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Key messages

- Improving health is critical to human welfare and essential to sustained economic and social development. Reaching the "highest attainable standard of health," as stated in the WHO Constitution, requires a new or continued drive towards universal coverage in many countries, and strong actions to protect the gains that have been achieved in others.
- To achieve universal health coverage, countries need financing systems that enable people to use all types of health services – promotion, prevention, treatment and rehabilitation – without incurring financial hardship.
- Today, millions of people cannot use health services because they have to pay for them at the time they receive them. And many of those who do use services suffer financial hardship, or are even impoverished, because they have to pay.
- Moving away from direct payments at the time services are received to prepayment is an important step to averting the financial hardship associated with paying for health services. Pooling the resulting funds increases access to needed services, and spreads the financial risks of ill health across the population.
- Pooled funds will never be able to cover 100% of the population for 100% of the costs and 100% of needed services. Countries will still have to make hard choices about how best to use these funds.
- Globally, we are a long way from achieving universal health coverage. But countries at all income levels have recently made important progress towards that goal by raising more funds for health, pooling them more effectively to spread financial risks, and becoming more efficient.

1

Where are we now?

The accident happened on 7 October 2006. Narin Pintalakarn came off his motorcycle going into a bend. He struck a tree, his unprotected head taking the full force of the impact. Passing motorists found him some time later and took him to a nearby hospital. Doctors diagnosed severe head injury and referred him to the trauma centre, 65 km away, where the diagnosis was confirmed. A scan showed subdural haematoma with subfalcine and uncal herniation. Pintalakarn's skull had fractured in several places. His brain had bulged and shifted, and was still bleeding; the doctors decided to operate. He was wheeled into an emergency department where a surgeon removed part of his skull to relieve pressure. A blood clot was also removed. Five hours later, the patient was put on a respirator and taken to the intensive care unit where he stayed for 21 days. Thirty-nine days after being admitted to hospital, he had recovered sufficiently to be discharged.

What is remarkable about this story is not what it says about the power of modern medicine to repair a broken body; it is remarkable because the episode took place not in a country belonging to the Organisation for Economic Co-operation and Development (OECD), where annual per capita expenditure on health averages close to US$ 4000, but in Thailand, a country that spends US$ 136 per capita, just 3.7% of its gross domestic product (GDP) (*1*). Nor did the patient belong to the ruling elite, the type of person who – as this report shall show – tends to get good treatment wherever they live. Pintalakarn was a casual labourer, earning only US$ 5 a day.

"Thai legislation demands that all injured patients be taken care of with standard procedure no matter what their status," says Dr Witaya Chadbunchachai, the surgeon who carried out the craniotomy on Pintalakarn at the Khon Kaen Regional Hospital in the country's north-eastern province. According to Chadbunchachai, medical staff do not consider who is going to pay for treatment, however expensive it might be, because in Thailand, everyone's health-care costs are covered.

At a time when many countries, including major economic powers such as China and the United States of America, are reviewing the way they meet the health-care needs of their populations, universal health coverage – what is it, how much does it cost and how is it to be paid for? – dominates discussions on health service provision. In this world health report, we examine the issue from the financing perspective, and suggest ways in which all countries, rich and poor, can improve access to good quality health services without people experiencing financial hardship because they must pay for care (Box 1.1).

The three critical areas of health financing are:

1. raise sufficient money for health;
2. remove financial barriers to access and reduce financial risks of illness;
3. make better use of the available resources (Box 1.1 provides details).

Box 1.1. What a health financing system does: a technical explanation

Health financing is much more than a matter of raising money for health. It is also a matter of who is asked to pay, when they pay, and how the money raised is spent.

Revenue collection is what most people associate with health financing: the way money is raised to pay health system costs. Money is typically received from households, organizations or companies, and sometimes from contributors outside the country (called "external sources"). Resources can be collected through general or specific taxation; compulsory or voluntary health insurance contributions; direct out-of-pocket payments, such as user fees; and donations.

Pooling is the accumulation and management of financial resources to ensure that the financial risk of having to pay for health care is borne by all members of the pool and not by the individuals who fall ill. The main purpose of pooling is to spread the financial risk associated with the need to use health services. If funds are to be pooled, they have to be *prepaid*, before the illness occurs – through taxes and/or insurance, for example. Most health financing systems include an element of pooling funded by prepayment, combined with direct payments from individuals to service providers, sometimes called *cost-sharing*.

Purchasing is the process of paying for health services. There are three main ways to do this. One is for government to provide budgets directly to its own health service providers (integration of purchasing and provision) using general government revenues and, sometimes, insurance contributions. The second is for an institutionally separate purchasing agency (e.g. a health insurance fund or government authority) to purchase services on behalf of a population (a purchaser-provider split). The third is for individuals to pay a provider directly for services. Many countries use a combination.

Within these broad areas, health service providers can be paid in many different ways, discussed more fully in Chapter 4. Purchasing also includes deciding which services should be financed, including the mix between prevention, promotion, treatment and rehabilitation. This is addressed further in Chapter 2.

Labels can be misleading. Each country makes different choices about how to raise revenues, how to pool them and how to purchase services. The fact that several countries decide to raise part of the revenue for health from compulsory health insurance premiums does not mean that they all pool the funds in the same way. Some countries have a single pool – e.g. a national health insurance fund – while others have multiple, sometimes competing pools managed by private insurance companies. Even when countries have similar pooling systems, their choices about how to provide or purchase services vary considerably. Two systems based largely on health insurance may operate differently in how they pool funds and use them to ensure that people can access services; the same applies to two systems that are described as tax-based. This is why the traditional categorization of financing systems into tax-based and social health insurance – or Beveridge versus Bismarck – is no longer useful for policy-making.

It is much more important to consider the choices to be made at each step along the path, from raising revenues, to pooling them, to spending them. These are the choices that determine whether a financing system is going to be effective, efficient and equitable, choices that are described in the subsequent chapters.

People at the centre. In all of this technical work, it is important to remember that people are at the centre. On the one hand, they provide the funds required to pay for services. On the other, the only reason for raising these funds is to improve people's health and welfare. Health financing is a means to an end, not an end in itself.

Health services cost money. One way or another, doctors and nurses, medicines and hospitals have to be paid for. Today, global annual expenditure on health is about US$ 5.3 trillion (*1*). With the burden of communicable diseases remaining stubbornly high in some parts of the world, and the prevalence of noncommunicable diseases – heart disease, cancers and chronic conditions such as obesity – increasing everywhere, health costs can only continue to rise. This trend will be exacerbated by the more sophisticated medicines and procedures being developed to treat them.

It would seem logical, therefore, that richer countries are better able to provide affordable health services. Indeed, the countries that have come closest to achieving universal coverage do generally have more to spend on health. OECD countries, for example, represent only 18% of the global population but account for 86% of the world's health spending; few OECD countries spend less than US$ 2900 per person each year.

But it is not always the case that lower-income countries have less coverage. Thailand is a striking example of a country that has vastly improved service coverage and protection against the financial risks of ill health despite spending much less on health than higher-income countries. It has done this by changing the way it raises funds for health and moving away from direct payments, such as user fees (Box 1.2). This is perhaps the most crucial element of developing financing systems for universal coverage; many countries still rely too heavily on direct payments from individuals to health service providers to fund their health systems.

Direct payments

Direct payments have serious repercussions for health. Making people pay at the point of delivery discourages them from using services (particularly health promotion and prevention), and encourages them to postpone health checks. This means they do not receive treatment early, when the prospects for cure are greatest. It has been estimated that a high proportion of the world's 1.3 billion poor have no access to health services simply because they cannot afford to pay at the time they need them (*2*). They risk being pushed into poverty, or further into poverty, because they are too ill to work.

Box 1.2. What are direct payments?

In health, charges or fees are commonly levied for consultations with health professionals, medical or investigative procedures, medicines and other supplies, and for laboratory tests.

Depending on the country, they are levied by government, nongovernmental organizations, faith-based and private health facilities.

They are sometimes officially sanctioned charges and sometimes unofficial or so-called "under-the-table" payments. Sometimes both co-exist.

Even where these charges are covered by insurance, patients are generally required to share the costs, typically in the form of co-insurance, co-payments and/or deductibles – payments the insured person has to make directly out of pocket at the time they use services because these costs are not covered by the insurance plan.

Deductibles are the amount of expenses that must be paid out of pocket before an insurer will cover any expenses at all. Co-insurance reflects the proportion of subsequent costs that must be met out of pocket by the person who is covered, while co-payments are set as a fixed amount the beneficiary must pay for each service.

We use the term *direct payments* to capture all these elements. However, because the term *out-of-pocket payments* is often used to capture the same ideas, we use the two terms interchangeably.

Direct payments also hurt household finances. Many people who do seek treatment, and have to pay for it at the point of delivery, suffer severe financial difficulties as a consequence (*3–6*). Estimates of the number of people who suffer financial catastrophe (defined as paying more than 40% of household income directly on health care after basic needs have been met) are available for 89 countries, covering nearly 90% of the world's population (*7*). In some countries, up to 11% of people suffer this type of severe financial hardship each year and up to 5% are forced into poverty because they must pay for health services at the time they receive them. Recent studies show that these out-of-pocket health payments pushed 100 000 households in both Kenya and Senegal below the poverty line in a single year. About 290 000 experienced the same fate in South Africa (*8*).

Financial catastrophe occurs in countries at all income levels, but is greatest in those that rely the most on direct payments to raise funds for health (*9*). Worldwide, about 150 million people a year face catastrophic health-care costs because of direct payments such as user fees, while 100 million are driven below the poverty line (*7*).

Catastrophic health spending is not necessarily caused by high-cost medical procedures or one single expensive event. For many households, relatively small payments can also result in financial catastrophe (*10*). A steady drip of medical bills can force people with chronic disease or disabilities, for example, into poverty (*11–13*).

Not only do out-of-pocket payments deter people from using health services and cause financial stress, they also cause inefficiency and inequity in the way resources are used. They encourage overuse by people who can pay and underuse by those who cannot (Box 1.3).

Pooled funds

Progress towards universal coverage depends on raising adequate funds from a sufficiently large pool of individuals, supplemented where necessary with donor support and general government revenues, and spending these funds on the services a population needs. The more people who share the financial risk in this way, the lower the financial risk to which any one individual is exposed. In general, the bigger the pool, the better able it is to cope with financial risks. Using the same reasoning, pools with only a few participants are likely to experience what actuaries term "extreme fluctuations in utilization and claims" (*16*).

For a pool to exist, money must be put into it, which is why a system of prepayment is required. Prepayment simply means that people pay before they are sick, then draw on the pooled funds when they fall ill. There are different ways of organizing prepayment for the people who can afford to pay (see Chapter 3) but in all countries there will be people who are unable to contribute financially. The countries that have come closest to achieving universal health coverage use tax revenue to cover the health needs to these people, ensuring that everyone can access services when they need them.

Countries are at different points on the path to universal coverage and at different stages of developing financing systems. Rwanda, for example, has a tax system that is still developing, and three robust health insurance organizations (Box 1.4). It may decide to build larger pools by merging the individual funds at a later date.

External assistance

In lower-income countries, where prepayment structures may be underdeveloped or inefficient and where health needs are massive, there are many obstacles to raising sufficient funds through prepayment and pooling. It is essential, therefore, that international donors lend their support. Investing in the development of prepayment and pooling, as opposed to simply funding projects or programmes through separate channels, is one of the best ways donors can help countries move away from user fees and improve access to health care and financial risk protection (*21*, *22*).

Over the past five years, many bilateral agencies have begun to help countries develop their health financing systems, with a view to achieving universal coverage. These agencies have also started to determine how their external financial assistance can support, rather than hinder this process. This is reflected in the adoption of the Paris Declaration on Aid Effectiveness and the subsequent Accra Action Agenda. The International Health Partnership and related initiatives seek to implement these principles into practice in the health sector, with the aim to mobilize donor countries and other development partners around a single, country-led national health strategy (*23*, *24*).

Box 1.3. Financing for universal health coverage

Financing systems need to be specifically designed to:

- provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective;
- ensure that the use of these services does not expose the user to financial hardship (*14*).

In 2005, the World Health Assembly unanimously adopted a resolution urging countries to develop their health financing systems to achieve these two goals, defined then as achieving universal coverage (*15*). The more that countries rely on direct payments, such as user-fees, to fund their health systems, the more difficult is it to meet these two objectives.

On the path to universal coverage

Many countries are reforming the way they finance health care as they move towards universal coverage, among them two of the most important global economies, China and the United States of America.

In April 2009, the Chinese government announced plans to provide "safe, effective, convenient and affordable" health services to all urban and rural residents by 2020 (*25*). If fully implemented, the reform will end market-based mechanisms for health that were introduced in 1978. Prior to then, the government had offered basic but essentially free health-care services to the entire population, but the new market-based approach resulted in a major increase in direct payments – from little more than 20% of all health spending in 1980 to 60% in 2000 – leaving many people facing catastrophic health-care costs. The new approach also meant that hospitals had to survive on patient fees, which put pressure on doctors to prescribe medicines and treatment based on their revenue-generating potential rather than their clinical efficacy.

The government took steps to address these issues. The New Cooperative Medical Schemes, initiated in 2003 to meet the needs of rural populations, and the Urban Residents Basic Medical Insurance scheme, piloted in 79 cities in 2007, are at the heart of the latest reforms. The government aims to reduce dependence on direct payments and increase the proportion of the population covered by formal insurance from 15% in 2003 to 90% by 2011, and to expand access to services and financial risk protection over time (*26*).

The recent health financing reforms in the United States will extend insurance coverage to a projected 32 million previously uninsured people by 2019 (*27*). Numerous strategies will be used to achieve this goal. Private insurers will no longer be able to reject applicants based on health status, for example, and low-income individuals and families will have their premiums subsidized (*28*).

Many low- to middle-income countries have also made significant progress developing their financing systems towards universal coverage.

Box 1.4. Sharing the risk of sickness: mutual health insurance in Rwanda

The Rwandan government reports that 91% of the country's population belongs to one of three principal health insurance schemes (*17*). The first, the *Rwandaise assurance maladie*, is a compulsory social health insurance scheme for government employees that is also open to private-sector employees on a voluntary basis. The second, the Military Medical Insurance scheme, covers the needs of all military personnel. The third, and most important for population coverage, is the cluster of *Assurances maladies communautaires* – mutual insurance schemes whose members predominantly live in rural settings and work in the informal sector. These mutual insurance schemes have expanded rapidly over the past 10 years, and now cover more than 80% of the population. About 50% of mutual insurance scheme funding comes from member premiums, the other half being subsidized by the government through a mix of general tax revenues and donor support (*18*).

The insurance schemes do not cover all health costs: households still have to pay a proportion of their costs out of pocket and the range of services available is clearly not as extensive as in richer countries. Nevertheless, they have had a marked impact. Per capita spending on health went up from US$ 11 in 1999 to US$ 37 in 2007; the increasing proportion of the population covered by some form of health insurance has translated into increased uptake of health services, and, most important of all, to improvements in health outcomes measured, for example, by declines in child mortality (*19*).

At an early stage of its development, challenges still exist. These include: making contributions more affordable for the poorest; increasing the range of services offered and the proportion of total costs covered; and improving financial management. Rwanda is also working to harmonize the different financing mechanisms, partly through the development of a national legal framework governing social health insurance (*20*).

These include well-known examples, such as Chile (*29*), Colombia (*6*), Cuba (*30*), Rwanda (*20*), Sri Lanka (*31*) and Thailand (*32*), but also Brazil (*33*), Costa Rica (*34*), Ghana (*35*), Kyrgyzstan (*36*), Mongolia (*37*) and the Republic of Moldova (*38*). At the same time, Gabon (*39*), the Lao People's Democratic Republic (*40*), Mali (*41*), the Philippines (*42*), Tunisia (*43*) and Viet Nam (*44*) have expanded various forms of prepayment and pooling to increase financial risk protection, particularly for the poor.

At the other end of the income scale, 27 OECD countries cover all their citizens with a set of interventions from pooled funds, while two others – Mexico, with its *Seguro Popular* voluntary health insurance scheme, and Turkey, with its Health Transformation Programme – are moving towards it (*45–47*).

Each of these countries has moved towards universal coverage in different ways and at different speeds. Sometimes their systems have evolved over long periods, often in the face of opposition; sometimes the path has been shorter and quicker (*21*, *48*).

The Republic of Korea, for example, started its journey in the early 1960s. Early investment focused on building infrastructure, but the programme expanded significantly in 1977 with vigorous high-level political support (*49*). Steady expansion of employer-based health-care schemes followed, starting with companies employing more than 500 staff, moving down the corporate chain to companies employing just 16, and more recently to those with only one full-time employee. Civil servants and teachers were brought into the scheme in 1981 and played a key role in raising awareness in the rest of the population. This, in turn, helped put universal coverage at the heart of the political agenda in 1988, when enrolment in social welfare programmes was a core issue in the presidential campaign. In 1989, coverage was extended to the remaining population – the indigent, the self-employed and rural residents (*50*). Since then, the system has sought to expand both the range of services offered and the proportion of the costs covered by the insurance system.

Sustaining existing achievements

Moving more rapidly towards universal coverage is one challenge, but sustaining gains already made can be equally difficult. Several countries have adapted their financing systems in the face of changing circumstances. Ghana, for example, began after independence in 1957 to provide medical care to its population free at the point of service through government-funded facilities. It abandoned this system in the early 1980s in the face of severe resource constraints, before introducing a form of national insurance more recently (Box 1.5).

Chile, too, has gone through different phases. After running a state-funded national health service for 30 years, it opted in 2000 for a mixed public/private approach to health insurance, guaranteeing universal access to quality treatment for a set of explicitly defined conditions. The number of conditions has expanded over time and the poor have been the major beneficiaries (*29*).

All countries face increasing demands for better services, disease threats and a growing list of often expensive technologies and medicines to maintain or improve health. Costs continually rise faster than national income, putting pressure on governments to restrain costs.

Box 1.5. Ghana: different phases of health financing reforms

After independence in 1957, Ghana provided medical care to its population through a network of primary-care facilities. The system was financed through general taxation and received a degree of external donor support. No fees were charged for services. In the 1980s, faced with worsening economic conditions, the country liberalized its health sector as part of broader structural reforms. Liberalization led to an explosion in the number of private health-care providers, which, combined with the introduction of fees to cover part of the costs of government facilities, led to a sharp drop in the use of health services, particularly among the poor. Those people who did seek treatment paid out of their own pocket often risked financial ruin as a result (*51*).

More recently, out-of-pocket payment has started to decrease as a proportion of total health expenditure as the country tries to reverse these developments. The process began with exemptions from user fees for diseases such as leprosy and tuberculosis, and for immunization and antenatal care. Ghana also waives fees for people with extremely low incomes. A National Health Insurance Scheme was introduced in 2004 and by June 2009, 67.5% of the population had registered (*35*). During the 2005–2008 period, national outpatient-care visits increased by 50%, from about 12 million to 18 million, while inpatient-care admissions increased by 6.3%, from 0.8 million to about 0.85 million.

For the time being, each of the district mutual health insurance schemes that comprise the national scheme effectively constitutes a separate risk pool. Fragmentation is thus a continuing problem, as is sustainability, but Ghana is committed to redressing the move away from universal coverage over the past few decades.

Universal coverage: the two prongs

Many countries, at varying stages of economic development, have shown it is possible to make substantial progress towards universal coverage. Nevertheless, the world as a whole still has a long way to go. To learn where we stand today, we must focus on the two key elements of universal health coverage described earlier: financial access to crucial health services; and the extent of financial risk protection provided to the people who use them (Box 1.3).

As mentioned earlier, an estimated 150 million people globally suffer financial catastrophe each year and 100 million are pushed into poverty because of direct payments for health services. This indicates a widespread lack of financial risk protection – a deficiency that affects low-income countries most, but is by no means limited to them. In six of the OECD countries, more than 1% of the population, or almost four million people, suffers catastrophic spending, while the incidence exceeds five per 1000 people in another five (*7*).

Furthermore, medical debt is the principal cause of personal bankruptcy in the USA. Harvard researchers in 2008 concluded that illness or medical bills had contributed to 62% of bankruptcies the previous year (*52*). Many of these people had some form of health insurance, but the benefits offered were insufficient to protect them against high out-of-pocket expenses. This development is not linked to the recent economic recession; medical bills were already the cause of 50% of bankruptcies in the USA in 2001.

On a global scale, medical bankruptcies are not yet a major concern, either because financial access to care is adequate or because formal credit is out of the reach of most of the population (*53*, *54*). However, if direct payments remain high and access to credit increases, this is likely to become a problem.

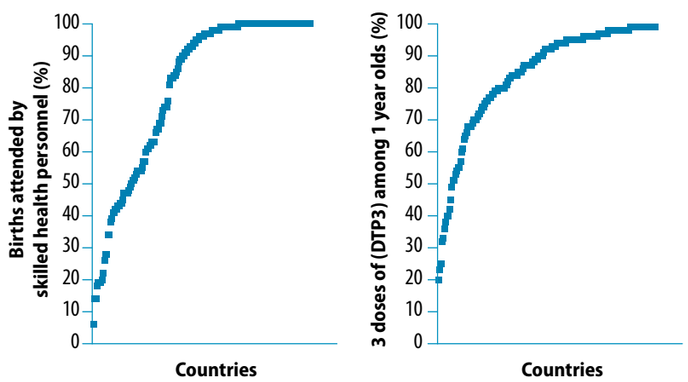
The reduction in the incidence of financial hardship associated with direct payments is a key indicator of progress towards universal coverage. However, country studies sometimes indicate little financial catastrophe or impoverishment of this nature among the most poor, because they simply cannot afford to use health services (*55*, *56*). The extent to which people are able to use needed services is, therefore, also an important indicator of the health of the financing system.

Data on financial access to health services are scarce, but there is information on coverage for some key interventions. This provides clues on the extent to which financial barriers prevent people from using services. For example, immunizing children under one year of age with the diphtheria–tetanus–pertussis vaccine (DTP3) saves many of their lives, while having skilled health personnel attend births is crucial to saving the lives of both new-borns and mothers. Information on the proportion of children fully immunized with DTP3 and the proportion of births attended by skilled health personnel is widely reported.

Fig. 1.1 shows reported coverage for both of these interventions, with each data point representing a country, ordered from lowest to highest on the horizontal axis. Many countries achieve, or almost achieve, 100% coverage for both interventions, though there is considerable variation across countries. At one extreme, in 16 countries, fewer than 40% of women deliver babies in the presence of a skilled health worker capable of saving their lives in the event of a complication. In seven countries, DTP3 immunization coverage is lower than 40%. This suggests that inequalities in coverage are substantial across countries and greater for services that require more infrastructure and skilled workers (such as childbirth) than for other interventions (such as vaccinations) (*57*).

Inequalities in coverage (and health outcomes) also exist within countries. Demographic and Health Surveys reveal substantial differences between income groups in many lower-income countries. Again, bigger discrepancies occur in access to skilled health workers during child delivery than in childhood immunization. With few exceptions, the richest people in even low-income countries enjoy access to services similar to that available in high-income countries. The poor, however, are almost always more deprived than the rich, though the extent varies. In some settings, coverage of DTP3 among the poor can be as low as 10% of that for the rich (*58*).

Fig. 1.1. **Coverage of births attended by skilled health personnel and diphtheria–tetanus–pertussis (DTP3) vaccination by country, latest available year[a]**



[a] Ordered from lowest to highest coverage.
Source: *(19)*.

The use of health services also varies substantially across and within countries (*59*, *60*). Data from the 52 countries included in the World Health Survey, spanning all income levels, showed that usage during a four-week period before the survey ranged from less than 10% of the population to more than 30% (*58*). In some settings, the rich reported using these services more than twice as much as the poor, despite the fact the poor need them much more.

While the data cited give an indication of coverage, they offer no insight into the quality of care. What evidence does exist suggests that the inequalities are even more pronounced in the standard of service provided. In other words, poor people in poor countries are not only largely excluded from these services, but when they do receive care, it is likely to be of a lower quality than that provided to richer people (*61*).

These broad indications offer a sobering picture, one in which millions of people, predominantly poor, cannot use the services they need, while millions more face severe financial difficulty as a result of paying for health services. Clearly, the reasons for low and unequal coverage do not all lie in the financing system, but we argue in this report that coverage could be considerably higher if there were additional funds, less reliance on direct payments to raise funds and more efficiency – all financing issues.

Several countries increase financial risk protection beyond that afforded by the health financing system by providing an element of financial security when people cannot work for health reasons – because they are sick or have had a baby. The International Labour Organization (ILO) collates information on the right to paid sick leave in the event of illness as well as on the right to paid maternity leave. In 2007, 145 countries provided the right to paid sick leave, although the duration of leave and income compensation differed markedly. Only 20% of those countries replaced 100% of the lost income, with the majority offering 50–75%. Most countries allow a month or more of paid sick leave each year for severe illness, but more than 40 limit payments to less than a month (*62*).

Most industrialized countries offer the right to paid maternity leave for formal sector employees, but the duration of leave and the nature of the payments also vary substantially. And even though there is a theoretical right to paid maternity leave, few low- and middle-income countries report any financial support for eligible women (Box 1.6).

Financial protection against work incapacity due to illness or pregnancy is generally available only to formal-sector workers. Typically in low-income countries, more than 50% of the working-age population works in the informal sector without access to income replacement at these times (*63*).

Although this report focuses on financial risk protection linked to the need to pay for health services, this is an important part of broader efforts to ensure social protection in health. As such, WHO is a joint sponsor with the ILO and an active participant in the United Nations initiative to help countries develop comprehensive Social Protection Floors. These include the type of financial risk protection discussed

Box 1.6. **Financial risk protection and income replacement: maternity leave**

The core element of maternity protection, which guarantees women a period of rest when a child is born (along with the means to support herself and her family and a guarantee of being able to resume work afterwards) is the cash benefit that substitutes the regular income of the mother during a defined period of pregnancy and after childbirth. The cash benefits do not usually replace prior income, but are nonetheless an important social protection measure without which pregnancy and childbirth could pose financial hardships for many families. Maternity leave and the income replacement system that comes with it can also have indirect health consequences; without these measures, women may feel compelled to return to work too quickly after childbirth, before it is medically advisable to do so.

Most industrialized countries allocate considerable resources for maternity leave. In 2007, Norway spent more than any other, allocating US$ 31 000 per baby, per year, for a total US$ 1.8 billion. In contrast most low- and middle-income countries report zero spending on maternal leave, despite the fact that several have enacted legislation guaranteeing it. This may be due to laws going unenforced but may also be explained by the fact that in some countries, maternity leave does not come with any income replacement element.

Source: International Labour Organization.

in this report and the broader aspects of income replacement and social support in the event of illness (*64*).

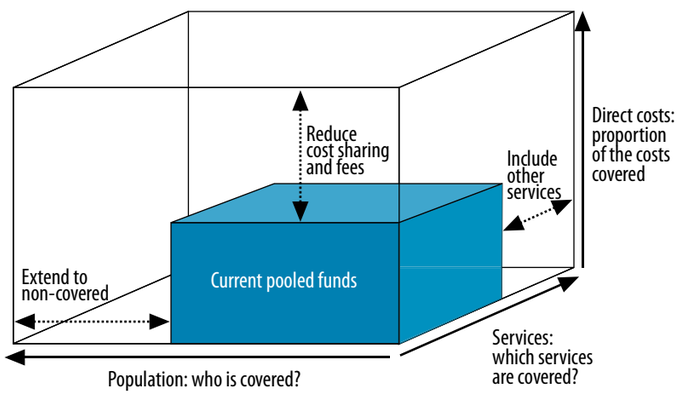
Making the right choices

There is no single way to develop a financing system to achieve universal coverage. All countries must make choices and trade-offs, particularly in the way that pooled funds are used. It is a constant challenge to balance priorities: funds often remain scarce, yet people demand more and the technologies for improving health are constantly expanding. Such conflicts force policy-makers to make trade-offs in three core areas (Fig. 1.2): the proportion of the population to be covered; the range of services to be made available; and the proportion of the total costs to be met.

The box here labelled "current pooled funds" depicts the situation in a hypothetical country where about half the population is covered for about half the possible services, but where less than half of 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 from pooled funds.

In European countries with long-established social health protection, this "current pooled funds" box fills almost the entire space. But in none of the high-income countries that are commonly said to have achieved universal coverage is 100% of the population covered for 100% of the services that could be made available and for 100% of the cost, with no waiting lists. Each country fills the box in its own way, trading off services and the costs met from pooled funds. Waiting times for services may vary greatly from one country to another, some expensive services might not be provided and citizens may contribute a different proportion of the costs in the form of direct payments.

Fig. 1.2. **Three dimensions to consider when moving towards universal coverage**



Source: adapted from (*21*, *65*).

Nevertheless, everyone in these countries has access to a set of services (prevention, promotion, treatment and rehabilitation) and nearly everyone is protected from severe financial risks thanks to prepayment and pooling of funds. The fundamentals are the same even if the specifics differ, shaped by the expectations of the population and the health providers, the political environment and the availability of funds.

Countries will travel different paths towards universal coverage, depending on where and how they start, and make different choices along the three axes outlined in Fig. 1.2. For example, in settings where all but the elite are currently 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 proportion of costs covered by pooled funds will be relatively small (*21*, *66*). Meanwhile, in a broad-based system, with just a few pockets of exclusion, the country may initially opt for 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.

Many countries setting out on the path to universal coverage begin by targeting groups employed in the so-called formal sector because these groups are more easily identified. But there are downsides to this targeted approach: it can lead to two-tier systems and make conditions worse for those left uncovered; and by achieving partial success, it can slow the impetus for more fundamental reform.

These issues will be taken up in more detail in Chapter 3.

Moving forward

WHO's Constitution describes the fundamental right of every human being to enjoy "the highest attainable standard of health". Universal coverage is the best way to attain that right. It is fundamental to the principle of Health for All set out more than 30 years ago in the Declaration of Alma-Ata. The declaration recognized that promoting and protecting health were also essential to sustained economic and social development, contributing to a better quality of life, social security and peace. The principle of universal coverage was reaffirmed in *The world health report 2008* on primary health care and the subsequent World Health Assembly resolution (*67*), and it was espoused by the 2008 Commission on Social Determinants of Health and the subsequent World Health Assembly resolution on that topic (*68*).

This report reiterates these long-standing beliefs, beliefs that have deepened as countries struggle with their health financing systems. While addressing technical issues related specifically to financing health systems, the report puts fairness and humanity at the heart of the matter. The focus is practical, and optimistic: all countries, at all stages of development, can take steps to move faster towards universal coverage and to maintain their achievements.

In preparing a path towards universal coverage, there are three points to remember.

1. Health systems are "complex adaptive systems" in which relationships are not predictable and components interact in unexpected ways. Participants in the system need to learn and adapt constantly, often in the face of resistance to change (*69*). Even though we offer various routes to universal coverage, countries will need to expect the unexpected.
2. Planning a course towards universal coverage requires countries to first take stock of their current situation. Is there sufficient political and community commitment to achieving and maintaining universal health coverage? This question will mean different things in different contexts but will draw out the prevailing attitudes to social solidarity and self-reliance. A degree of social solidarity is required to develop universal

health coverage, given that any effective system of financial protection for the whole population relies on the readiness of the rich to subsidize the poor, and the healthy to subsidize the sick. Recent research suggests that most, if not all, societies do have a concept of social solidarity when it comes to access to health services and health-care costs, although the nature and extent of these feelings varies across settings (*70*). Put another way, every society has a notion of social justice that puts a limit on how much inequality is acceptable (*71*).

3. Policy-makers then need to decide what proportion of costs will come from pooled funds in the longer run, and how to balance the inevitable tradeoffs in their use – tradeoffs between the proportion of the population, services and costs that can be covered. For those countries focused on maintaining their hard-won gains, continual monitoring and adaptation will be crucial in the face of rapidly developing technologies and changing age structures and disease patterns.

The next three chapters outline practical ways to:

- raise more funds for health where necessary, or maintain funding in the face of competing needs and demands;
- provide or maintain an adequate level of financial risk protection so that people who need services are not deterred from seeking them, and are not subject to catastrophic expenditures or impoverishment for doing so;
- improve efficiency and equity in the way funds are used, effectively ensuring that the available funds go further towards reaching the goal of universal health coverage.

The final chapter outlines practical steps that all countries and international partners can take to raise sufficient funds, achieve optimal pooling and efficiently use the available resources on the path to universal coverage. ■

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