WEEKLY EPIDEMIOLOGICAL REPORT

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The path to universal coverage (Part II)

This is the second in a series of two articles on Universal Coverage.

Other barriers to accessing health services

Removing the financial barriers implicit in direct-payment systems will help poorer people obtain care, but it will not guarantee it. Recent studies on why people do not complete treatment for chronic diseases show that transport costs and lost income can be even more prohibitive than the charges imposed for the service. Moreover, if services are not available at all or not available close by, people cannot use them even if they are free of charge. Many countries are exploring ways to overcome these barriers. Conditional cash transfers, where people receive money if they do certain things to improve their health (usually linked to prevention), have increased the use of services in some cases. Other options include vouchers and refunds to cover transport costs and microcredit schemes that allow members of poor households (often the women) the chance to earn money, which can be used in a variety of ways, including seeking or obtaining health services.

Promoting efficiency and eliminating waste

Raising sufficient money for health is imperative, but just having the money will not ensure universal coverage. Nor will removing financial barriers to access through prepayment and pooling. The final requirement is to ensure resources are used efficiently.

Opportunities to achieve more with the same resources exist in all countries. Expensive medicines are often used when cheaper, equally effective options are available. In many settings, antibiotics and injections are overused, there is poor storage and wastage, and wide variations in the prices procurement agencies negotiate with suppliers. Reducing unnecessary expenditure on medicines, using them more appropriately and improving quality control could save countries up to 5% of their health expenditure.

Medicines account for three of the most common causes of inefficiency outlined in this article. Solutions for the other six can be grouped under the following headings:

- Get the most out of technologies and health services
- Motivate health workers
- Improve hospital efficiency
- Get care right the first time by reducing medical errors
- Eliminate waste and corruption
- Critically assess what services are needed.

Conservatively speaking, about 20–40% of resources spent on health are wasted, resources that could be redirected towards achieving universal coverage.

All countries, no matter what their income level, can take steps to reduce inefficiency, something that requires an initial assessment of the nature and causes of local inefficiencies. Inefficiency can sometimes be due to insufficient, rather than too much, spending on health. For example, low salaries result in health workers supplementing their income by working a second job concurrently, reducing output for their primary employment. It is then necessary to assess the costs and likely impact of the possible solutions. Incentives for greater efficiency can be built into the way service providers are paid. Fee-for-service payment encourages overservicing for those who can afford to pay or whose costs are met from pooled funds (e.g. taxes and insurance), and under-servicing for those who cannot pay.

Many alternatives have been tried. All have advantages and disadvantages. Where fee-for-service is the norm, governments and insurance companies have had to introduce controls to reduce over-servicing. These controls can be costly to implement, requiring additional human capacity and infrastructure to measure and monitor the use (and possible overuse) of services.

In other settings, fee-for-service payments have been replaced by capitation at the primary-care

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level or by some form of case-based payment, such as diagnostic-related groups at the hospital level. Capitation involves payment of a fixed sum per person enrolled with a provider or facility in each time period, regardless of the services provided. Case-based payment is for a fixed sum per case, again regardless of the intensity or duration of hospital treatment. Both reduce incentives for over-servicing. However, it has been argued that diagnostic-related groups (i.e. payment of a standard rate for a procedure, regardless of how long patients stay in hospital) may encourage hospitals to discharge patients early, then to re-admit rapidly, thereby incurring two payments instead of one.

Paying service providers is a complex, ever-changing process and some countries have developed a mixed payment system, believing it is more efficient than a single payment mode. It is possible to find more efficient approaches to purchasing services, often described as strategic purchasing. The traditional system in which providers are reimbursed for their services (and national governments allocate budgets to various levels of administration based largely on the funding they received the previous year) has been termed passive purchasing. More active purchasing can improve quality and efficiency by asking explicit questions about the population's health needs: what interventions and services best meet these needs and expectations given the available resources? What is the appropriate mixture of promotion, prevention, treatment and rehabilitation? How and from whom should these interventions and services be purchased and provided? Strategic purchasing is more than making a simple choice between passive and active purchasing. Countries will decide where they can operate based on their ability to collect, monitor and interpret the necessary information, and to encourage and enforce standards of quality and efficiency. Passive purchasing creates inefficiency. The closer countries can move towards active purchasing, the more efficient the system is likely to be.

Inequalities in coverage

Governments have a responsibility to ensure that all providers, public and private, operate appropriately and attend to patients' needs cost effectively and efficiently. They also must ensure that a range of population-based services focusing on prevention and promotion is available, services such as mass communication programmes designed to reduce tobacco consumption, or to encourage mothers to take their children to be immunized. They are also responsible for ensuring that everyone can obtain the services they need and that all are protected from the financial risks associated with using them. This can conflict with the drive towards efficiency, for the most efficient way of using resources is not always the most equitable. For example, it is usually more efficient to locate services in populated areas, but reaching the rural poor will require locating services closer to them. Governments must also be aware that free public services may be captured by the rich, who use them more than the poor, even though their need may be less. In some countries, only the richest people have access to an adequate level of services, while in others, only the poorest are excluded. Some groups of people slip through the gaps in most systems and patterns of exclusion from services vary. Particular attention must be paid to the difficulties women and ethnic and migrant groups face in accessing services and to the special problems experienced by indigenous populations.

An agenda for action

No country starts from scratch in the way it finances health care. All have some form of system in place, and must build on it according to their values, constraints and opportunities. This process should be informed by national and international experience. All countries can do more to raise funds for health or to diversify their sources of funding, to reduce the reliance on direct payments by promoting prepayment and pooling and to use funds more efficiently and equitably, provided the political will exists. Health can be a trailblazer in increasing efficiency and equity. Decision makers in health can do a great deal to reduce leakage, for example, notably in procurement. They can also take steps, including regulation and legislation, to improve service delivery and the overall efficiency of the system – steps that other sectors could then follow. Simply choosing from a menu of options or importing what has worked in other settings will not be sufficient. Health financing strategy needs to be home-grown, pushing towards universal coverage out of the existing terrain. It is imperative, therefore, that countries develop their capacities to analyse and understand the strengths and weaknesses of the system in place so that they can adapt health financing policies accordingly, implement them and monitor and modify them over time.

Facilitating and supporting change

The lessons described above focus on the technical challenges of health financing reform. But the technical aspect is only one component of policy development and implementation; a variety of accompanying actions that facilitate reflection and change are necessary. These actions are

- Establishing the vision
- Situation analysis
- Financial assessment
- Constraint assessment
- Strategy for change
- Implementation
- Monitoring & evaluation

These actions are intended as a guide rather than a blueprint and it should be noted that while the processes envisaged are described as conceptually discrete in the article , they overlap and evolve on an ongoing basis. The seven actions described here apply not only to low- and middle-income countries. High-income countries that have achieved elevated levels of financial risk protection and coverage also need to continuously self assess to ensure the financing system achieves its objectives in the face of ever changing diagnostic and treatment practices and technologies, increasing demands and fiscal constraints. Devising and implementing health finance strategy is a process of continuous adaptation, rather than linear progress towards some notional perfection.

A message of hope

The first key message of the world health report is that there is no magic bullet to achieving universal access. Nevertheless, a wide range of experiences from around the world suggests that countries can move forward faster than they have done in the past or take action to protect the gains that have been made. It is possible to raise additional funds and to diversify funding sources. It is possible to move away from direct payments towards prepayment and pooling (or to ensure that efforts to contain the growth of expenditures do not, in fact, extend the reliance on direct payments) and to become more efficient and equitable in the use of resources.

Source-The World Health Report -Health System Financing, The path to universal coverage, available from *http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf*

Compiled by Dr. Madhava Gunasekera of the Epidemiology Unit

Table 1: Vaccine-preventable Diseases & AFP

23rd February – 01th March 2013 (09th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2013	Number of cases during same week in 2012	Total number of cases to date in 2013	Total number of cases to date in 2012	Difference between the number of cases to date in 2013 & 2012
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	00	00	00	00	00	00	00	00	00	01	10	13	- 23.0 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	02	00	01	00	00	00	00	00	00	03	02	54	10	+ 440.0 %
Tetanus	00	00	00	00	00	01	00	00	00	01	00	04	02	100.0 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	02	10	17	- 41.2 %
Tuberculosis	74	14	03	10	00	31	10	00	19	161	120	1601	1511	- 05.9 %

Table 2: Newly Introduced Notifiable Disease

23rd February – 01th March 2013 (09th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2013	Number of cases during same week in 2012	Total number of cases to date in 2013	Total number of cases to date in 2012	Difference between the number of cases to date in 2013 & 2012
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	14	08	26	04	08	10	06	01	15	92	138	738	922	- 19.5 %
Meningitis	03 CB=1 KL=1 GM=1	00	02 MT=1 GL=1	01 VU=1	00	02 KG=1 PU=1	00	01 BD=1	01 RP=1	10	08	172	131	+ 31.3 %
Mumps	02	00	02	02	01	03	01	00	02	13	98	250	742	- 66.3 %
Leishmaniasis	01 GM=1	01 ML=1	08 HB=4 MT=4	01 MU=1	00	01 KN=1	01 AP=1	02 MO=2	00	15	06	214	157	+ 36.3 %

Key to Table 1 & 2

Provinces: **W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.

DPDHS Divisions: **CB**: Colombo, **GM**: Gampaha, **KL**: Kalutara, **KD**: Kandy, **ML**: Matale, **NE**: Nuwara Eliya, **GL**: Galle, **HB**: Hambantota, **MT**: Matara, **JF**: Jaffna, **KN**: Killinochchi, **MN**: Mannar, **VA**: Vavuniya, **MU**: Mullaitivu, **BT**: Batticaloa, **AM**: Ampara, **TR**: Trincomalee, **KM**: Kalmunai, **KR**: Kurunegala, **PU**: Puttalam, **AP**: Anuradhapura, **PO**: Polonnaruwa, **BD**: Badulla, **MO**: Moneragala, **RP**: Ratnapura, **KG**: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Dengue Prevention and Control Health Messages

Thoroughly clean the water collecting tanks bird baths, vases and other utensils once a week to prevent dengue mosquito breeding.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

23rd February – 01th March 2013 (09th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	133	1625	1	30	0	7	4	30	0	9	4	40	1	2	0	14	0	0	**77**
Gampaha	26	763	2	21	0	5	0	10	0	1	3	34	0	6	2	47	0	0	**40**
Kalutara	17	314	1	35	0	8	0	14	0	7	7	66	0	1	1	5	0	0	**69**
Kandy	23	381	1	13	0	3	0	2	0	0	3	12	6	23	2	12	0	0	**78**
Matale	7	92	1	23	0	0	1	1	0	0	1	7	0	1	0	10	0	0	**58**
NuwaraEliya	3	46	1	13	0	2	0	1	1	2	0	1	0	16	0	0	0	0	**69**
Galle	27	134	0	17	0	5	0	0	0	2	9	26	2	10	0	2	0	0	**95**
Hambantota	9	73	2	14	0	0	0	3	3	5	6	57	1	20	1	36	0	0	**92**
Matara	10	128	2	8	0	5	0	1	0	3	6	28	1	15	5	65	0	0	**88**
Jaffna	19	190	4	39	0	1	10	99	0	4	0	0	13	118	1	5	0	0	**83**
Kilinochchi	1	11	0	7	0	0	0	3	0	1	0	1	1	3	0	0	0	0	**50**
Mannar	1	34	0	12	0	1	4	27	0	11	0	4	1	4	0	0	0	0	**40**
Vavuniya	2	21	0	13	0	5	0	3	0	4	1	9	0	1	0	0	0	0	**100**
Mullaitivu	4	23	0	2	0	1	0	2	0	0	0	4	0	2	0	0	0	0	**60**
Batticaloa	28	148	1	25	0	2	0	0	0	2	1	6	0	0	0	3	0	0	**64**
Ampara	1	29	1	28	0	0	0	1	0	0	0	4	0	0	0	1	0	0	**29**
Trincomalee	5	64	0	10	0	1	0	0	0	0	0	14	0	1	1	2	0	0	**75**
Kurunegala	32	1196	1	43	0	12	1	14	0	3	2	21	1	9	1	15	0	0	**73**
Puttalam	31	337	1	14	0	2	1	5	0	1	0	4	0	1	0	0	0	0	**50**
Anuradhapu	12	144	1	16	1	7	0	0	0	1	3	39	0	4	0	4	0	0	**32**
Polonnaruw	2	70	2	25	0	0	0	5	0	0	2	49	0	0	0	7	0	0	**43**
Badulla	9	97	4	24	0	0	0	4	0	0	2	9	4	8	0	9	0	0	**76**
Monaragala	2	49	1	15	0	2	1	4	0	17	7	35	0	8	0	17	0	0	**55**
Ratnapura	33	301	10	90	2	62	0	8	0	7	6	58	2	10	3	73	0	1	**67**
Kegalle	19	247	1	12	0	9	1	3	0	2	3	16	5	19	3	59	0	0	**91**
Kalmune	25	242	0	17	0	1	0	0	0	6	0	4	0	1	0	4	0	0	**15**
SRI LANKA	**481**	**6759**	**38**	**556**	**03**	**141**	**23**	**240**	**04**	**88**	**66**	**548**	**38**	**283**	**20**	**390**	**00**	**01**	**66**

Source: Weekly Returns of Communicable Diseases WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 01st March, 2013 Total number of reporting units 336. Number of reporting units data provided for the current week: 221
A = Cases reported during the current week. **B** = Cumulative cases for the year.

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to **chepid@sltnet.lk.**

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