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Executive summary

Why universal coverage?

Promoting and protecting health is essential to human welfare and sustained economic and social development. This was recognized more than 30 years ago by the Alma-Ata Declaration signatories, who noted that Health for All would contribute both to a better quality of life and also to global peace and security.

Not surprisingly, people also rate health one of their highest priorities, in most countries behind only economic concerns, such as unemployment, low wages and a high cost of living (1, 2). As a result, health frequently becomes a political issue as governments try to meet peoples' expectations.

There are many ways to promote and sustain health. Some lie outside the confines of the health sector. The "circumstances in which people grow, live, work, and age" strongly influence how people live and die (3). Education, housing, food and employment all impact on health. Redressing inequalities in these will reduce inequalities in health.

But timely access to health services[a] – a mix of promotion, prevention, treatment and rehabilitation – is also critical. This cannot be achieved, except for a small minority of the population, without a well-functioning health financing system. It determines whether people can afford to use health services when they need them. It determines if the services exist.

Recognizing this, Member States of the World Health Organization (WHO) committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them (4). This goal was defined as universal coverage, sometimes called universal health coverage.

In striving for this goal, governments face three fundamental questions:

1. How is such a health system to be financed?
2. How can they protect people from the financial consequences of ill-health and paying for health services?
3. How can they encourage the optimum use of available resources?

They must also ensure coverage is equitable and establish reliable means to monitor and evaluate progress.

In this report, WHO outlines how countries can modify their financing systems to move more quickly towards universal coverage and to sustain those achievements. The report synthesizes new research and lessons learnt from experience into a set of possible actions that countries at all stages of development can consider and adapt to their own needs. It suggests ways the international community can support efforts in low-income countries to achieve universal coverage.

As the world grapples with economic slowdown, globalization of diseases as well as economies, and growing demands for chronic care that are linked partly to ageing populations, the need for universal health coverage, and a strategy for financing it, has never been greater.

Where are we now?

The World Health Assembly resolution 58.33 from 2005 says everyone should be able to access health services and not be subject to financial hardship in doing so. On both counts, the world is still a long way from universal coverage.

On the service coverage side, the proportion of births attended by a skilled health worker can be as low as 10% in some countries, for example, while it is close to 100% for countries with the lowest rates of maternal mortality. Within countries, similar variations exist. Rich women generally obtain similar levels of coverage, wherever they live, but the poor miss out. Women in the richest 20% of the population are up to 20 times more likely to have a birth attended by a skilled health worker than a poor woman.

Closing this coverage gap between rich and poor in 49 low-income countries would save the lives of more than 700 000 women between now and 2015 (5). In the same vein, rich children live longer than poor ones; closing the coverage gap for a range of services for children under the age of five, particularly routine immunization, would save more than 16 million lives.

But income is not the only factor influencing service coverage. In many settings, migrants, ethnic minorities and indigenous people use services less than other population groups, even though their needs may be greater.

The other side of the coin is that when people do use services, they often incur high, sometimes catastrophic costs in paying for their care.

In some countries, up to 11% of the population suffers this type of severe financial hardship each year, and up to 5% is forced into poverty. Globally, about 150 million people suffer financial catastrophe annually while 100 million are pushed below the poverty line.

The other financial penalty imposed on the ill (and often their carers) is lost income. In most countries, relatives can provide some form of financial support, however small, to family members during periods of illness. More formal financial transfers to protect those too ill to work are less common. Only one in five people in the world has broad-based social security protection that also includes cover for lost wages in the event of illness, and more than half the world's population lacks any type of formal social protection, according to the International Labour Organization (ILO). Only 5–10% of people are covered in sub-Saharan Africa and southern Asia, while in middle-income countries, coverage rates range from 20% to 60%.

Health financing is an important part of broader efforts to ensure social protection in health. As such, WHO is joint lead agency with the ILO in the United Nations initiative to help countries develop a comprehensive Social Protection Floor, which includes the type of financial risk protection discussed in this report and the broader aspects of income replacement and social support in the event of illness (6).

How do we fix this?

Three fundamental, interrelated problems restrict countries from moving closer to universal coverage. The first is the availability of resources. No country, no matter how rich, has been able to ensure that everyone has immediate access to every technology and intervention that may improve their health or prolong their lives.

At the other end of the scale, in the poorest countries, few services are available to all.

The second barrier to universal coverage is an overreliance on direct payments at the time people need care. These include over-the-counter payments for medicines and fees for consultations and procedures. Even if people have some form of health insurance, they may need to contribute in the form of co-payments, co-insurance or deductibles.

The obligation to pay directly for services at the moment of need – whether that payment is made on a formal or informal (under the table) basis – prevents millions of people receiving health care when they need it. For those who do seek treatment, it can result in severe financial hardship, even impoverishment.

The third impediment to a more rapid movement towards universal coverage is the inefficient and inequitable use of resources. At a conservative estimate, 20–40% of health resources are being wasted. Reducing this waste would greatly improve the ability of health systems to provide quality services and improve health. Improved efficiency often makes it easier for the ministry of health to make a case for obtaining additional funding from the ministry of finance.

The path to universal coverage, then, is relatively simple – at least on paper. Countries must raise sufficient funds, reduce the reliance on direct payments to finance services, and improve efficiency and equity. These aspects are discussed in the next sections.

Many low- and middle-income countries have shown over the past decade that moving closer to universal coverage is not the prerogative of high-income countries. For example, Brazil, Chile, China, Mexico, Rwanda and Thailand have recently made great strides in addressing all three problems described above. Gabon has introduced innovative ways to raise funds for health, including a levy on mobile phone use; Cambodia has introduced a health equity fund that covers the health costs of the poor and Lebanon has improved the efficiency and quality of its primary care network.

Meanwhile, it is clear that every country can do more in at least one of the three key areas. Even high-income countries now realize they must continually reassess how they move forward in the face of rising costs and expectations. Germany, for example, has recognized its ageing population means wage and salary earners have declined as a proportion of the total population, making it more difficult to fund its social health insurance system from the traditional sources of wage-based insurance contributions. As a result, the government has injected additional funds from general revenues into the system.

Raising sufficient resources for health

Although domestic financial support for universal coverage will be crucial to its sustainability, it is unrealistic to expect most low-income countries to achieve universal coverage without help in the short term. The international community will need to financially support domestic efforts in the poorest countries to rapidly expand access to services.

For this to happen, it is important to know the likely cost. Recent estimates of the money needed to reach the health Millennium Development Goals (MDGs) and to ensure access to critical interventions, including for noncommunicable diseases in 49 low-income countries, suggest that, on average (unweighted), these countries will need to spend a little more than US$ 60 per capita by 2015, considerably more than the US$ 32 they are currently spending. This 2015 figure includes the cost of expanding the health system so that they can deliver the specified mix of interventions.

The first step to universal coverage, therefore, is to ensure that the poorest countries have these funds and that funding increases consistently over the coming years to enable the necessary scale-up.

But even countries currently spending more than the estimated minimum required cannot relax. Achieving the health MDGs and ensuring access to critical interventions focusing on noncommunicable diseases – the interventions included in the cost estimates reported here – is just the beginning. As the system improves, demands for more services, greater quality and/or higher levels of financial risk protection will inevitably follow. High-income countries are continually seeking funds to satisfy growing demands and expectations from their populations and to pay for rapidly expanding technologies and options for improving health.

All countries have scope to raise more money for health domestically, provided governments and the people commit to doing so. There are three broad ways to do this, plus a fourth option for increasing development aid and making it work better for health.

1. **Increase the efficiency of revenue collection**. Even in some high-income countries, tax avoidance and inefficient tax and insurance premium collection can be serious problems. The practical difficulties in collecting tax and health insurance contributions, particularly in countries with a large informal sector, are well documented. Improving the efficiency of revenue collection will increase the funds that can be used to provide services or buy them on behalf of the population. Indonesia has totally revamped its tax system with substantial benefits for overall government spending, and spending on health in particular.
2. **Reprioritize government budgets**. Governments sometimes give health a relatively low priority when allocating their budgets. For example, few African countries reach the target, agreed to by their heads of state in the 2001 Abuja Declaration, to spend 15% of their government budget on health; 19 of the countries in the region who signed the declaration allocate less now than they did in 2001. The United Republic of Tanzania, however, allots 18.4% to health and Liberia 16.6% (figures that include the contributions of external partners channelled through government, which are difficult to isolate). Taken as a group, the 49 low-income countries could raise an additional US$ 15 billion per year for health from domestic sources by increasing health's share of total government spending to 15%.
3. **Innovative financing**. Attention has until now focused largely on helping rich countries raise more funds for health in poor settings. The high-level Taskforce on Innovative International Financing for Health Systems included increasing taxes on air tickets, foreign exchange transactions and tobacco in its list of ways to raise an additional US$ 10 billion annually for global health. High-, middle- and low-income countries should all consider some of these mechanisms for domestic fundraising. A levy on foreign exchange transactions could raise substantial sums in some countries. India, for example, has a significant foreign exchange market, with daily turnover of US$ 34 billion. A currency transaction levy of 0.005% on this volume of trade could yield about US$ 370 million per year if India felt this path was appropriate. Other options include diaspora bonds (sold to expatriates) and solidarity levies on a range of products and services, such as mobile phone calls. Every tax has some type of distortionary effect on an economy and will be opposed by those with vested interests. Governments will need to implement those that best suit their economies and are likely to have political support. On the other hand, taxes on products that are harmful to health have the dual benefit of improving the health of the population through reduced consumption while raising more funds. A 50% increase in tobacco excise taxes would generate US$ 1.42 billion in additional funds in 22 low-income countries for which data are available. If all of this were allocated to health, it would allow government health spending to increase by more than 25% in several countries, and at the extreme, by 50%. Raising taxes on alcohol to 40% of the retail price could have an even bigger impact. Estimates for 12 low-income countries where data are available show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries. The potential to increase taxation on tobacco and alcohol exists in many countries. Even if only a portion of the proceeds were allocated to health, access to services would be greatly enhanced. Some countries are also considering taxes on other harmful products, such as sugary drinks and foods high in salt or transfats (7, 8).
4. **Development assistance for health.** While all countries, rich or poor, could do more to increase health funding or diversify their funding sources, only eight of the 49 low-income countries described earlier have any chance of generating from domestic sources alone the funds required to achieve the MDGs by 2015. Global solidarity is required. The funding shortfall faced by these low-income countries highlights the need for high-income countries to honour their commitments on official development assistance (ODA), and to back it up with greater effort to improve aid effectiveness. While innovative funding can supplement traditional ODA, if countries were to immediately keep their current international pledges, external funding for health in low-income countries would more than double overnight and the estimated shortfall in funds to reach the MDGs would be virtually eliminated.

Removing financial risks and barriers to access

While having sufficient funding is important, it will be impossible to get close to universal coverage if people suffer financial hardship or are deterred from using services because they have to pay on the spot. When this happens, the sick bear all of the financial risks associated with paying for care. They must decide if they can afford to receive care, and often this means choosing between paying for health services and paying for other essentials, such as food or children's education.

Where fees are charged, everyone pays the same price regardless of their economic status. There is no formal expression of solidarity between the sick and the healthy, or between the rich and the poor. Such systems make it impossible to spread costs over the life-cycle: paying contributions when one is young and healthy and drawing on them in the event of illness later in life. Consequently, the risk of financial catastrophe and impoverishment is high, and achieving universal coverage impossible.

Almost all countries impose some form of direct payment, sometimes called cost sharing, although the poorer the country, the higher the proportion of total expenditure that is financed in this way. The most extreme examples are found in 33 mostly low-income countries, where direct out-of-pocket payments represented more than 50% of total health expenditures in 2007.

The only way to reduce reliance on direct payments is for governments to encourage the risk-pooling, prepayment approach, the path chosen by most of the countries that have come closest to universal coverage. When a population has access to prepayment and pooling mechanisms, the goal of universal health coverage becomes more realistic. These are based on payments made in advance of an illness, pooled in some way and used to fund health services for everyone who is covered – treatment and rehabilitation for the sick and disabled, and prevention and promotion for everyone.

It is only when direct payments fall to 15–20% of total health expenditures that the incidence of financial catastrophe and impoverishment falls to negligible levels. It is a tough target, one that richer countries can aspire to, but other countries may wish to set more modest short-term goals. For example, the countries in the WHO South-East Asia and Western Pacific Regions recently set themselves a target of between 30% and 40%.

The funds can come from a variety of sources – income and wage-based taxes, broader-based value-added taxes or excise taxes on tobacco and alcohol, and/or insurance premiums. The source matters less than the policies developed to administer prepayment systems. Should these contributions be compulsory? Who should pay, how much and when? What should happen to people who cannot afford to contribute financially? Decisions also need to be taken on pooling. Should funds be kept as part of consolidated government revenues, or in one or more health insurance funds, be they social, private, community or micro funds?

Country experience reveals three broad lessons to be considered when formulating such policies.

First, in every country a proportion of the population is too poor to contribute via income taxes or insurance premiums. They will need to be subsidized from pooled funds, generally government revenues. Such assistance can take the form of direct access to government-financed services or through subsidies on their insurance premiums. Those countries whose entire populations have access to a set of services usually have relatively high levels of pooled funds – in the order of 5–6% of gross domestic product (GDP).

Second, contributions need to be compulsory, otherwise the rich and healthy will opt out and there will be insufficient funding to cover the needs of the poor and sick. While voluntary insurance schemes can raise some funds in the absence of widespread prepayment and pooling, and also help to familiarize people with the benefits of insurance, they have a limited ability to cover a range of services for those too poor to pay premiums. Longer-term plans for expanding prepayment and incorporating community and micro-insurance into the broader pool are important.

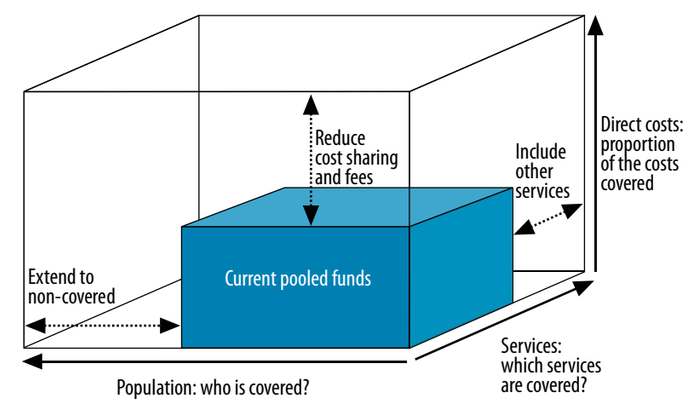
Third, pools that protect the health needs of a small number of people are not viable in the long run. A few episodes of expensive illness will wipe them out. Multiple pools, each with their own administrations and information systems, are also inefficient and make it difficult to achieve equity. Usually, one of the pools will provide high benefits to relatively wealthy people, who will not want to cross-subsidize the costs of poorer, less healthy people.

Cross-subsidization is possible where there are multiple funds, but this requires political will and technical and administrative capacities. In the Netherlands and Switzerland, for example, funds are transferred between insurance schemes that enrol people with few health needs (and who incur lower costs) to those enrolling high-risk people who require more services.

Even where funding is largely prepaid and pooled, there will need to be tradeoffs between the proportions of the population to be covered, the range of services to be made available and the proportion of the total costs to be met (Fig. 1). The box here labelled "current pooled funds" depicts the current situation in a hypothetical country, where about half the population is covered for about half of the possible services, but where less than half the cost of these services is met from pooled funds. To get closer to universal coverage, the country would need to extend coverage to more people, offer more services, and/or pay a greater part of the cost.

In countries with long-standing social health protection mechanisms such as those in Europe, or Japan, the current pooled funds box fills most of the space. But none of the high-income countries

Fig. 1. **Three dimensions to consider when moving towards universal coverage**



Source: Adapted from (9, 10).

that are commonly said to have achieved universal coverage actually covers 100% of the population for 100% of the services available and for 100% of the cost – and with no waiting lists. Each country fills the box in its own way, trading off the proportion of services and the proportion of the costs to be met from pooled funds.

Nevertheless, the entire population in all these countries has the right to use a set of services (prevention, promotion, treatment and rehabilitation). Virtually everyone is protected from severe financial risks thanks to funding mechanisms based on prepayment and pooling. The fundamentals are the same even if the specifics differ, shaped by the interplay of expectations between the population and the health providers, the political environment and the availability of funds.

Countries will take differing paths towards universal coverage, depending on where and how they start, and they will make different choices as they proceed along the three axes outlined in Fig. 1. For example, where all but the elite are excluded from health services, moving quickly towards a system that covers everyone, rich or poor, may be a priority, even if the list of services and the proportion of costs covered by pooled funds is relatively small. Meanwhile, in a broad-based system, with just a few pockets of exclusion, the country may initially take a targeted approach, identifying those that are excluded and taking steps to ensure they are covered. In such cases, they can cover more services to the poor and/or cover a higher proportion of the costs.

Ultimately, universal coverage requires a commitment to covering 100% of the population, and plans to this end need to be developed from the outset even if the objective will not be achieved immediately.

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 and 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 report. 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 drawing on the analysis in this report. 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 over-servicing for those who can afford to pay or whose costs are met from pooled funds (e.g. taxes and insurance), and underservicing 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 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-base 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 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 mix 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 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 captured in the health financing decision process represented in Fig. 2. It is intended as a guide rather than a blueprint, and it should be noted that while the processes we envisage are represented as conceptually discrete, 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.

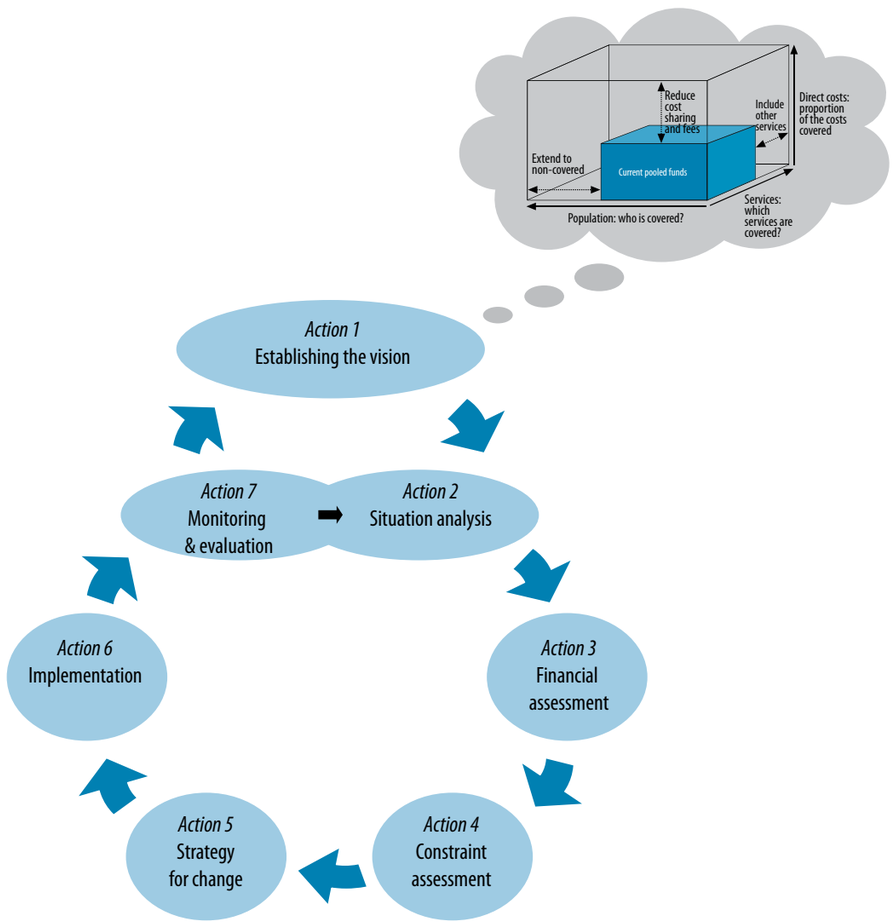
Devising and implementing health finance strategy is a process of continuous adaptation, rather than linear progress towards some notional perfection. It must start with a clear statement of the principles and ideals driving the financing system – an understanding of what universal health coverage means in the particular country. This prepares the ground for the situation analysis (action 2). Action 3 identifies the financial envelope and how this is likely to change over time. It includes consideration of how much people are paying out of pocket and how much is spent in the nongovernmental sector. Action 4 considers the potential constraints on

developing and implementing plans to move closer to universal coverage, while actions 5 and 6 cover the formulation and implementation of detailed strategies.

The cycle, as we envisage it, is completed (action 7) when a country reviews its progress towards its stated goals (action 1), allowing its strategies to be re-evaluated and new plans made to redress any problems. It is a process based on continual learning, the practical realities of the system feeding constant re-evaluation and adjustment.

Health financing systems must adapt, and not just because there is always room for improvement, but because the countries they serve also change: disease patterns evolve, resources ebb and flow, institutions develop or decline.

Fig. 2. **The health financing decision process**



Practical steps for external partners

As noted above, many of the poorest countries will be unable for many years to finance a system of universal coverage – even one with a modest set of health services – from their own domestic resources. To allow the poorest countries to scale up more rapidly, external partners will need to increase contributions to meet their previously agreed international commitments. This act alone would close almost all the financing gap identified for 49 low-income countries earlier, and save more than 3 million additional lives before 2015.

Traditional ODA can be supplemented by innovative sources of funding. As the high-level taskforce suggested, some of the innovative ways to raise funds discussed earlier could also be applied at the international level. Some are already being implemented, as evidenced by the Millennium Foundation's MassiveGood campaign. Many innovative financing mechanisms do not require international consensus. If each high-income country introduced just one of the options that have been discussed, it could raise serious levels of additional funding to support a more rapid movement towards universal coverage in the countries most in need.

External partners could also help to strengthen the financing systems in recipient countries. Donors currently use multiple funding channels that add considerably to the transaction costs at both the country and international level. Harmonizing systems would put an end to the many auditing, monitoring and evaluation mechanisms competing with domestic systems for accountants, auditors, and actuaries. It would also free health ministry and other government staff to spend more time extending health coverage.

The international community has made progress by adopting the Paris Declaration on Aid Effectiveness and the subsequent Accra Agenda for Action. The International Health Partnership and related initiatives seek to implement the principles laid out in the declaration and the agenda. However, much remains to be done. Viet Nam reports that in 2009 there were more than 400 donor missions to review health projects or the health sector. Rwanda has to report annually on 890 health indicators to various donors, 595 relating to HIV and malaria alone while new global initiatives with secretariats are being created.

A message of hope

The first key message of this 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 actions 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.

The principles are well established. Lessons have been learned from the countries that have put these principles into practice. Now is the time to take those lessons and build on them, for there is scope for every country to do something to speed up or sustain progress towards universal coverage. ■

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End notes

a In this report, the term "health services" is used to include promotion, prevention, treatment and rehabilitation. It includes services aimed at individuals (e.g. childhood immunization or treatment for tuberculosis) and services aimed at populations (e.g. mass media anti-smoking campaigns).