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Financing for Universal Health Coverage in low- and middle-income countries: a brief overview

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Introduction

The concept of universal health coverage (UHC) has amassed widespread political support and can be expected to retain momentum throughout the Sustainable Development Goals (SDG) agenda. Indeed, the argument has been won as pursuing UHC appears straightforwardly justifiable from a health systems performance and human rights perspective.[1] From a purely empirical perspective, evidence from multi-national panel data shows that greater coverage and greater pooled health spending indeed result in better population health.[2] Finally, there is agreement that investing in UHC makes good economic sense.[3,4]

Advancing towards UHC can translate into concrete in-country progress when policies relating to the main health system functions are aligned with the UHC goal. As a key health system function, health financing has received considerable attention to date in relation to the UHC agenda, not in the least because pursuing UHC requires substantial financial investment and governance reform. However, UHC is about more than health financing and increasing coverage, it is also about ensuring the quality of available interventions for those who need it.[5] This requires a system-wide response that includes, but is not limited to how health care is financed.

Governments face several fundamental health financing challenges in relation to UHC. Firstly, how to raise resources for it. Secondly, how to ensure/maintain financial risk protection. Thirdly, how to use resources efficiently.[6] The debate, particularly in low-income countries, can easily focus on bridging the financing gap for UHC, however it is important to acknowledge upfront that revenue collection is just one health financing function – pooling and purchasing deserve comparable consideration.

This note gives a brief overview of current knowledge on health financing for UHC in low- and middle-income countries (LMICs).

What has been done

A host of reforms touching all health financing functions have already been deployed during the past two decades with a view to improving one or more dimensions of UHC. Some countries have eliminated user fees (e.g. Sierra Leone[7]) to stimulate service utilisation, particularly among the poor, and improve financial protection. National health insurance has been introduced in others, funded through government funds, individual contributions (mandatory or voluntary) or a combination of the two (Table 1). Various types of taxes have been used to further finance the increase in coverage, either to fully fund UHC schemes (e.g. VAT tax in Ghana[8]) or in a complementary role (mobile phone and alcohol tax in Gabon).

Further health financing developments are underway. For example, South Africa is at an advanced stage of planning the rollout of national health insurance. Kenya's National Hospital Insurance Fund is increasing the mandatory contributions of formal sector enrolees for the first time since the scheme was launched in order to sustain the support increases in depth coverage and make insurance more attractive for those in the informal sector.

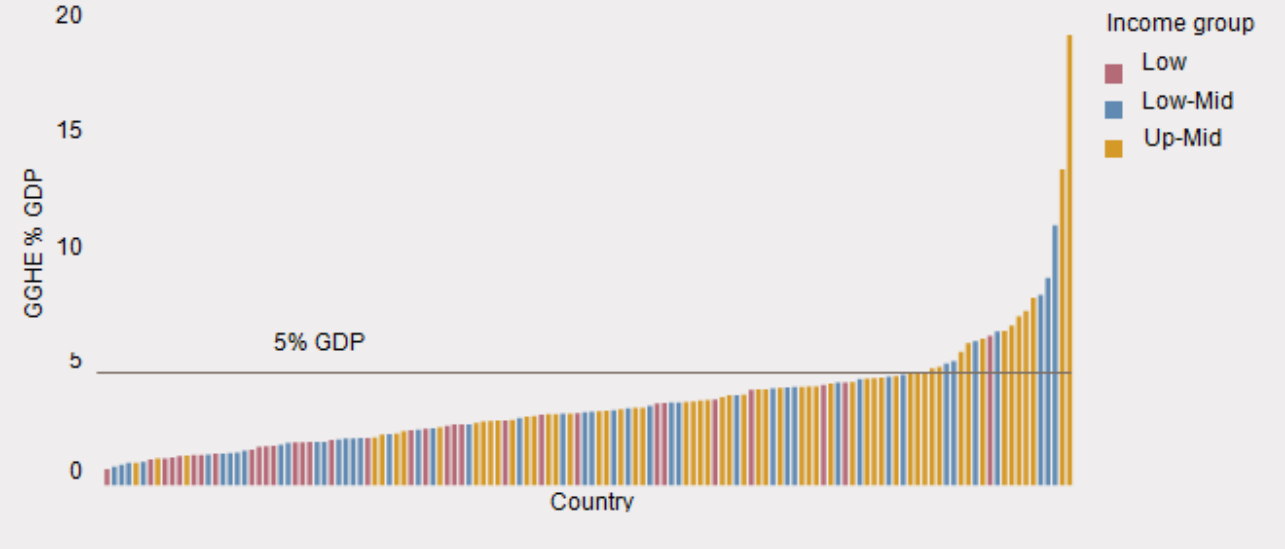
Table 1: Examples of health financing reforms in selected LMICs[9-12]

Type of initiative	Country examples
Introduce social and voluntary national health insurance	Ghana (NHIS, 2003), Indonesia (BPJS, 2004), Rwanda (Mutuelles, 2003), Vietnam (VSS, 2002; 2009), India (RSBY, 2008), Kenya (NHIF, 2002), Mali (Mutuelles, 2009), Nigeria (NHIS, 2009); Gabon (CNAGMS, 2007); Indonesia (Askeskin, 2004).
Taxes earmarked for specific UHC programs, non-UHC programs and general government health spending	Gabon (mobile phone and foreign transactions); Ghana (VAT); Costa Rica (luxury goods, alcohol, soda and imports); Jamaica (alcohol, petroleum, motor vehicles); India (alcohol); Guatemala (alcohol and tobacco); Mexico (alcohol and tobacco); Colombia (alcohol and tobacco); Thailand (alcohol and tobacco); Tunisia (transfers from parallel formal sector insurance program); Brazil (formulae for adjusting/benchmarking federal and municipal health expenditure).
Introduce new provider payment mechanisms	DRG systems in Indonesia, Thailand, Mongolia, Kyrgyzstan, Eastern Europe; case payments in Philippines, Ghana.

What is known

Despite growths in health expenditure over time, most LMICs are underspending in relation to estimated requirements for UHC and foreign aid will remain necessary. Several global benchmarks for government health expenditure have been proposed, primarily for advocacy purposes, including the $86 per capita (2012) for a comprehensive primary care package and 5% GDP (McIntyre and Meheus 2014). Although these benchmarks should be interpreted cautiously because they do not reflect country-specific needs, they are useful starting points for cross-country comparisons and for more detailed analyses. Low-income countries spend dramatically less than middle-income countries and much less than global benchmarks (Figure 1). External aid is likely to remain necessary in the medium term to complement domestic funds, particularly in low-income countries.

Figure 1: Government health expenditure in LMICs (%GDP)



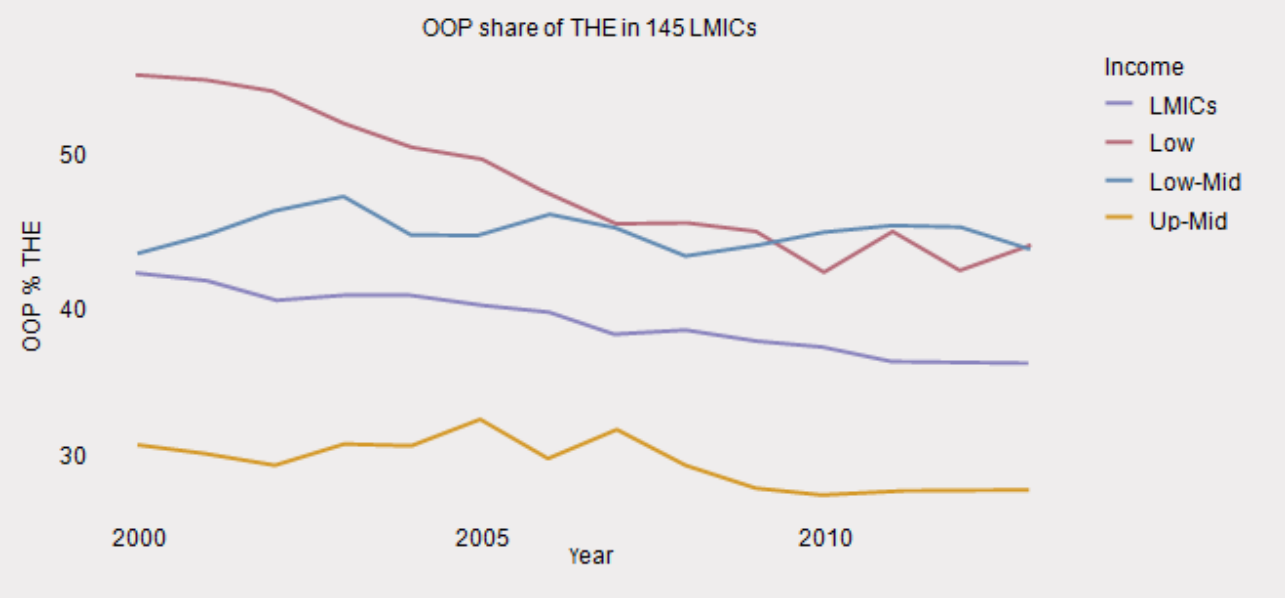
Source: OPM analysis of WHO Global Health Expenditure Database, 2013 data.

Government expenditure is key for financing UHC programmes, particularly for expanding service coverage among the poor. Countries that have advanced the furthest towards UHC also have high shares of public health expenditure. Approximately 70% of revenues across UHC programs covering the poor in 24 countries recently evaluated by the World Bank came from general

government revenues.[13] Specific coverage of the poor was non-contributory in all of these countries.

Out-of-pocket (OOP) payments remain an important financing source for health spending. The median OOP share has only improved slightly in LMICs since 2000 from 42% to 36% of total health expenditure (Figure 2), primarily driven by a sustained decrease in low-income countries. Despite this progress, the current OOP level remains too high given that the incidence of financial catastrophe and impoverishment falls to negligible levels when OOP represent less than 20% of Total Health Expenditure (THE),[6] therefore much more needs to be done to improve financial protection, particularly in low-income countries.

Figure 2: Median OOP share of Total Health Expenditure in LMICs, 2000-2013



Source: OPM analysis of WHO Global Health Expenditure Database, 2013 data.

Fiscal sustainability is a key consideration for UHC reforms. On the one hand, countries at early stages of their progress towards UHC are also the most dependant on external assistance for health, therefore must identify increasing domestic resources to finance UHC programs. On the other hand, countries that have already made important steps towards UHC must ensure the fiscal sustainability of existing programs. One policy lever that requires particular attention is the explicitness of benefit packages: loosely defined, comprehensive packages bear the risk of informal and inequitable rationing, while increasingly explicit packages are vulnerable to increased utilisation rates and the adoption of expensive health technologies. Thailand's example is a case in point: although a widely accepted example of progress towards UHC through a carefully formulated benefits package accompanied by a host of cost containment measures, the cost per member of the universal coverage scheme rose by 70% in real terms between 2002 and 2012.[14]

Most options available to governments for increasing domestic health expenditure imply serious trade- offs. The pros and cons of various approaches to increasing revenue, including taxes on income and goods/ services, have been discussed under the umbrella-term 'innovative financing'. Their potential to raise additional financing is mixed: while some countries have been using such mechanism to finance all or part of their national insurance schemes through taxes (e.g. 2.5% VAT tax in Ghana; 10% levy on mobile phone companies' turnover for coverage of the poor in Gabon), an OPM analysis for selected African countries pointed towards combined additional funding of less than 1% GDP,[15] much less than required for UHC and a highly optimistic estimate given that

no country can implement all mechanisms simultaneously. Improving health sector efficiency, on the other hand, has been indicated by several international analyses as a more promising avenue to free adequate resources; however, the 'how' of improving sector-wide efficiency has received less attention to date.

Mandatory financing mechanisms and reduced fragmentation of funding pools are widely endorsed as key health financing principles. Three decades worth of evidence have shown that voluntary insurance alone cannot be a main mechanism for UHC progress because of adverse selection, exclusion of the poor and financial unviability. There is now agreement that countries should fund their health systems primarily from mandatory sources, though voluntary prepayments can play a complementary role. Reducing fragmentation is particularly challenging because those benefitting from superior schemes, often those in the formal sector, are reluctant to give up their privileges. Experiences in Latin America (Costa Rica), Africa (Nigeria and Tanzania) and Asia (Thailand) show that extending insurance outside the formal sector can take decades.

UHC reforms appear to be most successful when their deployment is aligned with windows of opportunity such as election campaigns or support at the highest political level. Examples of reforms initiated during political windows of opportunity include the expansion of National Health Insurance coverage to all pregnant women in Ghana (2008), free health care for pregnant women and children in Sierra Leone (2010) and extending coverage to the entire informal sector in Thailand (2001). However, political will alone is insufficient. Insufficient awareness of health insurance benefits and lack of trust in the health sector can discourage utilisation and trump, as such, the benefits of an otherwise well-designed UHC program. Consequently, civil society, health professionals and the general public need to be involved in design and implementation, as well.

What is not (fully) known

UHC experience to date also identified key areas where more needs to be known in order to accelerate progress towards UHC through better designed programs. Some of the issues relevant for UHC health financing relate to:

- How can Ministries of Health demonstrate and improve value for money in the health sector in order to attract additional funding for health? While there is agreement that health is not sufficiently prioritised in many countries and requires more investment, there is often reluctance from Ministries of Finance to allocate additional funds in the absence of demonstrated value.

- What is the value of combining government revenues and mandatory contributory schemes in a single pool to minimise fragmentation? Most countries either follow one approach or the other for national schemes or have several pools financed through different means. There are few countries where the two are currently combined into a single pool (e.g. Costa Rica and Kyrgyzstan). What are the key learnings from different pooling arrangements?
- Which institutional arrangements are more conducive to strategic purchasing? This would entail, for example, comparing the effectiveness of public (e.g. autonomous institutions) and private (e.g. private insurance companies) organisations in purchasing services using public funds.

Insights from OPM country experience

We outline below several insights from OPM's country-level health financing work.

Morocco[16]

- Spending money better is essential, but identifying relevant and politically actionable areas for improvement requires careful analysis. While system-wide analyses can identify the magnitude of inefficiencies, they can only be the starting point for ensuring better value. Through in-depth analysis of the health system, in particular of the pharmaceutical and HRH sectors, OPM was able to propose and implement concrete measures to improve efficiency spending.
- Gradual solutions must be given a timeline. A clear work plan to achieve progress across all UHC dimensions must be agreed between Ministries of Health and Ministries of Finance so as to translate political promises into reality.
- Sound technical solutions are crucial, but can only go so far in isolation. Without the political commitment, the best laid out plans can easily accumulate dust in a locked cupboard.

Sierra Leone[17]

- Real political commitment is not enough. When announcing the removal of user fees in 2010, the president not only put all his political might in the balance, but also assigned technical working groups to devise a clear plan to reinforce the supply side and be able to cope with the increase in demand. The OPM evaluation of the Free Health Care Initiative showed that this was essential, but still not sufficient. Without additional resources, and additional fiscal space more broadly, the best of intentions can struggle to realise their potential.

Ethiopia[18]

- OPM's health financing work showed that additional resources in the country can be identified to fund the Government's ambitious plans. For example, gradually increasing health prioritisation in budgetary allocations coupled with increasing mandatory insurance contributions can reduce up to a third of the estimated financing gap.

- Health is prioritised based on different considerations from country to country. Understanding these considerations can guide the approach to health financing reforms. In Ethiopia, health is judged against its contribution to the economy, and the value for money of investing in health is contrasted with investment in more obviously productive sectors.

The way forward

While the key health financing principles to follow appear clear, their implementation is very much an open field. As more and stronger research results become available on the 'whys' of failure and success, it is equally important to also invest in practical tools that can support decision-makers in acting upon available knowledge and design effective policies, such as those produced by the Joint Learning Network.

For example, the concept of fiscal space for health has been applied to identify feasible sources for additional health expenditure. However, it has been applied largely retrospectively and there is no unified methodology to support prospective applications. Furthermore, there are tools available to assess technical and allocative efficiency in the health sector, but they currently say little about what is actionable and what are the expected benefits. Investing in such areas is essential to support effective knowledge translation and accelerate UHC progress.

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