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An agenda for action

Learning from experience

No country starts from scratch in the way it finances health services. All have some form of system in place and must build on it according to their values, constraints and opportunities. This process can and should be informed by international as well as national experience. From the review of the best available evidence described in earlier chapters, it is now time to draw the main conclusions, suggesting ways countries can take action for universal coverage.

1. Pay for health in ways that do not deter access to services

The most important conclusion is that globally, **there is too much reliance on direct payments as a source of domestic revenue for health.** The obligation to pay directly for services at the moment of need – whether that payment is made on a formal or informal basis – prevents millions of people receiving health care when they need it; for those who do seek treatment, it can result in financial hardship, even impoverishment. Many countries could do more to protect these people by ensuring the bulk of domestic funding for health is derived from a form of prepayment that is then pooled to spread financial risks across the population. Prepayment and pooling not only remove the financial barriers to access, but reduce the incidence of catastrophic health spending, two key objectives in the drive towards universal coverage.

There is strong evidence that raising funds through compulsory prepayment provides the most efficient and equitable path towards universal coverage. In the countries that have come closest to achieving universal health coverage, prepayment is the norm, organized though general taxation and/or compulsory contributions to health insurance. Neither mechanism is inherently superior, nor is there always a clear distinction between the two. Compulsory employer and employee contributions for health insurance are effectively a tax specified for health funding. That said, countries that rely heavily on employer and/or employee contributions from payroll taxes for prepaid revenue will need to consider diversifying their sources of funding as populations age – a smaller proportion of the total population will be in wage employment and contributing to the prepaid funds through payroll taxes. Many are already doing this.

Almost every country has the capacity to raise additional funding for health, either by giving health a higher priority in government spending or by raising additional revenues from underexploited levies, as discussed in Chapter 2. Taxes on harmful

products, such as tobacco and alcohol for example, improve health while raising additional funds, but have not been fully exploited in many countries.

Contributions to the health system must be perceived as affordable and fair if the system is to be sustainable. Assessing the fairness of contributions can be complex when people contribute through various types of taxes and/or insurance. Insurance contributions, for example, might not be based on income but this could be counterbalanced by a progressive tax system overall, in which the rich contribute a higher proportion of their income than the poor. What is important is that the overall contributions are based on ability to pay.

Universality can be achieved only when governments cover the health costs of people who cannot afford to contribute. Regardless of how wealthy a country might be, some people are simply too poor to contribute through income taxes and/or insurance contributions, or are able to contribute only a small amount. With some notable exceptions, few countries where health spending from general government revenues and compulsory insurance is less than 5–6% of GDP come close to achieving universal coverage because they are unable to make sufficient provision to subsidize the poor.

Eliminating direct payments will not necessarily guarantee financial access to health services, while eliminating direct payments only in government facilities may do little to improve access or reduce financial catastrophe in some countries. Transport and accommodation costs also prevent poor people using services, as do non-financial barriers, such as restrictions on women travelling alone, the stigma attached to some medical conditions and language barriers. Many potential solutions to these problems do not fall within the realm of finance, but some do. Conditional cash transfers (CCTs), for example, have been used by the health sector in some countries to extend coverage, particularly for prevention measures, while unconditional cash transfers are typically used by ministries of finance or social security to reduce income inequalities and allow people to buy the goods and services, including health services, they need.

Difficult choices cannot be avoided on the road to universal coverage. No country can guarantee access to every health service that may promote, protect or improve health. Decisions must be made on how far to expand coverage of the population, health services and costs with the funds available. The choices countries make will be partly pragmatic – how cost-effective is a given procedure, for example – and partly based on social values that reflect a country's attitudes to social solidarity and self-reliance.

Ultimately, however, universal coverage requires a commitment to cover 100% of the population. At this point, there will still be hard choices to make, between the proportion of the health services and the proportion of their costs that can be covered by pooled funds.

2. Consolidate funding pools and adopt compulsory prepayment

It is impossible to achieve universal coverage through insurance schemes when enrolment is voluntary. Low-risk people – usually the young and healthy – will opt out, while it is difficult to ensure the self-employed make contributions. Voluntary participation might help people see the benefits of prepayment, and certainly some financial-risk protection is better than none, but in the long run, participation will need to be compulsory if 100% of the population is to be covered.

Small pools are not financially viable in the long run. Small pools are vulnerable. One high-cost illness or procedure can exhaust their reserves. Community insurance and micro-insurance have their place where it is difficult to raise and pool funds for health in other ways, and can be a useful way to encourage a sense of solidarity while promoting the benefits of prepayment. They can also offer a degree of financial-risk protection to participants, but ultimately, bigger is better, and pool consolidation needs to be part of the strategy from the outset. This applies also to small government-managed pools, such as a district health budget. In some cases, adequate coverage in poorer districts can be achieved only when there is direct subsidy from central funding pools or districts can share costs.

Multiple pools serving different population groups are inefficient because they duplicate effort and increase the cost of administration and information systems. When a health ministry and a department of social security each run health services for different population groups, for instance, the consequences of duplication and inefficiency are magnified.

Multiple pools also make it more difficult to attain equity and risk protection. Ensuring an entire population has access to similar benefits generally requires the rich and poor to pay into and be covered from the same pool. Meanwhile, financial risk protection is also enhanced when people with different incomes and health risks pay into and draw from the same pool.

Multiple pools can achieve equity and financial protection in some circumstances but this requires considerable administrative capacity. Whether these pools are organized on a non-competitive geographical basis (government funding covering the population of a province or region, for example) or on a competitive basis (multiple insurers competing for consumers), it is possible to achieve equity and financial protection if there is sufficient public funding and participation is compulsory. But for such structures to work, it is necessary to ensure *pooling across pools*, effectively creating a *virtual* single pool through risk equalization, whereby funds are transferred from insurers or regions that cover low-risk people to those that cover higher-risk people. This approach is administratively demanding, requiring an ability to monitor risks and costs effectively and to collect and transfer funds across pools.

3. Use resources more efficiently and equitably

All countries can improve efficiency, sometimes by a great deal, thereby freeing resources to ensure more rapid progress towards universal coverage. Focusing on medicines alone (improving prescribing guidance, for example, or ensuring transparency in buying and tendering) can significantly reduce spending in many countries, with no loss of quality. Other common sources of inefficiency are outlined in Chapter 4, along with suggestions to address them.

Fragmentation leads to problems in pooling resources **and inefficiencies in purchasing and service delivery.** Inflows of development assistance for

health can inadvertently magnify this problem. Funding to programme-based strategies does not have to be provided through parallel funding streams, each requiring its own administrative and monitoring procedures, yet often they are organized this way.

Active or strategic purchasing of and contracting for health services helps countries move faster towards universal coverage but should not be undertaken lightly. Responsible officials for purchasing and/or contracting need to allocate resources based on value for money, performance and information on population needs. This requires good information systems and strong information management and analysis. Accurate assessment of population health needs, spending patterns and the cost–effectiveness of interventions also enhance quality and efficiency.

Incentives to provide efficient, equitable and quality services are essential whether service providers are publicly or privately owned. There is no evidence that privately owned/financed service providers are any more or less efficient than government owned/financed alternatives. From a health-financing policy perspective, deciding how best to provide services requires a pragmatic rather than an ideological approach.

Fee-for-service payment generally encourages overprovision for people who can pay (or who are covered by insurance) and underprovision for those who cannot. Beyond that general truth, payment mechanisms should be evaluated on their merits. For example, using capitation for outpatient services and forms of case-based payment, such as diagnostic-related groups, for inpatient care reduces the incentives for over-servicing encouraged by fee-for-service payment. But these approaches can create other problems, such as early discharge from hospital followed by readmission to capture an additional payment. Many countries are experimenting with a mix of payment and administrative procedures to exploit strengths and mitigate weaknesses.

Preventive and promotive interventions can be cost effective and reduce the need for subsequent treatment. Generally speaking, however, there is much greater pressure on politicians to ensure access to treatment, and many financing systems focus largely on paying for this rather than population-based forms of prevention and promotion. In addition, left to their own devices, individuals will generally underinvest in prevention. This means it is sometimes necessary for governments to fund population-based prevention and promotion activities separately from the financing system for personal services linked largely to treatment and rehabilitation.

Effective governance is the key to improving efficiency and equity. Some of the ground rules for good governance are established outside the health sector – financial management and audit, for example – but there is no reason why health should not be a trailblazer in this area. Decision-makers working in health can do a great deal to reduce leakage, for example, notably in procurement. They can improve quality in service delivery and the efficiency of the system, including through regulation and legislation.

The lessons described above, drawn from long experience in many countries, can help policy-makers decide how best to move forward, but simply adopting elements from a menu of options, or importing what has been shown to work in other settings, will not be sufficient. **Health financing strategy needs to be home-grown – pushing in the direction of universal coverage out of the existing terrain.** It is imperative that countries develop their own capacities to analyse and understand the strengths and weaknesses of the existing system so they can adapt health-financing policies accordingly, implement them, and monitor and modify them over time.

These lessons relate mainly to the technical challenges of health-financing reform but technical work is only one component of policy development and implementation. Other actions are necessary to engender reflection and change. These are considered in the next section.

Supporting change

The health-financing decision cycle represented here (Fig. 5.1) is intended as a guide rather than a blueprint, and while the processes we envisage are represented as conceptually discrete, in reality they overlap and keep evolving.

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 engage in continuous self-assessment to ensure the financing system continues to achieve its objectives in the face of ever-changing diagnostic and treatment practices and technologies, increasing demands and evolving fiscal constraints.

Designing and implementing health finance strategy involves continuous adaption rather than linear progress towards some notional perfection. The cycle is completed (Action 7) when a country reviews how far it has progressed towards its stated goals (Action 1), allowing it to re-evaluate its strategies and devise new plans to redress any problems. It is a process based on continual learning, the practical realities of the system feeding back into constant re-evaluation and adjustment.

Health financing systems must adapt, 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. 5.1).

Action 1: establishing the vision

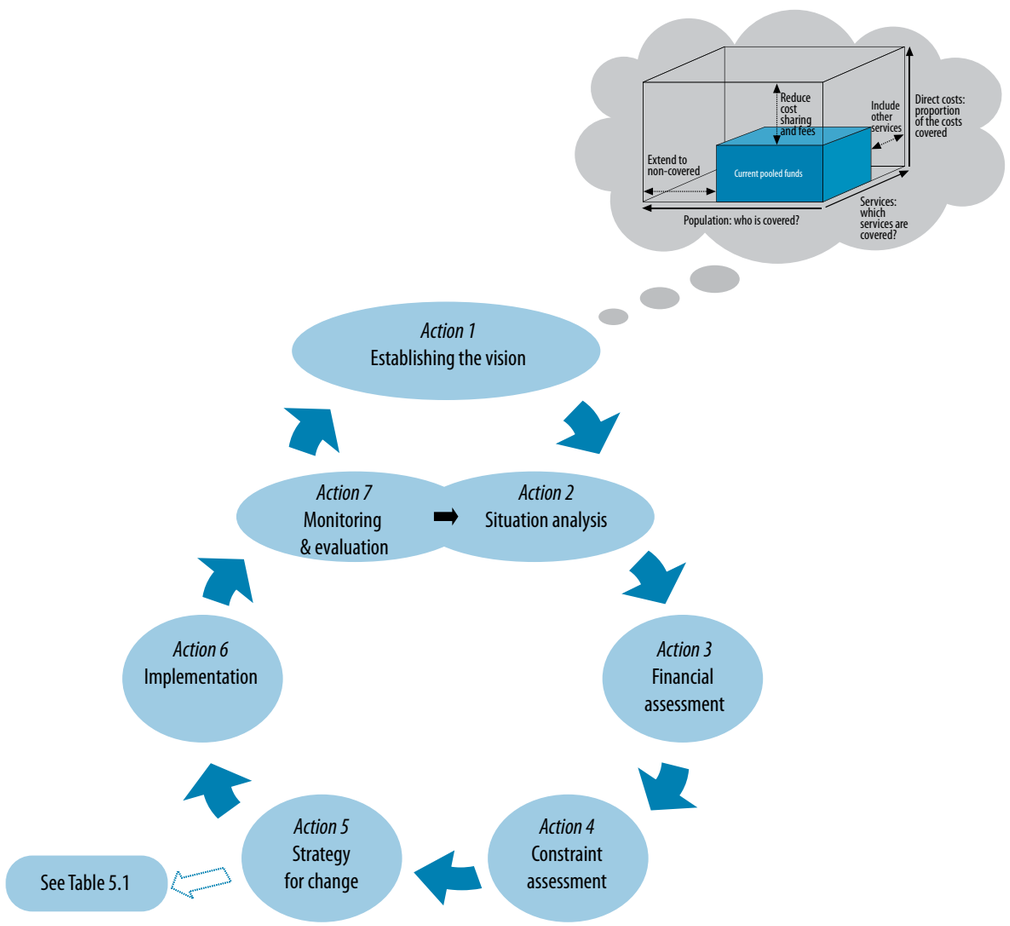
Establishing a vision for the future based on an understanding of the present is crucial because the paths countries choose towards universal coverage will necessarily differ. The commitment to universal coverage recognizes the objectives of reducing financial barriers to access and increasing and maintaining financial risk protection. It recognizes, however, that there will be trade-offs along the way in the proportion of the population, services and costs that can be covered for any given level of resources. It is important to outline the choices a country must make. For example, in a country where most people believe individuals must take some financial responsibility for their own health, it might be decided to cover only a proportion of the total costs of services from pooled funds and ask households to contribute the remaining part directly – at least for some services. In other countries where the concept of social solidarity is strong, it might be preferable to cover a higher proportion of the total cost, even though this may mean offering a narrower range of services. Recognizing these values and allowing them to inform the overall

vision for the system is important to determining how the technical work should proceed. It can also guide decision-makers in managing the coverage trade-offs that will inevitably arise as the financing system evolves.

Action 2: situation analysis – understanding the starting point

The situation analysis should focus on the two components of universal coverage from a financing perspective: access to needed services and financial risk protection. It would identify who is covered from pooled funds, for what services and for what proportion of cost, showing the gap between what is currently being achieved and what the country would like

Fig. 5.1. **The health-financing decision process**



to achieve (as defined in Action 1). In planning for the future, the situation analysis needs to consider factors inside and outside the health system that may affect progress on the path to universal coverage (Box 5.1). This is not just a technical process. While it is the basis of sound strategy development, having the right information – the current incidence of financial catastrophe linked to direct payments for health services, for example – can provide an impetus for political change (*1*).

Action 3: financial assessment

The current and likely future availability of funds for health from government, households, the private sector, nongovernmental organizations and external partners needs to be assessed to create a comprehensive funding framework for the health system. Assessment should include analysing the share of public resources allocated to the sector over time. The lack of continuity between policy, planning and budgeting is a matter of concern in many countries. Analytical tools such as a medium-term expenditure framework – a planning and budget formulation process that sets three-year fiscal targets based on macroeconomic projections, and allocates resources to strategic priorities within these targets – can help create an overall funding picture and inform dialogue between the health and financial/planning ministries (*2*).

In some countries, this stage will involve dialogue with international financial institutions and external partners to assess the resources likely to be available and how they will be channelled to government and nongovernment actors. Policy-makers will also want to establish whether government spending will be restricted and how spending limits might be increased. Finally, complementary roles for different sources of funds to the health system should be considered.

Box 5.1. **Key components of a situation analysis for health financing**

Financial risk protection

- What funds are available in relation to need and what are the sources? What priority does government give to health in its spending decisions?
- How much do people have to pay out of pocket for health services (e.g. direct payments) and what is the impact of financial risk protection on financial catastrophe and impoverishment?
- Who pays what in other contributions to the health system? (This is to allow an analysis of the perceived fairness of financial contributions.)
- Who is covered from pooled funds, for what services and for what proportion of the costs?

Access to needed services

- It is difficult to measure financial access to services directly, so the analysis will generally focus on current levels of coverage for key interventions. It will then undertake an assessment of the reasons for coverage that is considered low, particularly among vulnerable groups, and the extent to which changes to the financing system would improve this access.

Efficiency

- What are the main efficiency problems in the system, their consequences and their causes?

Health system characteristics and capacities

- Systematic description and quantification of arrangements for raising and pooling funds, and using them to finance or provide services. This includes more than just tracking funds but also understanding how they flow through the system, from source to use, including external funds, noting where/how the system is fragmented and where/how policy instruments are poorly aligned. Governance arrangements also need to be looked at, notably to whom and for what are purchasing agencies responsible.
- The availability, distribution and patterns of use of health facilities (government and nongovernment), health workers (government and nongovernment) and key inputs such as medicines and technologies. The result of this assessment determines the feasibility of different approaches to increasing coverage – e.g. conditional cash transfers are unlikely to work if there are no facilities located close to the people identified as having low coverage.

Factors outside the health system

- Demographic variables, such as population-growth rates, age structure, geographical distribution and migration patterns, labour force participation, extent of informal work, etc. have implications for how fast needs will increase and the feasibility of different methods for raising revenue.
- Main disease problems and likely changes over time, with implications for the costs of extending coverage over time.
- The scope of existing social safety nets that reduce the economic impact of (long-term) illness or reduce the financial barriers of accessing services.
- Relevant aspects of public-sector administration and the legal framework, to understand how much leeway there is for changes to the financing system within the context of existing regulations and laws. Key questions include: how are health workers paid and are these arrangements linked to civil service rules? What would be required to modify them if necessary? How is decision-making on financial resources allocated across levels of government (i.e. political-administrative decentralization issues)? How are budgets drawn up in the public sector? How much scope do state bodies (e.g. public hospitals) have for redistributing funds across line items?

In Chapter 2, a menu of options to help countries raise additional or alternative domestic funds for health was proposed. At a minimum, countries should consider whether health is receiving its rightful share of government spending and look at possibilities for raising taxes on tobacco, alcohol and other products harmful to health. Such taxes can contribute substantial additional funding, while directly improving population health. Almost every country could implement at least one of the options suggested in Chapter 2.

Understanding the language of economists is critical to raising more funds for health. When the health ministry is seen as an efficient and prudent manager of public resources that can demonstrate progress and good results, it is more likely to win the trust and confidence of the finance and other ministries. Being able to speak the language of economists will also enhance its ability to argue for additional funding. Critical to this effort is a health ministry's capacity to draw on health policy analysis skills to produce the necessary documentation and engage in dialogue with the finance and planning ministries.

Action 4: constraint assessment

Having done the groundwork, it is important at this stage for policy-makers to identify the main supporters of change and where significant opposition is likely. An assessment of potential constraints allows decision-makers to identify policy areas that require widespread consultation, with whom it should consult and in what way. Such an assessment would culminate in the political decision to move forward.

It is in this phase that decision-makers also identify what is technically and politically feasible and determine how government can build on and support social demand for a well-functioning health system. This is a process that overlaps with subsequent actions and should be repeated regularly. What is impossible today might well be possible tomorrow. The key points to remember are:

- Achieving universal health coverage is not just a technical matter; it is an expression of a country's perception of social solidarity. The impetus for adoption is always, at least partly, political.
- Health financing systems are resistant to change, partly because any change encroaches on the interests of powerful stakeholders. In the face of countervailing forces and deeply entrenched vested interests, support for change needs to be robust and sustained from the highest levels.
- At the grass-roots level, the dynamic is often inverted. Population surveys frequently reveal a desire for change/improvement in a country's health system. Grass-roots movements for health reform and civil society groups (including consumer organizations concerned with specific conditions) can be conduits for change at both the national and international level. Communication between such groups and the health ministry helps push health on to the wider political agenda and keep it there. This has been the approach taken by the Bangladesh government, for example, in its project to revitalize and extend community health clinics. Community management groups help to support planning and management, and the interaction between health workers and the population they serve (*3*).
- A proactive approach to the political sphere has borne fruit in many countries. Advocacy, communication and evidence-based arguments can go a long way in eliciting the political and financial support needed to seek universality.

Action 5: develop and formalize strategies and targets for change

This is the most time-consuming and labour-intensive action. It is also the focus of most of the literature on health financing and forms the bulk of technical support given to countries, sometimes on the assumption that the other actions have been, or will be, worked through. In reality, the other actions have often been overlooked or hurried through, despite the fact they form the foundation for the technical work. The development of strategies and targets in this phase must grow out of the situation analysis and assessment of the funding context (Actions 2 and 3).

Based on the situation analysis and an accurate assessment of the likely funding scenarios, detailed technical work on strategy can begin, focusing on the three key health financing phases: raising funds; pooling them; and using them to ensure that services are available.

To illustrate the range and nature of the core decisions to be taken, Table 5.1 draws on the key messages of Chapters 1–4.

Action 6: implementation, including assessing organizational structures and rules

In this phase, some countries will need to make only small changes to maintain achievements. Others will have to instigate reform, establishing new institutions and organizations. For example, a country may decide to develop a health insurance fund as a semi-governmental authority to bypass limitations on pooling and purchasing within the public-sector financial management system. Sometimes, however, existing institutions may simply need to adapt; for example, where compulsory insurance is to be organized through the private sector. Where a compulsory insurance fund exists as a public-sector agency, new laws and regulations might be required or existing regulations reinforced or repealed.

Legislation can certainly help the development of health financing systems for universal coverage and it can also help protect an individual's right to receive health care. In several countries recently, new laws and constitutional entitlements have resulted in more people going to court to uphold their right of access to health services (*4*). It is too early to know the implications of this for achieving universal coverage, though researchers have found in some cases that the poor and vulnerable have benefited less from this right to legal redress than the more affluent groups who are more eloquent in expressing their needs (*5*).

One of the biggest challenges many countries face in this implementation phase is a lack of technical and organizational capacity. Accountants, actuaries, auditors, economists and lawyers can be essential in different

settings and sometimes expertise can be scarce. It may, therefore, be necessary for countries to reassess educational/training priorities to develop the requisite skills and to develop strategies to attract and retain skilled professionals from outside the country.

The expansion of service coverage is often hampered by a dearth of health-service providers, and financing plans need to ensure an adequate supply of health workers with the appropriate skills. Financing plans must also enhance the quality and quantity of service delivery, and ensure appropriate medicines and technologies are available. Conversely, decision-makers need to be mindful of the implications for financing when reforming other areas of the health system.

Many of the changes will require intersectoral action, with health ministry staff working with other ministries.

Table 5.1. **Technical decisions required for Action 5**

Principal objective	Components	Decisions
Raising sufficient funds	**Sufficiency** (this part is closely related to Action 3, and some actions will be taken concurrently)	1. Choose the mix of taxes and/or insurance contributions that households will be requested to contribute. Decide on any other mechanisms for raising revenues for health domestically – e.g. contributions from businesses. Aim to ensure a stable and predictable flow of funds into the system.
	Equity in contributions	2. Develop a mechanism to cover people who cannot afford to contribute. This can be achieved by cross-subsidization, either through general government revenues or by setting health insurance contributions higher for people who can pay to cover non-contributing members.
		3. Implement a system of household contributions that are affordable.
	Efficiency in collection	4. Improve efficiency in raising funds by ensuring the people who are supposed to contribute, do so.
	Financial sustainability	5. Make evidence-based estimations on the potential to raise funds (domestic and external) in the future and match those with estimated needs and growth in needs (linked to Action 3)
Reducing financial barriers	**Affordability and access**	6. Based on Decision 1, establish institutional and administrative arrangements to collect and pool contributions from the various sources (thereby reducing reliance on direct out-of-pocket payments in countries where they are high).
		7. Determine whether user charges have been used to provide incentives for quality, such as supplementing salaries at the primary-care level. In replacing user fees, it is important to replace not only the total funding that would have been raised, but funding for the activities previously paid for by fees. Additional funds would also be required to meet the expected increase in demand. This minimizes the possibility of unofficial replacing official payments.
		8. Determine whether there are some groups of people or some specific interventions for which demand-side actions should be taken (vouchers, cash transfers) to ensure appropriate access.
	Equity in pooling	9. Make contributions to the health system (taxes and/or insurance) compulsory as soon as possible. This will ensure that people will contribute when they are healthy, not just when they fear illness. Allowing people to opt out should be avoided because it reduces the extent to which the poor and vulnerable are covered.
		10. If there are multiple pools, reduce fragmentation by either merging them into a larger pool or by implementing a mechanism for equalizing risks across them to ensure that the people in the different pools are treated equally.
		11. Define who is eligible to obtain services through the pool(s), the services to be provided and any level of co-payments. Develop a timetable for expanding these parameters according to the financial sustainability plan described above.
	Efficiency in pooling	12. Minimize fragmentation in holding funds as far as possible.
Using resources wisely	**Efficiency in use of resources**	13. Design and implement provider-payment mechanisms that create incentives for increases in quality and efficiency.
		14. Because all methods of paying providers have advantages and disadvantages, develop complementary steps that encourage quality and efficiency. Important elements include tackling waste and corruption, and designing cost-effective medicine selection, procurement and supply chains (see Chapter 4 for more detail).
		15. Decide how to allocate pooled resources between different types of health services and different levels of care, while ensuring that this does not create obstacles for coordination of care across levels.
		16. Engage in strategic purchasing/contracting to ensure the highest value for money.
		17. Decide if it is necessary to develop a separate pool of funds for health promotion and prevention.
		18. Routinely monitor results and efficiency in the use of funds.
	Equity in use of resources	19. Decide how to allocate pooled resources between geographical regions, accounting for relative population size, relative income/poverty, relative health needs and unavoidable differences in the costs of delivering services (e.g. due to low population density).
		20. Determine whether there remain inequalities in coverage and health outcomes that cannot be addressed by the financing system, and that require action in the rest of the health system (e.g. distribution of health facilities or human resources) or in other sectors. Decide which other ministries and civil society organizations can best contribute to solving these problems; develop and implement joint solutions.

Action 7: monitor and evaluate

Decision-makers need to know where their country stands. Whether planning reform that will lead to a system of universal coverage, engaged in the transition or already meeting their stated goals, they need to be able to assess both their status and momentum. They need to know whether the country is moving closer to or further away from universal coverage.

Financing systems do not necessarily respond to changes as planned. It is important, therefore, to be prepared for the unexpected and be able to make rapid adjustments. To do this, decision-makers need a constant stream of accurate intelligence. In Box 5.1 we outlined the type of information needed for meaningful situation analysis, much of which relates to how available financial resources are being used. Here we turn to the assessment of outcomes, which is necessary for a country to determine whether it is moving closer to or further from universal coverage.

Monitoring needs to focus on whether people have access to needed health services and risk financial hardship in paying for them. Some of the information required for an accurate assessment is difficult to obtain. For example, while it is relatively easy to measure the proportion of people covered by a specific health insurance scheme, this is not an indicator of true coverage because we would also like to know the proportions of the needed services and the costs that are covered.

In systems characterized by a mix of public and private services, funded partly by insurance and partly from tax revenues, the picture can be complex. In theory, everyone can use government services, but in practice, people in remote areas may not have physical access to them, or may not use

Table 5.2. **Monitoring universal coverage of protection from financial risk**

Objectives and actions	Associated indicators	Interpretation
1. Raising sufficient funds for health: what proportion of the population, services and costs is it feasible to cover?	1. Total health spending per capita	1. Must be related to population needs but the average minimum requirement across low-income countries is estimated at US$ 44 in 2009, rising to US$ 60 in 2015.
	2. Total health spending as a percentage of gross domestic product	2. This also reflects the availability of funds because total health spending/GDP generally increases with GDP per capita. Countries in the WHO South-East Asia and Western Pacific Regions have set themselves a target of 4%, although this might not be sufficient in itself. The 40 or so countries globally with GDPs per capita under US$ 1000 would not meet the minimum levels of funding needs with this spending.
	3. General government health spending as a percentage of total government spending[a]	3. Indicates government commitment to health. Sub-Saharan African countries set themselves a target of 15% of government spending to be allocated to health. In the WHO Eastern Mediterranean Region, Member States are discussing a target of 8% of government spending going to the health ministry.
	4. General government health spending as a percentage of gross domestic product	4. Indicates the capacity and will of government to shield the population from the costs of care. It is difficult to get close to universal coverage at less than 4–5% of GDP, although for many low- and middle-income countries, reaching this goal is aspirational in the short term and something to plan for in the longer run.
2. Levels of financial risk protection and coverage for vulnerable groups – a combination of who is covered and what proportion of the costs	5. Out-of-pocket spending as a percentage of total health spending, with information on which population groups are most effected	5. Empirical evidence shows that this is closely linked to the incidence of financial catastrophe and impoverishment due to out-of-pocket spending. Where out-of-pocket health payments/total health spending is lower than 15–20%, there is little financial catastrophe or impoverishment. Many countries still have higher ratios, and the countries in the WHO Western Pacific Region have set a target of 20–30%.
	6. Percentage of households suffering financial catastrophe each year by out-of-pocket health payments, with information on which population groups are most effected	6. Ideally, this would be measured directly, although indicator 5 is highly correlated with financial catastrophe.
	7. Percentage of households suffering impoverishment each year by out-of-pocket health payments, with information on which population groups are most effected	7. Same comment as with indicator 6.
3. Efficiency of resource utilization[b]	8. Median consumer price of generic medicines compared with the international reference price	8. Where this is higher than a 1:1 ratio, there is strong evidence of potential savings.
	9. Percentage of public spending on health allocated to fixed costs and salaries compared with medicines and supplies	9. This is more difficult to interpret, although most countries know when it is too high – when there are insufficient funds to buy medicines, for example. This might sometimes reflect insufficiency of funds more than inefficiency.

[a] General government health spending captures spending on health from general government revenues for all ministries, all levels of government and compulsory health insurance combined.
[b] It is difficult to establish valid, reliable and comparable indicators of health system efficiency. The two indicators are only illustrations, and countries will need to focus on other areas of inefficiency that are particularly important in their own contexts. Potential indicators include: share of total spending on primary versus hospital care; referral rate from primary to secondary level of care; use of generics versus brand-name medicines; day surgery versus hospitalizations; and overall administration costs.

them if the quality is poor or perceived to be poor. So identifying who is truly covered by publicly funded services can be difficult, even with reliable data from well-designed household surveys.

In Table 5.2 we propose indicators that have been shown consistently to be strong predictors of who is covered and the extent of the financial risk protection offered, the extent of out-of-pocket payments and their impact on financial catastrophe and impoverishment. Clearly, they do not cover every possible impact of a health financing system on people's lives. People already living in poverty, for example, will not be impoverished by health payments, but will be pushed deeper into poverty. Several other indicators, such as whether poor people have been made poorer by the need to pay for health services, are available for countries with additional monitoring capacity, but here we list a minimum set of indicators that are widely used (*6–8*).

We do not propose indicators for the coverage side here. Ideally, we would like to know the proportion of the population, broken down by key variables including age, sex and socioeconomic status, that does not have access to needed services because of financial barriers or other potential obstacles. This information, however, is not available in most countries and the range of services needed may vary considerably because of different disease and demographic patterns. We suggest that each country may want to monitor a different set of interventions for effective coverage. A set of possible indicators is provided annually in *World health statistics* (*9*), although they pertain mostly to low-income countries where communicable diseases predominate.

Regular flows of data in these areas, as well as those described for the situation analysis in Box 5.1, depend on two things:

- A functioning health information system that provides information on coverage of those in need, ideally broken down by age, sex, socioeconomic status and other indicators of vulnerability or deprivation. This requires that those responsible for managing health system administrative data have good links with national statistical agencies.
- A system for monitoring financial flows. National health accounts provide crucial information, as do intermittent household surveys, for measuring out-of-pocket spending and financial risk protection.

Policy-makers should strive to create a unified financial reporting system that is not broken down by programme, administrative decentralization or the insurance status of the population. Problems arise when donor funding for projects and programmes is tracked by parallel financial reporting systems that do not talk to each other. It is also vital to gather information from all the actors in a health system, private and public. In many countries, official health information systems collect little data from the nongovernment sector, making it difficult to obtain a full picture of the health status and usage patterns of the population.

An agenda for the international community

While countries can do a great deal for themselves by following the agenda outlined above, the international community has a vital role to play in supporting those countries requiring additional help. It is essential for development partners to:

Maintain levels of assistance or increase them to the required level

Only about half the countries reporting their official development assistance (ODA) disbursements to the Organisation for Economic Co-operation and Development (OECD) are on track to meet the targets they have committed to internationally. The other countries are falling short, some by a long way. While some donors have promised to maintain their assistance commitments for 2010 despite the global economic downturn, others have reduced or postponed their pledges. This is of great concern and it is to be hoped that development partners live up to the promises made in Paris and Accra.

Ensure that aid is more predictable

When countries cannot rely on steady funding, planning for the future becomes difficult. Some low-income countries rely on external resources to fund two thirds of their total health spending, making predictable aid flows of paramount importance. Development partners can help by structuring contribution arrangements that break out of traditional annual (ODA) commitments – as donors from the OECD's development assistance committee did in Accra, committing to three- to five-year funding cycles.

Innovate to supplement health spending for poor populations

Much has been achieved in this area, notably by the Millennium Foundation on Innovative Financing for Health, which most recently developed mechanisms for individuals to make voluntary contributions to global health when paying online for airline tickets, hotel rooms or rental cars. The sale of bonds guaranteed by donor countries, issued on international capital markets, is estimated to have raised US$ 2 billion since 2006. While such schemes have yielded promising results, much more could be done in this area. It is estimated, for example, that a global currency transaction levy could raise in excess of US$ 33 billion annually (see Chapter 2).

Support countries in their health plans rather than impose external priorities

The focus of many external partners on some high-profile programmes runs counter to the spirit of the 2003 Paris Declaration on Aid Effectiveness, which seeks to enable recipient countries to formulate and execute their own national plans according to their own priorities. What is required here is a refocusing on agreed financial contributions to national health plans, where reporting and follow-up of results take place at the national level.

Channel funds through the institutions and mechanisms crucial to universal coverage

Some recipient countries have argued that donors are unwilling to use the systems they are supposedly strengthening, preferring to establish and use parallel systems in: channelling funds to countries; buying inputs, such as medicine and equipment, and services; and monitoring results (*10*). One way to strengthen national systems would be to channel external funds through the recipient country's own risk pooling mechanism. This might take the form of sector-wide support, whereby donors specify that their funding is for the health sector, but allow governments to decide on its distribution across programmes and activities or through health insurance pools. Development partners should also seek to strengthen the domestic capacity of these institutions.

Support local attempts to use resources more efficiently

Reduce duplication in channelling methods and multiple application, monitoring and reporting cycles. The transaction costs they impose on countries are substantial. There were more than 400 international health missions to Viet Nam in 2009 (*11*). In Rwanda, the government has to report on more than 890 health indicators to various donors, 595 relating to HIV and malaria alone (*12*).

Set an example in efficiency by reducing duplication and fragmentation in international aid efforts

The fragmented way international aid is delivered leads to high administrative overheads for donors and recipients, unnecessary duplication and variations in policy guidance and quality standards at country level. It is imperative that major donors commit to aligning their efforts to reduce fragmentation in the way funds are channelled to and held in recipient countries. More than 140 global health initiatives are running in parallel, wasting resources and putting tremendous strain on recipient countries (*11*).

Conclusion

This is an interesting time for health finance. Two vast health-care systems, previously committed to using free-market mechanisms as the basis for funding – one in China, the other in the United States of America – are being reformed. China is moving its massive system back in the direction of universal coverage, funded partly out of general revenues. In March 2010, President Barack Obama signed into United States law a reform bill that extends health-care coverage to a projected 32 million previously uninsured Americans. While some way from embracing the principle of universality advocated in this report, the reform's easing of Medicaid eligibility thresholds extends publicly funded coverage to 20 million people who previously had none.

The reforms in China and the USA stand out, partly because of the size of systems involved, but these countries are not alone in re-evaluating their approach to funding health care. As this report has shown, health finance reform is taking place in many countries, at many levels of economic development. How each deals with the challenges faced will vary, but the programmes that come closest to meeting the needs of their populations will include some form of prepayment and pooling.

But beyond this basic truth, there is no set formula for achieving universal coverage. Country responses to the challenges will be determined partly by

their own histories and the way their health financing systems have developed, and also by social preferences relating to concepts of solidarity (*13*). Varied as the responses may be, they will be implemented in the face of the same intractable pressures. To ignore those pressures will be to fail in one of the most important tasks of government: to provide accessible health care to all.

Every country can do something to move closer to universal coverage or maintain what it has achieved. As daunting as the task may seem, policy-makers can take heart from the fact that many countries have gone before them in the struggle to establish a system of universal coverage, and those struggles are well documented. There are lessons to be learned. One concerns the importance of social solidarity expressed through political engagement, a theme we have returned to several times in this report. It would be an oversimplification to say that reform has always resulted where there is grass-roots demand and the active involvement of civil society, but this conjunction has happened often enough to demand consideration.

In Thailand, it was one of the driving factors in the development of the universal coverage scheme that brought health care to the millions of Thais who previously faced paying out of their own pocket or forgoing treatment. Neither of these options would have worked for Narin Pintalakarn as he lay in the wreckage of his motorcycle on Saturday, 7 October 2006. Luckily for Narin, there was a third option. It depended on millions of taxpayers, a specialist trauma centre located just 65 km from where he crashed and a surgeon with many years of training. The numbers were all on Narin's side that day. And there was strength in them. ■

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