The World Health Report

HEALTH SYSTEMS FINANCING

The path to universal coverage

World Health Organization

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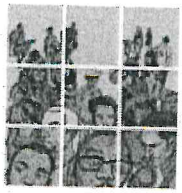

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In recent years, people's increasingly vocal demands for better health have pushed the issue further up political agendas. One result is that all Member States of the World Health Organization (WHO) have set themselves the target of developing their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

❶ Where and how can they find the financial resources they need?
❷ How can they protect people from the financial consequences of ill health?
❸ How can they make optimum use of resources?

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

Universal Coverage

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

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

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

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

The Status Quo

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

[1] Resolution WHA58.33

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

This can be illustrated in many ways, including:

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

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

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

CHALLENGES

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

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

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

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

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

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

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

THE WAY FORWARD

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

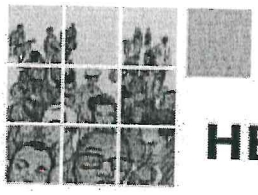
❶ **Raising more funds for health or diversifying funding sources.** Options include: making health a higher priority in existing government spending; making revenue collection more efficient; diversifying sources of revenue using innovative domestic financing; increasing external support.

❷ **Providing or maintaining an adequate level of financial risk protection.** This means relying largely on forms of prepayment (e.g. insurance and/or taxes) to raise funds, then pooling them to ensure access and spread financial risks. This helps minimize reliance on direct, out-of-pocket payments.

❸ **Improving efficiency and equity in the way funds are used.** The report identifies ten typical areas where improvements might be sought. These include: ensuring that people do not pay too much for medicines and using them more appropriately as well as improving quality control, improving hospital efficiency, choosing the right interventions, finding incentives that work, and avoiding fragmentation.

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

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



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KEY MESSAGES

In many countries, millions of people suffer because they cannot get the health care they need - or because paying for health services plunges them into poverty.

Elsewhere, in countries where health services have traditionally been accessible and affordable, governments are finding it increasingly difficult to respond to the ever growing needs of their populations and the increasing costs of services.

By adjusting their health financing systems, sometimes a little, sometimes a great deal, every country can increase health coverage and reduce the suffering associated with illness and the need to pay for services. This report shows how.

THE CHALLENGE: The world is still a long way from universal coverage, where all people have access to health services without the fear of financial hardship associated with using them.

Millions of people miss out on health care altogether because they can't afford to pay for it.

In some countries, just 10% of live births are attended by a skilled health worker. Women in the richest 20% of the population are up to 20 times more likely to have a birth attended by a skilled health worker than a poor woman. (*Executive Summary, page x*)

Each year, 100 million people are pushed into poverty because they have to pay directly for health services at the point of delivery (*p5*):

- In some countries, 5% of the population is forced into poverty each year because they have to pay for health services at the time they receive them (*page 5*).
- Financial hardship is not restricted to low and middle income countries: almost 4 million people in just six OECD countries (Greece, Portugal, Mexico, Republic of Korea, Hungary and Poland) experienced forms of financial hardship because they had to pay directly for health care (*page 9*). Medical debt has been the principal cause of personal bankruptcy in the USA (*page 9*).
- To eliminate financial catastrophe and impoverishment caused by direct, out-of-pocket payments for health services, these forms of payment should make up less than15% -20% of total health expenditure in a country (page 40). In 33 mainly low- and middle-income countries, direct payments still represent more than 50% of total health expenditures (*page xiv)*.

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WHO RECOMMENDATIONS:

All countries, rich and poor, can do more to move closer to universal coverage or to protect the gains they have made in the past. This World Health Report offers practical guidance on ways to increase health service coverage, improve health outcomes and protect people from financial catastrophe and impoverishment linked to using services. Building on country experiences, it presents options in three broad areas:

❶ Raising sufficient money for health using innovative approaches, as well as from traditional ones.

❷ Raising funds largely through "prepayment" rather than direct out-of-pocket payments, and then using consolidated arrangements that pool together resources for better distribution of financial risks among the population.

❸ Spending money more efficiently and equitably.

1. **Raising sufficient funds for health.** This can be done by:

⇨ **Making health a higher priority in existing government spending**

- In 2001 the heads of state of the African Union promised to increase this proportion to 15%, but only three countries (Liberia, Rwanda and the United Republic of Tanzania) achieved this commitment in 2007 - with substantial external support (*page 25*).
- 49 low-income countries could between them raise an additional US$ 15 billion per year for health from domestic sources by increasing health's share of total government spending to 15% (*page 25*).

⇨ **Making revenue collection more efficient**

- In Indonesia clear and consistent regulations and a policy of zero-tolerance for corruption increased tax yield from 9.9% to 11% of non-oil GDP over four years; health spending benefited more than other sectors (*page 26*).

⇨ **Diversifying sources of revenue.** Possible options include:

- *Value-added taxes:* Ghana funded its national health insurance partly by increasing the value-added tax (VAT) by 2.5% (*page 27*).
- *"Sin" taxes, particularly on tobacco and alcohol*: a 50% increase in tobacco tax alone would yield an additional US$1.42 billion just 22 low income countries for which sufficient data exists (*page 28*).
- *A currency transaction levy* would be feasible in many countries. For example, if India were to implement a levy of 0.005% on foreign exchange transactions, US$370 million per year could be raised (*page 28*).
- *Solidarity levies* - Gabon raised US$ 30 million for health in 2009 by imposing a 1.5% levy on companies handling remittances and a 10% tax on mobile phone operators (*page 30*).

⇨ **Increasing external support.**

- An average of US$ 44 per capita is required to ensure access to even a small set of quality health services in low income countries (*page 22*).
- 31 countries spend less than US$ 35 per person on health even thoug donor assistance has increased in recent years(*page 23*).
- Donor assistance has increased substantially but still accounts for less than 25% of all health spending in the typical low-income country. Few of them will be able to scale up domestic funding sufficiently to achieve the Millennium Development Goals without additional inflows (*page 23*).
- If all donor countries were immediately to keep their current overseas development assistance pledges, the estimated shortfall would be virtually eliminated - and more than 3 million lives saved by 2015 (*page 32*).
- Innovative ways of raising funds at the global level for health will be critical to supplement traditional development assistance. The currency transactions levy has the greatest potential and studies suggest it would have no impact on the viability of the financial sector (*page 27-28*).

2. **Relying largely on forms of prepayment (e.g. insurance and/or taxes) to raise funds, then pool them to ensure access and spread financial risks. This means minimizing reliance on direct, out-of-pocket payments.**

- 27 OECD countries currently cover all their citizens with a set of health interventions from pooled funds (*page 8*) supplemented with limited direct out-of-pocket payments, such as co-payments, co-insurance, deductables and other charges.
- It is possible to make substantial progress towards reducing direct payments, increasing prepayment and covering all people from pooled funds even at lower levels of national income. Chile, Colombia, Mexico, Rwanda, Thailand and Turkey have all made significant progress in the last decade - as have Brazil, China, Costa Rica, Ghana, Kyrgyzstan and the Republic of Moldova (*page 8*).
- These countries have chosen different mechanisms, mostly involving some mix of tax-based funding with various forms of mandatory insurance, although community based insurance and micro-insurance can play a valuable role in the early stages.
- Where people are allowed to opt-out of making contributions, it is difficult to ensure that everyone has access to needed services of good quality. The rich and the healthy opt out and the poor and sick are left with poor services.

3. **Improving efficiency and equity.**

Typically between 20% - 40% of health spending is wasted, depriving many people of badly needed care. **Increasing efficiency is a way of increasing**

coverage, financial protection and health outcomes for the available resources, not a way to reduce funds for health.

The report identifies ten typical areas where improvements might be sought (*page 63*). These include:

⇨ **Reducing unnecessary expenditure on medicines, using them more appropriately and improving quality control.**

- Better use of medicines could save countries up to 5% of their health expenditure *(page 72)*.
- France's strategy of generic substitution led to savings equivalent to US$ 1.94 billion in 2008 (*page 64*).
- More than half of all medicines globally are prescribed, dispensed, or sold inappropriately and half of all patients fail to take their medication as prescribed or dispensed (*page 65*).
- Some countries pay more for medicines than others - in some places prices are up to 67 times the international average price (*page 62*).

⇨ **Improving hospital efficiency.**

- Hospital care often absorbs from half to two thirds of total government spending on health (*page 67*).
- Almost US$ 300 billion is lost annually to hospital-related inefficiency (*page 67*)
- A recent review of more than 300 studies found that, on average, hospitals could achieve 15% more than they do now without spending any more (*page 67*)
- There is no strong evidence that public facilities are any more or less efficient than private hospitals (*page 68*). Efficiency can be improved everywhere.

⇨ **Choosing the right interventions:**

- In many cases, health authorities opt for high-cost, low-impact interventions, over lower-cost, higher-impact ones e.g. shifting to a more cost-effective mix of treatments for malaria could reduce costs by 20% in Zambia (*page 71*).
- Ensuring the right mix between prevention, promotion and treatment will ensure more health for the money (*page 70*).

⇨ **Finding incentives that work**

- Paying for performance can be a useful tool to improve efficiency, quality and even equity, but more research is required to evaluate its real impact (*page 76*).
- Paying providers a fee for service tends to encourage overuse. Increased demand and payment to doctors per intervention has increased use of Caesarean section deliveries in 69 of the 137 countries for which information is available - costing those countries an estimated US$ 2 billion per year (*page 74*).

- Other payment mechanisms can slow down the increase in costs. "Capitation" is one: paying primary care providers a predetermined fee to cover all the health needs of each person registered with them can also encourage a focus on prevention (*page 74*).

⇨ **Avoiding fragmentation**

- Systems with multiple funding channels and pools can duplicate effort and be more expensive to run. Some countries have streamlined: the Czech Republic, for example, has now combined different funds into a single pool (*page 49*).
- Fragmentation leads to less effective service delivery. In Estonia, injecting drug users were targeted by both HIV and drug-abuse programmes - which contracted service delivery separately with different NGOs. Both benefited when the government introduced a single contracting process, combining resources and packaging the interventions of both programmes (*page78*).
- Donor efforts, even if well intended, have also increased fragmentation by multiplying the ways funds are held globally and transmitted to countries; services are delivered; and the use of funds and outcomes are monitored and evaluated. More than 140 global health initiatives currently run in parallel. The Rwandese government has to report on more than 890 health indicators, 595 relating to HIV and malaria alone (*page 101*).