



HEALTH SYSTEMS FINANCING

The path to universal coverage

In recent years, people's increasingly vocal demands for better health have pushed the issue further up political agendas. One result is that all Member States of the World Health Organization (WHO) have set themselves the target of developing their health financing systems in order to accelerate and sustain progress towards universal coverage.¹ In so doing, they find themselves grappling with three fundamental questions:

- ① Where and how can they find the financial resources they need?
- ② How can they protect people from the financial consequences of ill health?
- ③ How can they make optimum use of resources?

In this report, WHO maps out what countries can do to modify their financing systems so they can move more quickly to universal coverage, and maintain it once it has been achieved. The report builds on lessons learnt and new research. It provides an action agenda for countries at all stages of development about what they can do domestically. It also proposes ways that the international community can better support efforts in low income countries to achieve universal coverage and improve health outcomes.

UNIVERSAL COVERAGE

Universal coverage, as defined by WHO Member States, requires all people to have access to needed health services - prevention, promotion, treatment and rehabilitation - without the risk of financial hardship associated with accessing services.

Attainment of the highest possible level of health is a fundamental human right - enshrined in the WHO constitution. Health is critical to individual wellbeing and brings economic benefits to individuals, households and countries because people are more economically productive.

Three key factors influence a country's capacity to provide the financial resources to move towards universal health coverage:

- ① **Affordability**, which is determined partly by the level of national income per capita (e.g. GDP per capita) and in some cases inflows of funds from external partners.
- ② **The level of political and public commitment to health:** this is what determines how much a government is willing to invest in health as opposed to other sectors and how much people are willing to pay to maintain and improve their own health.
- ③ **The prevailing attitude towards concepts such as solidarity**, which influence the population's willingness to subsidize the costs of ensuring access to services for people who are worse off - either because they are poor or ill.

THE STATUS QUO

Over the past century, a number of industrialized countries have achieved universal health coverage in the sense that 100% of the population is covered by a form of financial risk protection that ensures they have access to a range of needed services. European countries began, for example, to put social health protection schemes in place in the late 19th century, moving towards universal coverage after the Second World War through tax-financed or social health insurance systems, or more commonly, a blend of the two. A number of other low and middle income countries have recently ensured access to core services with

¹ Resolution WHA58.33

financial risk protection to their entire populations, while others are moving rapidly to increase coverage and financial risk protection using a variety of innovations. That said, the world still has a long way to go to attain and sustain universal coverage.

This can be illustrated in many ways, including:

Access to services - there are extraordinary variations in coverage with key interventions across and within countries. Only 20% of people in some countries report that they received treatment when they needed it compared to almost 100% in other countries. The proportion of deliveries attended by a skilled health worker ranged from a low of less than 10% to close to 100%. Similar variations exist within countries. In some, the richest income quintile report that they receive treatment when they need it twice as much as the poorest quintile.

Extent of financial catastrophe and impoverishment - when people have no choice but to use services, and where there is not a well functioning financing system, they may incur high, sometimes catastrophic costs from which they never recover. Taken together, around 150 million people suffer financial catastrophe annually while 100 million are pushed below the poverty line.

Ability to access social health transfers when too ill to work - the other financial penalty imposed by illness is that the patient (and often his/her carers), is too ill to work. Only one in five people in the world have adequate social security protection, which usually includes payment for lost work in the event of illness.

CHALLENGES

All countries, rich and poor, face challenges in assuring, then sustaining, universal coverage and all must address the three core issues of health financing described above - raising sufficient funds, protecting people against the financial problems associated with ill health, and using resources in the most appropriate way. The extent of these challenges varies across countries. For example:

High income countries: Maintaining universal coverage once it has been achieved is a constant challenge, particularly during economic downturns when it is most needed. Moreover, most high income countries face the problem of a high ratio of elderly people to the working aged population. This has led to an upsurge in non-communicable (NCDs) and chronic diseases which are relatively expensive to treat. The lower proportion of the population in active work also means that traditional sources of revenue to finance health in the form of income taxes and/or work-based insurance contributions are diminished. Nevertheless, people in these countries have high expectations and demands for health services (particularly curative care) are constantly increasing. As a result, health costs keep rising. The extent to which countries are struggling to meet needs and expectations is sometimes felt in lengthening waiting lists; increases in cost sharing such as levies on medicines; and a constant search by policy-makers to improve efficiency and reduce costs.

Low income countries: despite welcome increases in development assistance for health, a fundamental problem remains an acute shortage of funds to cope with the multiple burden of communicable diseases, maternal and child health issues, and the rise of NCDs and injuries. This is combined with heavy reliance on direct, out-of-pocket payments (e.g. user fees) to raise domestic funds for health. In many cases these direct payments prevent access; in others they impose severe financial stress on people using services. They encourage inefficiency and inequity in the way available resources are used, by encouraging over-servicing for people who can pay, accompanied by under-servicing for people who cannot.

Middle income countries: These countries face a mix of the challenges faced in high and low income settings. In many, the main challenge is to move away from direct out-of-pocket payments and introduce prepayment systems - where people pay before they need services so that they can draw on

them when needed. Another challenge is that demands and expectations frequently outstrip a country's capacity to provide services.

There is also evidence of inefficiency in the way resources are used, partly because health governance systems are often unable to keep pace with the expansion of the health sector.

In recent years, international and national attention has focused increasingly on identifying ways to finance health in low income countries, particularly in the context of achieving the Millennium Development Goals (MDGs). Although official development assistance (ODA) for health, has more than quadrupled since 2000, it is still far from adequate. Few donors have met international pledges which would go a long way towards reducing the financing gaps. While raising new external funds is important, there also is a critical need to support countries in developing their domestic financing mechanisms and institutions that are capable of attaining and maintaining universal coverage over the longer term. Domestic resources account for around 75% of all health spending in the typical low income country at present.

THE WAY FORWARD

All countries, at all stages of development, can take active steps to either move more rapidly towards universal coverage, or to sustain and maintain it once there. The report draws from the range of country experiences to suggest a variety of practical options in the following areas:

- ① **Raising more funds for health or diversifying funding sources.** Options include: making health a higher priority in existing government spending; making revenue collection more efficient; diversifying sources of revenue using innovative domestic financing; increasing external support.
- ② **Providing or maintaining an adequate level of financial risk protection.** This means relying largely on forms of prepayment (e.g. insurance and/or taxes) to raise funds, then pooling them to ensure access and spread financial risks. This helps minimize reliance on direct, out-of-pocket payments.
- ③ **Improving efficiency and equity in the way funds are used.** The report identifies ten typical areas where improvements might be sought. These include: ensuring that people do not pay too much for medicines and using them more appropriately as well as improving quality control, improving hospital efficiency, choosing the right interventions, finding incentives that work, and avoiding fragmentation.

While the report focuses heavily on domestic financing policies appropriate to countries at all income levels, it also describes how the international community can better support low-income countries to develop domestic financing strategies, capacities and institutions which include much more than simply providing additional funding.

The options suggested in the report represent technical responses to the challenges of developing health financing systems to support or maintain universal coverage. Technical responses are only one component of policy development and implementation, and a variety of accompanying actions that facilitate reflection and change are also necessary. Devising and implementing a health financing strategy is a process of continuous adaptation, rather than a linear process towards a notional ideal. The report concludes by discussing some of these adaptation processes, including the need to be able to frequently monitor and evaluate progress - a set of indicators is proposed - and then to adapt policy as necessary.