



ARGUING FOR UNIVERSAL HEALTH COVERAGE



ARGUING FOR UNIVERSAL HEALTH COVERAGE

The following pages include basic principles on health financing, country examples and evidence-based arguments to support Civil Society Organizations advocating for **health funding policies that promote equity, efficiency and effectiveness**, and ensure that the rights of the most vulnerable are not forgotten.



WHO Library Cataloguing-in-Publication Data

Arguing for universal health coverage.

1.Universal coverage. 2.Health services accessibility. 3.Insurance, Health. 4.Medical economics.

I.World Health Organization.

ISBN 978 92 4 150634 2

(NLM classification: W 74)

© World Health Organization 2013

All rights reserved. Publications of the World Health Organization are available on the WHO web site (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications –whether for sale or for non-commercial distribution– should be addressed to WHO Press through the WHO web site (www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Printed by the WHO Document Production Services, Geneva, Switzerland.

Acknowledgment

This handbook was produced under the overall direction of David Evans, Director of the Health System Governance and Financing department.

The principal writers of the report were Robert Yates and Gary Humphreys with inputs from Joseph Kutzin, Liliana Marcos and Annick Jeantet.

Contribution in the form of graphics, boxes or analysis were provided by: Joseph Kutzin and Nathalie van de Maele. Financial support from DFID is gratefully acknowledged.

Cover picture © Bethany Matta /IRIN

CONTENTS

INTRODUCTION	p. 6
WHAT IS UNIVERSAL HEALTH COVERAGE?	p. 9
WHY IS MOVING TOWARDS UNIVERSAL HEALTH COVERAGE IMPORTANT?	p. 10
= Health benefits	p. 10
= Economic benefits	p. 12
= Political benefits	p. 14
HOW CAN COUNTRIES ACCELERATE PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE?	p. 16
= The importance of human rights and Equity in filling the UHC box	p. 18
HOW CAN HEALTH FINANCING REFORMS ACCELERATE PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE?	p. 21
= Raising enough money for health services	p. 21
= Pooling funds to improve financial risk protection	p. 24
Health financing mechanisms that do not pool funds	p. 25
Health financing mechanisms that pool funds	p. 27
= Aid financing	p. 32
= Paying for health services – getting more health for the money	p. 33
CONCLUSION	p. 36



INTRODUCTION

Because progress towards Universal Health Coverage (UHC) involves a range of complex technical challenges, it is easy to lose sight of the fact that moving toward UHC is a **political process** that involves negotiation between different interest groups in society over the allocation of health benefits and who should pay for these benefits.¹ Over recent decades, civil society organizations (CSOs) have frequently played a crucial role in representing the views of the poor and the vulnerable in these negotiations, pushing for a more equitable distribution of both the responsibility for funding the system and the benefits received.² CSOs have also played an important part in shaping health systems at the national level, increasing communities' involvement in the decision making process, and in creating accountability mechanisms.

CSOs have achieved most when they have been able to develop robust positions based on solid arguments and compelling examples. It is to support CSOs in their efforts to develop such positions that this document was written. Intended for those

organizations involved in health financing policy debates, this tool articulates the pro-UHC arguments, and presents relevant evidence and examples. It is designed to support policies that promote equity, efficiency and effectiveness, and ensure that the rights of the most vulnerable are not forgotten.

The handbook also sets out some of the areas where CSOs can most effectively bring pressure to bear in order to advance the UHC agenda, notably:

- = **Advocating higher levels of public health spending.** This can be achieved by engaging in debates about overall fiscal policy to increase the size of government budgets and/or advocating a greater share of public funds to be allocated to the health sector.
- = **Encourage governments, development partners and other CSO providers to replace voluntary financing mechanisms with more efficient and equitable mechanisms based on compulsory contributions that are subsequently pooled to spread risks across the**

population. In particular, CSOs should challenge agencies and individuals that continue to advocate for direct out-of-pocket financing.

= **Participate in debates concerning UHC financing strategies and advocate for reducing the fragmentation of risk pools with contributions made according to ability to pay.**

= **Challenge strategies that create separate risk pools for more privileged groups in society** (for example civil servants or people working in the formal sector) especially if these groups are to be subsidized using public funds and advocate for strategies that include the poor and vulnerable at the out-set.

= **Engage in debates concerning the purchasing of services using pooled health funds (including the allocation of the government's health budget) and ensure that allocations are efficient and equitable.** In particular CSOs should be vigilant regarding allocations that disproportionately benefit tertiary hospital care at the expense of investing in local primary health care services, or that disproportionately benefit treatment

at the expense of prevention and promotion.

= **Conduct equity audits of health financing policies** (both in raising and allocating funds) to ensure that high-need and vulnerable groups receive their fair share of benefits and are not contributing unfairly. These groups may include women, children, elderly people, disabled people, poorer members of society, marginalized ethnic groups, people with chronic illnesses and rural communities.

= **Publicise through academic papers and the media (including social media) good and bad examples of health financing policies,** not being afraid to “name and shame” perpetrators of inappropriate policies. Holding powerful stakeholders to account is one of the most effective mechanisms to ensure that reforms proposed and/or implemented in the name of UHC are truly universal.

= **Mobilise support for UHC and financial risk protection being included as a top-level health goal in the post-2015 development framework and any new set of development goals.**

1. Savedoff W et al. Transitions in Health Financing and Policies for Universal Health Coverage: Final Report of the Transitions in Health Financing Project. Washington: Results for Development Institute; 2012. <http://r4d.org/sites/resultsfordevelopment.org/files/THF%20Summary%20-%20Transitions%20in%20Health%20Financing%20and%20Policies%20for%20Universal%20Health%20Coverage.pdf>, accessed 12 November 2013.

2. CSOs had a major role in securing the successful UHC reforms in Thailand. In particular 11 Non government organizations managed to mobilise 50,000 signatures to support a draft UHC bill which was put to the Thai Parliament in 2000. This spurred the Government into action which produced its own bill and co-opted 5 members of the CSO group into universal coverage policy formulation process. More recently in India, CSOs and in particular Jan Swasthya Abhiyan (the Indian circle of the People's Health Movement) were instrumental in persuading the State Government of Rajasthan to introduce a universal free generic medicines programme in 2011.



© Felicity Thompson / IRIN

WHAT IS UNIVERSAL HEALTH COVERAGE?

Universal Health Coverage exists when all people receive the quality health services they need without suffering financial hardship.³ UHC combines two key elements, the first relating to people's use of the health services they need and the second to the economic consequences of doing so.

The first objective is that everybody should be able to access a full-range of health services including promotion, prevention, treatment, rehabilitation and palliative care. These services should be of good quality. It is of no use having access to a scanner that is poorly calibrated or run by an untrained health worker. Because the emphasis here is on **everybody** getting the treatment they **need**, the objective includes an important equity dimension.

The second objective is to ensure protection from the financial risk associated with seeking care. The need to pay for care at the point of use (whether through explicit policies on user fees or informal payments) discourages people from using services, and can cause financial hardship for those that do seek care. The best way around this is to expand coverage with **compulsory** prepayment of some type – e.g. taxes and other government charges, social insurance premiums – that are subsequently pooled to spread risks.⁴ Contributions should reflect people's ability to pay which means that there will always need to be subsidies for the poor and vulnerable.

3. Evans D, Elovainio R, Humphreys G. World Health Report 2010. Health Systems Financing: the path to universal coverage. Geneva: WHO; 2010. <http://www.who.int/whr/2010/en/>, accessed 12 November 2013.

4. The main compulsory financing mechanisms commonly referred to are funding from the general tax revenues of government and specific, earmarked contributions (also called payroll taxes) for "social health insurance". Many countries use a combination of these mechanisms, and much of the innovation witnessed since 2000 involves breaking the traditional link between these funding sources and the overall health financing system with which they have been associated (i.e. national health service and social health insurance). Shifting mindsets away from these traditional models is crucial to the communication and advocacy efforts for UHC.

WHY IS MOVING TOWARDS UHC IMPORTANT?

For many UHC is literally a life or death issue, individuals without health coverage facing the prospect of untreated sickness and premature death for themselves and their children. UHC can also mean the difference between financial survival and destitution. For countries as a whole, increased coverage with health services has been shown to improve health indicators and contribute to stronger economic development, including the reduction of poverty levels. For political leaders, supporting a UHC agenda can deliver considerable political benefits for the simple reason that the majority of people (and of the electorate) wants access to affordable, good quality health services.

HEALTH BENEFITS

The beneficial effect of increasing coverage with needed health services of good quality is well documented. One

recent study of statistical trends from 153 countries published in *The Lancet* found that broader health coverage generally leads to better access to necessary care and improved population health, with the largest gains accruing to poorer people.⁵ These findings are borne out by recent experiences in scaling up service coverage with financial risk protection in countries with markedly different income levels.⁶ There are also many examples of countries that have significant improvements in population health as a result of initiatives designed to expand or improve coverage (box 1), though it is important to note that in each case the countries continue to struggle with coverage issues of one kind or another.

5. Moreno-Serra R, Smith P. Does progress towards universal health coverage improve population health? *The Lancet*. 2012; 380:917-23. doi:10.1016/S0140-6736(12)61039-3.

6. Evans D, Elovainio R, Humphreys G. Op. Cit., 9 p.

BOX 1: HEALTH BENEFITS OF UHC

In 1988 Brazil initiated an extensive programme of health reforms with the intention of increasing the coverage of effective services for the poor and otherwise vulnerable. Prior to 1988, the year the Unified Health System (*Sistema Único de Saúde* - SUS) came into being, just 30 million Brazilians had access to health services. Today, coverage is closer to 140 million, roughly three-quarters of the population.⁷ By boosting access to primary and emergency care, the SUS has been associated with significant improvements across a range of health indicators, notably infant mortality which fell from 46 per 1000 live births in 1990 to 17.3 per 1000 live births in 2010. Life expectancy at birth has also improved, reaching 73 years in 2010 compared to 70 years just a decade earlier. The reforms also reduced health inequalities with the life expectancy gap between the wealthier south of the country and poorer north falling from 8 years to 5 years between 1990 and 2007.

Health improvements have also been seen in some Sub-Saharan African countries that have implemented pro-UHC reforms. Even

though a range of factors may explain health improvement, the association between the results and the health reforms offers cause for optimism. Niger for example has seen a 5.1% reduction in infant mortality from 226 deaths per 1000 live births in 2000 to 128 in 2009⁸ – an annual average reduction of 5.1%, during which time the government has introduced policies supporting universal access, provision of free health care for pregnant women and children, and decentralised nutrition programmes.

Burundi has recorded a spectacular decline in infant and child mortality, which fell 43% between 2006-2011. This reduction coincides with a decision taken by the government in 2006 to eliminate user fees for services provided to pregnant women and children under five.⁹ In addition to removing financial barriers, the Government of Burundi also substantially raised public financing and introduced new performance-based financing systems. This helped channel public funds, including aid, to front line services more efficiently and enabled the government to meet the huge increase in demand for services.

7. Jurberg C, Humphreys G. Brazil's march towards universal coverage. *Bull World Health Organ* 2010; 88:646–647 doi:10.2471/BLT.10.020910.

8. Amouzou A, Habi O, Bensaïd K. Reduction in child mortality in Niger: a Countdown to 2015 country case study. *The Lancet*. 2012; 380:1169–78. doi:10.1016/S0140-6736(12)61376-2.

9. Burundi: Standard DHS, 2010. In: Measure DHS, Demographic and Health Survey [website]. Calverton: Measure DHS, 2010. <http://www.measuredhs.com/what-we-do/survey/survey-display-346.cfm>, accessed 19 November 2013. Zhang J. Results Count: How a Financing Scheme in Burundi Turned Nurses into Entrepreneurs. *Result Based Financing for Health*. May 2013. <http://www.rbhealth.org/news/item/797/results-count-how-financing-scheme-burundi-turned-nurses-entrepreneurs>, accessed 19 November 2013.

ECONOMIC BENEFITS

How health services are paid for is a key aspect of health system performance,¹⁰ but it also has profound implications for the broader economy. One of the most common forms of payment for health is direct, out-of-pocket payment for medicines and health services at the time of need and it is the poorer countries that rely on it most. An estimated 150 million people suffer financially crippling health payments because of this annually, while 100 million people are pushed below the poverty line simply because they need to use health services but must pay out-of-pocket for them.¹¹ One recent study showed that in the Indian state of Gujarat, 88 % of households falling below the poverty line attributed their plight to health care costs.¹² The problem is by no means limited to developing countries, however, as evidenced by the United States, where it is estimated that over half of personal bankruptcies are due to expenses for medical care, a situation that will hopefully change with as a result of the implementation of the Affordable Care Act.¹³

At the individual or household level, people can be protected from high out-of-pocket health expenditures through the extension of pre-paid pooled funds (boxes 2 and 3) which have the potential to reduce or eliminate the financial risk associated with sudden, unpredictable health costs. Families who benefit from such protection are not only healthier in financial terms, they also have less need to save for future health events, which often allows them to spend more on other things, boosting cash flow in the broader economy. Worries about health care bills have been the main cause of excessively high savings rates in some countries, notable among which China¹⁴, where it has had a negative impact on domestic consumption and perhaps even the world economy.

A number of countries have seen tangible economic benefits for households resulting from the introduction of UHC systems, and the reduction of out-of-pocket expenditures. Thailand is a prime example, financing its system with a mix of resources including general taxes, social health insurance contributions, private

10. Evans D, Elovainio R, Humphreys G. Op. Cit., 41 p.

11. Evans D, Elovainio R, Humphreys G. Op. Cit., 5 p.

12. Krishna A. The Mixed News on Poverty. *Current History*. 2013; 112: 20.
http://www.currenthistory.com/pdf_user_files/112_750_020.pdf (password needed), accessed 19 November 2013.

13. Himmelstein D, Thorne D, Warren E, Woolhandler S. Medical Bankruptcy in the United States, 2007: Results of a National Study. *The American Journal of Medicine*. 2009; 122:741-6 doi:10.1016/j.amjmed.2009.04.012.

14. Wheatley A. The Link Between Health Costs and National Savings Rates. *New York Times*. 3 August 2009.
<http://www.nytimes.com/2009/08/04/business/global/04inside.html>, accessed 19 November 2013.

15. Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010). Nonthaburi, Thailand: Health Insurance System.
<http://www.gurn.info/en/topics/health-politics-and-trade-unions/development-and-health-determinants/development-and-health-determinants/thailand2019s-universal-coverage-scheme-achievements-and-challenges>, accessed 19 November 2013.

16. Knaul F M et al. The quest for universal health coverage: achieving social protection for all in Mexico. *The Lancet*. 2012; 380: 1259-79. doi:10.1016/S0140-6736(12)61068-X.

BOX 2: THAILAND LOWERS OUT OF POCKET SPENDING

An independent review report on the first ten years of Thailand's Universal Coverage Scheme (UCS) shows a dramatic reduction in the proportion of out-of-pocket health expenditure, and associated falls in the number of households suffering catastrophic health expenditures and impoverishment due to health care costs. Between 1996 and 2008 the incidence of catastrophic health care expenditure amongst the poorest quintile of households covered by the UCS fell from 6.8 % to 2.8 %. The incidence of non-poor households falling below the poverty line because of health care costs fell from 2.71 % in 2000 to

0.49 %. The review calculated that the comprehensive benefit package provided by the UCS and the reduced level of out-of-pocket expenditure protected a cumulative total of 292,000 households from health related impoverishment between 2004 and 2009.¹⁵

This increase in financial protection was accompanied by an increase in the use of essential health services by UCS members in Thailand, with a 31 % increase in outpatient utilization rates and 23 % increase in inpatient utilization between 2003 and 2010. These rates had previously been too low.

BOX 3: MEXICO BRINGS HEALTH AND FINANCIAL COVERAGE

Recognising the negative impact of high out of pocket payments on the health and economic wellbeing of households, in 2004 the Government of Mexico introduced a national protection programme called *Seguro Popular*, which was mostly financed through general taxation, and modest annual contributions from richer households. Within a decade, 53 million people had enrolled, the majority coming from the four poorest income deciles. The reforms have resulted in a decrease in the incidence of catastrophic expenditures from 3.1 % to 2.0 % of the population between 2000 and 2010, and a drop in impoverishment due to health expenditure from 3.3 % to 0.8 %.¹⁶

There has also been an increase in the utilization of essential services by households,

and improved health outcomes. Between 2000 and 2006, for example, effective coverage of a number of key maternal and child health interventions, such as antenatal care, immunisations, and treatment of diarrhoea, has increased significantly with *Seguro Popular* members achieving higher coverage rates than uninsured people. This increase in service coverage has contributed to a sustained fall in child and maternal mortality rates and a reduction in health inequality. Between 2004 and 2010 child mortality rates fell by 5 % in children in families who were covered by social security and by 11 % in families who were previously uninsured but now covered by *Seguro Popular*.

insurance premiums and a relatively low level of direct out-of-pocket payments (OOP), estimated to be around 18 % of total health expenditure (box 2).¹⁷ Another country to have recorded higher levels of financial protection from health care costs following nationwide UHC-oriented reforms is Mexico (box 3).

POLITICAL BENEFITS

There is a growing recognition that reforms to promote progress towards UHC can also deliver political benefits. Financed sustainably and implemented well, such reforms can be a vote winner. It is perhaps not surprising then that many major UHC initiatives have come from political leaders in the run-up to elections and immediately following a transition of power. The following table provides a number of examples of UHC reforms which have been largely driven by a political agenda (table 1).

It is worth noting that many of the political leaders that have led these processes derived substantial political benefits in subsequent elections. Indeed some political pioneers of UHC have become national heroes. For example in 2004 the Canadian public voted in a national poll for Greatest Canadian¹⁸ and chose the architect of their UHC reforms, Tommy Douglas. Douglas fought to establish UHC in Saskatchewan Province where it proved successful and was adopted as national policy.

However, it is also important to note that initiating reforms to move towards UHC need to be planned very carefully in advance, notably in regard to their ultimate sustainability in the face of inevitable increases in demand for health care. Making promises that cannot be kept is worse than making no promises at all.

17. Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010). Op. Cit.

18. In early 2004, the Canadian television channel CBC put out a call to all people in Canada to nominate their greatest Canadian. Canadians from coast to coast were asked to vote for their greatest Canadian. After weeks of debates, Canadians chose Tommy Douglas, known as the father of medicare as The Greatest Canadian of all time. <http://www.cbc.ca/archives/categories/arts-entertainment/media/media-general/and-the-greatest-canadian-of-all-time-is.html>, accessed 19 November 2013.

TABLE 1

COUNTRY	YEAR	UHC REFORM	POLITICAL TIMING / REASON
United Kingdom	1948	Tax financed National Health Service with universal entitlement to services	Welfare state reforms of new government following the Second World War
Japan	1961	Nationwide universal coverage reforms	Provide popular social benefits to the population
South Korea	1977	National health insurance launched	Flagship social policy of President Park Jung Hee
Brazil	1988	Universal (tax-financed) health services	Quick-win social policy of new democratic government
South Africa	1994	Launch of free (tax-financed) services for pregnant women and children under six	Major social policy of incoming African National Congress Government
Thailand	2001	Universal coverage scheme extends coverage to the entire informal sector	Main plank of the populist platform of incoming government
Zambia	2006	Free health care for people in rural area (extended to urban areas in 2009)	Presidential initiative in the run up to elections
Burundi	2006	Free health care for pregnant women and children	Presidential initiative in response to civil society pressure
Nepal	2008	Universal free health care up to district hospital level	Flagship social policy of incoming government
Ghana	2008	National Health Insurance coverage extended to all pregnant women	Leading up to a Presidential election
China	2009	Huge increase in public spending to increase service coverage and financial protection	Response to growing political unrest over inadequate coverage
Sierra Leone	2010	Free health care for pregnant women and children	Presidential initiative which was a major factor in recent elections
Georgia	2012	Extending health coverage to all citizens	Key component of new Government's manifesto
USA	2012	National health reforms designed to reduce number of people without health insurance	Major domestic social policy of the President

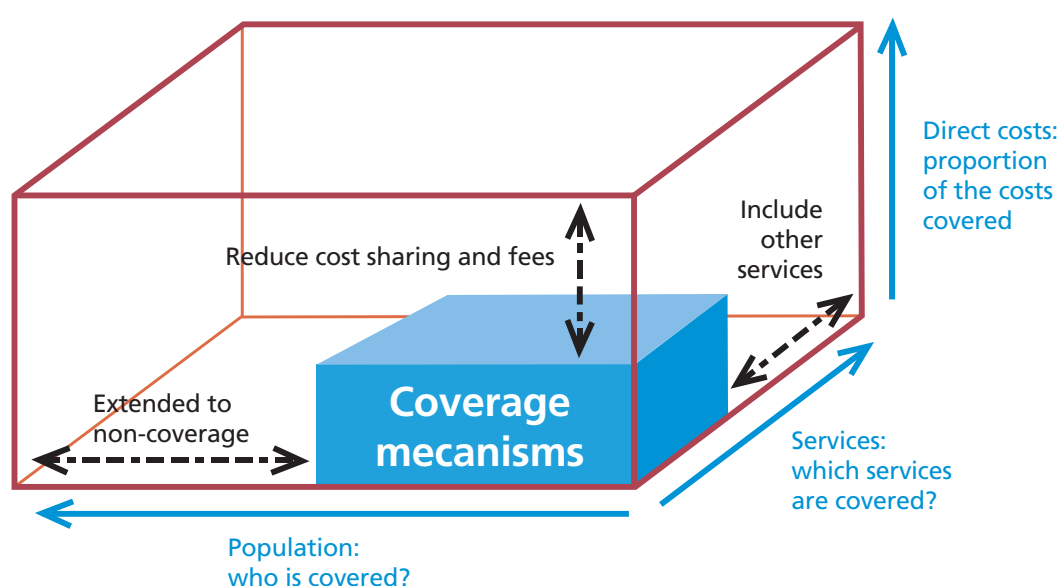
HOW CAN COUNTRIES ACCELERATE PROGRESS TOWARDS UHC?

In assessing current coverage levels and devising strategies to increase coverage, countries need to answer three questions:


- = Who is covered?
- = What services are covered (and at what level of quality)?

- = How much financial protection do citizens have when accessing services?

TOWARDS UNIVERSAL COVERAGE



Source: World Health Report, 2010 (19).



The ultimate goal of UHC is to move toward filling more of the larger cube depicted above from prepaid and pooled funds. In reality no country fills the whole cube, providing every single person with every health service they need and with full financial protection. This is primarily because all countries face resource constraints in financing their health systems and so must make difficult decisions to ration coverage along the three dimensions of population coverage, service availability and quality, and financial protection. Movement towards UHC is a process of progressive realization whereby the population understands that coverage with health services, service quality and financial risk protection will improve over time as more resources become available. Indeed, in many ways the search for UHC is a perpetual journey towards a destination that is always a little farther down the line. However, as we have seen, some countries are much closer to that destination or are making faster and more equitable progress than others.

Decision makers should recognize that progress along only one of these axis is not

sufficient. So, for example, politicians need to learn that guaranteeing everybody access to free health services is ineffective in reaching UHC if the promised services turn out to be unavailable or are of poor quality. Likewise the Ministry of Finance needs to understand the impact of adjusting the relative burden of public and private financing on the health system both in terms of service and population coverage. Finally health professionals need to be brought on board, recognizing the need to increase population coverage with services that are aligned with need, which may mean recognizing that it is sometimes appropriate to cut back on more expensive 'cutting edge' treatments in order to reach more beneficiaries.

Therefore the best way to make progress towards UHC is to involve all relevant stakeholders (including the general population) in producing a strategy that is most appropriate for the country. This strategy should agree priority actions and investments along each axis but will also recognise that trade-offs are necessary, and that imperatives change over time as the economy develops, the population ages, or the disease burden shifts.

19. Evans D, Elovainio R, Humphreys G. Op. Cit.

THE IMPORTANCE OF HUMAN RIGHTS AND EQUITY IN FILLING THE BOX

In formulating a strategy to fill the UHC box, stakeholders should also recognize that this is not purely a technical exercise; the UHC endeavour should be built on a foundation of human rights and equity.

Specifically, health systems reforms should reflect the fact that all countries in the world are signatories to the United Nations Convention on Human Rights which states²⁰: *“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”*

These fundamental rights were recently re-affirmed in a UN General Assembly (UNGA) resolution on UHC that was passed unanimously in December 2012. This resolution also explicitly recognized that prevailing coverage levels compromise the attainment of these rights, noting: *“- that for millions of people the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal, that especially for children*

and those living in poverty, the likelihood of achieving this goal is becoming increasingly remote, that millions of people are driven below the poverty line each year because of catastrophic out-of-pocket payments for health care and that excessive out of pocket payments can discourage the impoverished from seeking or continuing care.”

To redress this situation the recent UNGA resolution emphasises the importance of achieving universal **population** coverage, in acknowledging that: *“universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive²¹, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population.”*

In light of these statements, countries should ensure that the coverage needs of **all** their citizens are addressed. ‘Universal’ means universal and any strategy that explicitly leaves any person (especially people with greater needs) uncovered should be deemed unacceptable.

This does not mean that everybody has to receive their health services using the same financing sources and the same providers.

20. Universal Declaration of Human Rights, art. 25, 1948.

21. An unfortunate word that means ‘initiatives promoting health’.



© Guy Oliver/IRIN

If richer members of society choose to purchase health services using out-of-pocket financing or private insurance schemes then they should be free to do so. **However, strategies that prioritise covering privileged groups first – e.g. formal sector workers or civil servants–**

with better quality services and which leave poorer people to fend for themselves in the health care market are fundamentally inequitable, and indefensible in human rights terms.



HOW CAN HEALTH FINANCING REFORMS ACCELERATE PROGRESS TOWARDS UHC?

As already stated, the way health care is paid for is of fundamental importance with regard to UHC. In considering their financing options, governments need to consider three main functions of the health financing system:

- = Raising sufficient financial resources to cover the costs of the health system
- = Pooling financial resources to protect people from the financial consequences of ill-health, such as loss of income and having to pay for health services
- = Purchasing health services to ensure the optimal use of available resources

It should be noted that all countries, be they rich or poor, can make improvements in each of these areas in order to improve the performance of their overall health systems.

RAISING ENOUGH MONEY FOR HEALTH SERVICES

How much should countries be spending on health? There is not really a correct

answer to this question, but if UHC is the goal, then countries need to move towards predominant reliance on public funding for their health systems, as well as an organization of their systems that serves the entire population rather than catering to privileged groups. **Universal is universal.** Addressing the ever-increasing demands for service coverage is a major political and technical challenge, because both medical technology and the demand for health services are constantly increasing. This is driven by rising expectations from people who want to live longer and healthier lives, and the technological advances that make more services and interventions available. This problem does not go away as countries get richer. Indeed, evidence suggests that as countries develop, the relative demand for health services by the population compared to other goods and services increases, so the proportion of a country's Gross Domestic Product (GDP) spent on health actually increases ([graph 1](#)).

This aspect of the demand for health services has important implications for individuals and organisations such as CSOs that advocate higher levels of health spending. Countries should usually expect to spend a growing proportion of their national wealth on health as they develop in order to reflect popular demand. Given this popular mandate for increasing investment in the health system, CSOs should be prepared to challenge agencies that call for cuts in health expenditure while recognizing the legitimacy of calls for public funds allocated to health to be well-spent.

Broadly speaking, the volume and quality of services the population needs will be determined by the demographics of the country, its burden of disease (for example whether tropical diseases are prevalent and or whether there are high levels of obesity), what people's expectations are for the quality of services they should receive, and the capacity of governments, firms and individuals to provide resources for the system.

Because of this variability, there is no definitive figure for the cost of providing "full" population coverage. However, there are some international estimates that offer some indication of the kind of spending

required to support at least a minimum set of services for the entire population. One of the most recent estimates of these costs was provided by the High Level Taskforce on Innovative International Financing for Health Systems²², which estimated that around \$ 60 per person would be required in 2015 for a package that included a mix of services addressing both communicable and non-communicable diseases. For 38 countries²³ this sum represents more than 5 % of GDP and for 15, greater than 10 %. **This means that for many low-income countries external aid financing will be needed to augment domestic funds at least in the medium term.**

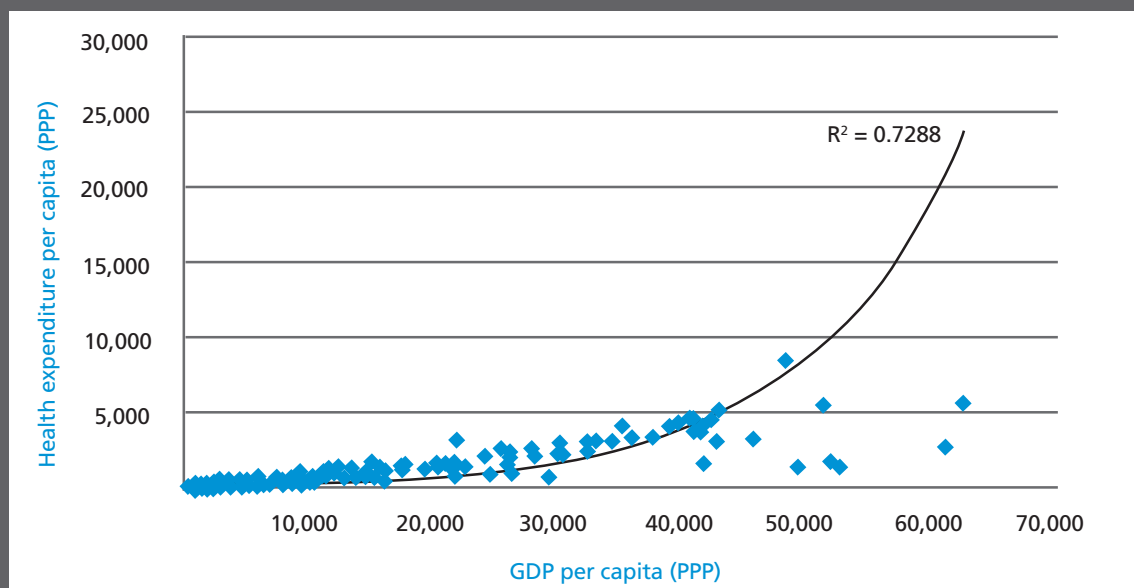
It is difficult to talk about a target for total health spending as a share of GDP because this share tends to increase on average as countries get richer. This reflects the fact that people and countries are willing to spend a higher proportion of their incomes to improve or maintain their health as they get richer. However, the low and middle income countries that have recently made good progress towards UHC all spent at least 3.5% of GDP on health even at this stage of their economic development (table 2). This translates into per capita expenditure of more than \$60 each year in all of them, often much more.

22. More money for health, and more health for the money. London: High-level Taskforce on Innovative International Financing for Health Systems; 2009. <http://www.internationalhealthpartnership.net/en/about-ihp/past-events/high-level-taskforce-for-innovative-international-financing-of-health-systems/>, accessed 19 November 2013.

23. National Account Main Aggregate Database (online database). New York: United Nation Statistic Division; 2013.

24. World Health Organization National Health Account database [online database]. Geneva: WHO; 2013. <http://apps.who.int/nha/database/DataExplorerRegime.aspx>, accessed 19 November 2013.

GRAPH 1: 2011 GLOBAL HEALTH EXPENDITURE DATA WHO MEMBER STATES
(excluding Monaco, Luxemburg and Qatar)



Source: WHO National Health Account Database, 2013 (24).

TABLE 2

COUNTRY	NOMINAL GDP per capita take out in (in US \$, UN estimates)	TOTAL HEALTH SPEND as a share of GDP	HEALTH SPEND per capita	PUBLIC HEALTH SPEND as a share of GDP	PUBLIC SPENDING as a % of total health expenditure
Cuba	6,106	10.0	610	9.5	95
Costa Rica	8,676	10.9	945	7.6	70
Mexico	10,063	6.2	624	3.0	48
Brazil	12,594	8.9	1121	4.1	46
China	5,439	5.2	283	2.9	56
Sri Lanka	2,812	3.4	96	1.5	44
Malaysia	9,977	3.6	359	1.6	44
Mongolia	3,060	5.3	162	3.0	92
Thailand	5,318	4.1	218	3.1	57
Bhutan	2,336	4.1	96	3.4	83
Rwanda	583	10.8	63	6.1	56

Source: adapted from (23, 24).

More important, however, is the role of government health spending within the public budget, the fifth column of the above table. Regardless of the precise mix of sources from which the health system is financed, it is public spending that plays a key role. Across countries, there is a clear link between public spending on health as a share of GDP and the dependence of systems on out-of-pocket payments: in general, the more money that governments spend on health, the less need for people to search for cash to obtain the services that they need.

Of course, it is not merely the level of funding but also the way it is organized and used that makes the difference. But independent of the specific approach to health financing that countries make, the poorest in our communities will not be able to contribute financially. They must be fully subsidized/ funded from government revenues. Moreover, as in all countries, government must directly fund many of the public goods in health, such as population-based promotion, regulation and legislation.

The countries that have succeeded in ensuring their populations access to a comprehensive set of health interventions, at good quality, with high levels of financial risk protection generally have more than 5 % of GDP devoted to

government health expenditures. These are largely OECD countries, however. Some of the countries in [table 1](#) spend less, but generally with smaller packages of services, longer waiting lists for services and/or less financial risk protection. Thailand is perhaps the notable exception because of its ability to keep costs under control by avoiding fee-for-service payments for health workers and institutions providing services to the universal coverage scheme.

POOLING FUNDS TO IMPROVE FINANCIAL RISK PROTECTION

The mechanisms used to pay for health services can be broken down into two main classifications: voluntary and compulsory. Taxes, government charges of various sorts, and mandatory insurance are examples of compulsory mechanisms. Non-mandatory insurance and out-of-pocket payment at the time of service use are voluntary to the extent that people choose whether or not to pay or to use services. These mechanisms may be further broken down into two subcategories, depending on whether the mechanism involves the pooling of financial resources or not.

As the name suggests, pooling involves the accumulation of prepaid contributions from individuals into an overall pool or fund which is then used to pay for services for all the members of the pool according to need. This can be funding specified for

TABLE 3

	VOLUNTARY MECHANISMS	COMPULSORY MECHANISMS
No interpersonal pooling of funds	Direct out-of-pocket payment	
	Individual health savings accounts (voluntary)	Individual health savings accounts (mandatory)
Pooling of Funds	Voluntary health insurance, managed by commercial for-profit companies, not-for-profit organizations, community groups, or governments	Government agencies including health ministries and local governments; public agencies with varying degrees of autonomy, such as compulsory/social health insurance agencies, or private (for-profit or non-profit) insurance funds that manage compulsory insurance
	Philanthropic Aid	Overseas Development Assistance

health –e.g. a health insurance pool–, or general government revenues some of which is used to finance health (e.g. in the UK). Pooling in this way reduces or eliminates the financial risks associated with ill-health. (table 3)

In assessing which of these financing mechanisms might prove useful for countries as they plan their UHC financing strategies, we need to evaluate them against three criteria. Namely is the financing mechanism:

- = **Effective**: in other words will it raise the funds required to pay for the population's need for health services?
- = **Efficient**: can funds be raised and used to buy health services without incurring large administration costs?
- = **Equitable**: does the mechanism raise funds according to people's ability to

pay and are the benefits distributed according to people's health needs?

HEALTH FINANCING MECHANISMS THAT DO NOT POOL FUNDS

Out-of-pocket payments

The simplest and most obvious financing mechanism is out-of-pocket payment, where people simply pay health service providers when they use their services. While this type of funding arrangement works well for some non-health services (for example people buying meals in a cafe) it is now universally agreed that direct out-of-pocket financing is the worst way to finance a health system. This is primarily because out-of-pocket financing fails so badly in terms of equity and financial risk protection, which are integral to achieving progress towards UHC.

“User fees for health care were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This did not happen. Instead, user fees punished the poor.”

Dr Margaret Chan, Director-General, World Health Organization, speech addressed at the 23rd Forum on Global Issues, 2009.

“The issue of point-of-service fees is critical. Anyone who has provided health care to poor people knows that even tiny out-of-pocket charges can drastically reduce their use of needed services. This is both unjust and unnecessary. Countries can replace point-of-service fees with a variety of forms of sustainable financing that don’t risk putting poor people in this potentially fatal bind. Elimination or sharp reduction of point-of-service payments is a common feature of all systems that have successfully achieved universal health coverage.”

Dr Jim Kim, President of the World Bank, speech addressed at the 66th World Health Assembly, 2013.

With out-of-pocket payment, health services are not allocated according to need but according to the ability to pay. Poor people are discouraged from seeking care, or continuing it in the case of chronic conditions. Where they have no choice but to seek care, they risk impoverishment because of the need to pay. Even when health service providers impose user fees that represent only a small part of the cost of the service provided, poor people can be excluded. Meanwhile, attempts to exempt certain groups from paying fees in order to improve access to care have often proved problematic and inefficient due to the administration costs associated with running exemption systems.²⁵

Given these different issues there is now a consensus that many countries will need to move away from out-of-pocket payments as a means of financing health services because they represent a major impediment to UHC.²⁶ It is also important to remember that a policy that simply eliminates user fees will not achieve the desired goals of increased access and greater financial risk protection if “informal payments” replace the formal fees or if quality falls. The key is to have comprehensive policies that really reduce the need for people to pay out of their own pockets.

25. Gilson L, Russell S, Buse K. The political economy of user fees with targeting: developing equitable health financing policy. *Journal of International Development*. 1995; 7(3):369-401 [DOI: 10.1002/jid.3380070305].
Masiye F, Chitah BM, McIntyre D. From targeted exemptions to user fee abolition in health care: experience from rural Zambia. *Social Science and Medicine*. 2010; 71(4):743-750.

26. Yates R. Universal health care and the removal of user fees. *The Lancet*. 2009; 373: 2078-81. doi:10.1016/S0140-6736(09)60258-0.

Individual Health Savings Accounts

As their name suggests health savings accounts are special savings accounts which individuals use to build up a personal or family fund to cover future health care payments. While this mechanism may have the advantage of smoothing payments over a period of time which can reduce the impact of punctual health care costs, the benefits only accrue to the people making the contribution, thus leaving others excluded. At the same time savings accounts held by the poor people do not pay for as much care as those held by the rich, thus failing to meet the equity criterion fundamental to attaining UHC. Where they have been introduced (e.g. Singapore), they provide only a small proportion of the overall funding for health.²⁷

HEALTH FINANCING MECHANISMS THAT POOL FUNDS

The advantages of financial risk pooling in relation to the funding of health services have already been touched on, and it because of these benefits that risk pooling schemes are widespread in the majority of countries. Whereas there is significant variation in these schemes in terms of membership, contribution rates, benefit packages and payment systems, they can still be classified into two broad groups: **voluntary insurance systems**, where people (or firms on behalf of their

employees) choose whether they want to join or remain uninsured, and **compulsory systems**, where people are either compelled by law to join an insurance programme under the terms set by the relevant legislation, or else are automatically covered as a consequence of their citizenship, residence of the country, or being part of a defined population group such as persons below the national poverty line. In the latter case, contributions take the form of government taxes and charges which are also compulsory.

Voluntary Health Insurance

In a voluntary health insurance (VHI) system people choose to pay regular contributions in exchange for financial protection from health care costs incurred when they use specified services. They may still make some direct payments (in the form of co-payments, deductibles or coinsurance) when they access care. Voluntary insurance schemes can be organized and managed in different ways, including by governments and non-profit firms. But to simplify, we choose two broad categories: Commercial (for profit) and Community (non for profit).

= **Commercial (or for profit) health insurance** which is managed by private sector companies. Insurance firms' margin depends on paying out less

27. Asher M, Ramesh M, Maresso A. Medical savings accounts in Singapore. Euro Observer. 2010; 10(4):9-11.

to health-care providers then they take in contributions (and revenue from investment). Commercial health insurance is common in developed economies where people who can afford it sometimes choose to purchase additional benefits to supplement those provided by public financing programmes. Some commercial insurance schemes can be very large (notably in the United States) and have millions of members.

- = **Community-based (not-for-profit) health insurance** which tend to be on a smaller scale and is often run by non-government organisations in developing countries. Some of these schemes may have a thousand members or less. While they do not make a profit, they too need to survive by ensuring there is a sufficient margin between their revenues and their health care expenditures, so that they can pay their staff and other administrative expenses.

Despite these different ownership arrangements, VHI schemes have much in common. They do allow for risk sharing and thus constitute a financing mechanism that is preferable to out-of-pocket financing. That being said, however, VHI markets have many inherent flaws that limit their scope to make a major contribution to the UHC agenda. They act as a magnet for older or sicker people, and

younger or healthier people who perceive that they are likely to pay in more than they will receive in benefits often opt-out. This 'adverse selection' means that schemes can easily become unviable because of the high proportion of members drawing benefits. To compensate for this, VHI schemes tend to either raise premiums for 'riskier' members, or exclude the services that such persons need from coverage. Moreover, the poor are simply unable to contribute to voluntary insurance schemes, something that has been observed with community-based (sometimes called "micro") health insurance in the absence of government subsidies. **The results are incompatible with the goal of UHC** –the poor are excluded and the healthy do not subsidize the sick.

Because of adverse selection and the exclusion of the poor, no country in the world has managed to come close to UHC by using voluntary insurance as its primary financing mechanism.

Even though community-based health insurance (CBHI) schemes are run on a not-for-profit basis, they are voluntary and suffer from the same problems of adverse selection and exclusion of the poor. Across the developing world there is a low uptake of membership from families who think they will pay into the scheme more than they will take out

BOX 4: CONCLUSION ON CBHI FROM RESYST REVIEW APRIL 2013

CBHIs have been seen as an important way of providing some protection against the user fees introduced at public sector health facilities in many African countries in the 1980s. However, the literature highlights that CBHIs generally achieve very limited population coverage if operating as voluntary schemes, tend to cover a very limited package of services and sometimes require co-payments.²⁸ There are also sustainability problems associated with these schemes due to the small risk pools. The ability of CBHIs to offer adequate

financial risk protection is dependent on whether the schemes are part of a national financial strategy that receives government support, the design (including premium rates and timing of contribution, whether the schemes cover outpatient and inpatient services, the range of accredited health care facilities), the share of costs covered by the scheme and implementation features of the scheme. Although evidence is currently limited, CBHI contributions tend to be a highly regressive form of financing health care.

in any year and many poor countries have been unable to participate. Despite this, over the last thirty years many hundreds of community-based health insurance schemes have started up with great optimism across the developing world. A recent review in Africa²⁹ (box 4) shows that overall results have been disappointing with schemes typically having low coverage rates, high drop-out rates, and high administration costs. Furthermore, the only way the poor could be included was with large subsidies from other sources (for example the government budget or donor support).

It is clear then that VHI is not likely to prove a long-term solution for achieving UHC. In some circumstances, however, voluntary prepayment may be needed simply because the fiscal constraints faced by certain countries are not adequate to provide the needed resources from compulsory mechanisms.³⁰ Real progress towards UHC requires much larger risk pools to enable redistribution to the sick and the poor. For this to happen, membership has to be compulsory.

28. Chuma J, Mulupi S, McIntyre D. Providing Financial Protection and Funding. Health Service Benefits for the Informal Sector: Evidence from sub-Saharan Africa. London: Resyst; 2013. http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/docs/reseources/WP2_financialprotection.pdf, accessed 19 November 2013.

29. Chuma J, Mulupi S, McIntyre D. Op. Cit.

30. While success stories are limited, the approach illustrated by Rwanda suggests that where such voluntary contributions are organized in an explicitly complementary manner to public financing under a national policy framework, it may be possible to make progress. But left on their own, small voluntary schemes will not achieve much – this is where a comprehensive health financing framework that ensures that local level risk pools are coordinated with overall national health policy.

Public Compulsory Health Financing Systems

It is now generally recognized that predominant reliance on mandatory contributions is crucial to establishing an equitable health financing system. Historically, countries have achieved this through two main mechanisms:

- = **General taxation and charges** where health funds are sourced from all the taxes and charges collected by government including direct taxes on income and profits, indirect taxes on the sales of goods and services and import duties.
- = **Mandatory contributions to health insurance** payments (typically called social health insurance). Traditionally contributions came from obligatory deductions from people's salaries and/or their employers, paid directly into a health insurance fund. Deductions are typically a proportion of salary, which makes contribution more equitable than the kind of flat rate payments charged by voluntary schemes.³¹

These different modes of mandatory contribution have historically been linked to different "models" of health financing systems, commonly referred to as the Beveridge (general tax revenue) and Bismarck (payroll tax for social health insurance) models. In fact, they have much in common, as each involves a

form of obligatory prepayment and the differences between them in practice has been blurred to the extent that the terms are no longer particularly relevant. For example, no social health insurance system now relies solely on wage-based deductions. General government revenues are now generally the dominant source of revenue. **Thailand's** universal coverage scheme, called insurance, is fully funded from government revenues.

Ghana's National Health Insurance Scheme combines payroll tax and earmarked value added tax into a single system with a common benefit package. (graph 2)

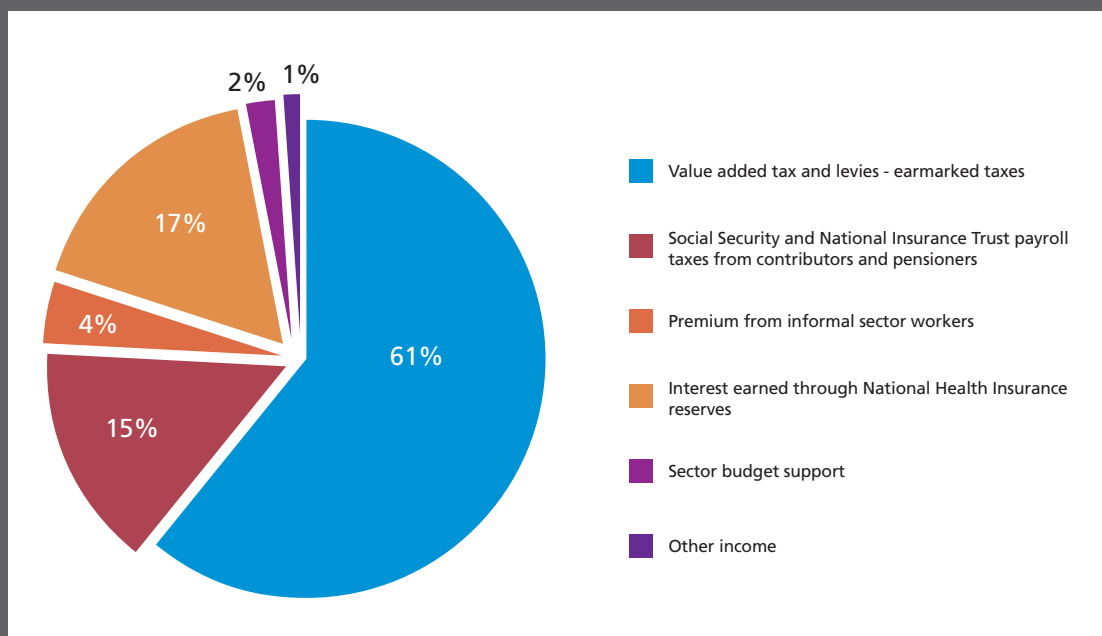
Compulsory mechanisms offer the opportunity to be more 'progressive' (meaning that the rich pay more than the poor as a percent of their ability to pay) then either VHI or out-of-pocket payments, although the extent to which this is achieved depends on how the taxes and compulsory insurance premiums are structured and who actually pays.

Experience shows that obligatory contribution mechanisms play an important role in accelerating progress towards UHC, constituting a funding basis that has the potential to be **effective, efficient and equitable**:

- = **Effective** because – if the country has an appropriate tax system and an effective

31. Note that social health insurance contributions do not have to be through salary-based contributions – in Switzerland and the Netherlands, for example, the purchase of health insurance is compulsory, but households pay them directly to the insurance funds.

GRAPH 2: GHANA'S NATIONAL HEALTH INSURANCE



Source: National Health Insurance Authority, 2009 (32).

collection machinery– they have the potential to raise substantial sums of money for the health sector, especially when richer households are obliged to contribute more.

- = Efficient because the administration costs of running compulsory taxation or premium collection systems are low relative to the cost of setting up a voluntary prepayment system, especially where they involve making computerized transfers from people's salaries or imposing value-added taxes. Where systems rely on the existing taxation system, the additional cost of raising funds from new taxes is less than in contexts where the health sector tries to establish its own collection arrangements.

Furthermore, if more people enter formal employment over time with economic growth, it becomes far easier to collect income tax and raise taxes on non-essential goods and services.

- = Equitable because it is only with increased reliance on compulsory contribution mechanisms that a country has the potential to expand its pooling arrangements to enable a larger pooled fund that can serve as a basis for redistributing health resources and services from the relatively healthy and wealthy to the poorer and sicker parts of the population.

Obligatory prepayment at the national level also offers the potential to improve

32. National Health Insurance Authority, Annual Report, Accra: 2009. [http://www.nhis.gov.gh/files/1\(1\).pdf](http://www.nhis.gov.gh/files/1(1).pdf), accessed 31 December 2013.

efficiency and equity in the health financing system if countries decide to merge smaller risk pools. **Reducing the number of risk pools brings down administrative costs and reduces barriers to redistribution, making it easier to subsidise coverage for the poor. It also worth noting here that countries that start out with fragmented pooling systems often find it difficult to merge them later because people benefitting from better schemes (i.e. higher benefits and/or lower contributions associated with schemes for civil servants or the formal sector) are reluctant to give up their privileges.**

Gabon, for example, has had to deal with the sensitive issue of social solidarity and cross subsidies by dividing its national health insurance fund (Caisse Nationale d'Assurance Maladie et de Garantie Sociale), into three separate funds and ensuring that each is sustainably financed: the poor with revenue derived from a 10 % levy on mobile phone companies' turnover, and a 1.5 % levy on money transfers outside the country, public sector workers with state budget funds, and private sector workers out of a payroll tax on employers and employees.³³

AID FINANCING

In a number of low-income countries even if efforts are raised to increase domestic funding for health and if they are pooled more efficiently, the sums raised will not be sufficient to finance services of adequate quantity and quality to the entire population. External aid financing will therefore be needed for the foreseeable future until the domestic economies of such countries are strong enough to provide sufficient resources. For aid financing to be useful in helping countries move towards UHC, it too should meet the UHC criteria of effectiveness, efficiency and equity. **This is more likely to be achieved when aid financing is used to augment domestic pooled resources (for example in providing budget support) rather than financing fragmented vertical projects.**

In addition to increasing the overall level of funds available for countries to provide health care, external aid can also be used to help countries plan and implement appropriate health financing strategies or strategies designed to strengthen human resources for health or information systems, for example. Here it is vital that donor initiatives and projects are consistent with the equity principles that should be the foundation of any UHC strategy.

33. Humphreys G, Gabon gets everyone under one social health insurance roof. Bulletin of the World Health Organization 2013;91:318-319. doi: <http://dx.doi.org/10.2471/BLT.13.020513>.



© Wendy Stone/IRIN

Donors working to support health financing should therefore be mindful of the impact their work has on the population as a whole, and particularly the poor and otherwise vulnerable, rather than being solely focused on their project's immediate beneficiaries. For

example health insurance schemes that selectively benefit those in employment³⁴ may actually impede progress towards UHC, if the Ministry of Finance is less inclined to increase the health budget because more vocal, richer members of society have secured adequate coverage.

34. World Bank/GPOBA program for IT-employees [website]. Health Insurance Fund; 2013. <http://hifund.org/index.php?page=world-bank-gbopa-program-for-it-employees>, accessed 19 November 2013.

PAYING FOR HEALTH SERVICES – GETTING MORE HEALTH FOR THE MONEY

As demand for health care has a tendency to increase and resources are limited, all countries should strive to maximise the efficiency of their health spending. However, **the purpose of encouraging countries and organisations to optimise their use of resources is not the same as encouraging reductions in health expenditure.** Rather, cost-savings should be seen as an opportunity to free up financial resources to pay for more and better services which can reach more beneficiaries.

There is considerable scope to improve efficiency in the areas of service delivery, health workforce, information, financing and governance (table 4). CSOs can play an active role in helping countries improve efficiency in each of these areas and can help governments take a more strategic and cost-effective approach when providing or buying health services. In particular, to improve overall health sector efficiency, CSOs should encourage

governments to invest in cost-effective primary health care services (in particular preventive services) and not allow expensive tertiary-level services to absorb a disproportionate share of public health spending. And when a ministry of health can demonstrate that it is getting increased value for money – more health for the money – it is easier to engage in dialogue with a ministry of finance about the need for additional funding.

One area where CSOs have a particularly good track record in helping countries improve efficiency is in improving access to medicines. Here CSOs have been shown to be very effective in helping countries switch from providing expensive branded medicines to cheaper generic drugs and in enabling countries to purchase medicines at fair prices. Here the use of international reference price information has been particularly useful.³⁵ CSOs have also been active in negotiations and disputes concerning intellectual property rights for medicines and have been very effective in promoting a rights-based approach to essential medicines.³⁶

35. See as an example the MSH International Drug Price Indicator Guide.
<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=DMP&language=English>, accessed 19 November 2013.

36. See as an example the Access Campaign of Medicines Sans Frontiers.
<http://www.msfaaccess.org/>, accessed 19 November 2013.

37. Evans D, Elovainio R, Humphreys G. Op. Cit., 63 p.

TABLE 4: TEN LEADING SOURCES OF INEFFICIENCY

SOURCE OF INEFFICIENCY	COMMON REASONS FOR INEFFICIENCY	WAYS TO ADDRESS INEFFICIENCY
1. Medicines: underuse of generics and higher than necessary prices for medicines	Inadequate controls on supply-chain agents, prescribers and dispensers; lower perceived efficacy/safety of generic medicines; historical prescribing patterns and inefficient procurement/distribution systems; taxes and duties on medicines; excessive mark-ups.	Improve prescribing guidance, information, training and practice. Require, permit or offer incentives for generic substitution. Develop active purchasing based on assessment of costs and benefits of alternatives. Ensure transparency in purchasing and tenders. Remove taxes and duties. Control excessive mark-ups. Monitor and publicize medicine prices.
2. Medicines: use of substandard and counterfeit medicine	Inadequate pharmaceutical regulatory structures/mechanisms; weak procurement systems.	Strengthen enforcement of quality standards in the manufacture of medicines; carry out product testing; enhance procurement systems with pre-qualification of suppliers.
3. Medicines: inappropriate and ineffective use	Inappropriate prescriber incentives and unethical promotion practices; consumer demand/expectations; limited knowledge about therapeutic effects; inadequate regulatory frameworks	Separate prescribing and dispensing functions; regulate promotional activities; improve prescribing guidance, information, training and practice; disseminate public information.
4. Health-care products and services: overuse or supply of equipment, investigations and procedures	Supplier-induced demand; fee-for-service payment mechanisms; fear of litigation (defensive medicine).	Reform incentive and payment structures (e.g. capitation or diagnosis-related group); develop and implement clinical guidelines.
5. Health workers: inappropriate or costly staff mix, unmotivated workers	Conformity with pre-determined human resource policies and procedures; resistance by medical profession; fixed/inflexible contracts; inadequate salaries; recruitment based on favouritism.	Undertake needs-based assessment and training; revise remuneration policies; introduce flexible contracts and/or performance-related pay; implement task-shifting and other ways of matching skills to needs.
6. Health-care services: inappropriate hospital admissions and length of stay	Lack of alternative care arrangements; insufficient incentives to discharge; limited knowledge of best practice.	Provide alternative care (e.g. day care); alter incentives to hospital providers; raise knowledge about efficient admission practice.
7. Health-care services: inappropriate hospital size (low use of infrastructure)	Inappropriate level of managerial resources for coordination and control; too many hospitals and inpatient beds in some areas, not enough in others. Often this reflects a lack of planning for health service infrastructure development.	Incorporate inputs and output estimation into hospital planning; match managerial capacity to size; reduce excess capacity to raise occupancy rate to 80–90 % (while controlling length of stay).
8. Health-care services: medical errors and suboptimal quality of care	Insufficient knowledge or application of clinical-care standards and protocols; lack of guidelines; inadequate supervision.	Improve hygiene standards in hospitals; provide more continuity of care; undertake more clinical audits; monitor hospital performance.
9. Health system leakages: waste, corruption and fraud	Unclear resource allocation guidance; lack of transparency; poor accountability and governance mechanisms; low salaries.	Improve regulation/governance, including strong sanction mechanisms; assess transparency/vulnerability to corruption; undertake public spending tracking surveys; promote codes of conduct.
10. Health interventions: inefficient mix/inappropriate level of strategies	Funding high-cost, low-effect interventions when low-cost, high-impact options are unfunded. Inappropriate balance between levels of care, and/or between prevention, promotion and treatment.	Regular evaluation and incorporation into policy of evidence on the costs and impact of interventions, technologies, medicines, and policy options.

Source: World Health Report, 2010 (37).

CONCLUSION

An understanding of the reasons for pursuing UHC—including the all-important human rights aspects of universal health coverage, and the health financing imperatives that underpin workable approaches—is the foundation of effective UHC advocacy. This brief handbook has attempted to present that foundation, and it is the hope of the writers that the arguments and examples given here will prove useful to CSOs seeking to engage governments, development partners, and

academia. As noted in the introduction, CSOs have already played an important role in advancing the UHC agenda. They have either helped building consensus around the implementation of effective policies and strategies, or supported the effective implementation of policies and strategies that ensure that universal health coverage is truly universal, ensuring the health needs of the poor and vulnerable are not forgotten. It is our conviction that they will continue to do so in the future.

REFERENCES

1. Savedoff W et al. Transitions in Health Financing and Policies for Universal Health Coverage: Final Report of the Transitions in Health Financing Project. Washington: Results for Development Institute; 2012.
<http://r4d.org/sites/resultsfordevelopment.org/files/THF%20Summary%20-%20Transitions%20in%20Health%20Financing%20and%20Policies%20for%20Universal%20Health%20Coverage.pdf>, accessed 12 November 2013.
3. Evans D, Elovainio R, Humphreys G. World Health Report 2010. Health Systems Financing: the path to universal coverage. Geneva: WHO; 2010.
<http://www.who.int/whr/2010/en/>, accessed 12 November 2013.
5. Moreno-Serra R, Smith P. Does progress towards universal health coverage improve population health? The Lancet. 2012; 380:917-23. doi:10.1016/S0140-6736(12)61039-3.
6. Evans D, Elovainio R, Humphreys G. Op. Cit., 9 p.
7. Jurberg C, Humphreys G. Brazil's march towards universal coverage. Bulletin World Health Organization 2010; 88:646–647 doi:10.2471/BLT.10.020910.
8. Amouzou A, Habi O, Bensaïd K. Reduction in child mortality in Niger: a Countdown to 2015 country case study. The Lancet. 2012; 380:1169-78. doi:10.1016/S0140-6736(12)61376-2.
9. Burundi: Standard DHS, 2010, in Measure DHS, Demographic and Health Survey [website]. Calverton: Measure DHS, 2010.
<http://www.measuredhs.com/what-we-do/survey/survey-display-346.cfm>, accessed 19 November 2013.
Zhang J. Results Count: How a Financing Scheme in Burundi Turned Nurses into Entrepreneurs. Result Based Financing for Health. May 2013.
<http://www.rbfnhealth.org/news/item/797/results-count-how-financing-scheme-burundi-turned-nurses-entrepreneurs>, accessed 19 November 2013.
10. Evans D, Elovainio R, Humphreys G. Op. Cit., 41 p.
11. Evans D, Elovainio R, Humphreys G. Op. Cit., 5 p.
12. Krishna A. The Mixed News on Poverty. Current History. 2013; 112: 20.
http://www.currenthistory.com/pdf_user_files/112_750_020.pdf (password needed), accessed 19 November 2013.
13. Himmelstein D, Thorne D, Warren E, Woolhandler S. Medical Bankruptcy in the United States, 2007: Results of a National Study. The American Journal of Medicine. 2009; 122:741-6 doi:10.1016/j.amjmed.2009.04.012.
14. Wheatley A. The Link Between Health Costs and National Savings Rates. New York Times. 3 August 2009.
<http://www.nytimes.com/2009/08/04/business/global/04inside.html>, accessed 19 November 2013.
15. Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010). Nonthaburi, Thailand: Health Insurance System.
<http://www.gurn.info/en/topics/health-politics-and-trade-unions/development-and-health-determinants/development-and-health-determinants/thailand2019s-universal-coverage-scheme-achievements-and-challenges>, accessed 19 November 2013.
16. Knaul F M et al. The quest for universal health coverage: achieving social protection for all in Mexico. The Lancet. 2012; 380: 1259-79. doi:10.1016/S0140-6736(12)61068-X.
17. Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010). Op. Cit.
19. Evans D, Elovainio R, Humphreys G. Op. Cit.
20. Universal Declaration of Human Rights, art. 25, 1948.

22. More money for health, and more health for the money. London: High-level Taskforce on Innovative International Financing for Health Systems; 2009.
<http://www.internationalhealthpartnership.net/en/about-ihp/past-events/high-level-taskforce-for-innovative-international-financing-of-health-systems/>, accessed 19 November 2019.
23. National Account Main Aggregate Database (online database). New York: United Nation Statistic Division; 2013.
24. World Health Organization National Health Account database [online database]. Geneva: WHO; 2013.
<http://apps.who.int/nha/database/DataExplorerRegime.aspx>, accessed 19 November 2013.
25. Gilson L, Russell S, Buse K. The political economy of user fees with targeting: developing equitable health financing policy. *Journal of International Development*. 1995; 7(3):369-401 [DOI: 10.1002/jid.3380070305].
Masiye F, Chitah BM, McIntyre D. From targeted exemptions to user fee abolition in health care: experience from rural Zambia. *Social Science and Medicine*. 2010; 71(4):743-750.
26. Yates R. Universal health care and the removal of user fees. *The Lancet*. 2009; 373: 2078-81. doi:10.1016/S0140-6736(09)60258-0.
27. Asher M, Ramesh M, Maresso A. Medical savings accounts in Singapore. *Euro Observer*. 2010; 10(4):9-11.
28. Chuma J, Mulupi S, McIntyre D. Providing Financial Protection and Funding. *Health Service Benefits for the Informal Sector: Evidence from sub-Saharan Africa*. London: Resyst; 2013.
http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/docs/reseources/WVP2_financialprotection.pdf, accessed 19 November 2013.
29. Chuma J, Mulupi S, McIntyre D. Op. Cit.
32. National Health Insurance Authority, Annual Report, Accra: 2009. [http://www.nhis.gov.gh/files/1\(1\).pdf](http://www.nhis.gov.gh/files/1(1).pdf), accessed 31 December 2013.
33. Humphreys G, Gabon gets everyone under one social health insurance roof. *Bulletin of the World Health Organization* 2013;91:318-319. doi: <http://dx.doi.org/10.2471/BLT.13.020513>.
34. World Bank/GPOBA program for IT-employees [website]. Health Insurance Fund; 2013.
<http://hifund.org/index.php?page=world-bank-gbopa-program-for-it-employees>, accessed 19 November 2013.
37. Evans D, Elovainio R, Humphreys G. Op. Cit., 63 p.



ARGUING FOR UNIVERSAL HEALTH COVERAGE | 2013

This handbook includes basic principles on health financing, country examples and evidence-base arguments to support Civil Society Organizations advocating for health funding policies that promote equity, efficiency and effectiveness, and ensure that the rights of the most vulnerable are not forgotten.



**World Health
Organization**

ISBN 978 92 4 150634 2



9 789241 506342