Policy Choices for Progressive Realization of Universal Health Coverage

Comment on “Ethical Perspective: Five Unacceptable Trade-offs on the Path to Universal Health Coverage”

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Despite the cost-ineffectiveness and large budget impact, are covered except a few in the list. reform, with the application of negative list, where all services benefit package was fully applied in all financial risk protection, equity or pragmatism. Often there is limited technology assessment capacity in developing countries. implementing tax financed scheme dedicated for the poor, or exempting them from paying user fees is challenging. Thailand medical welfare scheme for the low income households introduced in 1975; premium funded voluntary health card scheme for the informal sector in 1984; and payroll tax financed SHI scheme for private sector employees in 1990 demonstrated the explicit political decision on population extension on the X axis based on ethical principles, the more vulnerable they are, the higher priority they receive.

Within each of the three dimensions, there are trade-offs. On the X axis, we concur with Norheim’s assertion, on an ethical ground, that the poor, the worse off and certain disadvantaged groups who are unable to pay their medical bills should be covered first. This ethical choice will gain high political support, if these population sub-groups are vocal constituencies who cast their votes or influence others in an election every four to five years in developing countries. Unfortunately, very often they are voiceless and powerless. Increasingly, private sector employment are growing especially in middle-income context, that payroll tax financed social health insurance (SHI) systems should be introduced as soon as possible, in order to minimize the regressive out of pocket payment, with a caveat that payroll tax finance must be designed as a progressive source, where the higher income employees pay higher contribution than the lower income counterparts. When window of opportunities open, SHI can be introduced immediately, and no need to wait for full coverage of the poor.

In developing countries, implementing tax financed scheme dedicated for the poor, or exempting them from paying user fees is challenging. Thailand medical welfare scheme for the low income households introduced in 1975; premium funded voluntary health card scheme for the informal sector in 1984; and payroll tax financed SHI scheme for private sector employees in 1990 demonstrated the explicit political decision on population extension on the X axis based on ethical principles, the more vulnerable they are, the higher priority they receive.

On the Z axis, which service package is offered to different population group is a political choice, often governed by the government fiscal spaces and how priority is made; should not the universal coverage scheme (UCS) members, certain patients died from inadequate out of pocket financed dialysis, leaving behind a large debt to repay by family.

Inequity arises when certain services are not available in remote rural areas where the poor live, but enjoyed by urban rich population. Introducing UHC without adequate and equitable distribution of supply side capacity is prone to pro-rich outcomes, as demonstrated in China and Philippines. While extensive geographical coverage of functioning primary healthcare determines the pro-poor UHC outcomes, The Thai UHC was introduced after three decades of government investment in health service infrastructure in particular district health systems, and ensuring functioning of health service through mandatory rural services by health professional graduates. Skilled birth attendance had reached 99.3% of total births; and contraceptive prevalence 79.2% of women age 15-49 in 2000, well before UHC achievement in 2002. An extensive geographical coverage of functioning health services is the foundation for effective UHC implementation.

On Y axis, cost sharing is interlinked with X axis, which population group should or should not co-pay, and interlink with Z axis, which services should be fully subsidized. Clearly, Thailand applied equity principle where the poor are exempted from payment or copayment; and efficiency principle where services such as maternal and child health, immunization, cost effective interventions and community-based public health interventions are fully subsidized to the whole population, not only the poor due to external benefits. Until recently when UHC was achieved in 2002 that all services in the benefit package are fully covered, free at point of services; this is not because improved fiscal capacity but the application of close end payment which has the merits of cost

**UHC Cube: Trade-off Within and Across Three Dimensions**

Trade-off is a situation where one must decide to choose between or balance the two alternatives that are opposite or cannot be taken at the same time. There are three dimensions of the UHC cube (see Figure 1). The X axis is the population coverage, the Y axis is the cost coverage measured by level of out of pocket cost sharing by members, and the Z axis is the service coverage, how comprehensive the benefit package would cover? There are also trade-offs between these three dimensions such as should the country cover more services to certain groups, or same service for the whole population?

**X Axis: Population Coverage**

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**Z Axis: Service Coverage**

On the Z axis, which service package is offered to different population group is a political choice, often governed by the government fiscal spaces and how priority is made; either informed by cost-effectiveness evidence, financial risk protection, equity or pragmatism. Often there is limited technology assessment capacity in developing countries. Though global evidence is available such as Disease Control Priority and Cost-effectiveness and strategic planning (WHO-CHOICE), countries need capacities to translate them into policies and implementation. As comprehensive benefit package was fully applied in all financial risk protection schemes, it is not possible to apply a new positive list covering basic essential package; hence pragmatism is applied by Thai reform, with the application of negative list, where all services are covered except a few in the list. Despite the cost-ineffectiveness and large budget impact, renal replacement therapy for kidney failure patients, a life threatening condition, was approved by the government in 2008 on equity ground and financial protection. Two other schemes, the government employee and the private sector employee schemes have full coverage of renal replacement treatment; should not the universal coverage scheme (UCS) get this similar service? Cost of treatment is catastrophic to UCS members, certain patients died from inadequate out of pocket financed dialysis, leaving behind a large debt to repay by family.

Inequity arises when certain services are not available in remote rural areas where the poor live, but enjoyed by urban rich population. Introducing UHC without adequate and equitable distribution of supply side capacity is prone to pro-rich outcomes, as demonstrated in China and Philippines. While extensive geographical coverage of functioning primary healthcare determines the pro-poor UHC outcomes, The Thai UHC was introduced after three decades of government investment in health service infrastructure in particular district health systems, and ensuring functioning of health service through mandatory rural services by health professional graduates. Skilled birth attendance had reached 99.3% of total births; and contraceptive prevalence 79.2% of women age 15-49 in 2000, well before UHC achievement in 2002. An extensive geographical coverage of functioning health services is the foundation for effective UHC implementation.

**Y Axis: Cost Coverage**

On Y axis, cost sharing is interlinked with X axis, which population group should or should not co-pay, and interlink with Z axis, which services should be fully subsidized. Clearly, Thailand applied equity principle where the poor are exempted from payment or copayment; and efficiency principle where services such as maternal and child health, immunization, cost effective interventions and community-based public health interventions are fully subsidized to the whole population, not only the poor due to external benefits. Until recently when UHC was achieved in 2002 that all services in the benefit package are fully covered, free at point of services; this is not because improved fiscal capacity but the application of close end payment which has the merits of cost
Abbreviation: UHC, universal health coverage.

Figure 2. Thailand Trajectories Towards UHC. Abbreviation: UHC, universal health coverage.

Thailand UHC Trajectory: A Long March Between 1975 and 2002

Figure 2 portrays three distinct groups of Thai population, for which different prepayment schemes are introduced. At the bottom layer, people living below national poverty line was covered by publically financed medical welfare schemes, launched in 1975, which gradually extended to cover all elderly, children under 12 years old, persons with disability and village health volunteers. At the top layer, government employees and their dependents are historically covered by non-contributed tax financed scheme, as part of the comprehensive welfare. Civil servants’ salary is claimed to be lower than labour market. The private sector employees are covered by payroll tax financed SHI, launched in 1990, as part of the comprehensive welfare. Civil servants’ coverage and high financial risk protection for UCS and SHI employees and dependants 15%.

Finally, the reform in 2002 resulted in UCS for the bottom and middle layers, 75% of total people; while keeping intact the Civil Servant Medical Benefit Scheme for government employees and SHI for private employees. The application of closed end budget facilitates more comprehensive service coverage and high financial risk protection for UCS and SHI members. The key designs contributing to favorable outcomes are; a comprehensive benefit package and free at point of service contributes to high level of financial risk protection as measured by the incidence of catastrophic health expenditure and medical impoverishment; contracting with district health systems contributes to pro-poor use of services and public resources as measured by benefit incidence; testing from demand and system efficiency. Efficiency frees up more resources for zero co-pays.

A caveat on copayment, introducing copayment as percentage of the medical bills in particular when insurance agency applies fee-for-service is harmful to the patients in particular the low income; ample evidence shows that fee-for-service stimulates supplier induced demand (demand in excess of what patient would choose) because of information asymmetry in healthcare market, hence professional acts as patients’ agent and making decision on their behalf. Fee-for-service provides opportunities for professionals to maximize services.7 Copayment can be applied to discourage bypassing primary healthcare. However, ensuring quality at primary healthcare to gain citizens' trust and confidence are important prerequisites.

Strategic purchasing comes into play to contain cost and protect members from catastrophic spending and medical impoverishment. Institutional capacities to manage purchasing by insurance agencies are contributing factors to efficiency and equity.7 Cost coverage in Y and service coverage in Z axes are interlinked under the strategic purchasing design and implementation.9 UHC achieves favorable outcomes as it was implemented when there was a full geographical coverage of primary healthcare coverage in all districts and sub-districts after three decade of health infrastructure investment and health workforce development since 1980s.

After UHC: Fragmentation Across Different Schemes

Fragmented schemes are essential feature of UHC transition when most countries apply targeting population groups. Norheim assumes a single entity in making decisions about how to expand coverage; there are many actors having stakes on UHC, such as Ministry of Health, Ministry of Labour and also private insurance agencies. Expansions of services that are privately financed are hard to influence in a laissez faire economy.

In the stride towards UHC, various countries extend coverage to different population sub-group when windows of opportunity are opened; whether due to new political leadership or changing economic condition. Clear and wise choices must be made in order to transition the fragmented schemes to more comprehensive ones.

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of opportunity opened, for example the poor subsidized by
general tax, the private sector employees by SHI payroll tax
financed scheme, and informal sector by premium financed
voluntary community based health insurance, with or without
government subsidies, such as the case of Thailand, China.17
Lao PDR.18 These trajectories result in discrepancies across
different insurance schemes in term benefit package and
provider payment — causing inequity and inefficiency.
In the paths towards UHC, LMICs should recognize these
challenges facing the pathfinder countries; efforts should be
given to minimize the gap of inequity through harmonization
strategic purchasing (in particular benefit package, level of
public subsidies and provider payment methods) across
different schemes, if unavoidably different schemes for
different population groups are applied.

Conclusion
We fully support Norheim’s recommendation that “Robust
public accountability and participation mechanisms are,
therefore, essential when deciding on the overall strategy and
the appropriateness of central trade-offs on the path to UHC.”
However, not all LMICs have such platform. Cross country
learning and sharing lessons from UHC pathfinder countries
convened by international development partners, as well as
institutional capacity strengthening focusing on strategic
purchasing function are further recommended.

Expansions of financial risk protection are incremental
processes where there is no “clean slate” furnished with all
ethical options for making UHC choices; reformists should
stand ready when the political windows open to re-orient
toward more equitable and ethical choices.

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Ethical issues
Not applicable.

Competing interests
Authors declare that they have no competing interests.

Authors’ contributions
VT conceptualizes and starts the first draft. All authors contribute to strengthening
the manuscript, reviewed and signed off the final version.

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