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Progress report on improving health care financing and progress towards social health protection in the Region

1. Every year, millions of people in the world and in the Eastern Mediterranean Region are deprived of needed health services, and millions more experience financial hardship because of the way health services are financed. Out-of-pocket payment, which is payment made at the point of using health services, is recognized as the main cause of financial catastrophe and its consequences. The World Health Report 2010 on universal health coverage paved the way for countries to enhance social health protection by providing the diagnosis and the remedy. Defined using the three dimensions of breadth, depth and cost, universal health coverage ensures that "all" people have access to a range of needed services without the risk of financial ruin. The World Health Report 2010 describes practical steps that countries can take to move closer to and sustain the goal of universal health coverage.

2. A paper[1] presented to the 57th Session of the Regional Committee for the Eastern Mediterranean in 2010 drew attention to the extremely high share of out-of-pocket in total health expenditures in most low-income countries and many middle-income ones. In addition, the paper pointed out the insufficient investments made in health in many low-income countries and the inefficient use of scarce health resources in most countries. Six strategic directions and related actions were proposed to expedite the move of countries towards universal health coverage: 1) mobilizing sufficient resources for universal coverage; 2) developing prepayment schemes; 3) promoting and supporting strategic purchasing; 4) promoting, supporting and generating knowledge to promote universal health coverage; 5) coordinating national and international partners and improving aid effectiveness; and 6) monitoring and evaluation. The Regional Committee in resolution EM/RC57/R.7 urged Member States to adopt and adapt the strategic directions.

3. Two years having elapsed, this report provides an update on the situation in the Region,[2] focusing on recent development and identifying next steps to boost improvement within the three categories of countries in the Region.[3] Progress is described across the three health care financing sub-functions: collection, pooling and purchasing.

Progress on universal health coverage in the Region

Collection

4. The collection sub-function refers to the capacity of a country to raise sufficient and sustainable revenues in an equitable manner. In resolution EM/RC57/R.7 Member States were urged to increase

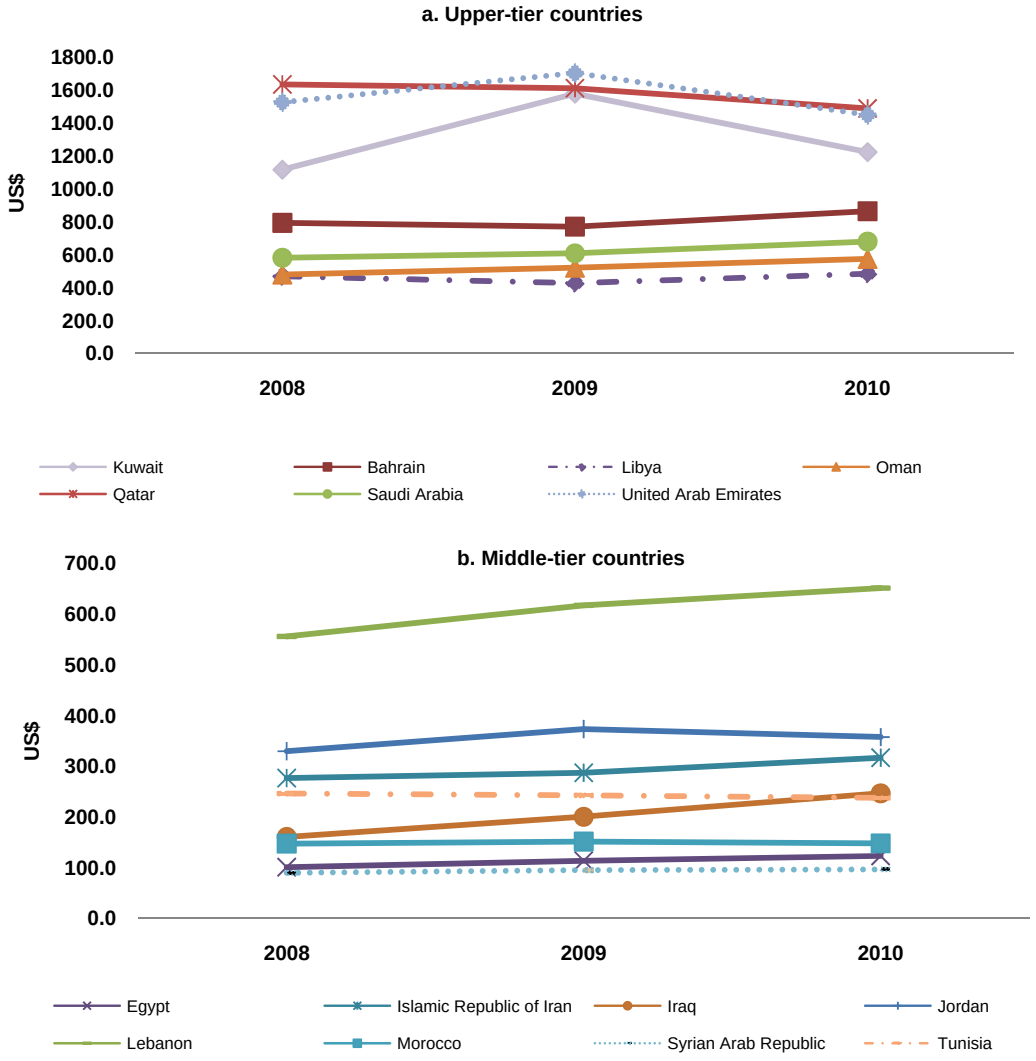
[1] *Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015* (Document no. EM/RC57/Tech.Disc.1)

[2] As a result of delays in reporting expenditure data, information in this report is for 2009 and 2010.

[3] Countries are classified using a three tier system according to their socioeconomic status, expenditure on health and health outcomes. Seven countries fall in the upper tier; they are the six GCC countries plus Libya (oil economies). Seven other countries are in the lower tier: Afghanistan, Djibouti, Pakistan, Somalia, South Sudan, Sudan and Yemen. The middle tier consists of the remaining eight countries: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Morocco, Syrian Arab Republic and Tunisia, in addition to the occupied Palestinian territory.

investment in health. Progress is examined by estimating per capita total health expenditure within and across countries.

5. With regard to countries belonging to the upper tier, Oman and Saudi Arabia witnessed steady increase in per capita total health expenditure, and Qatar showed a relative decrease in health spending going from US$1636 to US$1489 (current prices). However, Qatar remains the highest spender on health in the Region. Other countries belonging to the upper tier witnessed a mixed picture (Figure 1a). In countries belonging to the lower tier, Afghanistan witnessed some increase in per capita total health expenditure (from US$31.8 to US$37.7) while per capita total health expenditure in Yemen decreased from US$68.2 to US$63.2. Djibouti, Pakistan and Sudan have witnessed a mixed picture (Figure 1c). In the period 2008–2010, all countries belonging to the middle tier, with the exception of Tunisia where per capita total health expenditure decreased from US$133.2 to US$129.1, witnessed an increase in the amount of resources spent on health (Figure 1b).



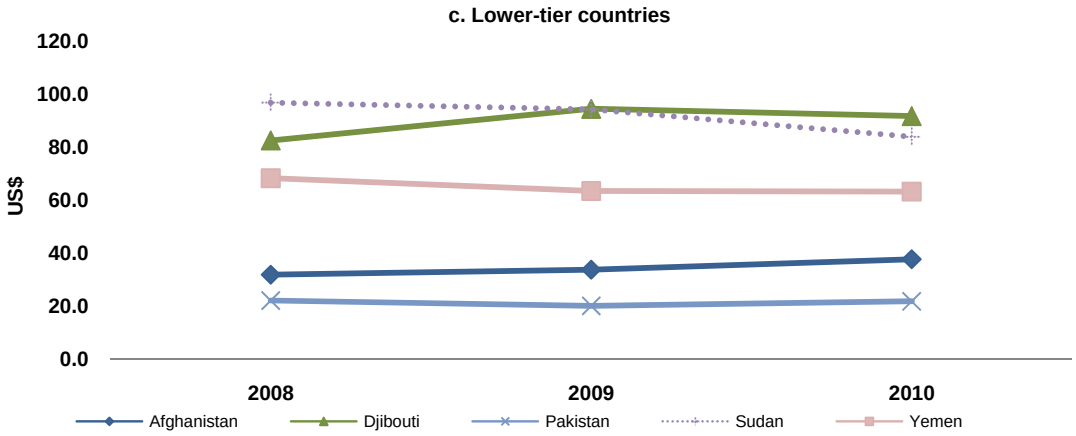
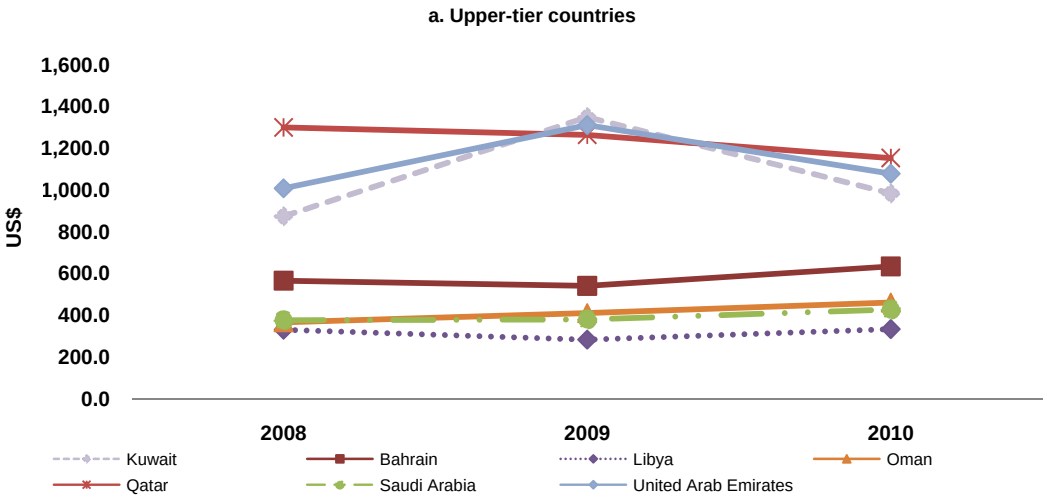


Figure 1a–c. Per capita total health expenditure, 2008–2010

Pooling

6. The pooling sub-function refers to managing collected revenues to equitably and efficiently pool health risks. In the resolution, the Regional Committee urged Member States to promote prepayment schemes. This was examined by assessing per capita general government health expenditure, incorporating all public prepayment schemes; in addition to the percentage of out-of-pocket in total health expenditure.

7. In the case of countries belonging to the upper tier, while Oman and Saudi Arabia witnessed an increase in the absolute value of general government health expenditure, Qatar observed a minor decrease from US$1635.5 to US$1488.8. In most countries belonging to the lower tier, the amount contributed by the general government has decreased. In Pakistan, however, the amount of general government health expenditure increased slightly, from US$4.3 in 2008 to US$6.4 in 2010. Figure 2a–c shows the evolution of the absolute value of general government health expenditure across the three categories of countries.



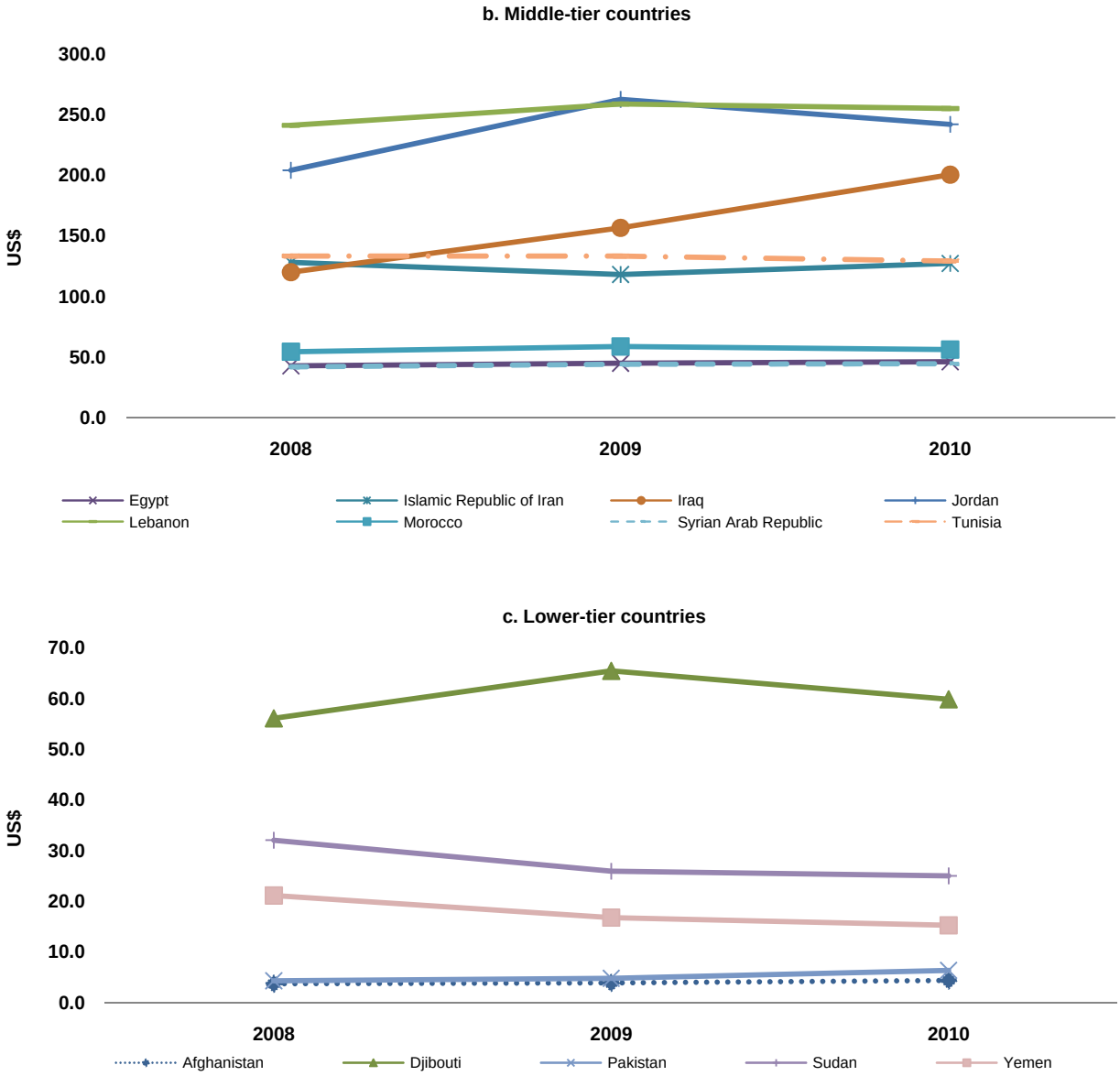


Figure 2a–c. Per capita general government health expenditure, 2008–2010

8. With regard to the percentage of out-of-pocket payment in total health expenditure, all six GCC countries continue to have relatively low (less than 20%) share of out-of-pocket expenditure in total health expenditure; in the case of Libya, this percentage was 31.2% in 2010. Countries of the lower tier seem not to have managed to limit the relatively high share of out-of-pocket payment in their total health expenditure. In the case of Yemen, this percentage has even increased from 68.0% to 74.8%. The same is observed in countries belonging to the middle tier, where the percentage of out-of-pocket payment in total health expenditure remains relatively high in Egypt and the Islamic Republic of Iran (61.2% and 57.8% in 2010, respectively). Figure 3a–c shows the evolution of the share of out-of-pocket expenditure in total health expenditure across the three categories of countries.

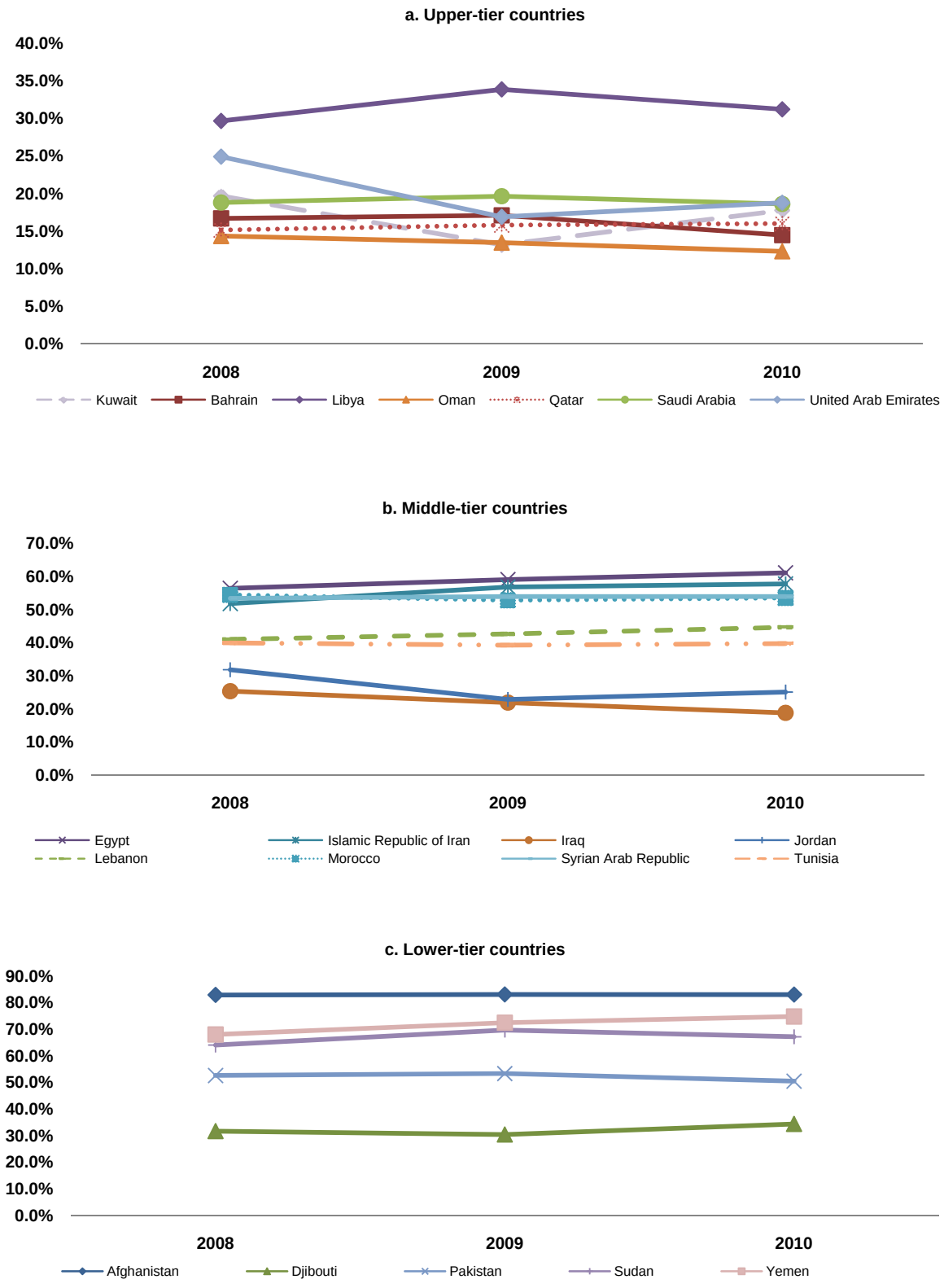


Figure 3a–c. Share of out-of-pocket expenditure in total health expenditure, 2008–2010

Purchasing

9. The purchasing sub-function refers to using the pooled revenues to purchase a range of health services in a manner that is efficient. In resolution EM/RC57/R.7 Member States were urged to introduce strategic purchasing mechanisms to promote efficient use of resources. In the Region, attention is being given to four main sources of inefficiency: human resources for health, medicine and technology, service delivery, and provider payment mechanisms. Efforts were made to assess the problems of inefficiency in selected countries and results were shared with policy-makers and decision-makers in an inter-regional expert meeting that took place on 13–15 December 2011 in Lebanon.

Challenges and conclusions

10. The main challenges identified for the Regional Committee in 2010 continue to prevail in most countries. These can be summarized as follows.

- Absence of a clear vision or strategic directions for health care financing and weak commitment from the side of the governments to equity in health.
- Limited capacity for mobilization and management of adequate levels domestic resources and suboptimal coordination of inputs from international development partners.
- A growing unregulated private sector, extensive informal sector and omnipresent dual practice, which undermine public delivery and lead to limiting the capacity of governments to collect and rationalize the use of scarce health care resources.
- The complex emergencies prevailing in several countries, which make it difficult to develop the long-term plans required to provide adequate social health protection to the population.

Next steps

11. Experience shows that substantial advances towards universal health coverage can be achieved within the prevailing health financing system by implementing and enforcing existing legal and regulatory provisions and strengthening organizational capacity. An analytical tool for assessing health financing has been developed with the aim of identifying opportunities for improvement: OASIS (Institutional and Organizational Assessment for Improving and Strengthening Health Financing). The new tool assesses the institutional design and organizational practices and identifies options for necessary changes.[4] Assessing the systems of health financing in all countries will support the generation of evidence and help initiate policy dialogues among concerned stakeholders for enhancing the performance of the prevailing system of health financing.

12. Assessing progress towards universal health coverage in the Region should be given priority. An assessment framework is also being developed and implementation is planned to be extended to all Member States. This will support countries and WHO in monitoring equity in health financing and progress towards social health protection.

13. Focus should be also given to generating evidence using the new system of health accounts (SHA 2011) methodology. The limited system is being introduced, and expanding its implementation in the Region will help provide policy relevant information for enhancing the performance of the health financing system. Another recently developed tool, the OneHealth costing tool, aims to assess the cost of

[4] Institutional design is understood as formal rules while organizational practice refers to the implementation aspect of these rules. Nine generic health financing performance indicators are used to assess the performance.

implementing national strategic health plans, including health financing strategies. Making use of this new tool will help in assessing the cost of implementing the strategies to be developed.

14. Finally, the move towards universal health coverage is increasingly recognized as a move towards reorganizing the entire health system, which calls for concerted efforts and integrated actions. Institutional arrangement decisions made by countries should give attention to fulfilling the three functions of collection, pooling and purchasing in a manner to ensure equity and efficiency and promote social health protection by expediting countries' move towards universal health coverage.