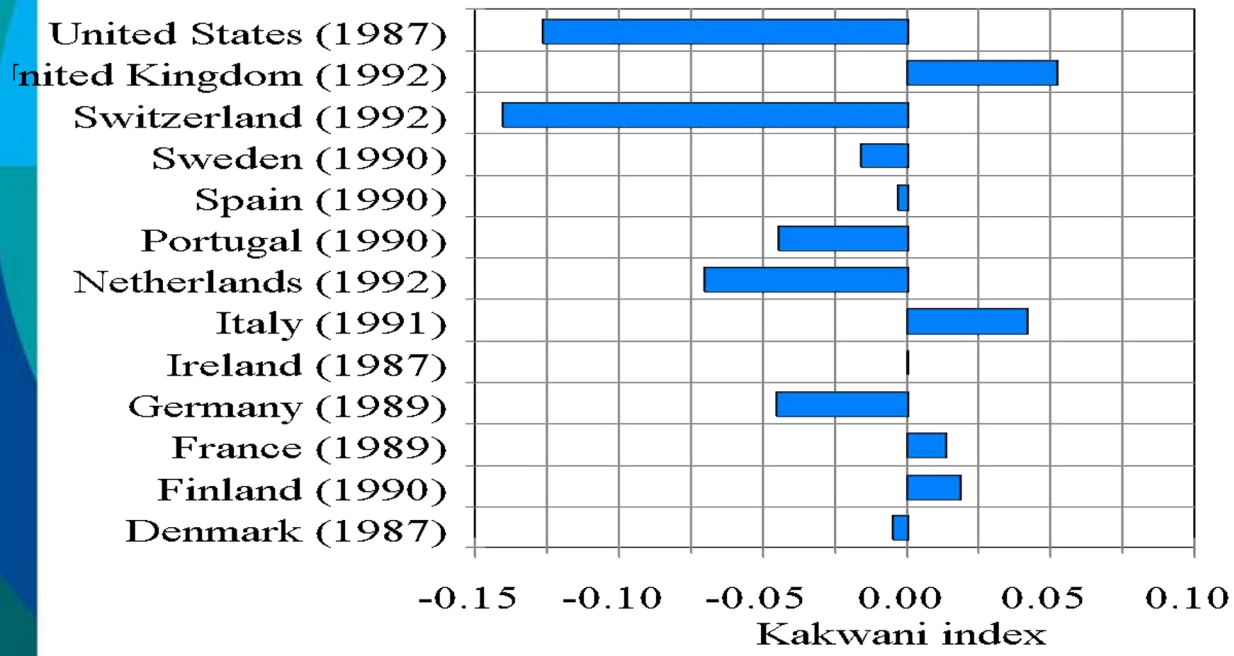
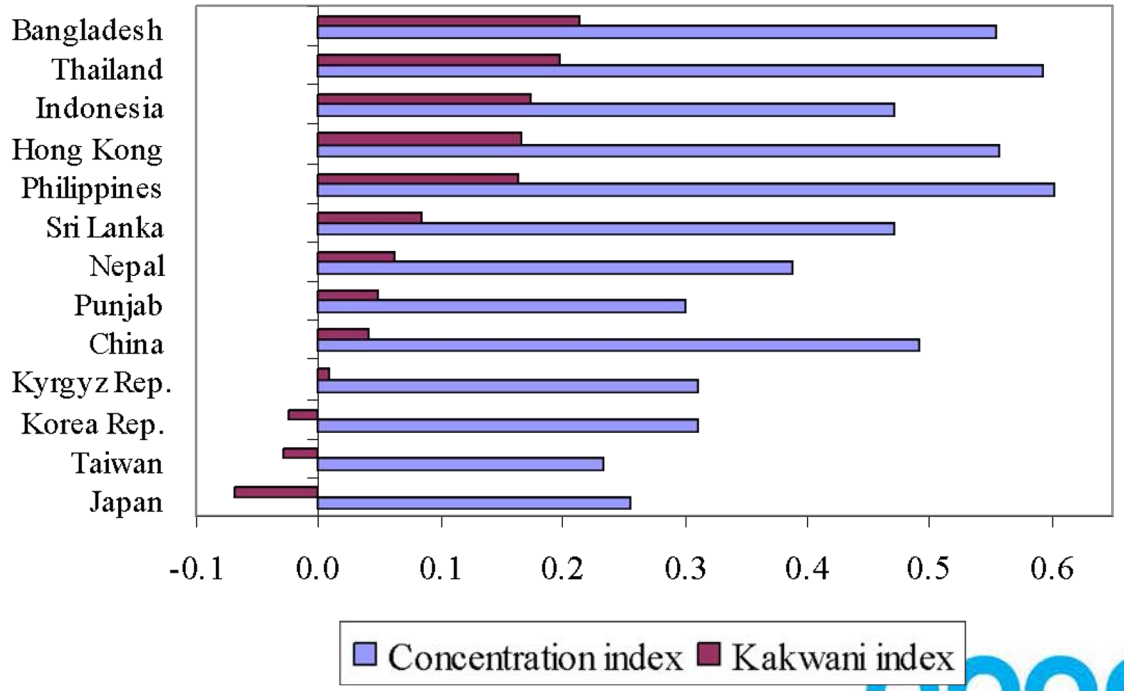
In OECD: mostly regressive



Source: Wagstaff, Van Doorslaer et al (1999)

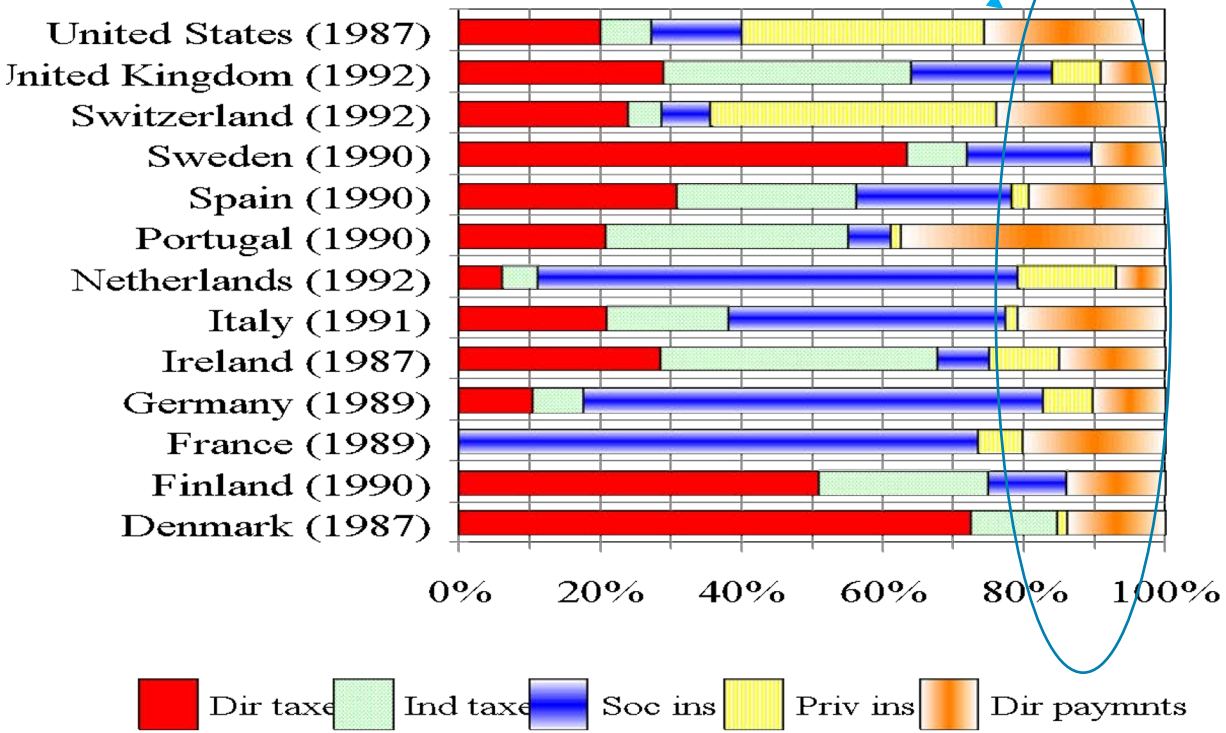
In Asia: mostly (very) progressive

Figure 6: Concentration and Kakwani indices for total health financing

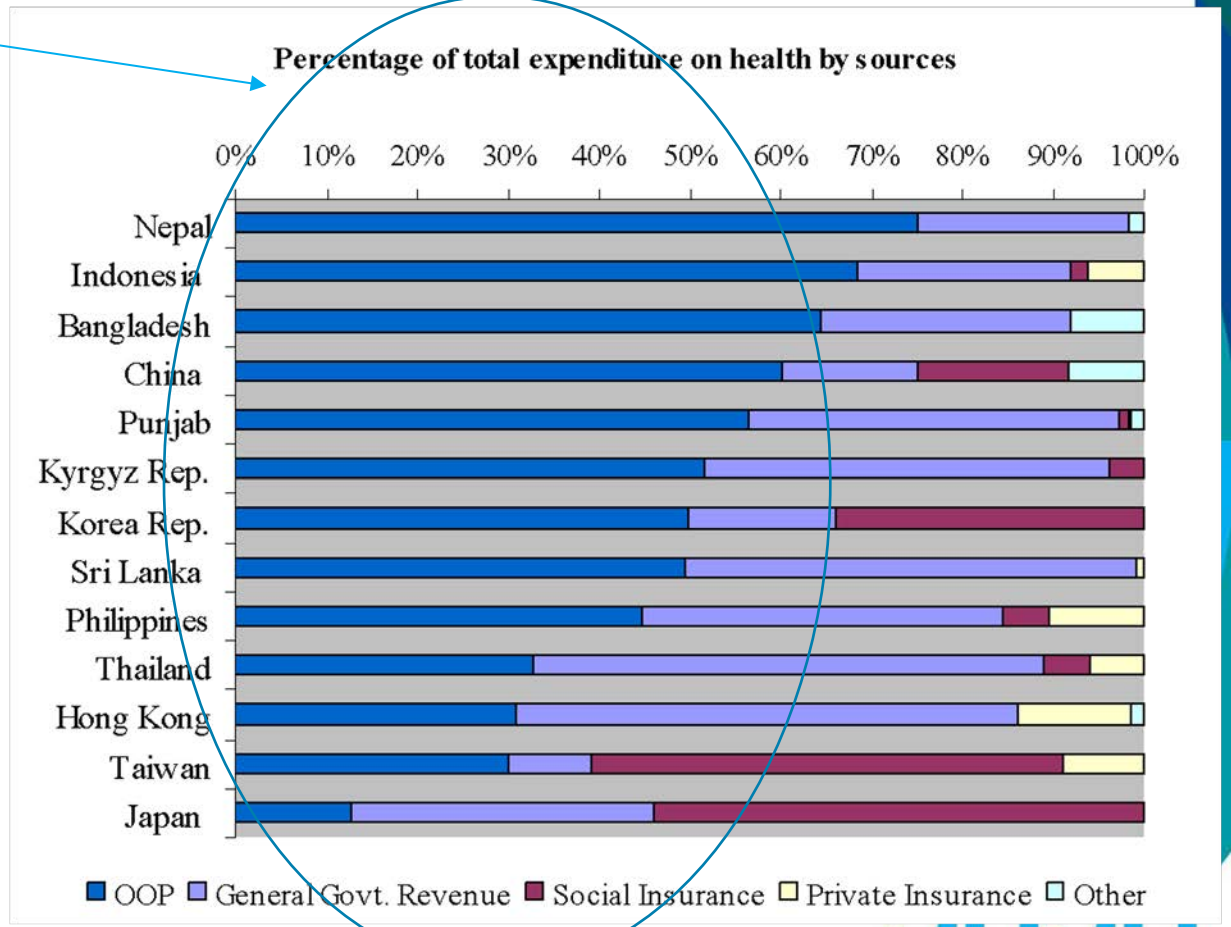


Source: O'Donnell, Van Doorslaer et al (2008)

Why is that? Very different financing mixes
Prepayment share versus direct out-of-pocket payments share is crucial



Source: Wagstaff, Van Doorslaer et al (1999)



Source: O'Donnell, Van Doorslaer et al (2008)

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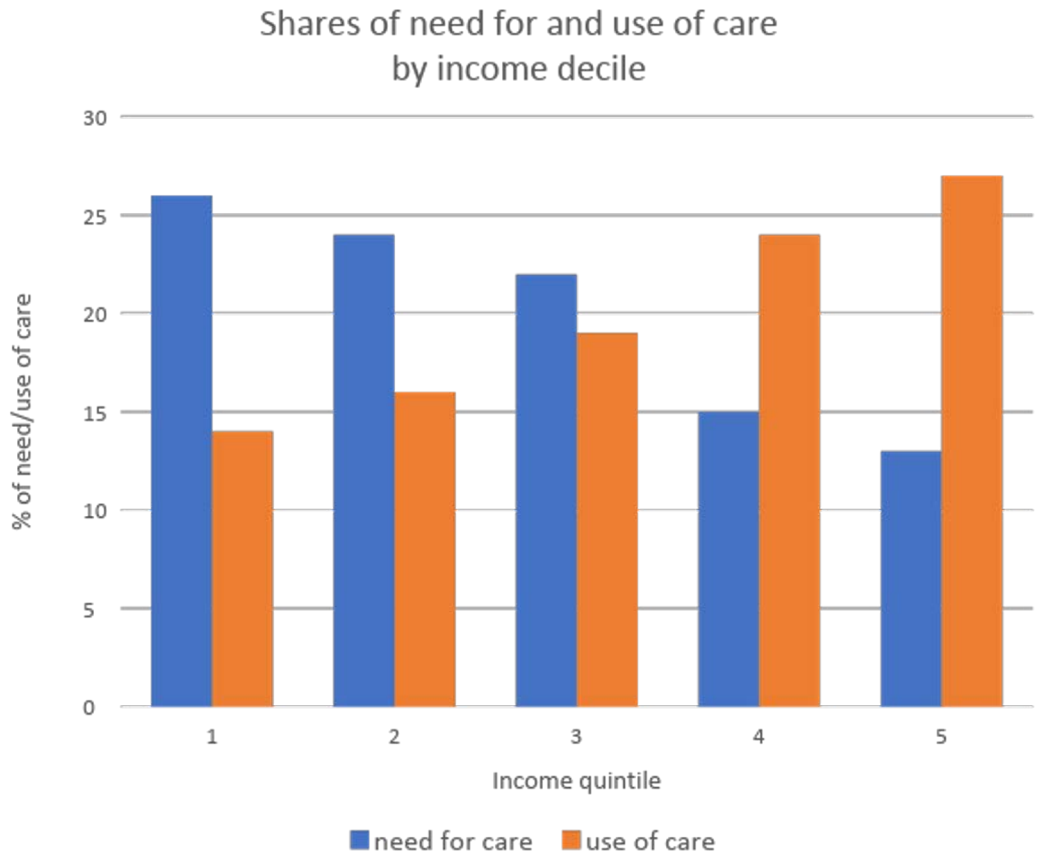
A graphical approach to equal treatment for equal need:

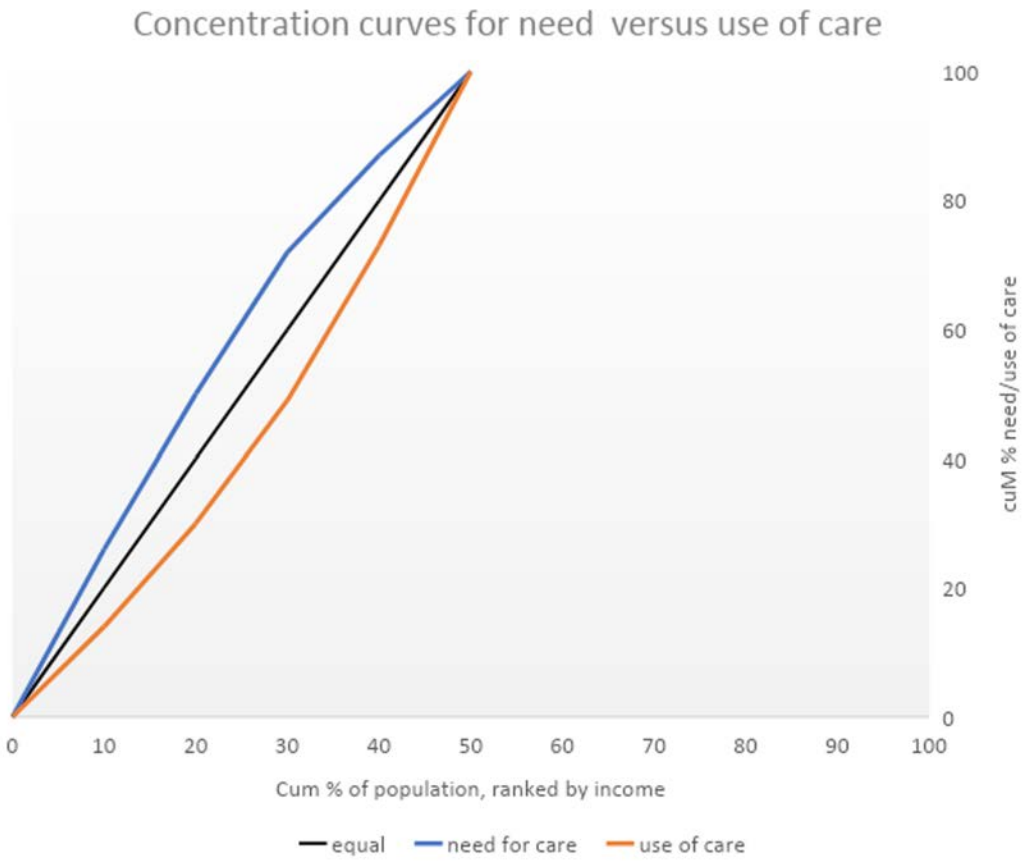
pro-rich inequality in use (C>0) and pro-poor inequality in need (C<0)

W-VD inequity index: I>0 is pro-rich; I<0 = pro-poor inequity

From relative distributions



To cumulative distributions

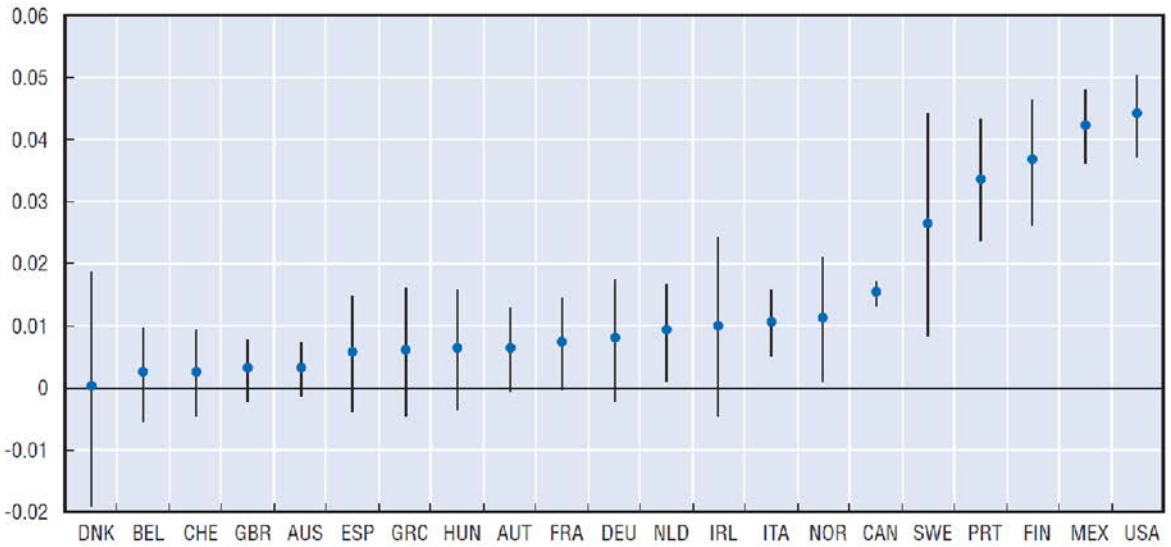


Inequity in the delivery of care?

In OECD: often pro-poor for primary
but pro-rich for some secondary care
(after need correction)

In Sub Sah Africa?

Figure 3.2. **HI indices for probability of a doctor visit, by country**



Source: Van Doorslaer et al. for OECD.

Source: Bonfrer, Van Doorslaer et al (2014)

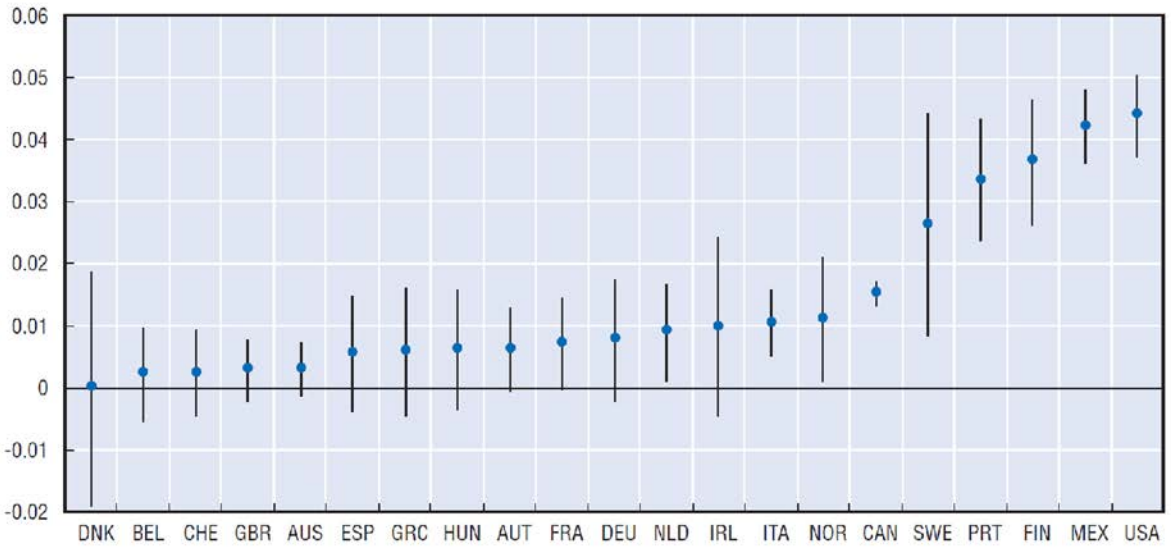
Inequity in the delivery of care?

In OECD: often pro-poor for primary but pro-rich for some secondary care (after need correction)

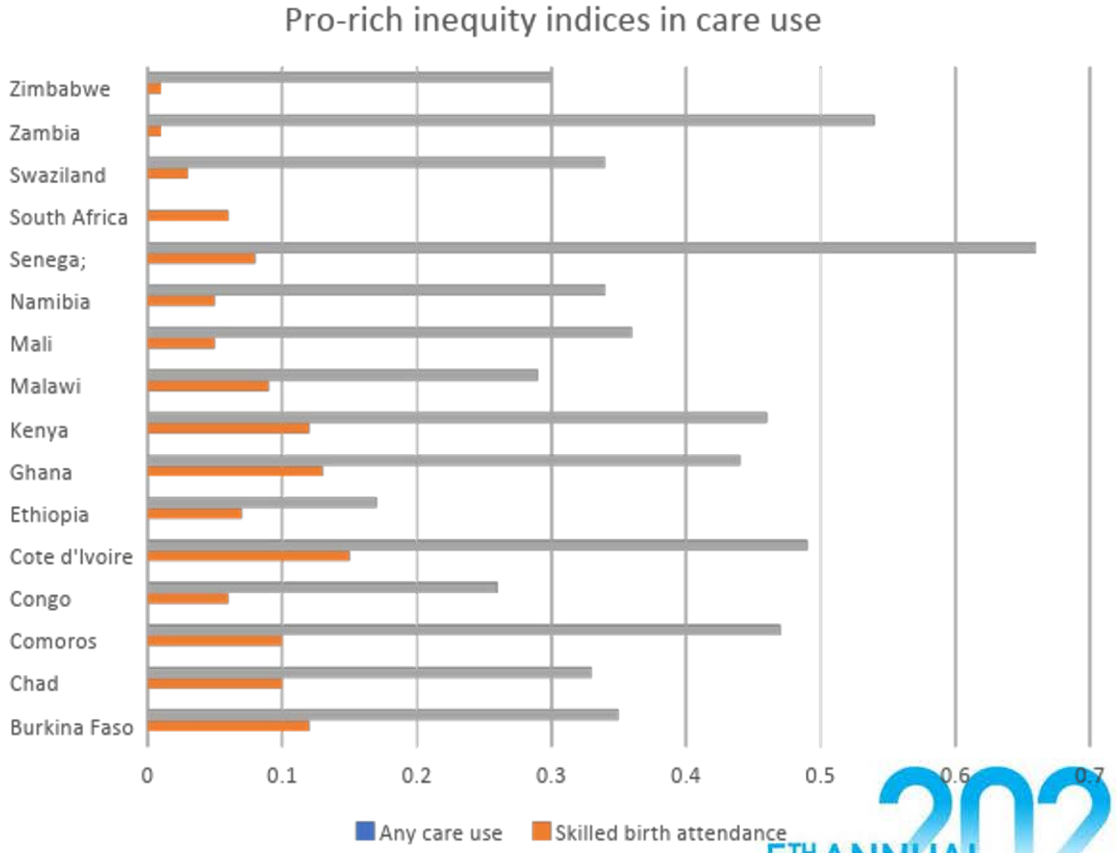
In Africa: also pro-rich use, but pro-poor needs grossly underestimated

Needs adjustment makes little difference

Figure 3.2. **HI indices for probability of a doctor visit, by country**



Source: Van Doorslaer et al. for OECD.



Source: Bonfrer, Van Doorslaer et al (2014)

Equity measurement as in high-income countries not so suitable for LMICs

Finance

- Not egalitarian redistributive goals but avoidance of "*undue financial hardship as a result of getting services they need*" (SDG 3.8.2)
- Focus on two concepts: catastrophic and impoverishing out-of-pocket payments

→ Replace income redistributive effect by financial protection (=FP)

Delivery

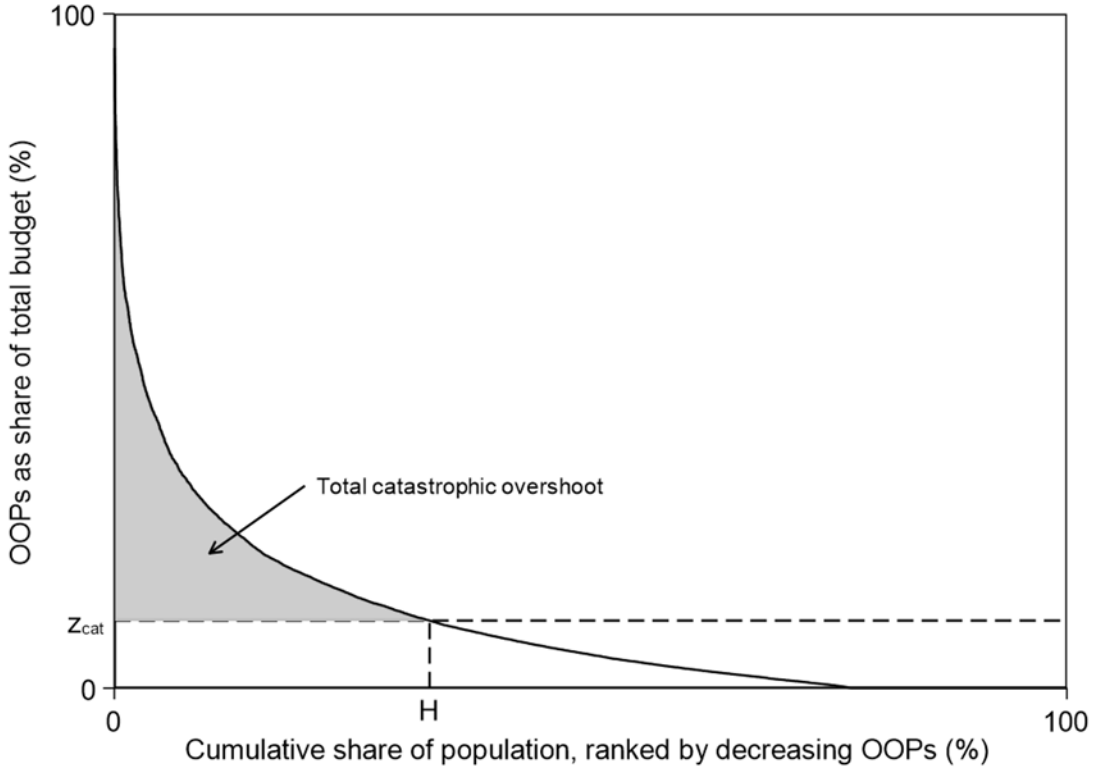
- Assumption "on average, the system gets it right" is typically not satisfied (Van de Poel et al, 2012)
- Self-perceived needs can be very deceptive (Bonfrer et al, 2014)

→ Replace broad-brush system approach by bottom-up approach measuring service coverage (=SC)

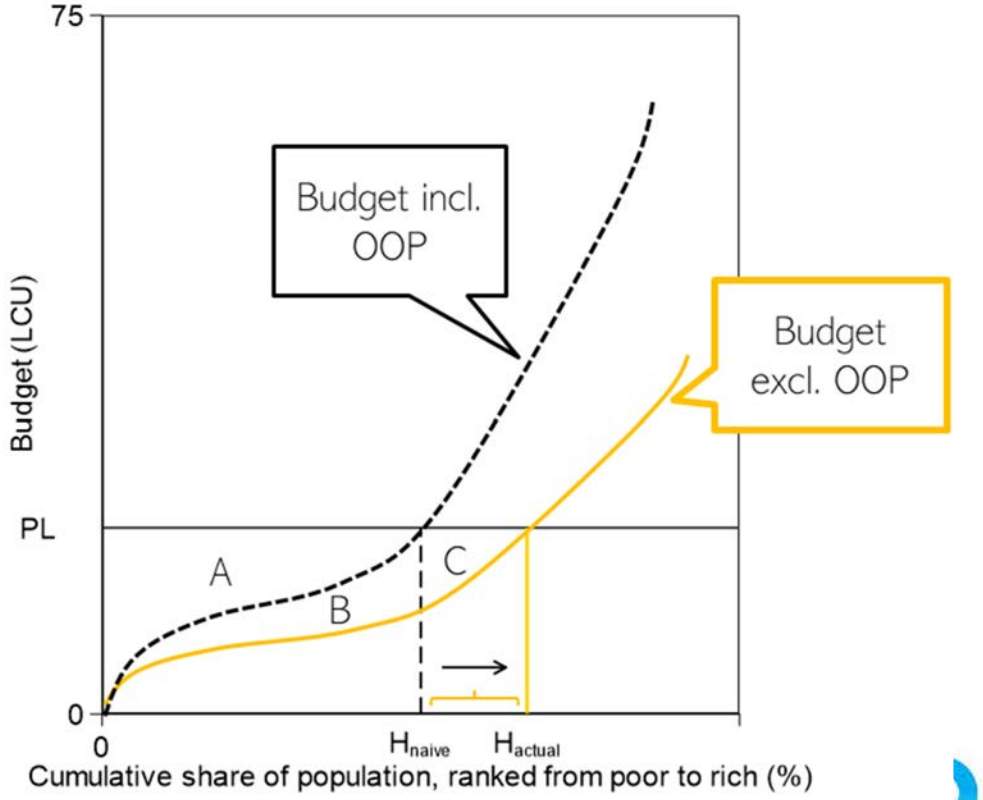
i.e. ensuring that "*Everyone—poor and rich alike—gets the health services they need*"
(SDG 3.8.1)

Measuring the degree of financial protection: to what extent are out-of-pocket payments for care of households

Catastrophic?



Impoverishing?

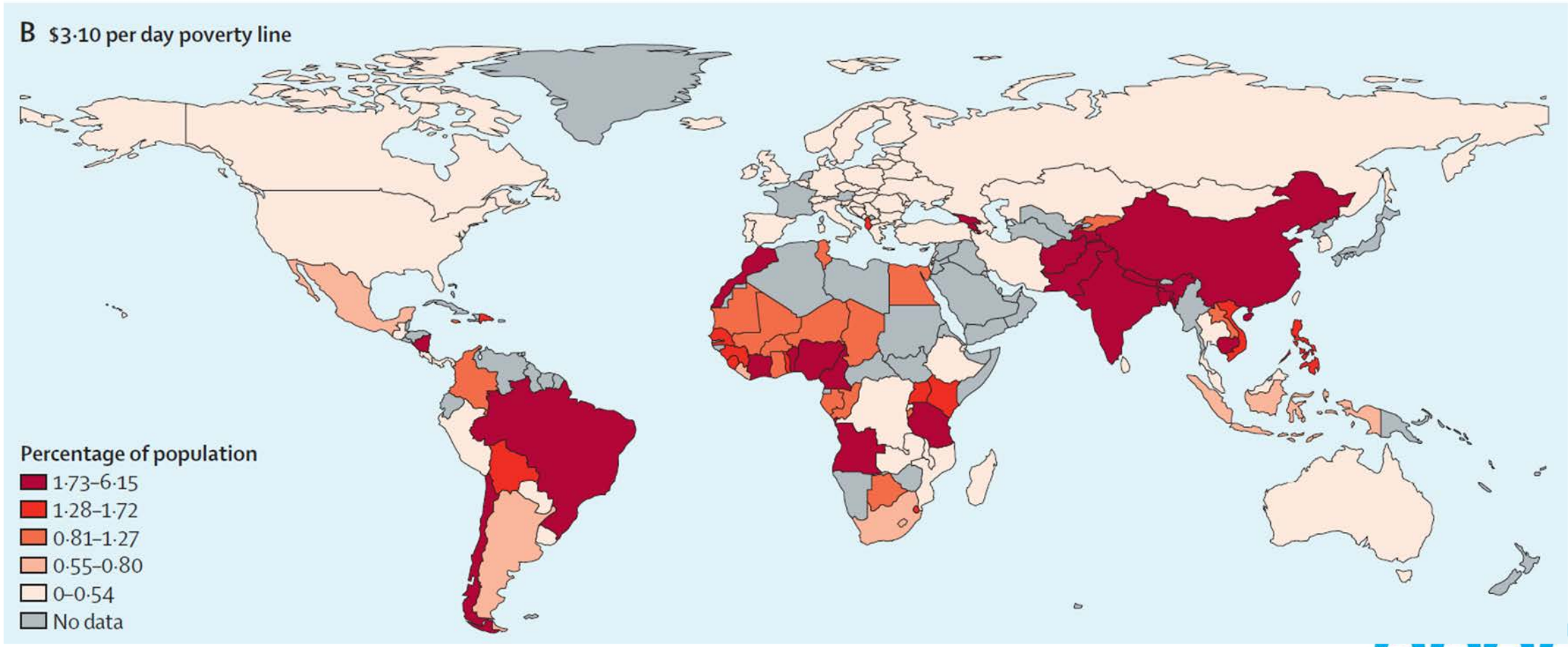


Source: Wagstaff and Van Doorslaer et al (2003)

Which countries/systems protect their populations better?

- Initial studies by WHO and EQUITAP (for Asia)
- Measures of FP were included in SDGs and monitored in 100+ countries by WB/WHO UHC monitoring collaboration (Wagstaff et al, Lancet Global Health, 2017a,b)
- Findings in a nutshell:
  - Catastrophic payment incidence fell in over 50% of countries from 2000 to 2010
  - Impoverishment fell at low pov line (USD 1.9/day): from 2.1% of world pop in 2000 to 1.4% in 2010
  - But it increased at higher pov line level (USD 3.1/day)
  - Greater use of (public) prepayments is key in shielding populations against both cat and impov spending
- Good news!
  But what does financial protection mean if people forego care in absence of coverage?

Impoverishment through out-of-pocket payments around the world



Source: Wagstaff et al (2017b)

Effective coverage of services

- Early work by WHO and IHME
- Recent addition by Wagstaff and Neelsen (The Lancet Global Health, 2020)
- Bottom-up approach instead of broad-brush
- Two challenges:
    1. Selecting indicators reflecting the "health service they need"
    2. Capturing equity ("Everyone – poor and rich alike")

And can be adjusted for pro-poorness (1-CI)

A possible set of Service Coverage indicators what fraction of those in need receive the services?

Domain	Numerator	Denominator
Prevention	4+ ANC visits	Pregnant women
	Child fully immunized*	Child age 15-23 months
	Mammogram in last 2 years	Women age 50-69
	Pap smear in last 3 years	Women age 20-69
Treatment	Skilled birth attendant at delivery	Women giving birth
	Formal provider visit for acute respiratory infection (ARI)	Children 0-59 months with ARI symptoms
	Received oral rehydration salts (ORS)	Children 0-59 months with diarrhea
	Hospital admission last year**	Adults (18+)

* BCG, Polio1-3, DTP1-3, Measles

** Benchmarked against WHO's 9.03% admission rate

The rabbit from the hat: a UHC index (Wagstaff and Neelsen, 2020)

- $$UHC_{GM} = SC^{0.5} \times FP^{0.5}$$

Not an arithmetic but geometric mean, to account for diminishing marginal substitution

For example, with

FP = $(1 - CATA10)$

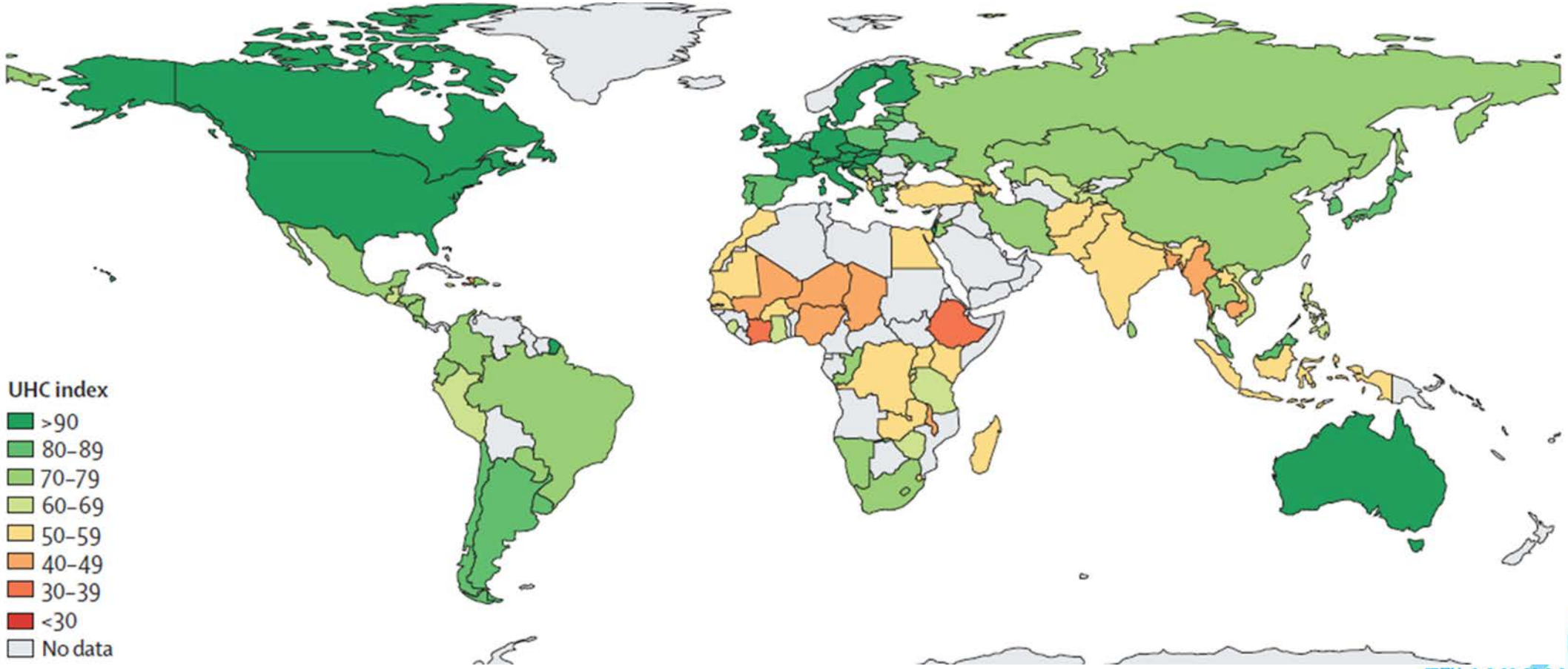
SC = $(ANC)^{1/16} \times (VAC)^{1/16} \times (MAM)^{1/16} \times (PAP)^{1/16} \times (SBA)^{1/8} \times (ARI)^{1/8} \times (ORS)^{1/8} \times (ADM)^{3/8}$

With weights according to spending shares

And possibility to penalize pro-rich distribution

How is the world doing?

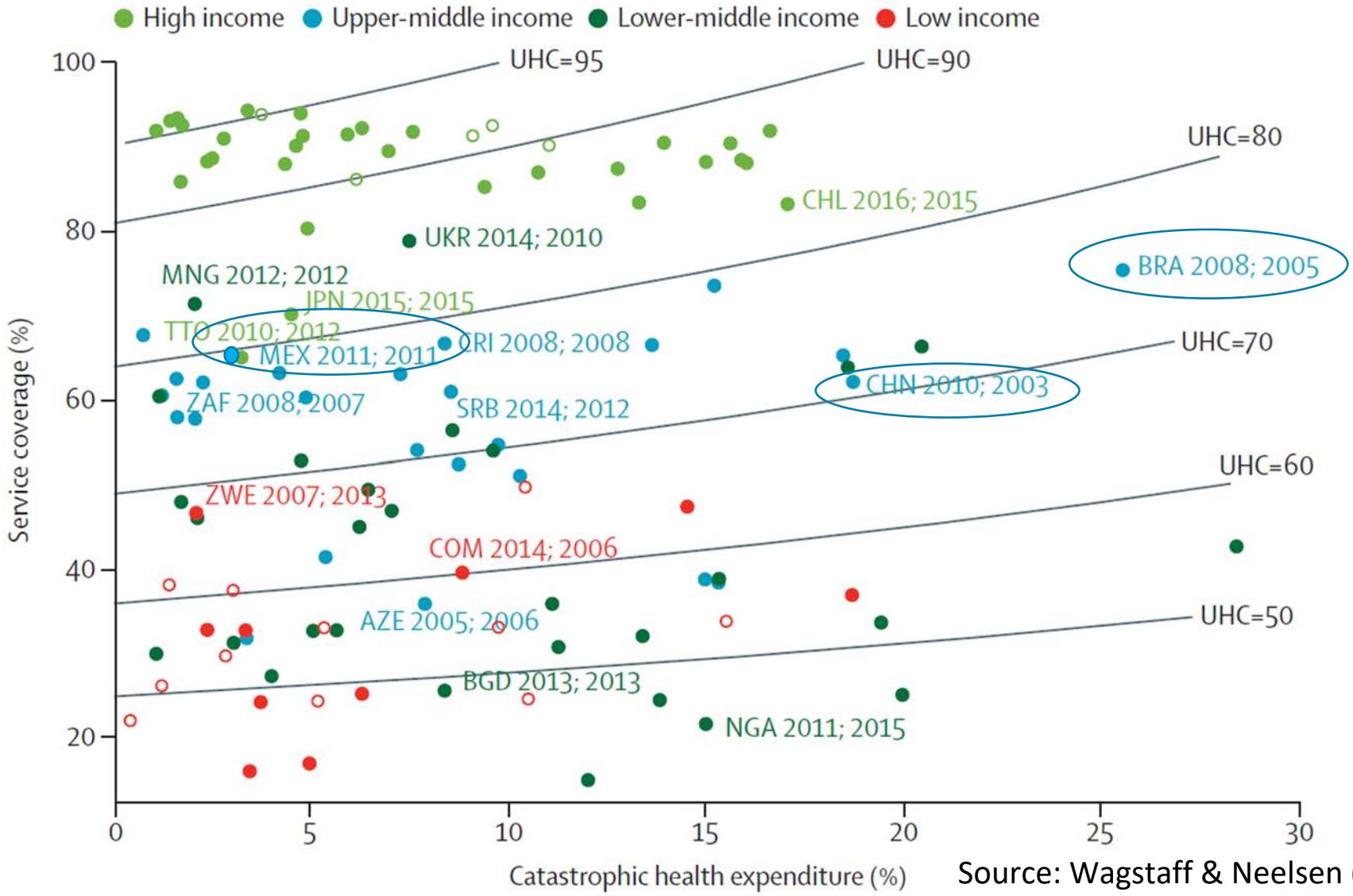
Obviously, income matters: Most HICs have UHC (index > 90) -- Many UMICs are getting closer -- SSA and South Asia lagging behind



Source: Wagstaff & Neelsen (2020)

UHC contours show trade-offs between SC and FP:

compare e.g. China, Mexico, Brasil



Source: Wagstaff & Neelsen (2020)

Conclusions – lessons learned from Adam's pioneering work

On measurement:

- UHC is about equity, but not simply old wine rebottled
- Egalitarian inequity measures developed for monitoring high-income, near-universal coverage countries – not well suited for LMICs
  - Finance: from progressivity and redistribution to financial protection
  - Delivery: from equal treatment for equal need to (effective) service coverage
  - From separate analysis to maximizing a properly weighted combination of both dimensions in a index

Some lessons on best practices

On finance: how best to fund health care?

- Lesson 1: increase prepayment share
- Lesson 2: among prepayments, voluntary premiums for private cover not very successful
- Lesson 3: among (compulsory) taxes, labor taxes not the best idea (Yazbeck et al, 2020)

On coverage: how best to cover populations?

- Lesson 4: depth of coverage matters
- Lesson 5: effective coverage embraces quality
- Lesson 5: address more objective needs assessment (denominator)

Old wine rebottled?

If ECuity indices were young Beaujolais nouveau, then the UHC index holds the promise of a Grand Cru: it still needs maturing but its “Appellation d’Origine Contrôlée” (AOC) is definitely Adam Wagstaff!

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Adam Wagstaff Memorial Prize

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Winnie Yip

President of the International Health Economics Association (iHEA),

Professor, Harvard T.H. Chan School of Public Health

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Reminder

We look forward to seeing you at

Meeting Growing Spending Needs during a Prolonged Pandemic

Pre-session:

December 2nd at 7:00am.

Session:

December 2nd at 8:00 am

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