Costing, delivery and financing for hepatitis – the linkages

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Growing concerns

• Funders prioritizing to cope with fewer resources and more goals.

• Hepatitis programmes identify this as a concern, wanting to know about:
  – Domestic resource mobilization?
  – External donor funding?
  – Innovative financing mechanisms?
Possible answers?

• Disease-specific approaches:
  – earmarked taxes (like tobacco)?
  – dedicated funding sources (like GFATM)?

• But consider the lessons of these experiences:
  – *sustainability* is not just about *revenue*,
  – *purchasing, pooling* and *delivery* must be efficient too.
Two Key Health System Functions

• **Service delivery:**
  – Type of service (*what is the delivery model?*)
  – Organizational arrangements (*who does what and where?*)
  – Governance/management (*how do institutions operate?*)

• **Financing:**
  – Revenue raising (*how do we raise the money?* taxes etc.)
  – Pooling of funds (*how are the funds consolidated?*)
  – Purchasing (*how are providers paid?*)
Are we seeing only one tree in the forest?

- Financing:
  - Revenue raising
  - Pooling of funds
  - Purchasing (provider payments)

- Service delivery:
  - Type of service
  - Type of organizational arrangements
  - Type of governance/management

What everyone wants to focus on!
Alignment = coherence of functions

Financing
to serve a common system goal...

Delivery

Revenue raising
Pooling funds
Purchasing
Service model
Organization
Governance

THEORY
PRACTICE
**Fragmentation = barrier to sustainability**

**Sources**
- employees
- employers
- self-employed
- individuals, firms, consumers
- External sources

**Collection**
- Compulsory health insurance contributions
- General tax payments (income, VAT, etc.)
- Local governments

**Pooling**
- General Tax Office/State Budget

**Purchasing**
- MOJ Prison Health programs
- EHIF
- Uninsured
- MoSA
- ARV / TB medicines
- HIV/AIDS program
- GFAIM program (HIV)
- Drug abuse program
- TB program
- Other sources

**Provision**
- MOJ Prison Health facilities
- Contracted health care providers
- NGOs providing TB, HIV and drug abuse interventions (separately)
- County governments, municipalities
- Municipal TB & HIV related interventions

**The Fragment!**
Looking through a UHC lens

The **unit of analysis** is the health system:

- Develop your financing strategy at the sectoral level, not for “hepatitis” only.
- Formulate your goals at population level, not just for hepatitis programme beneficiaries.
Or, think like the Ministry of Finance:

• Don’t focus on sustaining “a programme”:
  – (programmes are a means, not an end).

• Focus on:
  – increased effective coverage
  – of (five) priority interventions.
The silo problem

Emerges when programs are seen as sufficiently different to require separate solutions:

– Infectious diseases are different (externalities).
– But there is no *a priori* reason for separate pooling and purchasing arrangements.
– Same with service delivery.
– And certainly not separate IT, procurement, supply chain, governance, HRH, etc.
A balanced approach

• **Streamline** health system architecture across programmes while ensuring results.
• Both politically and technically, it is essential to **ensure results** and show **accountability** while **correcting imbalances** and duplications.
• Let’s look at the previous example...
Easy wins are achievable although perfection is often out of reach

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Purchasing
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Provision
- MOJ
  - Prison Health programs
- MOJ
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- Contracted health care providers

External sources
- Local governments
- MOJ
  - Prison Health programs
- EHIF
- Uninsured
- Contracted health care providers

Big problems noted here

**Easy wins are achievable although perfection is often out of reach**

**Big problems noted here**
Consolidation across programmes is achievable (but maybe not across the entire system)
Achieving efficiency across programs: how?

• Think about financing and programme design to “reach clients” rather than “fund programmes”.

• In the previous example, the main clients of all programmes were people injecting drugs.
  – implication: HIV and drug use programmes needed to work together.
  – lesson: Use a person-centred approach when designing hepatitis programmes and financing.
Fragmented funding = fragmented services

• Facts:
  – Separate funding for HIV and rest of system.
  – Each programme sets independent priorities.
  – “Follow the money”...

• Implications:
  – Separate health workers and facilities.
  – Separate budget and administrative processes.
  – Perverse result: “It is better to have HIV and hepatitis than to have hepatitis alone”.

• Lessons:
  – Streamline financing with common pooling and purchasing arrangements.
Thoughts to keep in mind

• On **health financing**: can priority interventions be integrated into benefit packages and purchasing arrangements?
  – Can hepatitis be the disease that solves a health system problem?

• **Beyond health financing**: will not strong, unified support systems also serve priority interventions?
  – e.g. procurement, IT, M&E, supply chain.
Conclusions

• The core of sustainable financing is a programme optimized in cost and impact.

• Benefit from lessons learned with HIV/AIDS and avoid:
  – off-budget, parallel systems, or
  – separate delivery and financing arrangements.

• Understand the key aspects of services (who benefits, how organized) and design finance accordingly.

• Bottom line: integration = sustainability