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ACHIEVING UNIVERSAL HEALTH COVERAGE: DEVELOPING THE HEALTH FINANCING SYSTEM

World Health Organization
Department of Health Systems Financing
Health Financing Policy

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To ensure universal coverage in countries that have not already done so, it will be necessary to increase the extent of prepayment and reduce the reliance on out-of-pocket payments and user fees. This can be done by developing more extensive and equitable tax-based systems, or social health insurance-based systems or mixes of those. This brief describes key decisions that have to be made during the transition for improving the health financing functions of revenue collection, pooling and purchasing or provision of services.

What is universal coverage and how can it be achieved?

Universal coverage of health care means that everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost.[1] Universal coverage thus implies *equity of access* and *financial risk protection*. It is also based on the notion of equity in financing, i.e. that people contribute on the basis of ability to pay rather than according to whether they fall ill. This implies that a major source of health funding needs to come from prepaid and pooled contributions rather than from fees or charges levied once a person falls ill and accesses services.[2]

Universal coverage requires choices to be made in each of the three components of a health financing system:

- *revenue collection*: financial contributions to the health system have to be collected equitably and efficiently;
- *pooling*: contributions are pooled so that the costs of health care are shared by all and not borne by individuals at the time they fall ill (this requires a certain level of solidarity in the society); and
- *purchasing*: the contributions are used to buy or provide appropriate and effective health interventions.

Countries that have achieved universal coverage have developed prepayment systems that are commonly described as *tax-based* or *social health insurance-based* (SHI). In a tax-based system, general tax revenue is the main source of financing, and the available funds are used by the government to provide or purchase health services. In an SHI system, contributions come from workers, the self-employed, enterprises and government. In both, the contributions made by all contributors are pooled and services are provided only to those who need them. The financial

[1] See the background document "Social health insurance---Sustainable health financing, universal coverage and social health insurance" to the Resolution of the Executive Board at its 115th Session (Resolution EB115.R13), www.who.int/health_financing . The Resolution itself is presented in the Annex.

[2] See HSF's Technical Brief for Policy-Makers 2 on Designing Health Financing Systems to Reduce Catastrophic Health Expenditure

risks associated with ill health in the population as a whole are shared by all contributors, and the pooled funds therefore perform an insurance function. In tax-based systems, however, the insurance is implicit (in general, people do not know how much of their taxes they are contributing to fund health services), whereas in SHI it is explicit (in general, people know what they are paying for health). In both systems, the funds are usually used to purchase or provide services from a mix of public and private providers. In an SHI system, the individual contributors generally have the right to a specific, defined benefit package; in a tax-based system, benefit packages also exist in terms of the type of services available, or the time at which services can be accessed, but details are not always explicit.

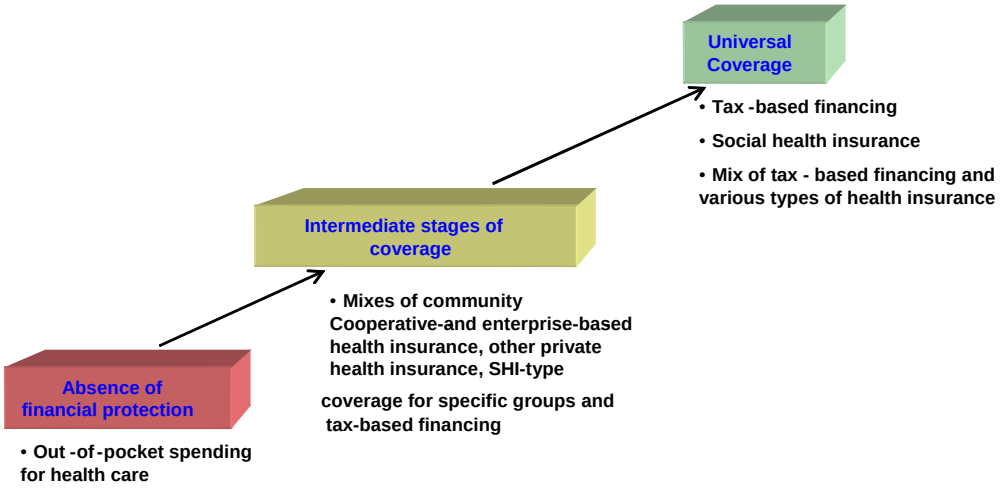
It is quite common for countries to have a *mixed* financing system, with specified groups covered by health insurance and the remainder of the population by general taxes. In almost all systems, individuals or households are still required to make some out-of-pocket payments when receiving selected services (e.g. fees or co-payments for consultations, medication, tests, hospitalization etc.), although the contribution these payments make to total health expenditures is generally small compared to countries that have not yet attained universal coverage.

Transition to universal coverage

The financing systems required to achieve universal coverage in countries that have not yet done so will need to evolve over a number of years. At the beginning of the transition, population coverage is incomplete, with the poorest groups often the least likely to be protected. There is high reliance on fees and charges households must pay to receive services. In the early phases, it will be necessary to move away from direct payment for services by households to forms of prepayment, which might combine different approaches to protecting people from financial risks while ensuring adequate funds are available to provide services. These might involve community-, cooperative- and enterprise-based health insurance, other forms of private health insurance, and compulsory SHI-type coverage for particular population groups. It will almost certainly require some continued tax-based funding (see Figure 1).

The mechanisms that exist in the intermediate stage do not necessarily disappear when universal coverage has been achieved. Indeed, they can be important institutional mechanisms to build upon. In addition, *within* each of the universal coverage mechanisms, private health insurance can be used to finance health services that are not part of the universal health care package.

Figure 1: The transition to universal coverage



A crucial issue in the transition phase is "pool fragmentation", in which many small fund pools exist at the same time. They might so small that a few people requiring expensive care will bankrupt the scheme or put it at financial risk. Policy-makers should ensure at an early stage that organizational mechanisms – known as risk equalization measures – are in place to allow funds to be transferred from schemes with relatively low risk exposure to those at greater risk. In addition, where funds are geographically-based, or are allowed to restrict access to rich or healthy people, some funds will be wealthy while some are poor. This leads to inequitable access to services, inviting governments to redress this inequity via regulation.

Speed of the transition

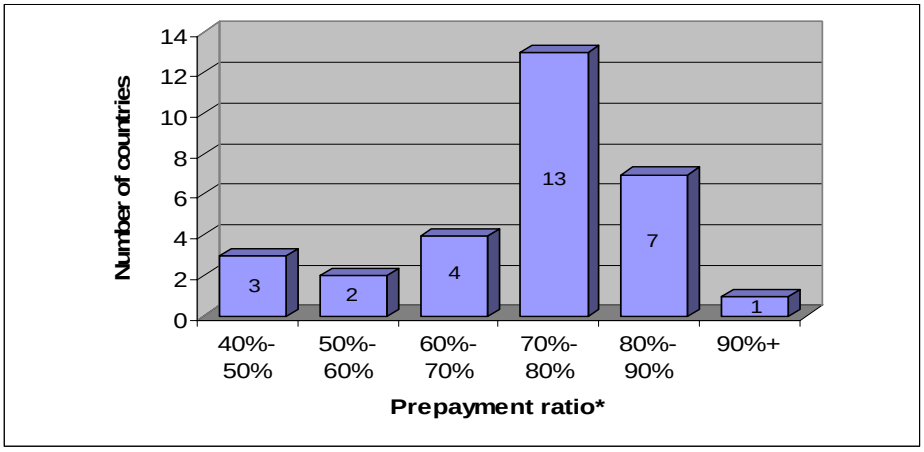
Whatever type of health financing mechanism a country decides to adopt, the transition to universal coverage may take several years, even decades. For example, in Japan 36 years elapsed between the enactment of first law related to health insurance and the final law implementing universal coverage. A similar time was needed to achieve a universal tax-based system in the United Kingdom.

A number of factors influence the speed of transition to universal coverage. Major factors that can speed up the transition include: high economic growth, which increases people's capacity to contribute to a health financing scheme; a growing formal sector, which makes it easier to assess incomes and collect contributions; and availability of skilled personnel to administer a nationwide system. Other important facilitating elements are acceptance of the concept of solidarity by the society, effectiveness of the government's stewardship, and the population's trust in government.

Level of prepayment

Few systems meet the entire costs of health care from the prepaid and pooled funds. Most require some type of co-payment or charge households are required to pay out-of-pocket to use health services; this also helps contain excessive utilization, of medication, diagnostics and hospitalization, for example. It is crucial that the out-of-pocket payments made by patients at the time of service are not so high that they reduce access to care, or expose individuals to serious financial risks. By way of illustration, Figure 2 shows the level of prepayment in the 30 countries of the Organisation for Economic Co-operation and Development (OECD), all of which have, or are approaching, the stage where universal coverage is achieved. As can be seen, all but three of the countries meet the majority of their health care costs through prepaid, pooled funds, while for twenty-one of them, the prepayment ratio is greater than 70%.

Figure 2: Prepayment ratios in the OECD countries



* equals health expenditure financed via the UC-health financing system / total health expenditure

Which health financing mechanism should countries select?

It is not possible to say that one way of raising funds is the best for all settings, or has distinct advantages in terms of impact on health outcomes, responsiveness to patients, and efficiency. Indeed, of the OECD countries, 15 have a system dominated by SHI financing, 12 have a tax-based system, and 3 have a mixed system.

There are, however, important decisions that need to be made with each type of health financing mechanism.

- *Administrative efficiency and transparency.* Tax-based financing is often associated with greater efficiency in revenue collection, since the funds flow directly from the Ministry of Finance to the Ministry of Health, and are then allocated to health services or districts within the country. However, the SHI option may be a more transparent method of financing, since households and enterprises contribute directly, and receive a specified benefit package. Where there are several insurance funds, individuals may have some choice as to which fund they join. However, in poor countries with a large informal sector, it is difficult to identify how much people earn, and to collect taxes and health insurance contributions. Ways of improving the efficiency and equity of revenue collection are important to develop.
- *Stability of funding*. It is difficult to distinguish a clear advantage of one system in this area. Tax-based systems draw their revenue from a broad base of sources, with policy negotiations often focusing on the percentage to be allocated for health. Conversely, in SHI systems, the focus is more on seeking ways to avoid sole reliance on wage-based contributions, including the use of government subsidies.
- *Equity*. It is not possible to state that one method always performs better than the other. In tax-based systems, equity in financing depends on the relative progressivity or regressivity of the tax system. In SHI systems, the issue is whether contributions are identical for all enrolees, or whether they vary according to income. The former method is regressive. Another important issue is whether all people have access to the same set, or package, of health services and again, this is sometimes equitable in tax based systems, and sometimes inequitable. The same is true for SHI systems. So important decisions need to be made about how to raise funds equitably and how to ensure equity in access, regardless of the type of system,
- *Pooling*. Both systems are vulnerable to pool fragmentation in the absence of appropriate regulation. In tax-based systems, fragmentation is likely to be geographically based, especially when there is a high level of decentralization. In SHI, fragmentation occurs between funds, whose membership may be based on characteristics other than place of residence, e.g. profession. For both, risk equalization measures should be in place to reduce disparities in the exposure to risk of funds, or to ensure that poor funds can provide a similar set of health services as rich funds.
- *Purchasing*. All health financing systems face similar challenges in choosing which health services to buy or provide, who should provide them, and which payment mechanisms are used. The fact that government plays a critical role in the collection of funds for health does not necessarily mean that governments should provide care. Most systems use a variety of methods of service provision, involving a mix of public, private for profit and private not-for-profit providers. Similarly, a variety of methods for purchasing care from the non-government sector are used, both in SHI and tax-based systems. The key objective is to build incentives for high quality, appropriate care. A subsequent Technical Brief for Policy-Makers will focus on provider-payment mechanisms and the incentives they provide for good quality care - preventive and curative.

Policy-makers seeking to move their countries down the road to universal coverage must therefore make important decisions about how to raise funds, how to pool them and how to

provide or purchase services, regardless of the health financing mechanism they opt for. The convergence to a particular mechanism is likely to be influenced primarily by its history and constraints and opportunities of a social, economic or political nature. A first crucial factor is the organizational context, and the possibility of building on existing successful institutions. For instance, if a country already has a well run tax-based system, it may be appropriate to continue along this route. Conversely, if there is a tradition of mutual health organizations or nongovernmental sickness funds, the country may decide to build on this. In all cases, *government stewardship* and a strong *political will* to undertake the necessary health financing reform are essential.

Another important influencing factor is the *state of the economy*. A tax-based financing system will appear very attractive when the economy is strong and growing steadily, so that government finance can be tapped in a sustainable way. An SHI system may become attractive, however, when there are continued constraints on government finance, so that other actors have to contribute and there are earmarked funds for health. However, there is a risk of negative effects on employment especially in low-income countries (should SHI revenues depend excessively on payroll taxes) and questions of managerial feasibility (referring especially to potential problems with registration and collection of contributions from the self-employed and informal sector workers).

Regardless of how funds are raised, informed decisions must be made about how to pool the funds, and how to use them to purchase or provide services. It is partly for this reason that such a variety of different types of organizational mechanisms can be observed across the countries that have achieved universal coverage.

Conclusion

Ultimately, a country's choice of health financing system should be guided by how best it can achieve universal coverage given its current situation. Prepayment and pooling of resources and risks are basic principles in ensuring access to needed services and financial protection. Universal coverage will not be achieved without the development of institutions that allow prepaid funds to be pooled and used to provide services (promotive, preventive, curative and rehabilitative) in an efficient and equitable way. Government has an important stewardship role in steering this process, while maintaining a certain level of pragmatism during the transition to respond to changes in the society or the economy.

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ANNEX

WHA58.33
25 May 2005

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY

Agenda item 13.16

Sustainable health financing, universal coverage and social health insurance

The Fifty-eighth World Health Assembly,

Having considered the report on social health insurance;

Noting that health-financing systems in many countries need to be further developed in order to guarantee access to necessary services while providing protection against financial risk;

Accepting that, irrespective of the source of financing for the health system selected, prepayment and pooling of resources and risks are basic principles in financial-risk protection;

Considering that the choice of a health-financing system should be made within the particular context of each country;

Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, including the introduction of social health insurance;

Noting that some countries have recently been recipients of large inflows of external funding for health;

Recognizing the important role of State legislative and executive bodies in further reform of health-financing systems with a view to achieving universal coverage,

1. URGES Member States:

(1) to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;

(2) to ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that the insurees will receive equitable and good-quality health services according to the benefits package;

(3) to ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole;

(4) to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to achieving health for all;

(5) to recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular macroeconomic, sociocultural and political context of each country;

(6) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government stewardship;

(7) to share experiences on different methods of health financing, including the development of social health insurance schemes, and private, public, and mixed schemes, with particular reference to the institutional mechanisms that are established to address the principal functions of the health-financing system;

2. REQUESTS the Director-General:

(1) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly prepayment schemes, including social health insurance, with a view to achieving the goal of universal coverage and taking account of the special needs of small island countries and other countries with small populations; and to collaborate with Member States in the process of social dialogue on health-financing options;

(2) to provide Member States, in coordination with the World Bank and other relevant partners, with technical information on the potential impact of inflows of external funds for health on macroeconomic stability;

(3) to create sustainable and continuing mechanisms, including regular international conferences, subject to availability of resources, in order to facilitate the continuous sharing of experiences and lessons learnt on social health insurance;

(4) to provide technical support in identifying data and methodologies better to measure and analyse the benefits and cost of different practices in health financing, covering collection of revenues, pooling, and provision or purchasing of services, taking account of economic and sociocultural differences;

(5) to provide support to Member States, as appropriate, for developing and applying tools and methods to evaluate the impact on health services of changes in health-financing systems as they move towards universal coverage;

(6) to report to the Fifty-ninth World Health Assembly, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Fifty-eighth World Health Assembly.

Ninth plenary meeting, 25 May 2005
A58/VR/9