

# The World Health Report

## HEALTH SYSTEMS FINANCING

*The path to universal coverage*



World Health  
Organization

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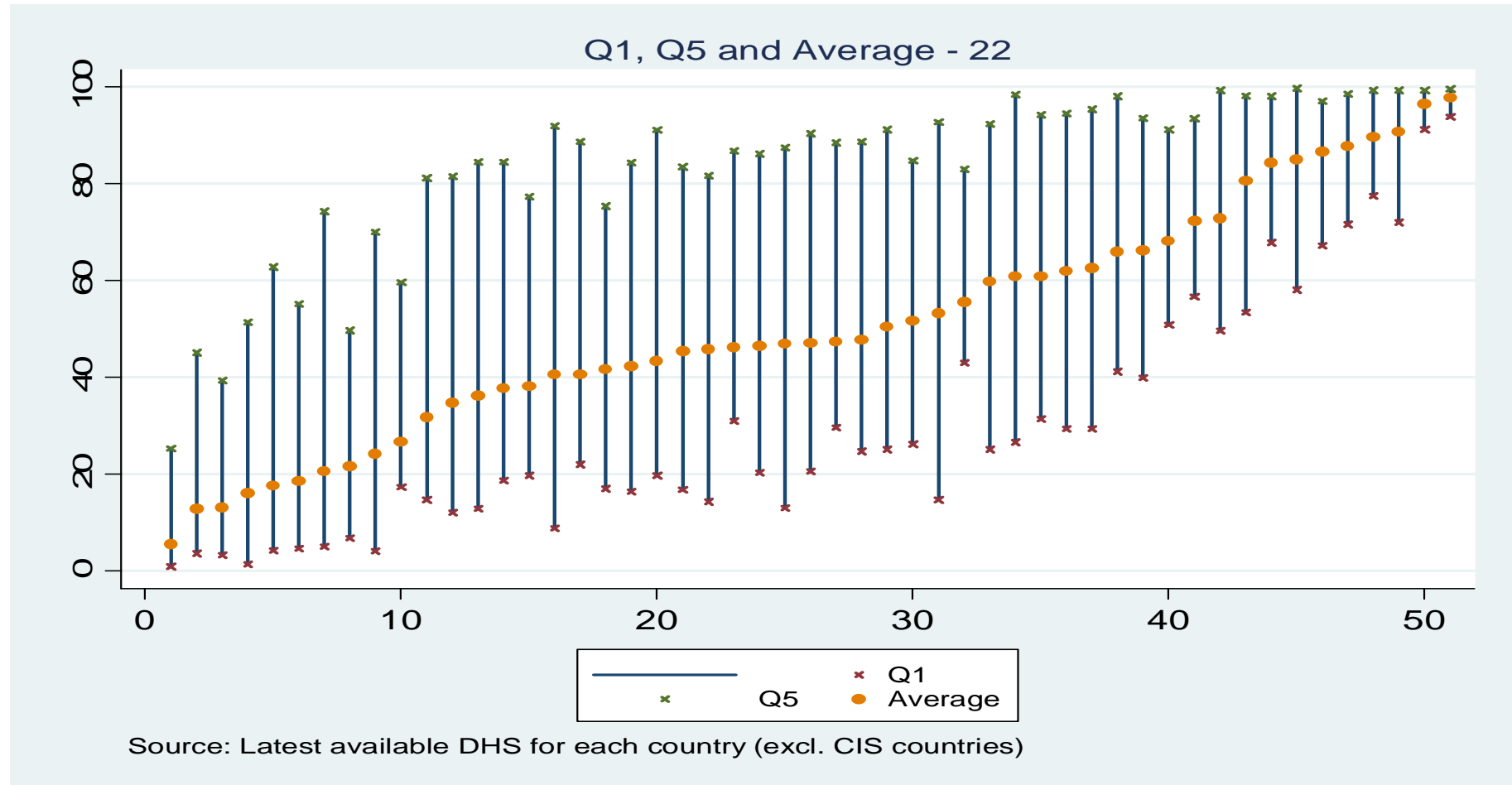
# OUTLINE

- 1. How universal is coverage?**
- 2. Health systems financing:  
determinant and solution**
- 3. The World Health Report 2010  
and beyond**

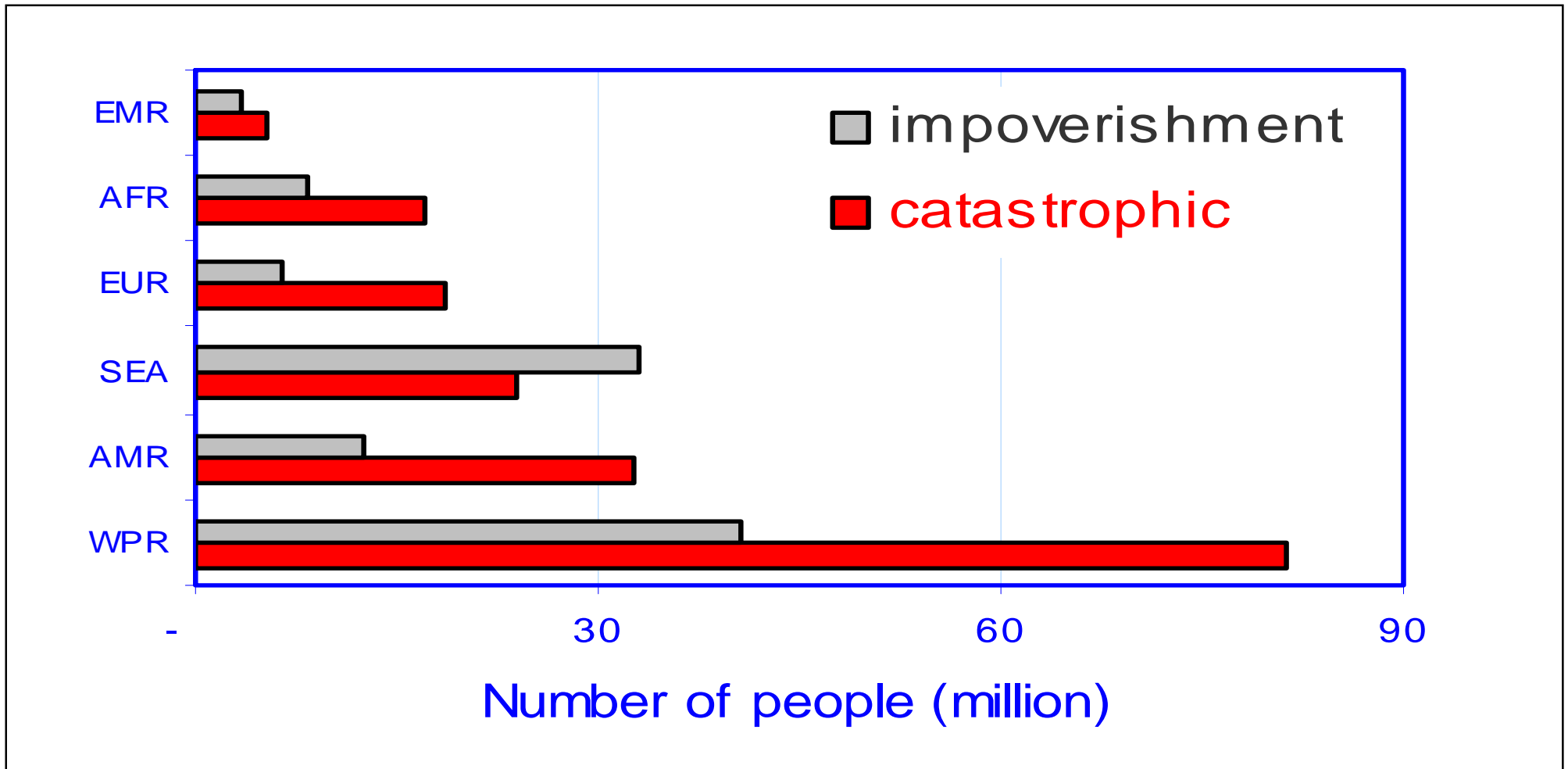


# Millions miss out on needed health services

## Percentage of births by medically trained persons



# Millions more suffer financially when they use health services



# Diagnosis: *What are the causes?*

- ① **Exclusion linked to factors outside the health system** – inequalities in income and education and social exclusion associated with factors such as gender and migrant status.
- ② **Weak health systems:** Insufficient health workers, medicines and health technologies. Ineffective service delivery. Poor information systems and weak government leadership.
- ③ **Health financing systems that do not function.** The other parts (health system building blocks) cannot function if the financing system is weak.

# Formal Definition of Universal Coverage

**World Health Assembly Resolution 58.33, 2005:**

**Urged countries to develop health financing systems to:**

- Ensure all people have access to needed services**
- Without the risk of financial ruin linked to paying for care**

**Defined this as achieving **Universal Coverage**: coverage with health services; with financial risk protection; for all**



# Universal Coverage: an important component of Primary Health Care



# Proposing Solutions: *The World Health Report 2010*

1. Draws on country experiences and the best evidence to suggest options: countries can adapt to their own health financing problems.
2. The WHR is not aimed solely at low income countries. All countries, rich and poor, face at least one of the following problems:
  - ➔ *The continual need to search for sufficient funds for health;*
  - ➔ *The need to ensure/maintain financial risk protection – financial barriers do not prevent people using needed health services nor lead to financial ruin when using them.*
  - ➔ *The need to address inefficiency and inequity in using resources.*



# 1: *Insufficient funds: low-income countries*

- **A set of essential health services focusing on the Millennium Development Goals would cost on average US\$ 42 per capita in low-income countries in 2009, rising to US\$ 65 in 2015.**
  - ⇒ 31 of the 49 low-income countries spend less than US\$ 35 per capita
  - ⇒ Only 8 have any chance of reaching the required funding from domestic sources by 2015 - even assuming rapid growth of their domestic economies.
  - ⇒ **More, and more predictable external funds for health are urgently needed.**

# 1: Insufficient Funds: high and middle-income countries

**High and middle-income countries are also constantly searching for sufficient funds because:**

- ➔ *Technological advances (e.g. in medicines, diagnostics, surgical procedures, prevention options) increase the opportunities for promoting and maintaining health;*
- ➔ *Technical advances generally come at higher cost; and*
- ➔ *Aging populations and the increase in non-communicable diseases increase needs.*

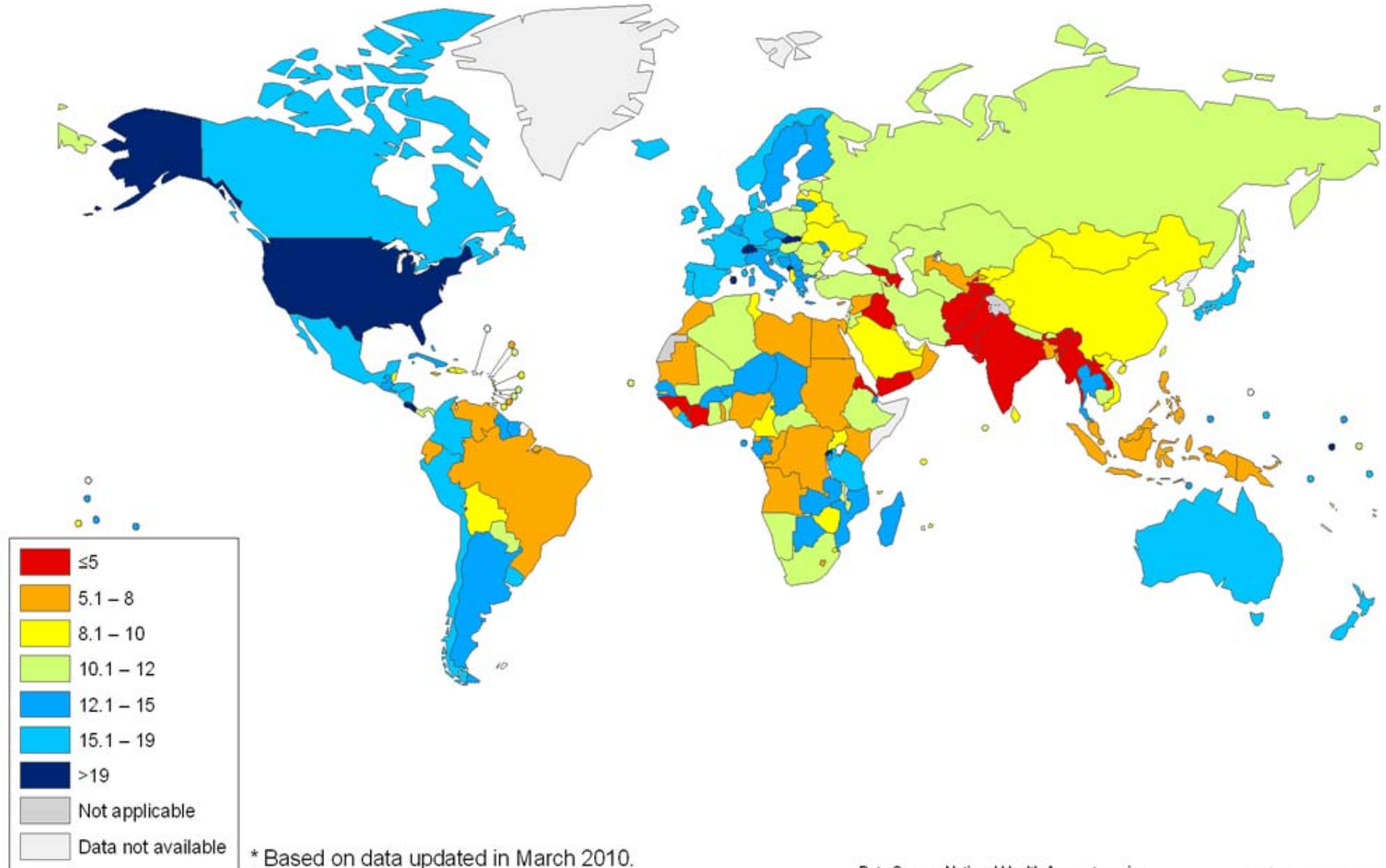
# Proposing Solutions: Increased Priority to Health

## Increased priority to health in budget allocations

- 45 governments devote less than 8% of their spending to health, and 14 devote less than 5%
- Only three of the signatories of the 2001 Abuja Declaration (promising 15% of government expenditures to health) reached it in 2007
- Taken as a group, the 49 low-income countries could raise an additional US\$ 15 billion per year for health from domestic sources by moving to 15% - almost doubling government health expenditures



## Government expenditure on health, 2007 \* (share of the total government expenditure, %)



The boundaries and names shown and the designations used on this map 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.

Data Source: National Health Accounts series,  
World Health Organization  
Map Production: Public Health Information  
and Geographic Information Systems (GIS)  
World Health Organization



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# Proposing Solutions: Raise more domestically

## Raise revenue for health more efficiently

- In Indonesia clear and consistent regulations and a policy of zero-tolerance for corruption increased tax yield from 9.9% to 11% of non-oil GDP over 4 years

## Find new or diversified sources of funds e.g.

- **Sales taxes:** *Ghana funded its national health insurance partly by increasing the value-added tax (VAT) by 2.5%*
- **"Sin" taxes, particularly on tobacco and alcohol:** *a 50% increase in tobacco tax alone would yield an additional US\$1.42 billion just 22 low income countries for which sufficient data exists – allowing government health expenditure to increase by 25%.*
- **A currency transaction levy would be feasible in many countries - India could raise US\$ 370 million per year from a very small levy (0.005%).**
- **Solidarity levies - Gabon raised \$30 million for health in 2009 partly by imposing a 1.5% levy on companies handling remittances from abroad**

## 2: *Direct payments prevent some people using health services and result in financial ruin for many who do*

- ➔ Direct, out-of-pocket payments include charges or fees (official and unofficial) levied for consultations, investigations, hospitalization, medicines and other supplies that patients must pay themselves.
- ➔ Where there is health insurance, they also include all charges that are not reimbursed or paid directly by the insurance system.
- ➔ Direct payments are the major reason why a large proportion of the world's 1.3 billion poor cannot use the health services they need, and why 100 million are pushed into poverty simply because they use health services.
- ➔ The incidence of severe financial hardship linked to paying directly for health services falls to negligible levels, and financial access to services increases, when out-of-pocket payments account for less than 15%-20% of all health expenditures.
- ➔ **33 countries currently raise more than half their funds for health from forms of direct payments, while another 60 raise more than 30%**

# Proposing Solutions: *Reducing the impact of direct payments on the vulnerable*

- 1. Mechanism:**  
➔ **Increasing "prepayment" through health insurance and/or taxes with pooling.**
- 2. Recent experience in Brazil, Chile, China, Colombia, Costa Rica, Ghana, Kyrgyzstan, Mexico, Republic of Moldova, Rwanda, Thailand, Turkey and Sierra Leone show that major advances can be made even in low- and middle-income countries.**
- 3. Community and micro-insurance can play a useful role in the early stages, but plans to merge them over time are important - bigger pools are more financially viable than small community-based pooled funds.**
- 4. It is difficult to ensure universal coverage without making contributions (taxes and/or insurance) compulsory. If the rich and the healthy opt out, the poor and sick are left with sub-standard services from the limited funds that remain.**

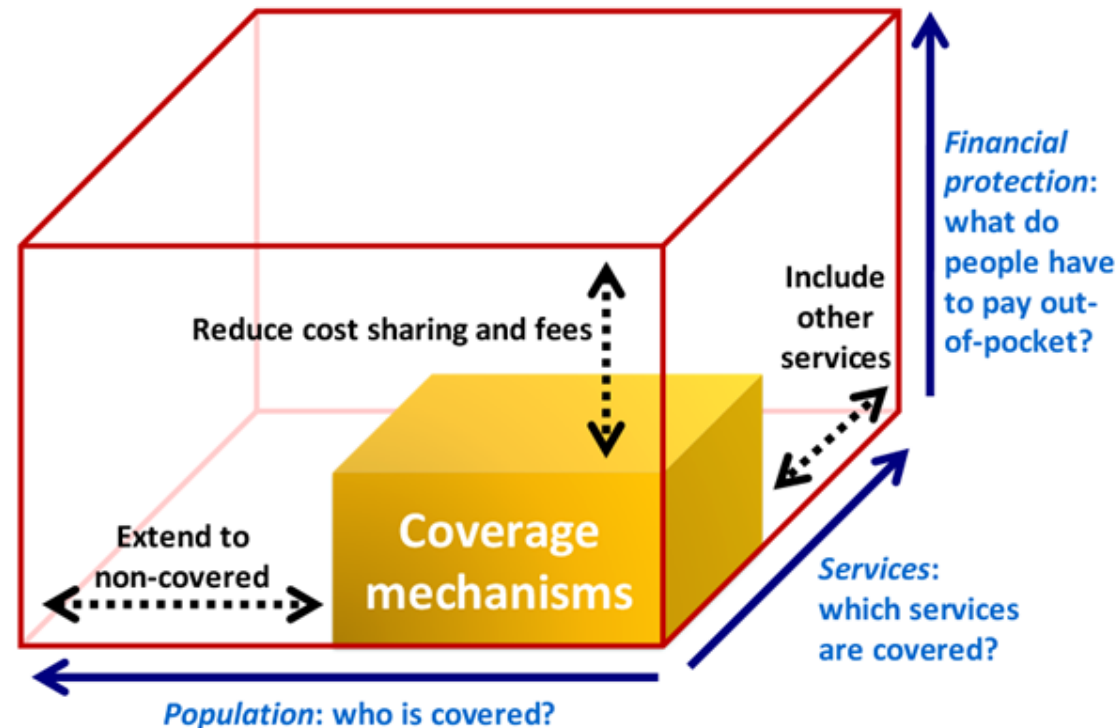


# The Three Dimensions (policy choices) of Universal Coverage

- **Philippines** has health insurance:
- BUT financial protection still low with high OOP of  $\pm 50\%$  of THE

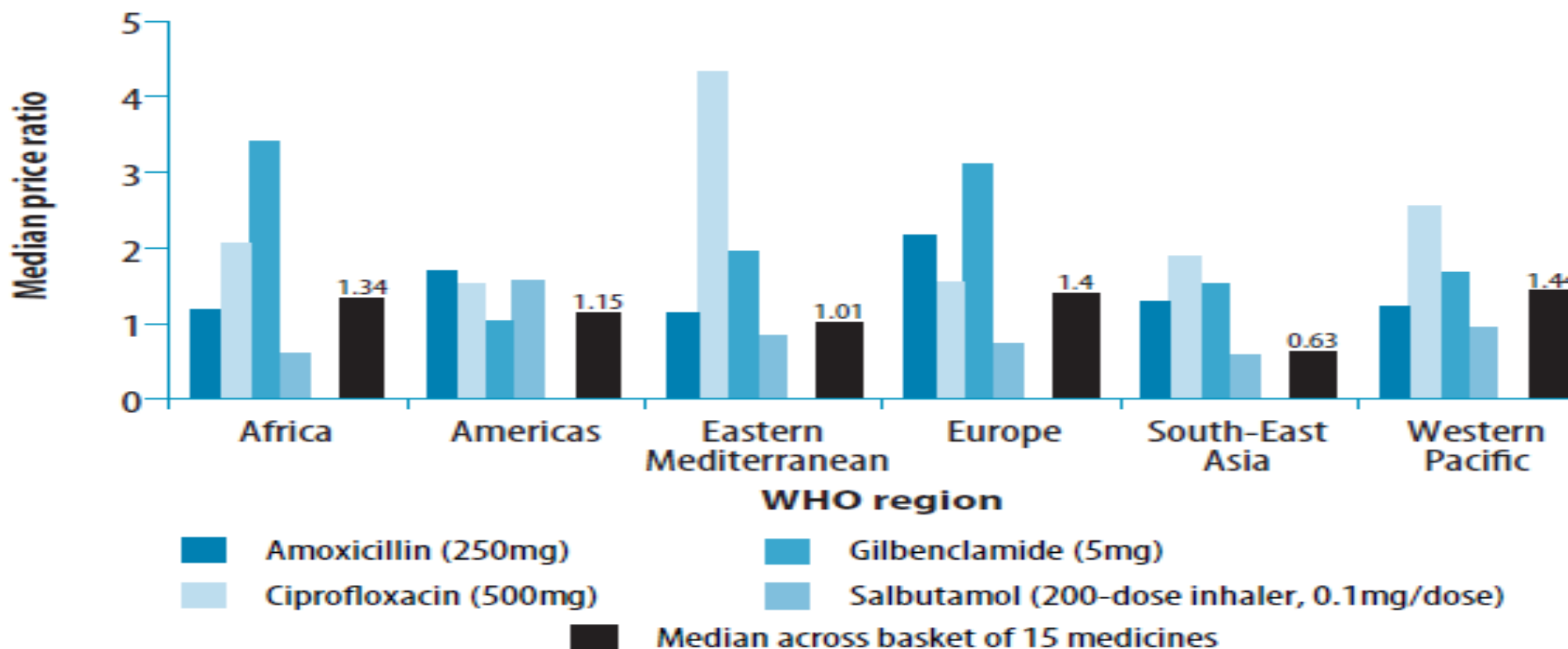
1. Population Coverage (35-85%)
2. Benefit package: OPD
3. Reimbursement levels

## Towards universal coverage



# 3. Inefficiency

**Fig. 4.2. Median price ratios of public-sector procurement prices for generic medicines,<sup>a</sup> by WHO region**



<sup>a</sup> Ratio of the median procurement price to the international reference price of the Management Sciences for Health.

# Causes of Inefficiency

- ➔ Inefficiency is found in all countries. Common causes:
  - *Spending too much on medicines and health technologies, using them inappropriately, using ineffective medicines and technologies*
  - *Leakages and waste, again often for medicines*
  - *Hospital inefficiency particularly over-capacity*
  - *De-motivated health workers, sometimes workers with the wrong skills in the wrong places*
  - *Inappropriate mix between prevention, promotion, treatment and rehabilitation, or between levels of care*
  
- ➔ If all types are present, efficiency gains would effectively result in increasing the available funds for health by 20-40%. i.e. substantially more health for the money could be obtained by reducing inefficiency

# Proposing Solutions: Encourage greater efficiency

- Identity and reduce the specific sources of inefficiency (e.g. medicines)
- Examine and reduce incentives that current encourage inefficiency

## *For example:*

- 1. Paying providers:** move away from fee for service if possible. Consider results-based payment where good monitoring is possible.
- 2. Reduce duplication** – e.g. reduce duplicative:
  - Funding channels;
  - Laboratory systems;
  - Auditing and monitoring systems;
  - Reporting systems including reporting to donors.

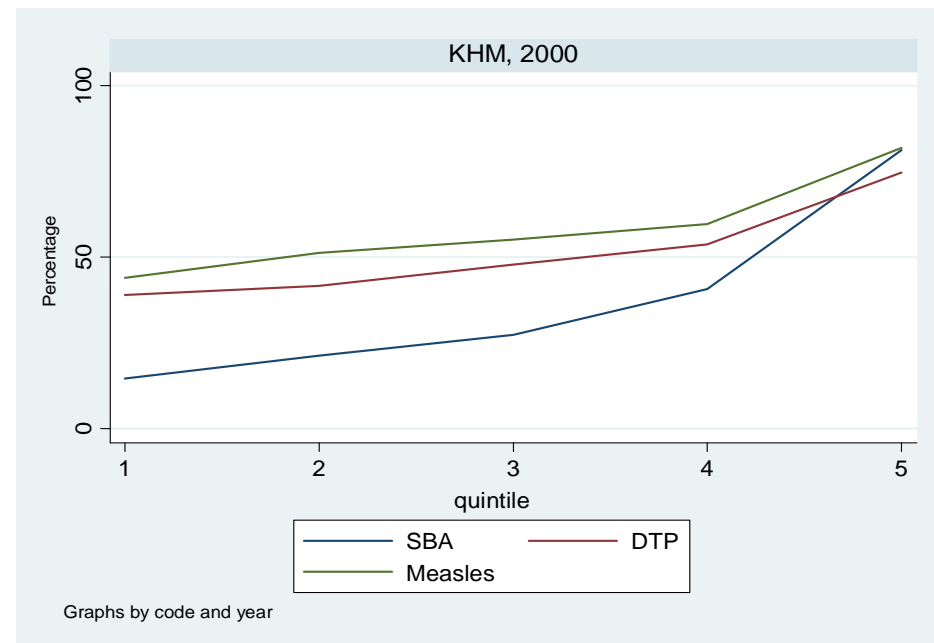
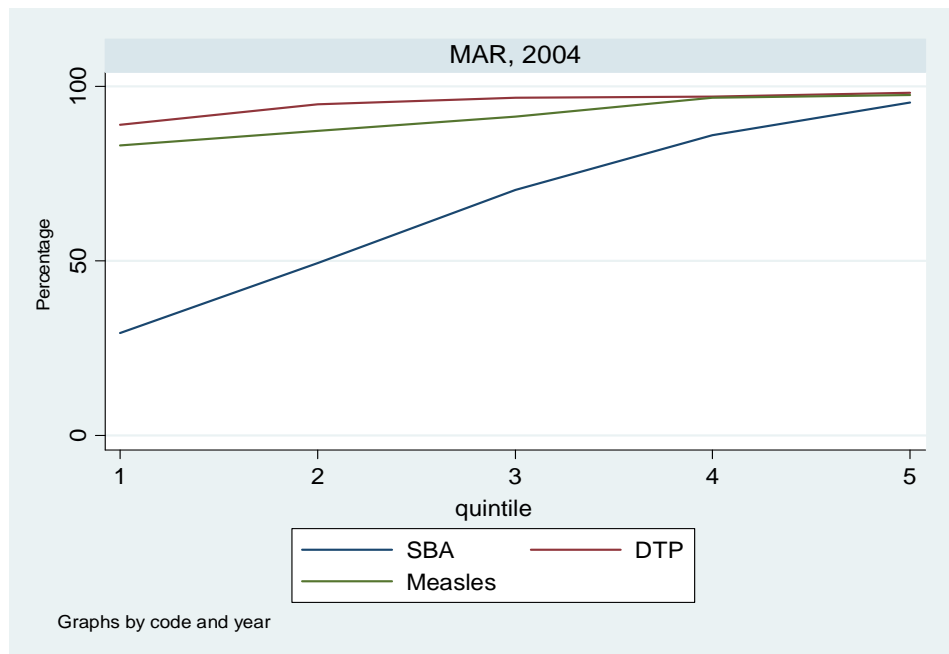
# Proposing Solutions: Protect the poor and vulnerable

## ● Special attention needs to be paid to the poor and vulnerable

*Options (in addition to prepaid and pooled resources) to ensure greater coverage and lower financial barriers:*

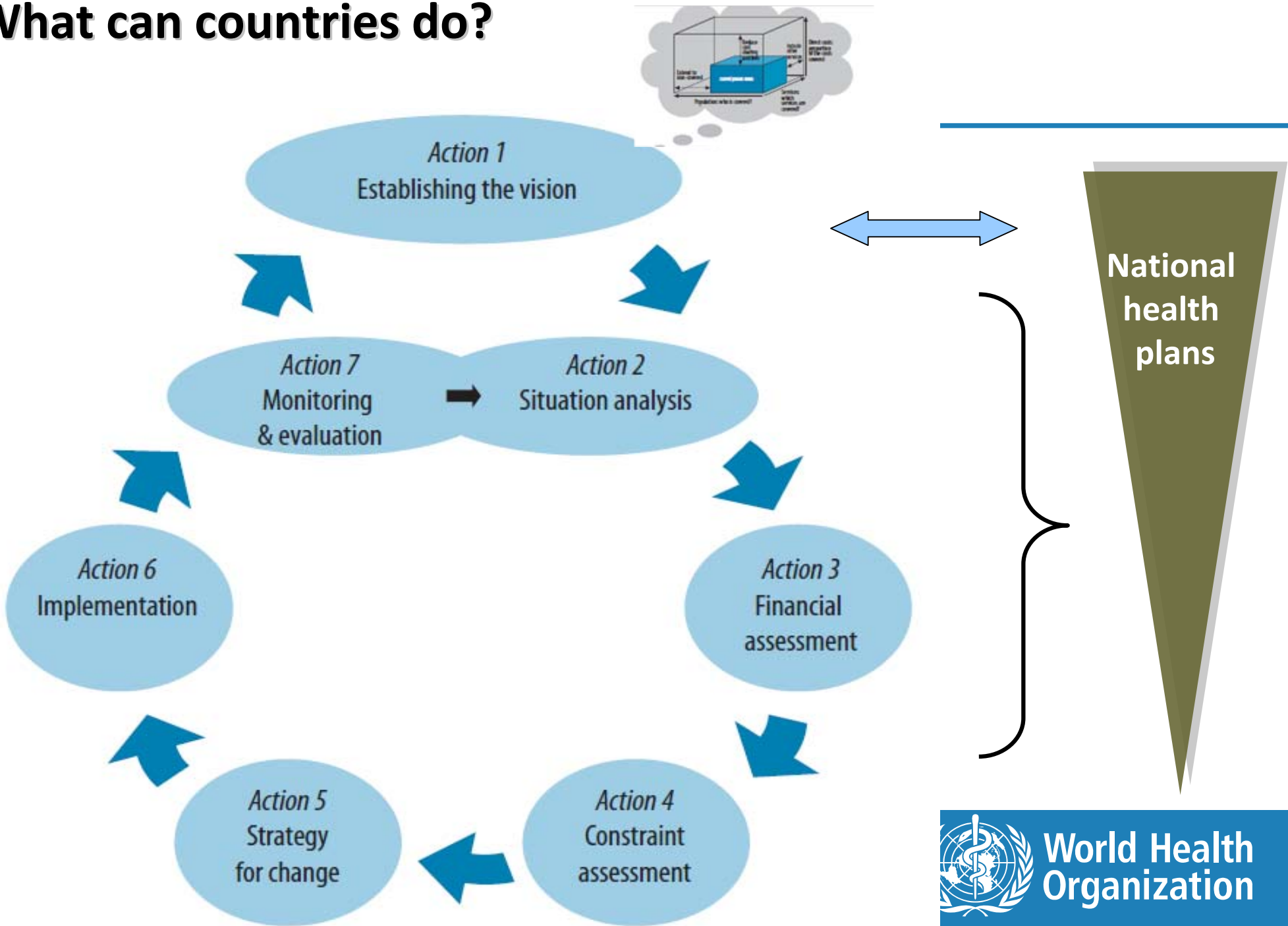
- ➔ **Free or subsidized services** (e.g. through exemptions or vouchers) for specific groups of people (i.e. the poor) or for specific health conditions (i.e. child or maternal care) e.g. Sierra Leone.
- ➔ **Subsidized or free enrolment in health insurance** –e.g. Mexico, Thailand
- ➔ **Cash payments** to cover transport costs and other costs of obtaining care reduce some financial barriers for the poor. Sometimes these are paid only after the recipient takes actions, usually preventive, that are thought to be beneficial for their health or the health of their families.

# Patterns of exclusion: delivery by a medically trained person (SBA), DTP3 (DTP) and MCV (Measles) – from DHS



- Overall coverage and level of inequity differ by types of services
- Generally access to delivery by medically trained person more inequitable than vaccination services

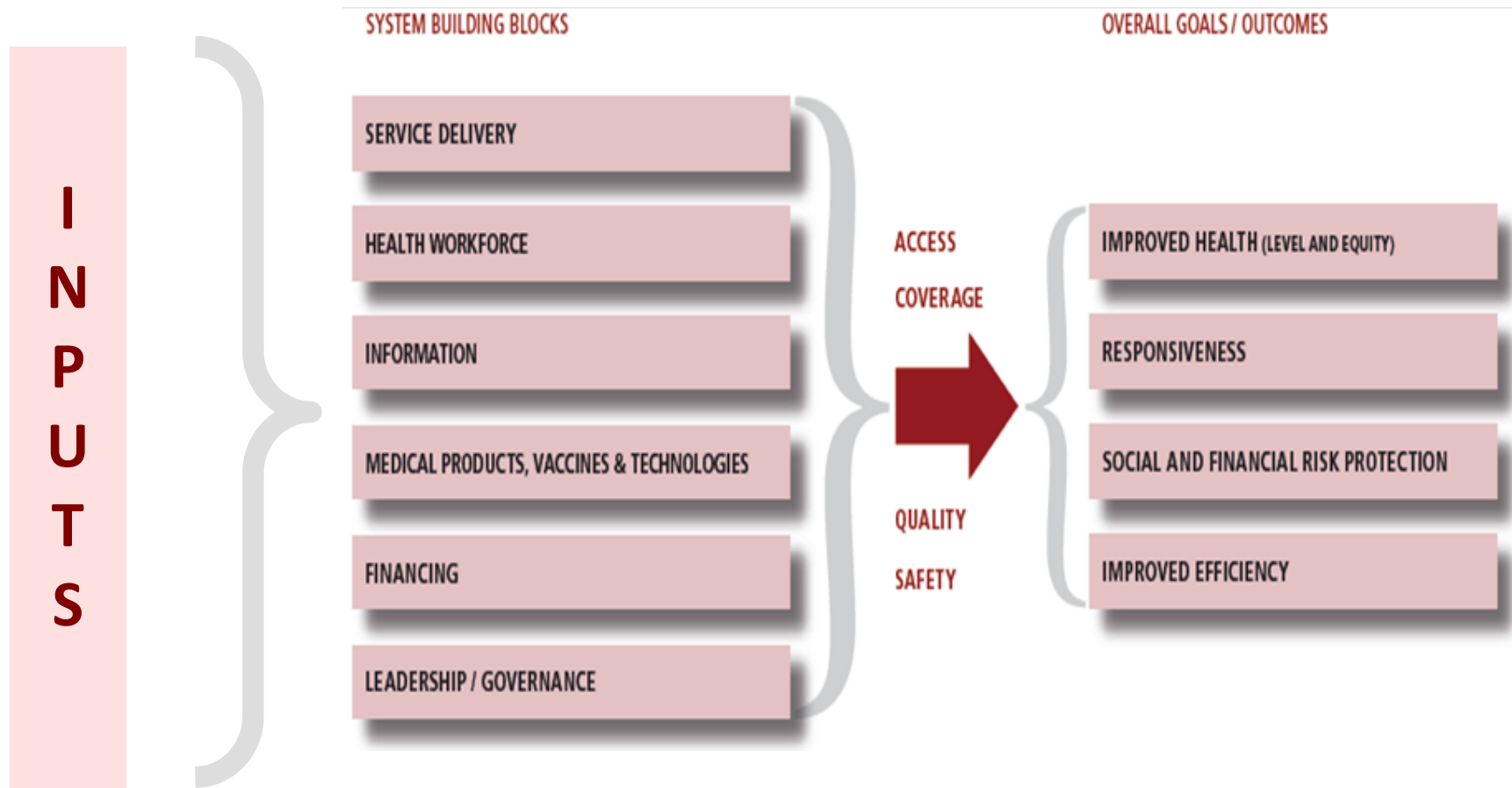
# What can countries do?



# Many interacting solutions but health financing is key

## WHO Framework for Assessing Health Systems

(World Health Report 2000; Everybody's Business 2006)



# What can the international community do? *Global solidarity with improved global efficiency*

- ➔ Keep current promises: Much of the current deficit in funding in low income countries would disappear if bilateral donors kept their existing promises. Increased, predictable and stable flows for health are necessary.
- ➔ Innovative international financing such as that undertaken by the Millennium Foundation is valuable to supplement traditional sources.
- ➔ Stop continually introducing more global initiatives with more secretariats at the international level, with funding being channelled through an increasing number of initiatives and mechanisms.



# *Global solidarity to build capacity in recipient countries*

1. Reduce the costs imposed on countries in accessing external funding - Rwanda has to report on 890 different health indicators to the various donors, almost 600 for HIV and malaria alone. Vietnam had 400 aid missions to review health projects in 2009.
2. Actively support countries to develop and implement domestic health financing strategies, and consistent health plans, to move more quickly towards universal coverage.
3. Buy into these plans and channel funds to countries in ways that build domestic financing capacities and institutions, rather than bypassing weak systems – e.g. fund Sector Wide Approaches, General Budget Support, health insurance systems.



## *WHAT NEXT?*

1. National reviews, situation analyses and dialogues – plans for developing financing systems for universal coverage. Sometimes might be part of a broader review of social protection. Multi-stakeholder participation. Strong interaction and iteration with National Health Plans.
2. More active evaluation and sharing of experiences of what works and what does not work.



# Summary

- ➔ The world is still a long way from ensuring that everyone can use needed health services without the risk of financial ruin.
- ➔ Even richer countries struggle to raise sufficient funds and to protect the poor and vulnerable in the face of aging populations and increasing options for improving and maintaining health.
- ➔ The **global community** can do more to raise needed funds in poorer countries to improve the efficiency of the global architecture, and to ensure that funds channelled to countries strengthened domestic financing institutions and capacities
- ➔ **All countries** can do something more to develop their financing systems to move closer to universal coverage or maintain it where it has been achieved

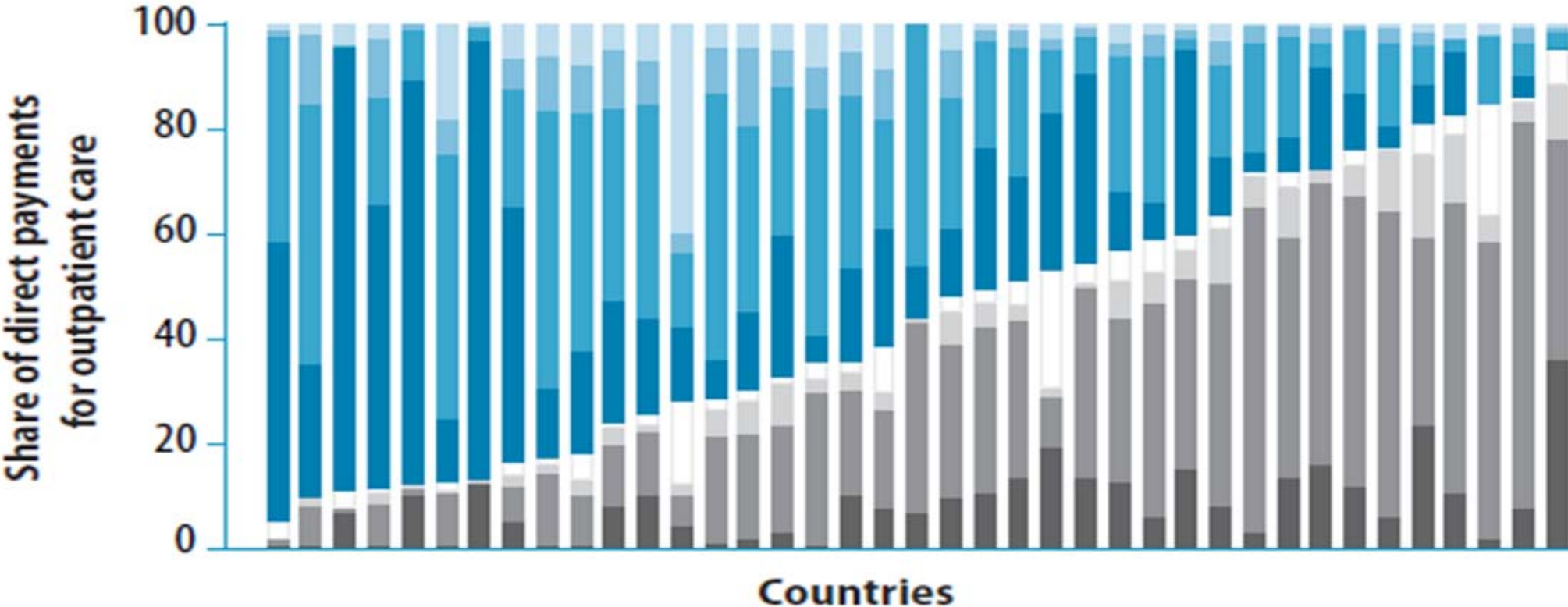


[www.who.int/whr/2010](http://www.who.int/whr/2010)



Thank you

**Fig. 3.3. Direct payments made at public and private facilities in 39 countries**



Private facilities:    ■ Consultation fees    ■ Medicines    ■ Tests    ■ Other

Public facilities:    ■ Consultation fees    ■ Medicines    ■ Tests    ■ Other