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Key messages

- Systems requiring direct payments at the time people need care – including user fees and payments for medicines – prevent millions from accessing services and result in financial hardship, even impoverishment, for millions more.
- Countries can accelerate progress towards universal coverage by reducing reliance on direct payments. This requires introducing or strengthening forms of prepayment and pooling.
- The countries that have come closest to ensuring universal health coverage mandate contributions for people who can afford to pay, through taxation and/or insurance contributions.
- Compulsory prepaid funds should ideally be combined in one pool rather than be kept in separate funds. By reducing fragmentation, there is an increased potential to provide financial protection from a given level of prepaid funds, which in turn makes it easier to achieve equity goals.
- Voluntary schemes, such as community health insurance or microinsurance, can still play a useful role where compulsory sources provide only minimal levels of prepayment. If they are able to redirect some of their direct payments into prepaid pools, they can expand protection to some extent against the financial risks of ill health and help people understand the benefits of being insured.
- Some people will face financial barriers to access even if direct payments are eliminated; transport and accommodation costs to obtain treatment might still prove prohibitive. Governments must consider options, including conditional cash transfers, for reducing these barriers.

3

Strength in numbers

The problems with direct payments

How health services are paid for is a key aspect of health system performance. While raising sufficient resources is obviously imperative to running a health system, how those resources are used to buy goods and services – how payment is effected, in other words – is just as important. One of the most common forms of payment around the globe is direct payment for medicines and health services at the time of need, and it is the poorer countries that rely on it most (*1*).

> *"User fees have punished the poor."*
>
> Dr Margaret Chan (*2*)

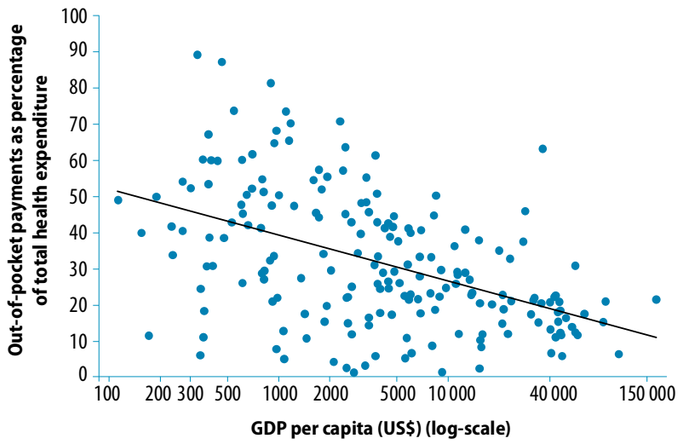
A recent study of 50 low- and middle-income countries based on WHO health wexpenditure data, a health systems typology survey and interviews with key informants, revealed that only six of the countries did not require direct payment of some form at government facilities (*3*).

But direct payment is not restricted to lower-income countries or less-sophisticated health financing systems (Fig. 3.1). Charging users when they request care is the predominant fund-raising mechanism in 33 countries and accounts for more than 25% of all the funds raised for health in another 75 (*4*). As we saw in Chapter 1, direct payments take many forms, including doctor consultation fees, payments for procedures, medicines and other supplies, and for laboratory tests. They can also come in the form of deductibles, such as co-insurance and co-payments for people covered by insurance.

One of the reasons direct payment is unsuited to the delivery/consumption of health care is that it inhibits access. This is especially true for poorer people, who must often choose between paying for health and paying for other necessities such as food or rent. For people who feel they simply must receive treatment – for the growing lump in the breast or the child's fever that will not come down – there is the risk of impoverishment or even destitution. Burundi introduced user fees in 2002. Two years later, four out of five patients were either in debt or had sold assets (*5*). In many countries, people are forced to borrow or sell assets to finance health care (*6*, *7*).

The incidence of financial catastrophe associated with direct payments for health services – i.e. the proportion of people who spend out of pocket more than 40% of their incomes after deducting expenses for food each year – can be as high as 11% per year at a national level and is typically more than 2% in low-income countries. Perhaps not surprisingly, within countries the incidence is generally lowest among

Fig. 3.1. **Out-of-pocket payments as a function of gross domestic product (GDP) per capita, 2007**



Source (*4*).

richer people, but the poorest do not always suffer most in this specific financial sense because they cannot afford to use services at all and do not incur health expenses. Recent research also suggests that households with a disabled member and those with children or elderly members are more likely to experience catastrophic health expenditures (*8–11*).

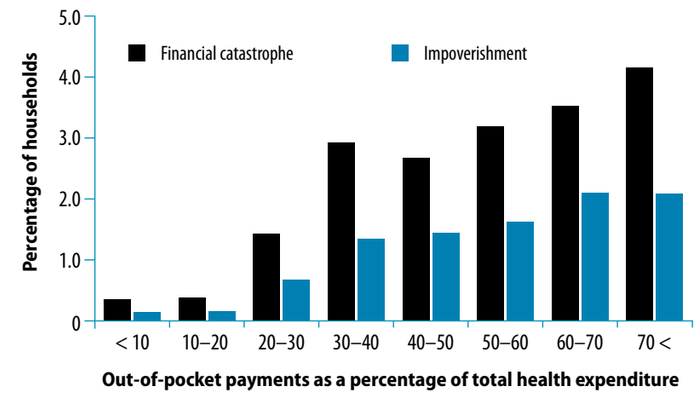
It is only when the reliance on direct payments falls to less than 15–20% of total health expenditures that the incidence of financial catastrophe routinely falls to negligible levels (Fig. 3.2) (*1*). It is largely the high-income countries that have achieved these levels, so low- and middle-income countries might wish to set themselves more attainable short-term goals. The countries of the South-East Asia and Western Pacific Regions of WHO, for example, recently set themselves a target of 30–40% (*12*, *13*).

Even when relatively low, any kind of charge imposed directly on households may discourage using health-care services or push people living close to poverty under the poverty line. An experimental study in Kenya showed that introducing a US$ 0.75 fee for previously free insecticide-treated bed nets decreased demand by 75% (*14*), while the introduction of a small charge for de-worming drugs reduced uptake by 80% (*15*). Direct payments, however small, may also encourage inappropriate self-treatment and self-medication – the use of dated or substandard medicines or partial doses, for example – or postponing often crucial early consultations with a health professional (*16*).

Direct payments do not have to be official to restrict access. In Armenia, for example, until recently only about 10% of direct payments at hospitals were official user charges levied by government facilities. A substantial portion of the other 90% was made up of the unofficial or informal payments to health workers. The government has now devised strategies to eliminate unofficial payments, recognizing that they, too, prevent people from accessing needed care and introduce an added layer of anxiety for the sick and their families because of the unpredictable nature of unofficial rates (*17*). Informal payments are found in many countries all around the world (*18–20*).

Direct payments are the least equitable form of health funding. They are regressive, allowing the rich to pay the same amount as the poor for any particular service. Socioeconomic background is not the only basis for inequality. In cultures where women have a lower status than men, women and girls must often wait for treatment behind the men of the household when user fees are charged, and therefore, are less likely to access services (*21*).

Fig. 3.2. **The effect of out-of-pocket spending on financial catastrophe and impoverishment**



Source (*1*).

The benefit derived from direct payments is restricted to the individual served and the provider or facility that collects the fee. A coin given to a nurse in a village clinic ensures the paying individual obtains a service or medicines. This is not bad in itself, but it is bad if, as health minister, you want to help also the people in the surrounding hills who may not have any coins to offer. Direct payments tend to preclude spreading the cost across groups of people in formalized expressions of solidarity – between the rich and poor, for example, or between the healthy and the sick. They also make it impossible to spread costs over an individual's lifetime. With direct payment, people cannot pay contributions when they are young and healthy, then draw on them as needed later in life. They must pay when they are sick. They must pay when they are most vulnerable.

Given the shortcomings of direct payment as a health financing mechanism, why is it so widespread?

First, a high reliance on direct payments is found when governments are unwilling to spend more on health or do not believe or understand that they have the capacity to expand prepayment and pooling systems. This leaves a gap between necessary service coverage and the coverage the government does manage to provide. Typically, health workers are caught in the middle, making do with low salaries (supplemented sometimes with informal charges) while trying to provide services with limited supplies and medicines. In these scenarios, many governments have chosen to implement formal user fees or co-payments to supplement health worker salaries and make medicines and supplies more available.

Second, direct payments offer the opportunity to tap into resources in areas where health facilities might otherwise have no money at all – perhaps in areas where government funding arrives irregularly, if at all. In the Democratic Republic of the Congo, geographical remoteness, sporadic conflict and natural disasters have sometimes isolated, at least temporarily, many parts of the country. This isolation from government support and control, especially in the eastern provinces, made direct payment from patients the default method (aside from external aid) to keep the services running, at least at some level (*22*). Direct payments commonly become the default method of financing health in the aftermath of crises, notably after a period of armed conflict. At a time when people most need access to health services, many simply cannot afford to be treated (*23*).

Third, direct payment can seem like an attractive option during periods of economic recession. In fact, the first wave of user fees for health

services at government facilities in developing countries was catalysed by the 1970s global recession. The global debt crisis sparked the structural adjustment policies that restricted government spending (*24*). At that time it was suggested that charging fees might be a way to generate the needed additional revenue, reduce overuse and encourage the provision of services that carried low charges and costs (*25*).

The 1987 Bamako Initiative was one of the outcomes of that type of thinking. Approved by African health ministers, the initiative built on a rationale that, in the context of a chronically underresourced public health sector, direct payments would ensure at least some funding to pay for needed medicines and, sometimes, staff at the local level (*26*). There is evidence that reforms inspired by Bamako improved the availability of services and medicines in some contexts, but there is other evidence that direct payments also created barriers to access, especially for the poor (*27–31*).

Finally, many countries impose some form of direct payment, often to curb the overuse of health services, as a form of cost-containment. This is a relatively blunt instrument for controlling costs and has the unwanted side-effect of deterring use in some of the population groups who need it most. It will be discussed further in Chapter 4.

Do exemptions from charges work?

Most countries that rely on direct payments try to avoid the exclusion they give rise to by exempting specific groups – pregnant women or children, for example – or by providing certain procedures free of charge. In 2006, the Burundi government waived fees on maternal and child care, including deliveries. Three months after this fee exemption was implemented, the use of outpatient services for children under five increased by 42% (*32*). Senegal removed user fees for deliveries and caesarean sections in 2005; according to the first round of evaluations, this policy lead to a 10% increase in deliveries in public health facilities and more than a 30% increase in caesarean sections (*33*).

Income has also been used to assess eligibility for exemptions. Germany, for example, imposes co-payments for some services, but only up to a limit determined by the person's income. France also offers free complementary insurance – insurance to cover co-payments – to the poor (*34*). But exemption schemes based on income have been shown to be less efficient in lower-income countries. Where most people are subsistence farmers or not in formal wage employment, it is difficult for means-testers to identify which people are the poorest. They are caught between using broad categories to avoid excluding deserving groups – an approach that leads to benefits going to the less deserving – and too-strict criteria that give rise to undercoverage, leaving the barriers to access more or less in place (*35*).

Simply declaring exemptions is unlikely to be sufficient in most settings. In Cambodia, for example, an assessment of the impact of user fees five years after their introduction in the 1990s showed that exemptions were ineffective: because 50% of the fee income was redistributed to health staff, each exemption case represented a loss of income for poorly paid health workers (*36*). To be effective, exemptions require a funding mechanism to compensate facilities for potential lost revenues. Cambodia subsequently took such a course. Health equity funds were introduced, with funding from specific donor agencies, to compensate health facilities and staff for lost revenues when granting exemptions to the poor.

This was associated with an increased use of health facilities by the poorest groups, in both urban and rural settings (*37, 38*). There have also been gains in financial risk protection; borrowing money to pay for care was lower for health equity funds' beneficiaries than for fee-paying patients (*39*). Support for this approach has grown, with the health equity funds now being financed mostly through the pooled donor funds in the Cambodian Health Sector Support Project, although since 2007, they have also attracted more domestic funds from the ministry of economy and finance. A similar approach was taken in Kyrgyzstan (*40*).

But there are other factors that deter poor people from using services even when exemptions or subsidies to cover their costs are available, factors that are more difficult to quantify: poor people's reluctance to be stigmatized by seeking an exemption or a subsidy, for example, or the way health workers sometimes treat the poor. Where health workers are dependent or partially dependent on direct payments for their income, there is a clear incentive to refuse requests for exemption. A World Bank study found that facilities in Kenya rarely granted more than two waivers per month to the entire population, 42% of which lived below the poverty line (*41*). As troubling as that might be, we should bear in mind that health workers often struggle on inadequate salaries.

On the other hand, it appears that targeting by income might work in some settings, especially at the community level. In Cambodia, for example, community leaders were asked to determine who should be exempted from fees to be financed by the health equity fund. Their assessment proved accurate, at least to the extent that the people selected for exemptions were more destitute than those not selected (*42*). In Pakistan, the HeartFile project is exploring innovative exemption mechanisms that will be evaluated shortly (*43*).

Several countries that were part of the former Soviet Union found the levels of public spending on health declining rapidly in the 1990s, with a subsequent rapid growth in informal out-of-pocket payments. This created severe financial barriers to care for those unable to pay. As a result, many of these countries introduced formal fees or co-payments designed to curtail informal payments and raise additional resources. They then had to introduce exemption mechanisms to identify and protect those unable to pay (*44*). Despite this, many of these countries still have relatively high rates of financial catastrophe linked to direct payments for health services (*45*).

The retreat from direct payments

The practical problems that hamper efforts to target specific groups dissolve when policy-makers expand exemptions to the entire population. Six low-income countries have recently abolished direct payments in government facilities, and one extended the policy to nongovernmental organization health facilities (*46*). In some cases, this action significantly increases the number of people seeking treatment. Removing fees in rural Zambia in April 2006 and January 2007, for example, resulted in a 55% increase in the

use of government facilities; districts with a greater concentration of poor people recorded the biggest increases (*47*). Attendance rates at health centres in Uganda jumped 84% when fees were scrapped in 2001 (*48*).

However, in both these cases, abolishing fees was not a stand-alone measure; increasing rural health facility budgets was an integral part of the policy. In Zambia, increased allocations from domestic sources, combined with donor support, meant the districts received 36% more in budget support than they had received from user fees in the previous year. The Ugandan government increased spending for medicines and gave facility managers more control over budget funds so that they would not lose the flexibility previously derived from fees.

Some observers have argued that direct charges at government facilities can be eliminated without too much pain because they have generated only limited income (*49*, *50*). Studies on official user fees at government facilities in 16 sub-Saharan countries revealed they generated on average 5% of total recurrent health system expenditure, not including administrative costs (*51*, *52*).

However, budgeted funds are largely tied up with the fixed costs of staff and infrastructure, leaving little for key patient treatment inputs, such as medicines and other disposable items. This is where revenues from fees often play a critical role. A study from one region of Ghana revealed that while direct payments provided only 8% and 27% of the total expenditures of a sample of health centres and hospitals, respectively, they accounted for 66% (health centres) and 83% (hospitals) of non-salary expenditures, constituting an important part of the only relatively flexible funds under the facility managers' control (*53*).

Whatever their precise value within a system, policy-makers must consider the consequences of removing direct payments. Without context-specific planning for increased demand and lost fees, abolishing them can result in under- or unpaid and overworked staff, empty medicine dispensaries and poorly maintained or broken equipment (*46*, *54*). It is worth noting that the incidence of catastrophic health expenditure among the poor did not fall after the abolition of user fees in Uganda, most likely because the frequent unavailability of drugs at government facilities after 2001 forced some patients to go to private pharmacies (*55*). It is also possible that informal payments to health workers increased to offset the lost user-fee revenue.

A return to informal payment appears to be one of the attendant risks of withdrawing user fees, although the extent to which this happens is not clear. Nor is it clear whether the countries that introduced official fees to try to curtail informal payments have managed to eliminate them despite some success in reducing them (*56*).

These experiences show that to reduce dependence on direct payment – a major obstacle to universal coverage – it is essential to find resources elsewhere to replace the official or unofficial money that was formerly paid. This can occur directly if governments are able and willing to channel more funds into health (*57*). But there are alternatives to simply spending more that involve making other changes to the financing system.

Such alternatives are not only for the most resource-constrained countries to consider. Although direct payments play a relatively unimportant role in most countries of the Organisation for Economic Co-operation and Development (OECD), an upward trend in direct payments was evidenced in many even before the global economic downturn. Many had increased patient cost sharing through direct payments to limit government contributions and discourage the unnecessary use of services (*58*). These direct payments create financial hardship for some people and reduce access to services for others. As we noted in Chapter 1, direct payments result in more than 1% of the population, or almost four million of people, suffering catastrophic payments each year in just six OECD countries.

Strength in numbers

The most effective way to deal with the financial risk of paying for health services is to share it, and the more people who share, the better the protection. Had Narin Pintalakarn joined with the people in his village to set up an emergency fund to be drawn on in cases of illness or accident, the cost of his brain surgery and care at Khon Kaen Regional Hospital would have exhausted its reserves. Fortunately, he banded together with Thailand's tax-paying public, which finances the universal coverage scheme. This was not a conscious decision; it was a decision taken and fought for by others over many decades. Pintalakarn was part of such a large group of people that even though, as a casual labourer earning the equivalent of US$ 5 a day, he was unable to contribute a single baht at the time of his care, he could still be treated and made well again. There is strength in numbers (Box 3.1).

People have long been voluntarily pooling their money to protect themselves against the financial risk of paying for health services. The Students' Health Home insurance scheme started in West Bengal in 1952 and schemes in several western African countries, including Benin, Guinea, Mali, Senegal, have been operating since the 1980s, often with no more

Box 3.1. **Strength in numbers**

Policy-makers planning to move away from user fees and other forms of direct payments have three interrelated options. The first is to replace direct payments with forms of prepayment, most commonly a combination of taxes and insurance contributions. The second is to consolidate existing pooled funds into larger pools, and the third is to improve the efficiency with which funds are used (this is the topic of Chapter 4).

Prepayment does not necessarily mean that people pay the full costs of the care they will receive, but that they make payments in advance. It means they contribute to a pool that they, or others, can draw on in the event of illness. In some years, they may receive services that cost more than their contributions, and in some years, less.

Whether or not pools are consolidated into one national pool, or kept separate to stimulate competition or to reflect the needs of different regions, is partly a matter of national preference. In most high-income countries, collecting and pooling happens at the level of central government – with the collecting and pooling functions split between the ministry of finance, or the treasury, and the ministry of health. The Republic of Korea, for example, chose to merge more than 300 individual insurers into a single national fund (*59*).

But there are exceptions. Swiss citizens have voted overwhelmingly to keep multiple pools rather than go for a single *caisse unique* and resources are pooled for smaller groups of people (*60*). The Netherlands has had a system of competing funds since the early 1990s (*61*). In both cases, insurance contributions are compulsory and both governments seek to consolidate the pools, at least to some extent, through risk equalization, whereby money is transferred from insurance funds that service a greater proportion of low-risk people to those that insure predominantly high-risk people and thereby incur higher costs.

Nevertheless, experience suggests that a single pool offers several advantages, including greater efficiency (see Chapter 4) and capacity for cross-subsidization within the population. There is strong evidence that fragmented pooling systems without risk equalization can work against equity goals in financing, because each pool has an incentive to enrol low-risk people and the parts of the population that receive more benefits are unwilling to share their pooled funds with the parts of the population that are worse off (*62*).

Risk equalization also takes place when central governments allocate funds for health to lower levels of government or to health facilities in different geographical areas. The people and businesses in richer regions with fewer health problems generally contribute more to the pool in taxes and charges than they receive, while those living in poorer regions with greater health problems receive more than they contribute. Some countries also use complex allocation formulae to decide what are fair allocations to the various geographical areas and facilities (*63*).

than a few hundred members (*64–67*). These schemes are highly localized, often tied to a village or a group of professionals. In Ukraine, for example, individuals have formed so-called sickness funds to help meet the costs of medicines where there is limited budgetary provision to local health facilities. Contributions are usually about 5% of wages and often supplemented by money raised at charitable events. While coverage is small when measured at the national level, the funds play an important role in some small towns with underfunded health facilities (*68*).

In the absence of an effective alternative – a functioning publicly regulated pooling mechanism – such schemes often prove popular among different population groups. A total of 49 health-related community schemes operate in Bangladesh, India and Nepal, with the Indian schemes serving informal workers such as labourers and small farmers. These schemes can have hundreds of thousands of members (*69*), but in relative terms, they are generally too small to function effectively as risk pools, providing only limited coverage for expensive interventions such as surgery. They do, however, offer a degree of protection, covering primary-level care costs, and in some cases, part of the cost of hospitalization; they also familiarize people with prepayment and pooling, and can engender the solidarity needed to build a wider movement towards universal coverage (*70*).

Community health insurance, or microinsurance, can also be an institutional stepping stone to bigger regional schemes, which in turn, can be consolidated into national risk pools, although this almost always requires government encouragement. Many of the countries that have moved closest to universal coverage started with smaller voluntary health insurance schemes that gradually consolidated into compulsory social insurance for specific groups, finally achieving much higher levels of financial risk protection in much larger pools. Voluntary health insurance schemes were important in helping to develop, many years later, universal coverage in Germany and Japan.

More recently, several countries have chosen a more direct route to universal coverage than was followed by Germany and Japan a century ago. Prior to the universal coverage reforms that began in 2001, Thailand ran several separate schemes: the Health Welfare Scheme for the Poor, the Voluntary Health Card scheme, the Civil Servants Medical Benefit Scheme, the Social Security Scheme for the formal sector, and private insurance. Despite rapidly expanding coverage during the 1990s, about 30% of the Thai population was still without coverage in 2001 (*71*). The civil servants scheme also received a much greater government subsidy per member than did the Health Welfare Scheme for the Poor (*72*). In effect, these arrangements increased inequalities.

The universal coverage reform programme of 2001 moved rapidly to reduce the fragmented array of schemes and supply-side subsidies the government made to health facilities. Policy-makers rejected slowly expanding coverage through insurance contributions, recognizing that a large proportion of the people who remained uncovered were in informal employment and many were too poor to contribute insurance payments (*73*). Instead, they replaced the former Health Welfare and Voluntary Health Card schemes, and used general budget revenues that previously flowed to these and to public providers, to create a national pool for what is now called the universal coverage scheme (previously the so-called 30 Baht scheme). The civil servants and the social security schemes remained separate, but the universal coverage scheme still pools funds for nearly 50 million people, and has reduced the proportion of the population without insurance coverage from 30% to less than 4%.

All countries using competing insurers for mandatory coverage use some system of risk equalization to avoid the negative effects of fragmentation. The Czech Republic started with a range of health insurers, but one fund shouldered the burden of a considerably older and poorer client base. In 2003 the government extended its risk equalization mechanism to all compulsory prepaid revenues for health insurance, effectively transferring resources from funds covering low-risk people to those covering higher-risk people. This reform also created a mechanism to compensate insurers for high-cost cases (*74*).

Where and how to cover more people?

In moving towards health financing based on prepayment and pooling, policy-makers must first decide which sections of the population are to be covered. Historically, many of the high-income countries in Europe and also Japan have begun with formal-sector workers, who are easy to identify and whose regular wage income is relatively easy to tax.

However, starting with the formal sector today would risk further fragmentation and inequality rather than move the system towards a large risk pool that enables subsidies to flow from rich to poor, and healthy to sick. Since 1980, perhaps only the Republic of Korea has moved towards universal coverage in this way. In that country, the system evolved under strong government leadership and amid rapid economic growth and high levels (compared with most low- and middle-income countries) of formal-worker participation (*75*, *76*).

Elsewhere, results have been less positive. Typically, groups that initially receive coverage push for increased benefits or reduced contributions, but not to extend coverage to others, especially those unable to contribute. This exacerbates inequalities given that those in formal employment are generally more secure financially than the rest of the population. This was Mexico's experience 15 years ago when different types of pooled funds covered different population groups, each with different levels of benefits (*77–79*). Such arrangements are not only inequitable, but inefficient and costly (*80*, *81*). This was the rationale for the more recent reforms in Mexico aiming to provide more effective coverage to the poorest groups (*82*).

Focusing on the poor

When planning to finance universal coverage, policy-makers must not exclude those who cannot contribute, perhaps because they do not earn

enough to pay income taxes or make insurance contributions. The key issue is whether entitlements should be linked to contributions. Should those who do not contribute financially get free health care? What little research there is on this subject suggests that while most people believe the poor should get help with health-care costs, they also believe such help should stop short of paying for everything (*83*). Each country will see this issue through its own socioeconomic lens, but policy-makers must remember that health financing systems that are perceived to be fair have the best chance at long-term sustainability.

The danger of exclusion is not limited to the sick and the poor. There are the poor in dangerous jobs, for example. In the region where Narin Pintalakarn had his accident, labourers are the people most likely to end up in an intensive care unit or, if no provision has been made to pay for their treatment, in the village morgue.

Whatever system is adopted, some general government revenues will be needed to ensure that the people who cannot afford to contribute can still access health services, by subsidizing their health insurance premiums or by not imposing direct payments, for example. Where the combined total of expenditure from general government revenues and compulsory health insurance contributions is lower than about 5–6% of gross domestic product (GDP), countries struggle to ensure health service coverage for the poor (*84*). The WHO Regional Office for the Americas advocates for a 6% level (*85*, *86*). Only the richer countries achieve this level of compulsory pooling, but countries aiming for universal coverage need to develop strategies for expanding contributions that will cover the poor over time. This can be done in many ways, including subsidizing insurance contributions or providing services at no charge.

While who is to be covered needs careful consideration, where the money comes from – whether from general government revenues, or some form of compulsory health insurance contribution – is less of an issue. In fact, breaking down the options into a tax/social health insurance dichotomy can be unhelpful. In most health financing systems, hybridization prevails, the collection, pooling and expenditure of resources relying on a mix of mechanisms. Sources of revenue do not necessarily determine how funds are pooled or who benefits. Insurance contributions made by employers and/or employees can be put into the same pool as contributions from general government revenues. In the Republic of Moldova, the government introduced its National Health Insurance Company in 2004, drawing on two main sources of funds: a new tax of 4% was levied on wages (increased to 7% in 2009); and general budget revenues that previously flowed to district and national health facilities were redirected to the company (*87*).

Pooling general budget revenues with compulsory insurance contributions virtually eliminated the fragmentation of the decentralized budgetary system and, when combined with a shift from input- to output-based payment methods, led to greater equalization in per capita government health spending across local government areas. There was also a decline in the level of out-of-pocket payment for the poorest 20% of the population (*88*, *89*), though the Republic of Moldova still faces challenges in extending coverage to segments of its population (Box 3.2).

Even Germany, which is regarded as having the world's oldest employment-based social health insurance, has increased the share of general government revenues in the insurance pool. This move was a response to the challenges posed by an ageing population and the resulting dwindling base for wage-linked health insurance contributions. The country has also had to consider the impact of the global economic crisis that began in 2008 on employment and contribution rates. Subsequently, Germany has injected additional funds from general government revenues into the insurance system and reduced wage-based health insurance contribution rates from 15.5% to 14.9% (*91*, *92*).

Other barriers to access

While moving from direct payments to a system of prepayment and pooling helps poorer people obtain care, it does not guarantee access. Direct payments are only one of the financial costs people face in seeking health services, and user fees paid at government facilities can be a small proportion of these costs. Furthermore, financial costs are only one of the potential barriers to care (*93*, *94*). There are cultural and language barriers in societies that are multicultural, for example, where women are prevented from travelling by themselves in some settings.

Results from the World Health Surveys in 39 low- and lower-middle-income countries show than, on average, only 45% of the total out-of-pocket costs of outpatient care were for payments at government facilities, including doctors' fees, medicines and tests (the grey segments in Fig. 3.3). In some countries, it was less than 15%. The remaining 55% represented payments to private facilities, including nongovernmental organizations, and for medicines and tests bought privately (*95*). Offering health services that are free in government facilities only goes part of the way to lowering financial barriers to access; in some countries, it is quite a small part.

Transport can be another major expense, especially in remote rural areas. The same World Health Surveys study of 39 countries showed that transport costs represented, on average, more than 10% of total out-of-pocket payments incurred when people sought health care (*95*). Transport costs can also persuade people to delay treatment (*96*). A prolonged stay in hospital often necessitates accommodation and meals for carers. This, too, adds to the

Box 3.2. The Republic of Moldova entitlement issues

The Republic of Moldova introduced a national system of mandatory health insurance in 2004. Laws stipulate that the economically active population make contributions through a payroll tax, or if self-employed, pay a flat-rate contribution. The remainder of the population, including those registered as unemployed or non-working, is exempt from making contributions and insured by the government, which makes a contribution on their behalf. The shift in the basis of entitlement from being a citizen of the Republic of Moldova to being an individual who pays a premium has meant that about one quarter of the population (27.6% in 2009) has inadequate access to health care. These people, rural agricultural workers for the most part, do have access to life-saving services and a limited number of consultations with primary health care providers, but all other services must be paid for directly, out of pocket (*87*).

Not only did the government demand that these people – many living below the poverty line – pay a premium, that premium is fixed for all self-insured people, including doctors, notaries and lawyers. Another law was passed in February 2009, which ensures that all those registered as poor under the recently approved Law on Social Support will automatically receive fully subsidized health insurance. Coverage concerns were further addressed through legislation approved in December 2009 that expanded significantly (e.g. all primary care) the package of services for all citizens regardless of their insurance status. Despite some persisting equity issues, the centralizing of all public funding for health care and the split between purchasing and providing functions has led to greater geographical equity in government health spending per capita since the health insurance reform was introduced in 2004 (*90*).

cost of treatment (*97*). Even in settings where there are no or limited user fees, transport costs and other direct payments can be a significant impediment to households' receiving timely care (*98*).

There are several ways to overcome these additional financial barriers. One of the most obvious is to invest in primary care, ensuring everyone has inexpensive and easy physical access to services. This was a key factor in Thailand's movement towards universal coverage. Health financing reform was accompanied by a nationwide extension of primary care and a rural health service in which new medical school graduates were required to serve (*99*).

Other countries have opted for gradual reform, using vouchers or conditional cash transfers (CCTs) that give people the financial means to access services and/or undertake some specific health actions, usually linked to prevention (*100*, *101*).

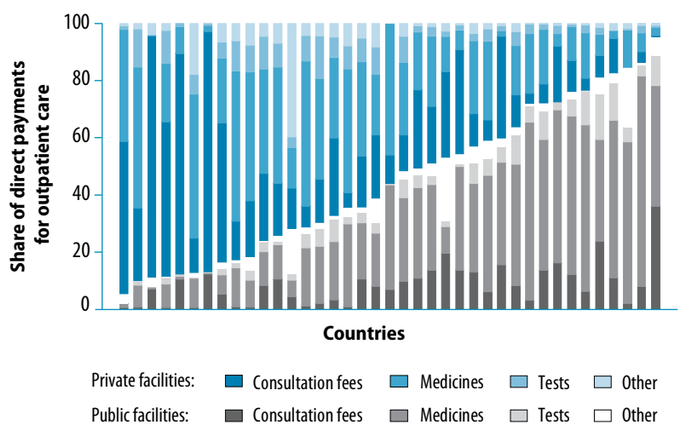
The use of these transfers has been most widespread in Latin America, where they have had some success in Brazil, Colombia, Honduras, Mexico and Nicaragua (*102–104*). In Mexico, the Oportunidades CCT scheme (previously known as Progresa), which started in 1997 and covers 5 million families with almost US$ 4 billion of public spending, has improved child health and reduced infant mortality (*105*, *106*).

CCTs have also been implemented in a range of countries, including Bangladesh, Ecuador, Guatemala, India, Indonesia, Kenya, Nepal, Pakistan, Turkey and the USA. While they have their place in health financing, they are of little use in areas where services are limited or of poor quality, as is the case in much of rural sub-Saharan Africa.

CCTs and voucher schemes to offset the costs and lost income in seeking health care only work if they are targeted in a meaningful way. This means incurring potentially substantial costs and risking inefficiencies, such as leakage to the non-poor, who, because of their education or connections, are better able to exploit such benefits.

However, in areas where the barriers to access are substantial – poor, isolated rural areas, for instance – CCTs and voucher schemes may be the only short-term means to ensure people get the timely care they need.

Fig. 3.3. **Direct payments made at public and private facilities in 39 countries**



Source (*95*).

Conclusion

The past three decades have provided lessons on the failings of direct payments such as user fees in financing health systems. The answer is to move towards a system of prepayment and pooling, sharing the financial risks of ill health across the largest population group possible. This must be carefully planned to avoid exacerbating the desperate situation of many of the world's poor and vulnerable, especially those living in remote areas. Box 3.3 summarizes the evidence presented in this chapter, information that can be used to inform country decision-making.

Long-term goals should be to lower the level of direct payments to below 15–20% of total health expenditure and to increase the proportion of combined government and compulsory insurance expenditure in GDP to about 5–6%. Reaching these targets will take time in some countries, which might set themselves more achievable short-term goals. The transition may seem daunting but great strides have recently been made by many countries, including countries with limited resources.

For those countries unable to generate the funding or lacking the technical capacity to support transition, external financial support will be vital. It is important that this support be given in the spirit of the Paris Declaration, in a way that allows aid recipients to formulate and execute their own national plans according to their priorities. The fragmented manner in which donors channel funds to countries should be avoided. Development partners also need to remember that many of the governments now relying on user fees introduced them in response to external advice and sometimes donors' requirements.

The transition to a system of prepayment and pooling requires action at the national and international level to honour lending commitments made over the past decade. Success will depend to a degree on the sustained mobilization of resources at the level to which governments have committed. Without investment in health services, especially in infrastructure and staff capable of delivering adequate primary-level care, the question of how health care is purchased is irrelevant. No care is no care, however you might want to pay for it.

Finally, even in countries where a system of prepayment and pooling is the norm, there will always be needy people for whom health care really must be free. ■

Box 3.3. **Core ideas for reducing financial barriers**

The key question for today's decision-makers is this: how can we alter our existing health financing system to take advantage of the strength in numbers, or protect the gains that have been made? Here are some core considerations for policy-makers seeking to increase financial protection for the population while reducing barriers to using needed services.

Pooling pays

Countries can make faster progress towards universal coverage by introducing forms of prepayment and pooling to take advantage of the strength in numbers.

Consolidate or compensate

There are opportunities for improving coverage by consolidating fragmented pools, or by developing forms of risk compensation that enable the transfer of funds between them.

Combine tax and social health insurance

Where the funds come from does not have to determine how they are pooled. Taxes and insurance contributions can be combined to cover the population as a whole, rather than being kept in separate funds.

Compulsory contribution helps

Countries that have come closest to universal coverage use some form of compulsory contribution arrangement, whether they are funded by general government revenues or mandatory insurance contributions. This allows the pooled funds to cover the people who cannot pay found in all societies.

Voluntary schemes are a useful first step

Where the wider economic and fiscal context allows for only low levels of tax collection or compulsory insurance contributions, voluntary schemes have the potential to provide some protection against the financial risks of ill health and might help people understand the benefits of prepayment and pooling. But experience suggests that their potential is limited.

Drop direct payment

Only when household direct payments get to 15–20% of total health expenditures does the incidence of financial catastrophe decline to negligible levels, although countries and regions might wish to set themselves intermediate targets as we reported earlier for the South-East Asia and the Western Pacific Regions of WHO.

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