Lessons for the Universalization of Health Care in Emerging Economies

organized by: United Nations Research Institute for Social Development (UNRISD)

Panelist 1: Ilcheong Yi, UNRISD
Panelist 2: Armando de Negri Filho, World Social Forum on Health and Social Security
Panelist 3: William Hsiao, Harvard School of Public health
Panelist 4: Shufang Zhang, The Global Fund
Discussant: Indrajit Roy, Oxford University
Moderator: Kelly Stetter, UNRISD
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Lessons for the Universalization of Health Care in Emerging Economies

Moderator
Kelly Stetter, UNRISD

Kelly Stetter is a Research Analyst with the Social Policy and Development programme at UNRISD. She holds Master's degrees in Latin American and Caribbean Studies (New York University) and Development Studies (Graduate Institute, Geneva). She has been the recipient of numerous awards, including the US Department of Education Foreign Language and Area Studies Fellowship, the Tinker Foundation Field Research Grant and a FERIS Foundation scholarship. Her research has focused on social service provision in fragile context and, more recently, on industrial policy and skills development.
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Panellist
Mr. Ilcheong Yi, UNRISD

Ilcheong Yi is Senior Research Coordinator at UNRISD. He joined UNRISD in October, 2008. Born in the Republic of Korea, he was trained as both political scientist (B.A. and M.A. from the Dept. of Political Science, Seoul National University, Korea) and social policy analyst (D.Phil from Oxford University, UK). He specializes in the issues of poverty, social policy, labour policy and historical analysis of the economic and social development process. Prior to this, he was Associate Professor of Kyushu University, Japan (2004-2008), Korean Foundation Visiting Professor, Dept. of East Asian Studies of Malaya University, Malaysia (2003-2004) and Visiting Research Fellow of the Stein Rokkan Centre, Bergen University, Norway (2002-2003).
Lessons for the Universalization of Health Care in Emerging Economies

Panellist

Mr. Armando de Negri Filho, World Social Forum on Health and Social Security

Is the Coordinator of the Executive Committee of the World Social Forum on Health and Social Security, a thematic branch of the World Social Forum - WSF. Born in Porto Alegre in 1962. He was trained as a Medical Doctor (UFRGS), social epidemiologist (UFPEL), Public Health Researcher on Health Policy and Systems/Global Health and Health Diplomacy, clinical manager and medical coordination, Health Policy and Systems/Hospitals policy and planning.

Former main policy advisor of the Venezuela Ministry of Health and Social Development, of the Bogota Public Health Secretary, of the Paraguay Ministry of Health, and short term advisor of the national governments or social movements in Peru, Ecuador, Guatemala, Bolivia and India. Worked as expert with the Pan American Health Organization PAHO - WHO, the UNDP, the UNFPA, the IDRC and the French and German Cooperation.
Lessons for the Universalization of Health Care in Emerging Economies

Panellist

William Hsiao, Harvard T.H. Chan School of Public Health
William Hsiao is the K.T. Li Research Professor of Economics in Department of Health Policy and Management and Department of Global Health and Population, at Harvard T.H. Chan School of Public Health. He received his Ph.D. in Economics from Harvard University. Dr. Hsiao’s health economic and policy research program spans across developed and less developed nations. He is a leading global expert in universal health insurance, which he has studied for more than forty years. He has been actively engaged in designing health system reforms and universal health insurance programs for many countries, including the USA, Taiwan, China, Colombia, Poland, Vietnam, Hong Kong, Sweden, Cyprus, Uganda and most recently for Malaysia and South Africa.
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Discussant
Indrajit Roy, Oxford University
Indrajit Roy is ESRC Research Fellow at Wolfson College/Department of International Development, University of Oxford. He studies democratic deepening and societal transitions in the Global South. His specific research interests lie in studying citizenship in the emerging markets, the connections between political change and social transformation, and South Asian politics. Indrajit completed his first degree in History from Delhi University, and worked for several years as a development practitioner.
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Panellist
Ms. Shufang Zhang, The Global Fund
Shufang currently works at the Global Fund to Fight AIDS, Tuberculosis and Malaria, coordinating technical support needed to assist countries in intervention prioritization and resource allocation to maximize impact. She previously worked with UNRISD to coordinate the project *Migration and Health in China*.

Shufang obtained her doctoral degree in health economics from Harvard University and worked at the World Bank managing training portfolios for senior Chinese government officials on poverty reduction and sustainable development. She is a founding member of the Chinese Health Policy and Management Society and served on the Board of Directors of the Chinese Economists Society and the Corporate Environmental Advisory Council of Dow Chemical Company.
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Lessons for the Universalization of Health Care in Emerging Economies

Ilcheong Yi
UNRISD
Health for all, All for Health
Lessons from the universalization of health care in Emerging economies

Ilcheong Yi
Senior Research Coordinator
UNRISD
Geneva, Switzerland
Leaving no one behind in the health sector

- Universalism
- Struggles over the norms, values, principles and the means
- Movements towards universal health care
- Prejudice against universal health care
Factors enabling universalization of health care

- Empowered civil society, working together with government
- Political will, institutional capacity and political support for reform to create fiscal space for universal health care
- Democratic mechanisms to build consensus between different interest groups and maintain reform momentum
• Strategies to reduce resistance in and from the private sector
• Comprehensive and coherent national framework for health care with mechanisms to ensure vertical coherence of policies between different levels of government
• Tax-financed health care systems
Universal health care and the 2030 Agenda for Sustainable Development

• Health in all policies

• Strong institutional capacity within and beyond the health system to work across silos;

• The political will and capacity to mobilize broader support for reforms within and beyond the health sector.
Lessons for the Universalization of Health Care in Emerging Economies

Armando de Negri Filho
World Social Forum on Health and Social Security
Towards Universal Social Security in Emerging Economies

Dr. Armando De Negri Filho MD MSc MPH PhD
Manager of the LIGRESS / HCor Brazil
Coordinator of the Executive Committee of the World Social Forum on Health and Social Security

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General Remarks

• The initiative of this project in 2012 was from the LIGRESS – Innovations Laboratory on Health Policy and systems of the Heart Hospital – HCor of Sao Paulo Brazil, in the context of the National Program of Institutional Strengthening of the Unified Health System of Brazil – PROADI SUS, using the opportunity of technical support from UNRISD team lead by Dr. Ilcheong Yi.

• The motivation of the research was a follow up of the I World Conference on the Development of Universal Social Security Systems, organized in Brasilia in December 2010, with more than 100 countries delegations of governments and civil societies. That Conference was a consequence of a decision of the II World Social Forum on Health and Social Security assembly in Nairobi 2007. The aim of the I Conference was to introduce in the agenda of the nations the alternative of universal comprehensive and egalitarian social security systems, questioning the hegemony of fragmented and insurance based proposals sustained by the international agencies.
• Achieved that message spread, the alternative of universal systems, we would need to understand how to proceed to make it real in different contexts, since the complexity of decision making of universal systems combined with the long and challenging process of implementation of the universalistic approach demands comparative analysis and mutual support and collaboration at national and international level.

• So the Research *Towards Universal Social Security in Emerging Economies* is considered a direct input for a second world conference at a time that is a guide for other national and regional initiatives, making criticism regards the real scope and impact of actions like the UHC – Universal Health Coverage.
• The initial subject of the research was the full field of social security – in its classic version of work protection, pensions and retirements, social assistance and health, expanded, as proposed at the I Conference, to fields of rights as education, housing, safety, energy, economical security, food, etc.

• Finally we convened to focus mostly on health but making reference to the whole field of social security. Is fundamental to pursue that perspective, otherwise health will have limited possibilities to engage high policy decisions.
• The fact that the most important experiences on universal social security systems were adopted in moments of severe economic restrictions, make clear that this is a political decision in favor of the citizenship and it is a political decision that will oblige economic rules to adapt and support the social protection schemes. It is a radical expression of democracy and justifies democracy as a regime able to produce social justice.
We have to face and debate tree hegemonic narratives that dominate society, and limit our possibilities of a critical approach to the subject of universal social security systems.

1. The narrative of the natural proportionality
2. The narrative of the meritocratic deserve of the formal workers regards social security
3. The narrative of the social policy as poverty reduction, in a context of fragmented policies and fragmented organizations at civil society, eliminating the debate of development and the meaning of economic growth and the need of (re)distributive policies.

• It is particularly important, in this context, to consider the fairness of the tax system to engage tax justice and the existence of available public services oriented to serve all social classes, with no distinction, exclusion or privilege. It is the base of the fundamental redistributive experience of the Nordic countries as democratic welfare states.
• So is essential to spread the understanding of the political economy of the universalism to go ahead through transitional process to universal, comprehensive and egalitarian systems.

• The myth of creation is fundamental to generate a perspective for long course process of implementation of universal systems. A system that is born to be universal will be able to make it easier than others that are not.

• We invite you to read and make critics about the concepts, methods and case studies that compose the research, because that will be the only way to develop this important process of political reflection and action.

• We are particularly interested to research the dynamics of this social security universalization in contexts as the regional integration of Southern and Latin America, Africa and Asia, so any interest to develop a partnership on that, will be very welcome.
The case of Brazil - a very long pathway towards a universal, comprehensive and egalitarian health system.

• The constitutional creation of the SUS – Unified Health System in Brazil in 1988 – as a universal, comprehensive and egalitarian system considered as part of the Universal Social Security System, was the first step of the implementation challenges that we are facing till now and for the future.

• As a case of Transformation of Big and Complex Systems, the SUS implementation process demanded till now a wide range of political, legal, economic and social process that face a continuous resistance of the status quo to provide enough economical resources to the public system at the same time that subsides the private sector.
• With 9% of the GNP as health expenditure, we have only 45% of the expenditure linked with the public system, with the others 55% dedicated to insurances and out of pocket expenditures.

• A persistent ideological blockade against more resources to SUS and the lack of consensual analysis of fiscal space to expand the system and its performance, is leading to a very critical situation where the growth and ageing of the population is forcing for more and more complex care that need to be ordered to manage cost and results in a context of provoked scarcity, despite the evidences that health as economical sector that is very responsive in terms of public investment and economic growth.

• As a consequence we have a persistent division in two subsystems, one universal and comprehensive for more than 206 millions of inhabitants and other for around 50 millions of private insured persons but that are users of the SUS when they need, creating a double door system with privileges.
• Despite all constraints and ideological struggle is necessary to say that SUS is now a big health system that offers a full range of services, with a strong base on primary health care and important qualified specialized care covering all fields and engaging innovations continuously. The fact that it is installed in all the more than 5.700 municipalities of the country of 8.500.000 square kilometers is a proof of a vitality of a tax funded public policy, that engage universalism in a country that is deeply unequal and has a history marked by slavery and social exclusion.

• As a federative republic and pursuing a national integration with development of a democratic participation, the decentralization of health resources and decision making in the 90’s was fundamental to implement the municipal basis of the SUS and install a participative councils in all levels of the Federation with real decision powers.
• With all its advances and difficulties the SUS is an example of the possibility of universal system as alternative hegemony in a context of emerging economies and in the global south as a whole.

• The engagement of research on policy making and implementation with the aim of the universalization of the right to health in a context of neoliberal hegemony, will help to reinforce the knowledge to protect the SUS against the recent attacks of the neoliberal de facto federal government.

• Thanks
Lessons for the Universalization of Health Care in Emerging Economies

Prof. William Hsiao
School of Public Health, Harvard University
Lessons for the Universalization of Health Care in Emerging Economies: the Case of China

Prof. William Hsiao, PhD
K.T. Li Research Professor of Economics
Harvard TH Chan School of Public Health
Converging streams of forces drive universal health coverage

The problem stream forces policy makers to recognize the importance of a problem and give it priority.

The policy stream is the process by which policy proposals are generated, debated, revised, and put forth for serious consideration.

The fiscal capacity imposed constraints on the government when it implements a major safety net reform.

The politics stream refers to political factors that influence agendas, such as changes in elected officials, political climate or mood, and the voices of advocacy or opposition groups.

Adapted from Kingdon (1984)
The Chinese government focused on economic reform, problems in the social sector were considered distractions or embarrassments and were often negated.

The SARS epidemic in 2003 marked a new era. SARS was not an isolated incident, given China’s weak health care system caused by decades of dysfunctional health policy.

2009 Health Reform Targets

1. Expanding insurance coverage
2. Making public health services available and equal for all
3. Improving the primary care delivery system to provide basic health care
4. Establishing a national essential drug system
5. Piloting public hospital reforms
Assessing UNC Progress in China: Dramatic Increase in Coverage

Source: Qingyue Meng, Ke Xu. Progress and challenges of the rural cooperative medical scheme in China; Bulletin of the World Health Organization, Jan 2014
Assessing UNC Progress in China: Improved Financial Protection Overall

Share of the Total Health Expenditure by Source

Data Source: WHO Global Health Expenditure Database
Assessing UHC in China: Inequality Remains among Population Groups

**UEBMI**: Urban Employee Basic Medical Insurance
**URBMI**: Urban Residence Basic Medical Insurance
**NCMS**: New Rural Cooperative Medical Scheme
### Assessing UNC Progress in China: non-uniformality among Social Insurance Schemes

#### Summary of China’s Three Public Insurance Programs, 2011.

<table>
<thead>
<tr>
<th></th>
<th>UEBMI</th>
<th>URBMI</th>
<th>NCMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target population</strong></td>
<td>Urban employees</td>
<td>Urban children, students, unemployed, disabled</td>
<td>Rural residents</td>
</tr>
<tr>
<td><strong>Enrollment rate (%)</strong></td>
<td>92</td>
<td>93</td>
<td>97</td>
</tr>
<tr>
<td><strong>Number of enrollees (million)</strong></td>
<td>252</td>
<td>221</td>
<td>832</td>
</tr>
<tr>
<td><strong>As % of China’s 1.3 billion population</strong></td>
<td>19</td>
<td>16</td>
<td>62</td>
</tr>
<tr>
<td><strong>Unit of enrollment</strong></td>
<td>Individuals</td>
<td>Individuals</td>
<td>Households</td>
</tr>
<tr>
<td><strong>Risk-pooling unit</strong></td>
<td>City</td>
<td>City</td>
<td>County</td>
</tr>
<tr>
<td><strong>Premium per person per year (US$)</strong></td>
<td>240</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td><strong>Including government subsidy (US$)</strong></td>
<td>0</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td><strong>Benefit coverage</strong></td>
<td>Inpatient reimbursement rate (%)</td>
<td>68</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>% of counties or cities covering general outpatient care</td>
<td>100</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>% of counties or cities covering outpatient care for major and chronic diseases</td>
<td>100</td>
<td>83</td>
</tr>
<tr>
<td><strong>Annual Reimbursement Ceiling</strong></td>
<td>Six-times average wage of employee in the city</td>
<td>Six-times disposable income of local residents</td>
<td>Six-times income of local farmers</td>
</tr>
<tr>
<td><strong>Overseeing government department</strong></td>
<td>MOHRSS</td>
<td>MOHRSS</td>
<td>NHFP</td>
</tr>
</tbody>
</table>

**Note:** MOHRSS—Ministry of Human Resource and Social Security; NHFP—National Health and Family Planning Commission.

Source: Han Yu, Universal health insurance coverage for 1.3 billion people: What accounts for China’s success? Health Policy, Vol. 119 Issue 9, Page 1145-1152

**UEBMI:** Urban Employee Basic Medical Insurance  
**URBMI:** Urban Residence Basic Medical Insurance  
**NCMS:** New Rural Cooperative Medical Scheme
The government’s new commitment to health sector reform established a powerful Inter-Ministry Task Force to design and launch health sector reform, consisting of 14 ministries.

May 2007
Commissioned seven domestic and international non-governmental organizations to develop alternative health sector reform proposals.

April 2009
The Chinese central government announced the new policy, stating that the goal of the health reform was to establish a universal health care system.

Since 2013
Pro-market approach centred by public hospital reform through privatizing public hospitals to increase provider competition and promoting private insurance to supplement basic social insurance.
Remaining Challenges

Inequity in:
• Service utilization
• OOP
• Health status between rural and urban residents (e.g. 5 years difference in life expectancy)

Unequal access to reasonable quality of affordable health care is an ultimate measure

As the SHI programmes expand, China is confronting high rates of health expenditure inflation
Lessons learnt

• Universal insurance coverage does not mean equal available reasonable coverage of quality services.

• Introduce insurance coverage is easier than reform delivery system and alter poor practitioner behaviour. Physicians and other practitioners resist change.

• Reasonable quality health care likely require major alteration of the payment/incentive mechanisms, reforming the organization and management of health organizations, improve competency of practitioners, establishing information systems, and strengthening accountability for outcomes.

• UHC likely to mean complex health system changes requiring technical expertise and a long-term commitment to implementation.
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Indrajit Roy
Oxford University
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Questions and Answers

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Book: Towards Universal Health Care in Emerging Economies: Opportunities and Challenges

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