

## Investment needs for ambitiously moving towards universal health coverage

**An estimated annual additional investment of \$158 billion would be needed to scale up to reach UHC targets in 2030. This is equivalent to \$38 per person per year or 10¢ per person per day with variations across different subregions.**

Sustainable Development Goal (SDG) 3 aims to ensure healthy lives and promote well-being for all at all ages and embeds within it the 1946 World Health Organization (WHO) constitution's vision of "...the highest attainable standard of health as a fundamental right of every human being."<sup>1</sup> SDG 3 builds on the MDGs by giving due attention to emerging health priorities including non-communicable diseases (NCDs), injuries and environmental issues.

Central to SDG 3 is target 3.8 aiming to achieve universal health coverage (UHC) by 2030 - where people and communities can access promotive, preventive, curative, rehabilitative and palliative health services that are effective while also ensuring that cost of such services does not place the user at risk of financial hardship (WHO, 2018a). Health-related targets are also embedded in other goals including nutrition (SDG 2.2); safe drinking water, sanitation and hygiene (SDG 6.1, 6.2); clean cooking fuel (SDG 7.1); and pollution and waste management (SDG 11.6).

Good health enables better education outcomes, reduces time lost in caring for dependents, and increases productivity to escape poverty. Improved nutrition reduces vulnerability to illnesses especially in childhood, leading to proper cognitive development. Healthier individuals have the ability and incentive to save more and invest accumulated capital to fuel growth. However, emerging trends, such as population ageing, cross-border epidemics and climate change, will place greater demands for and capacity constraints on health-care systems.

### Where the region stands

Based on a UHC service coverage index developed by WHO and the World Bank, levels of coverage vary widely, with developing countries in East and Southeast Asia, such as China, Malaysia, the Republic of Korea, Singapore, Thailand and Viet Nam among those with higher levels of coverage compared to South Asian countries.

Similarly, out-of-pocket payments (OOP) in Asia-Pacific range from less than 30 per cent as in OECD countries, to higher than 70 per cent of total health-care expenditures (WHO and World Bank, 2017). Between 2000 and 2016, a decline in OOP as a percentage of current health expenditure is seen in countries with improved health service coverage such as China (from 60% to 36%) and Thailand (from 34% to 12%) (WHO, 2018a). In Asia, some 13 per cent of the population face catastrophic payments which can result in the poor

using up their life savings or forgoing their children's chance for education. Globally, some 100 million people are pushed into extreme poverty due to health-care costs (DESA, 2018; WHO, 2018a). It is worth noting that lower levels of OOP and catastrophic spending does not necessarily mean people are protected from financial hardship. Individuals may choose to forego health care due to transportation expenses or the need to sacrifice a day's wage.

The WHO Global Health Expenditure Database (WHO, 2018b) shows an overall increase in Asia-Pacific health expenditure as a percentage of GDP from 5.7 per cent in 2000 to 6.7 per cent in 2016 (unweighted average) with government expenditure as the main source. This represents a positive development as higher public spending is associated with better financial protection and lower OOP spending. Slight declines in government health spending are evident in low income countries where external financing has increased since 2000. Expanding publicly financed UHC to the most vulnerable will strengthen social protection and lower poverty (SDG 1).

### Costing investments in health

Investment needs assessments in health date back to at least the Commission on Macroeconomics and Health (WHO, 2001), which estimated a set of essential interventions that would cost \$34 per person per year. More recent estimates include those of Jamison and others (2013), which projected the average annual need per person at \$63 in the period 2016-2025 and \$83 in the period 2026-2035.

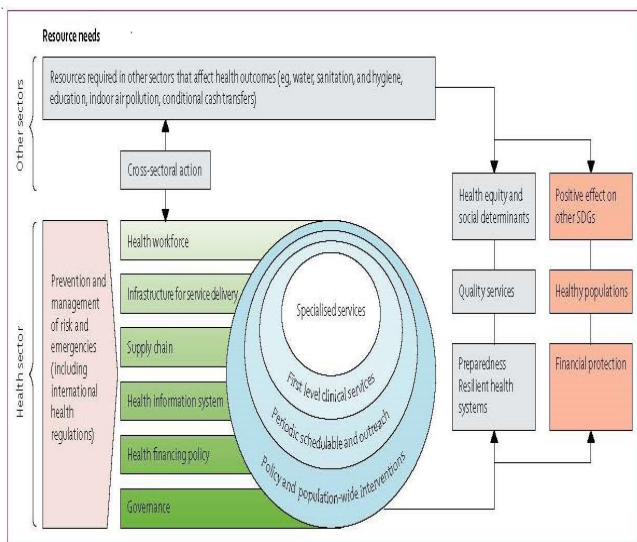
More recent studies focusing on costing UHC have been undertaken by WHO, namely the SDG Health Price Tag (Stenberg and others, 2017) estimates that an additional \$274-\$371 billion per year (\$41 to \$58 per person) is needed in 67 developing countries to scale up health systems (health services, work force, facilities among others). The Disease Control Priorities study (DCP3) (Watkins and others, 2017) costed interventions under an "essential UHC" and "highest priority UHC" package for 83 countries where incremental annual cost between \$26 to \$58 per person is needed to reach full health coverage. Both studies show different pathways in reaching UHC and that even the most essential interventions required significant increase in resources. An ESCAP study in 2013 estimated an additional spending between 2 to 9 per cent of GDP is required for Asia-Pacific countries to reach UHC by 2030.

## Estimating investment needs to achieve health SDGs

In our attempt to estimate the cost of achieving the health SDG in Asia and the Pacific, we use the WHO SDG Health Price Tag framework (Stenberg and others, 2017) as it covers health system components including health interventions, workforce and facilities which are all part of the SDG 3 targets. For 19 countries from the Asia-Pacific region (representing 93 per cent of the region's population and 81 per cent of the region's GDP). The framework models a scale up of investment to progressively expand service coverage to reach UHC. It assumes that specific SDG 3 targets are an integrated part of the broader attainment of UHC. Scaling up health system involves progressive expansion of service coverage of 187 essential health interventions delivered through five delivery platforms (population wide intervention, periodic services, first level clinical services and specialized care); health system components (health workforce, infrastructure, supply chain, information system, financing policy & governance); and prevention and management of risk and emergencies (figure 1).

The general approach is a bottom-up costing, where costs to close the gap between current coverage and reaching set benchmarks are multiplied by country-specific prices. Health systems are assumed to scale up to global benchmarks under two scenarios, progressive and ambitious.<sup>2</sup> The distinct levels of ambition among the two scenarios recognizes that not all countries may fully achieve these targets through resource constraints, or limited capacity to absorb new funding and efficiently translate into service delivery. The pace of scale up to identified benchmarks will depend on the level of development of existing health system, resources and current service delivery performance of each country. To capture this, countries are grouped into five types (conflict affected, vulnerable systems, and those with varying degrees of health systems). Modelling scale up curves for health service and related impact was done through the OneHealth Tool (OHT), a software application developed and overseen by the UN Inter Agency Working Group on costing.<sup>3</sup>

Figure 1. Conceptual framework for transforming health systems towards SDG 3 targets



Source: Stenberg and others, 2017.

## Investment needs to scale up health systems towards UHC

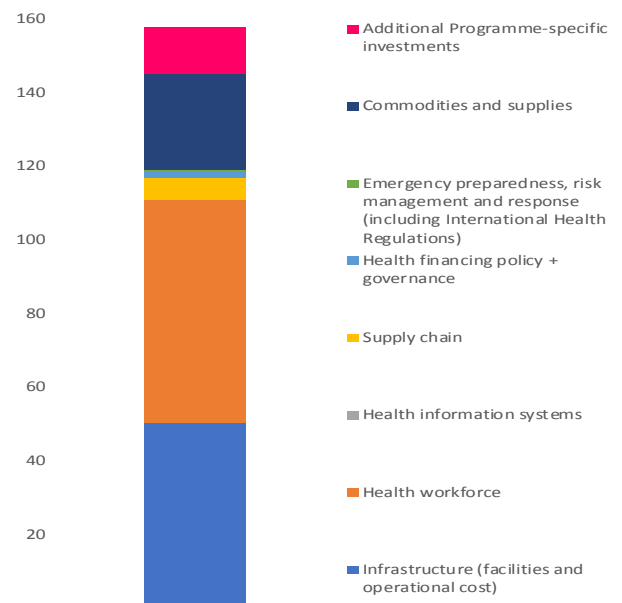
For the 19 countries covered in the WHO study, an additional investment of \$158 billion, or \$38 per person, would be needed on average during 2016-2030 to ambitiously scale up health systems towards achieving Goal 3 targets. The region accounts for more than half of the additional health investment required in the developing world. Within the region, South and South-West Asia requires the highest additional investment in health. Added to current spending levels, total public spending on health in the region would rise to about 5.3 per cent of GDP by 2030. Calculation of lower bound estimates (covering maternal and child health, HIV and non-communicable diseases (NCDs) but excluding tuberculosis (TB) and cancer) suggest life expectancy gains of 4.1 years in least developed countries, 3.5 years in South and South-West Asia, 2.6 years in South-East Asia and 1.9 years in North and Central Asia.

The main cost drivers are infrastructure and health workforce (figure 2). Substantial investments are needed in infrastructure in the initial years to increase coverage of service delivery, peaking in 2029. Health workforce costs are higher in the latter stage of the scale up as coverage increases and health targets are achieved.

### Policy and financing options

Developing countries with limited financial and human resources can first expand coverage in primary health services, a cost-effective aspect of UHC (WHO, 2018a), by providing contraceptives, basic vaccination and prevention and treatment of infectious and non-communicable diseases as well as mental health services. Similarly, population-wide interventions or outreach services, related to alcohol abuse, tobacco use, sugar consumption, early screening of non-communicable diseases (NCDs), or promoting physical exercise can deliver high impacts for long-term health at relatively low costs. Such interventions can be rapidly scaled up to cover the entire population compared to facility-based health services that require infrastructure.

Figure 2. Annual average investment gap to reach UHC, 2016-2030 (Billions of United States dollars in 2016 constant prices)



Source: Estimation provided by WHO.

Finally, as achievement of health also depends on policies in other sectors, such as nutrition and water, sanitation and hygiene infrastructure, an integrated approach will be needed.

In terms of financing, countries that have successfully worked towards UHC, such as Sri Lanka, Thailand and Turkey, provide almost the entire population with health services free of charge, financed through general tax revenues. This approach improves equity compared with contribution-based schemes, but also requires strategies to enhance budget efficiency and secure financial sustainability. Mechanisms such as capitation and co-payment can help to limit unnecessary services or overutilization.

Fiscal policies can also influence public health outcomes through taxes on tobacco, alcohol and sugary drinks while contributing to the government budget. Though arguably, “sin taxes” may not be the most efficient policy instrument as people who have occasional alcoholic and sugary drinks are being heavily taxed the same way as heavy drinkers (The Economist, 2018).

A WHO (2010) report estimates that 20-40 per cent of all health spending is wasted due to inefficiency. In estimating health spending efficiency in Asia-Pacific developing countries, we used the efficiency frontier method which indicates that slightly more than 30 per cent of health spending could be saved. However, there is no one-size-fits-all solution for improving health expenditure efficiency as there is no universal standard on the best trade-offs, and the linkages between health interventions and health outcomes are complex and often unclear. Eliminating distorted incentives and promoting better practices of health service provides including health finance providers such as insurance companies can reduce excessive diagnosis, overtreatment and excessive prescription of drugs. These are some areas that can help strengthen health expenditure efficiency.

## Endnotes

1. The right to health is also enshrined in the Universal Declaration on Human Rights (Article 25), the International Covenant on Economic, Social and Cultural Rights (Article 12) and the Convention on the Rights of Persons with Disabilities.

2. Progressive scenario, varied targets are assumed across services. Ambitious scenario: where most countries attain the global targets and the full package of services is expanded towards 95 percent coverage. For more detail please refer to the online technical appendix and Stenberg and other, 2017.

3. OneHealth tool (OHT) includes pre-populated country profiles including demographic and epidemiological data by country, cost assumptions around consumables, health workforce inputs. The OHT incorporates a variety of impact estimation models such as the Lives Saved (LiST) tool, FamPlan model, and many non-communicable diseases models to help project the costs and health impacts of scaling up specific interventions and activities in a country. For interventions not included in the OHT, data was supplemented through an excel spreadsheet. [www.who.int/choice/onehealthtool/en/](http://www.who.int/choice/onehealthtool/en/)

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The MPFD Policy Briefs aim at generating a forward-looking discussion among policymakers, researchers and other stakeholders to help forge political will and build a regional consensus on needed policy actions and pressing reforms. Policy Briefs are issued without formal editing. This issue was prepared by Kiatkanit Pongpanich. It benefited from modelling inputs and comments from Karin Stenberg (World Health Organization); and comments and suggestions from Kunihiko Chris Hirabayashi (The United Nations Children’s Fund); Daniel Jeongdae Lee, Sweta Saxena, Mahesh Uniyal (Macroeconomic Policy and Financing for Development Division, ESCAP). For further information on this issue, please contact Hamza Ali Malik, Director, Macroeconomic Policy and Financing for Development Division, ESCAP ([escap-mpdd@un.org](mailto:escap-mpdd@un.org)).